GAPWISE ULTRA 2021

1. INTRODUCTION

This policy is underwritten by GENRIC Insurance Company Limited (GENRIC) (FSP 43638) GENRIC is an Authorised Financial Services Provider andregistered Short-Term Insurer.

This is not a medical scheme, and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership. Membership of a valid medical scheme registered in terms of the Medical Schemes Act 131 of 1998 is required to qualify for coverunder this policy.

This is a Short-term Insurance accident and health policy regulated by the Financial Sector Conduct Authority (FSCA) and Prudential Authority (PA)under auspices of the Short-Term Insurance Act 53 of 1998 and the Insurance Act 18 of 2017.

The Overall Annual Limit (OAL) of **R183 000** (one hundred and eighty-three thousand rand) per beneficiary per annum.All fees, commissions, benefits, and premium values quoted are inclusive of Value Added Tax (VAT).

2. BENEFITS UNDER THIS POLICY

This policy covers the below for both planned and emergency treatments (unless stated otherwise) within the borders of South Africa by aregistered medical professional registered with the Health Professionals Council of South Africa.

2.1. In-Hospital

All benefits in this section are subject to the Overall Annual Limit (OAL).

2.1.1 Gap Cover:

- This benefit covers an additional 500% of the difference between your medical scheme rate and what a provider charges for in-hospitaltreatment. Subject to overall annual limit.

2.1.2 Co-Payment Cover:

- This benefit covers co-payments or excesses imposed by your medical aid up to **R15 000** per admission. This benefit excludes oncologyco-payments. Please refer to “Cancer” benefit below.

2.1.3 Admission Fee Cover:

- This benefit covers admission fees required at a private hospital prior to being admitted up to **R5 000** per admission.

2.1.4 Penalty Fee Cover:

- This benefit covers penalty fees imposed by your medical aid when making use of a hospital outside of the approved

- network up to **R5000** per admission. **R10 000** per beneficiary per annum.

2.1.5 Appliance Benefit:

- This benefit covers the difference between your medical scheme rate and cost of defined list of appliances up to **R3 000** per beneficiaryper annum. Appliances covered:

  - Hearing Aids,
  - Wheelchairs,
  - C-PAP Machine,
  - Humidifiers,
  - Insulin Pump,
  - Glucometer,
  - Nebulisers,
  - Intraocular Lenses

2.1.6 Emergency Room Benefit:

- This benefit covers any casualty event at a registered medical facility where immediate treatment is required for illness or accident andtrauma. Limited to **R5 000** per beneficiary per annum.

2.1.7 Hospital Account Shortfall Cover:

- This benefit covers shortfall between the hospital account and what the Medical Scheme has paid relating to hospitalisation. EachBeneficiary is entitled to 3 claims per annum limited to **R1 500** per claim.

2.1.8 Day-Hospital Cover:

- This benefit covers the difference between your medical scheme rate and what a provider charges for surgical procedures performed asan out-patient in clinics, day hospitals or consultation rooms.

2.1.9 Sub-limit Enhancer

- Applicable where benefit limit on your medical scheme has been reached for internal prosthetics, MRI scans or CT scans. Limited to **R20 000** per claim up to **R40 000** per beneficiary per annum.

2.2. Cancer

All benefits in this section, except Initial Diagnosis, are subject to the Overall Annual Limit (OAL) limit.

2.2.1 Initial Cancer Diagnosis

- Lump sum payment of **R20 000** per beneficiary on the initial diagnosis of cancer as defined.

2.2.2 Cancer Shortfall Cover

- **R164 000** per beneficiary per annum for any Gap or Co-Payment paid from the oncology benefit or as part of your oncology treatmentplan.

2.2.3 Cancer Top-Up

- **R100 000** per beneficiary per annum where scheme imposes a Rand value limit for cancer cover and can only be accessed once this limithas been reached and further treatment is required.

2.2.4 Reconstructive Surgery Benefit

- 300% of Gap portion where reconstructive surgery of effected breast is approved by the medical scheme subject to the **R100 000** limit forCancer Top-Up benefit.
- Additional **R25 000** stated benefit for reconstruction of unaffected breast.

2.3 Day-to-Day

All benefits in this section are subject to the Overall Annual Limit (OAL) limit.

2.3.1 Primary Care Benefit

Gap portion of consultations fees only. 3 claims per beneficiary per annum for each of the following:
- **General Practitioners:** 3 claims per beneficiary at R200 per consultation.
- **Dentists:** 3 claims per beneficiary at R200 per consultation.
- **Alternative Care Providers:** 3 claims per beneficiary at R300 per consultation.

2.3.2 Specialist Consultation

Gap portion of day-to-day specialist consultation. 3 claims per beneficiary per annum up to **R1 000** per consultation.

2.3.3 Preventative Care

Gap portion of treatment or procedures related to the below preventative procedures. **3** claims per beneficiary per annum up to **R1 500**
per claim. Procedures covered:

- Pap smear
- Cholesterol test
- Blood glucose test
- Flu vaccination
- Childhood immunisation (up to 12 years old)
- Bone density scans
- Prostate specific antigen tests
- Mammogram
- Contraceptive device implantation

2.4 Value Added Benefits

Benefits in this section are not subject to Overall Annual Limit

2.4.1 Accidental Death

In the event of accidental death of any of the beneficiaries covered under this policy a lump sum will be paid as below:

- Principal Beneficiary: R15 000
- Adult Dependant: R10 000
- Child Dependant: R5 000
- GapX Premium Waiver

In the event of death or permanent disability of the premium payer, premiums will be covered for a period of 12 months. Premium cannot betransferred or converted to cash.

2.4.2 Medical Aid Contribution Cover

In the event of death or disability of the contribution payer, this policy will pay towards the medical aid contribution of the policyholder upto **R5 000** per month for a period of 6 months. Proof of cover with medical scheme to be supplied monthly.

3. Waiting Periods and Exclusions

3.1 General Waiting Periods

Unless stated otherwise under endorsements, all newly incepted policies are subject to:

- A 3-month general waiting period.
- In the event of an option upgrade, 3-month general waiting period will apply on the additional benefit or limits.
- A 10-month waiting period on pre-existing conditions, diseases or illnesses.
- 10 month waiting period for pregnancy and confinement.
- 12 month waiting period on all pre-existing cancer treatments.

3.2 Policy Specific Waiting Periods

The following list of conditions is subject to a 10-month waiting period with 50% of benefit accessible from month 7 to 10:

3.2.1 Myringotomy and Grommets,
3.2.2 Adenoidectomy,
3.2.3 Tonsillectomy,
3.2.4 Hysterectomy where not malignant,
3.2.5 Spinal, back, neck, and joint related procedures where not due to an accident.

3.3 Policy Specific Exclusions

No benefit will be provided, or claims assessed in case of the following:

3.3.1 The first 100% of the medical scheme tariff.
3.3.2 Any claims rejected or not authorised by your medical scheme unless defined as a stated benefit under this policy wording.
3.3.3 Claims that exceed benefit limits or the Overall Annual Limit as stated in this policy wording.
3.3.4 Experimental treatments and medications.

3.4 General Policy Exclusions

Unless specifically mentioned in this policy wording, no benefit will be provided or claims assessed for any condition, disease, injury, illness,consequence of treatment resulting from or associated with:

3.4.1 Any claim that must be paid in terms of any other act such as the Compensation for Occupational Injuries Act 90 of 1993, the RoadAccident Fund Act 56 of 1996.
3.4.2 Any psychiatric or psychological condition or disorder.
3.4.3 Suicide, attempted suicide, or injury as a result of self-harm.

3.4.4 Medication, drugs, prescriptions, consumables, and equipment used. Devices, such as artificial joints, braces, crutches, dental implants, orthodontic, prosthodontic and all cosmetic dentistry including all forms of internal and external prosthesis as defined, unless specifiedas part of the benefit entitlement of this policy.
3.4.5 Cosmetic surgery unless specified under any benefit in this policy.
3.4.6 Robotic surgery, specialised mechanical, or computerised appliances or equipment.
3.4.7 Any illness, injury or condition resulting from or directly associated with professional sport.
3.4.8 Any claim arising directly or indirectly from active involvement in war, invasion, act of a foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or political risk of any kind, or any act of any person acting on behalf of orin connection with any organisation, group or activity aimed at overthrowing any government by force or any deliberate act of terrorism or violence.
3.4.9 Any riot, strike or public disorder (including civil commotion, labour disturbances or lock-out) or any act or activity resulting in orcalculated to bring about riot, strike or such disorder.
3.4.10 Active military duty, police duty, police reservist duty, civil commotion, labour disturbances, riot, strike or the activities of locked outworkers.
3.4.11 The act of any lawfully established authority, police force, security force or any other local, provincial or national body, in controlling,preventing, suppressing or in any other way dealing with any event referred to in the clauses above.
3.4.12 Compensation in terms of the War Damage Insurance Act 85 of 1976.
3.4.13 Nuclear weapons or nuclear material, ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel. For the purpose of this exception combustion shall include any self-sustaining process ofnuclear fission.
3.4.14 Any loss arising from any contractual liability.
3.4.15 Any consequential loss or damage whatsoever.
3.4.16 Any attempt by you to commit an unlawful act.

4. How this Policy Works

This policy is effective and provides cover after receipt of first month premium from the date of inception as indicated on the policy schedule up to thecancellation date indicated on the policy schedule or such time where two or more premiums are outstanding. This policy will renew on the 1st of January every year unless cancelled

This policy wording, together with your policy schedule and endorsements, are the basis of your cover under this policy. Please ensure you are familiarwith these documents and that the information displayed on the schedule of insurance is accurate and up to date.

All beneficiaries listed on the schedule of insurance is covered under this policy. Any person(s) covered on the medical scheme of any of the beneficiaries but not listed on the schedule of insurance is not covered under this policy. Dependants should be related, dependant on or codependantto be covered under one policy.

Any dependants added after the original inception date of the policy will be subject to underwriting, applicable to that beneficiary only, from the datecovered.

5. Claim Payments

Claims have to be submitted within **90** days of payment of the medical scheme and any claims submission needs to be accompanied by the medicalscheme statement and the accounts of the relevant providers that were short-paid by the scheme. In certain cases, more documentation may be required to substantiate the claim.

Claims will only be assessed for payment if the following is met:

- Beneficiary is covered under this policy and premiums are up to date at date of treatment.

- Claim has been validated and benefit for the assessed claim or treatment has been confirmed.
- Any documentation required to accurately assess the claim has been received.

Claims will be paid to the nominated account and in the absence of a nominated account to the account premiums are collected from. In the event thatthe account holder is deceased, claims will be paid to the deceased estate.

6. Claim disputes

The policyholder can, within **90** days of payment or notice of rejection, lodge a dispute in writing either on our website or by sending an email tocomplaints@genric.co.za.

You will be provided written feedback within **31** days of submission and any further disputes may be raised with the Ombudsman for Short-termInsurance.

An additional **6** months, following the initial **121**-day period, will be provided to the policyholder to consider any legal action. Following this periodyour claim will be deemed prescribed.

7. Premiums

Premiums are calculated per beneficiary any are determined by the age of the beneficiary at the date of inception of the policy and subsequentrenewal dates.

It is the responsibility of the principal policy holder to ensure premiums are up to date.

Premiums are billed monthly and payable in the month for the month of cover. Premiums will only be collected via debit order on selected days. If weare unable or unsuccessful in collecting your premium on the agreed date, a double debit will be collected the next month. If this debit is also unpaid, the policy will be cancelled effective the last day of the month for which premium was received.

8. Refunds

Other than the death of the policyholder, refunds will only be considered up to a maximum of **3** months.

9. Conditions

9.1 Jurisdiction and Territorial limits

Only expenses incurred within the borders of the Republic of South Africa will be covered under this policy.

This agreement shall be governed, interpreted, and construed in accordance with the laws of the Republic of South Africa. Any legal action or proceedings arising out of or in connection with this policy which is to be instituted in a court of law shall be brought in the Court of South Africaand irrevocably submitted to the exclusive jurisdiction of such court.

9.2 Fraud, misrepresentation, and non-disclosure

Your application form with completed health questionnaire and any subsequent changes or policy endorsements form the basis of this policy.Any material non-disclosure or incomplete information may lead to this policy be terminated or declared null and void.

10. Consent clause

By entering into this policy, you hereby consent to the sharing of claims or underwriting information with any third party in relation to, but not limitedto, any of the following:

- Assisting with risk assessment and underwriting.
- Protection against fraudulent claims.

11. Complaint procedure

Any complaints must be submitted in writing to complaints@genric.co.za and will be responded to within 30 days. If you are not satisfied with thefeedback, you may direct your complaint to the Ombudsman for Short-term Insurance:

The Short-term Insurance
OmbudsmanP O Box 32334,
Braamfontein, 2107
(011) 726 8900
info@osti.co.za

12. Definitions

12.2 **Accident:** An event that occurs unintentionally and usually results in harm, injury, damage, or loss. Policy cover only extends toaccidents occurring after inception of the policy.

12.3 **Accidental Death:** An event that results in an accidental death.

12.4 **Acute:** A condition, which is generally unforeseen, of rapid onset in nature, is severe and treatable, but does not last for a prolongedperiod and is therefore not chronic.

12.5 **Acute Hospital:** A hospital that treats all major and minor conditions.

12.6 **Admission Fee:** The fixed amount you have to pay in terms of your Medical Scheme Rules when you are admitted to hospital as an In-Patient.

12.7 **Appliances:** An instrument or device designed for a particular medical use.

12.8 **Beneficiary:** A person(s) other than the policyholder of an insurance policy who is entitled to receive benefits.

12.9 **Body Mass Index (BMI):** A measurement tool to establish the ideal weight of a person based on weight and height. Additional fees arecharged for management of patients who fall outside the prescribed BMI.

12.10 **Cancer:** Diseases in which abnormal cells divide without control and are able to invade other tissues. This definition includes leukaemia,lymphoma and Hodgkin's disease but specifically excludes benign, pre-cancerous/in-situ tumours or growths as well as all stage zero cancer diagnoses. Any cancer that is diagnosed and treated through primary biopsy and not requiring additional intervention such as radiation therapy- or chemotherapy shall not be deemed as cancer and will not have any benefit paid.

12.11 **Certificate of Membership (COM):** An official document issued by your medical scheme or Gap Cover Provider indicating all relevantbeneficiaries, waiting periods and/or contributions/premiums applicable to the medical scheme/policy.

12.12 **Consumable medical supplies:** Non-durable medical supplies that:
- Are usually disposable in nature;
- Cannot withstand repeated use by more than one individual;
- Are primarily and customarily used to serve a medical purpose.

12.13 **Contraceptive Devices:** Devices used to prevent pregnancy, including the diaphragm, condom, and intrauterine devices.

12.14 **Co-Payment:** The fixed amount excess imposed in terms of your Medical Scheme Rules for undergoing a specific procedure whether inor out of hospital. This will include, for example MRI, CT and Ultrasound Scans and scopes.

12.15 **Council of Medical Schemes (CMS):** A statutory body established by the medical schemes act (131 of 1998) to provide regulatorysupervision of private health financing through medical schemes.

12.16 **Corrective procedures:** In relation to Cosmetic procedures that aim to correct function or structural defect.

12.17 **Cosmetic Surgery:** Procedures performed to repair, change or restore body parts to look normal, or to change a body part to lookbetter.

12.18 **Dependant:** Someone who is dependant upon the policy owner for access to the benefits available within this policy.

12.19 **Designated Service Provider (DSP):** The hospital/specialists/network providers prescribed by your Medical Scheme Rules where youcan obtain diagnosis and treatment benefits without co-payments or penalties.

12.20 **Diagnostic:** A procedure or test which is performed to find out what is wrong with a patient. Diagnostic procedures do not aim to treator cure a condition but is informative and exploratory in nature. This includes, for example, any examination, such as laboratory diagnostic or x-ray examination that does not result in a bona fide non-medical expense cover as a result of hospitalisation for treatment purposes.

12.21 **Elective procedures:** Treatment that is not clinically essential such as surgery to correct a cosmetic condition that is not life-threatening.

12.22 **Emergency treatment:** A serious situation or occurrence that happens unexpectedly and demands immediate medical attention in theEmergency Room.

12.23 **Excess:** The first portion of any claim payable by you before cover commences.

12.24 **Family:** This is defined as a group consisting of parents and children living together in a household.

12.25 **General Waiting Period:** A Period in which a policyholder is not entitled to claim any, or may only claim certain, policy benefits.

12.26 **Gap Portion:** The difference between the amount charged by the service provider and the Medical Scheme tariff.

12.27 **Hazardous/Dangerous (Sport):** Participation in extreme sports*:

- Abseiling.
- Mountaineering.
- Rock climbing.
- Hang gliding.
- Micro-lighting.
- Base jumping.
- Parachuting.
- Skiing.
- Hunting.
- Kite surfing.
- Underwater activity involving the use of artificial breathing apparatus.
- All other forms of racing or speed trial or contest.

*The **Underwriter** reserves the right to add to this list from time to time.

12.28 **Health Event:** An event relating to the health of the body of the Beneficiary person, adversely affected by illness or injury and necessitatingbona-fide In-Patient non-medical expense cover as a result of hospitalisation and Out-patient procedures or other treatment approved by the Underwriter.

12.29 **Hospital:** An institution providing medical, surgical treatment and nursing care, for sick or injured people. This definition includes dayhospitals and clinics.

12.30 **Non-medical expense cover as a result Hospitalisation:** Confinement in a hospital as a resident In-patient under the

12.31 professional care ofa Registered Medical Professional as defined below and approved by the Insurer.

12.32 **ICD-10 Coding:** The International Classification of Diseases is a diagnostic coding standard that was adopted by the South Africannational Department of Health in 1996.

12.33 **Illness:** A disease or period of sickness affecting the body, which warrants treatment at an emergency facility.

12.34 **Incident:** Any single discrete occurrence of a health event/claim incident, including all costs related to the original event.

12.35 **Individual:** A single human being as distinct from a group or family.

12.36 **Initial Diagnosis:** The very first clinically confirmed diagnosis of any form of cancer, specifically excluding preliminary, tentative or otherdiagnosis not supported by clinical evidence of malignancy This definition excludes any incidence of cancer/pre-cancer prior to inception of the policy.

12.37 **Injury:** Damage to a body part sustained in an unforeseen future event, caused solely and directly by violent, accidental, external andvisible means independant of and untraceable to any other cause.

12.38 **In-patient:** A patient who is "admitted" as a resident to the hospital as an "in-patient" and who spends time in a hospital ward admittedas such.

12.39 **In Room Procedures:** A procedure in a surgical suite that meets the requirements of a restricted area and is designated and equippedfor performing surgical operations or other invasive procedures that require an aseptic field which would/could ordinarily be undertaken in an Acute facility.

12.40 **Insurance Company/Insurer:** The Insurance Company, indicated on your Schedule of Insurance, which offers insurance policies inreturn for premiums.

12.41 **Medical Scheme:** A medical scheme is a form of insurance where you pay a monthly amount, called a contribution in return for financialcover for medical treatment you may need as well as any related medical expenses.

12.42 **Medical Scheme Premium Waiver:** Only in event of Death and or Total Permanent Disability of the premium payer, will we contributetowards your medical scheme payments, provided the Medical Scheme membership is active for a 6- month period. See benefit description.

12.43 **Medical Scheme Rate:** It means the set fee that your scheme pays the service provider (doctor, hospital).

12.44 **Medical Specialist:** A practitioner who has completed advanced education and clinical training in a specific area of medicine, which includes but are not limited to Cardiologists, Gastroenterologists, Gynaecologists, Oncologists, Ophthalmologists, Orthopaedic surgeons, Physicians, Paediatricians & Urologists. For purposes of this policy the definition specifically excludes all Basic and SpecialisedDentistry, Optometry, Orthodontics, Orthotics, Physiotherapy, Psychiatry, Supplementary and Complementary Medical Practitioners aswell Pathology and Radiology unless defined.

12.45 **Oncology Co-Payment:** The percentage excess/co-payment your Medical Scheme imposes on claims paid after you reach your annualOncology Limits. (Oncology Co-payments are only covered under the Cancer Benefit).

12.46 **Out-Patient:** Any consultation, investigative test or surgical procedure that a Registered Medical Professional performs whilst you arenot admitted as a hospital in-patient or any intervention that would not clinically require in-patient admission to a hospital.

12.47 **Overall Annual Limit (OAL):** The total value of the compensation allowed for all aggregated claims as defined within this schedule, perbeneficiary registered on the policy.

12.48 **Penalty Fee:** The amount you have to pay in terms of your Medical Scheme Rules when you are admitted to hospital that is not a DSPas provided for in your Medical Scheme Rules.

12.49 **Policy:** The formal contract issued by the Insurer, which contains terms and conditions of the short-term insurance cover and serves asits legal evidence.

12.50 **Policy Owner/Policyholder:** If you own an insurance contract or policy, you are a policyholder, also known as the policy owner. As apolicyholder, you may also be the person covered by the policy.

12.51 **Pre-existing Conditions:** Any illness, injury, condition, or disorder which existed before this policy activated.

12.52 **Prescribed:** The expiry or lapsing of legal rights in terms of the policy.

12.53 **Prescribed Minimum Benefits (PMB):** A set of benefits as defined in the Medical Schemes Act and Regulations which ensures that allscheme members have access to certain minimum health benefits, regardless of your Medical Scheme Option. This includes a requirement for Medical Schemes to pay the full cost of diagnosis and treatment of a list of medical conditions.

12.54 **Prescribed Period:** A defined 12 (twelve) month benefit cycle determined from your date of inception.

12.55 **Principal:** The Signatory to the application for inception of the policy.

12.56 **Professional sport:** This is a sport which is registered where an individual derives their livelihood (income) from fulltime participation insaid sport.

12.57 **Prosthesis (Internal or External):** Replacement or repair of tissues by prosthetic devices, permanent or temporary, weight bearing or non-weight bearing, free or fixed and the removable replacement of a missing body part, specifically through trauma, disease and orcongenital conditions.

12.58 **Psychiatric or psychological condition:** Any kind of mental illness and disability. This includes all forms of major affective disorders, anxiety disorders, psychiatric conditions and all other mental disorders outlined under ICD-10 Coding F01:F99–Mental, Behavioural &Neurodevelopmental disorders.

12.59 **Registered Medical Professional:** A person legally licensed and duly qualified to practice medicine and surgery (other than the Beneficiary or a member of the Beneficiary's immediate family). This includes people legally licensed, duly qualified and registered in theSpecialist Register of the Health Professional Board of the Republic of South Africa and recognised as such by the Insurer.

12.60 **Scholar:** A Beneficiary that is attending primary or secondary school. This definition specifically excludes any student or attendant of atertiary institution.

12.61 **Surgical Procedure:** A course of action with the intention of treating, curing, or restoring anatomical functions or structure andspecifically excludes rehabilitation and other policy exclusions, not specifically defined as covered.

12.62 **Trauma/Counselling:** Serious injury to the body, as a result of physical violence or an accident.

12.63 **Treatment:** Services provided to a patient, by a specialist or therapist approved by the Underwriter for acute, life-threatening medicalconditions.

12.64 **Treatment Plan:** A plan developed and approved by your medical scheme in consultation with the relevant medical practitioner.

12.65 **Total Permanent Disability:** Means that because of a sickness or injury, a person is unable to continue work in their own or anyoccupation for which they are suited by training, education, or experience.

PROCESSING OF INSURANCE INFORMATION

Your privacy is of utmost importance to Us. We will take the necessary measures to ensure that any and all information, including Personal Information (as defined in the **Protection of Personal Information Act 4 of 2013**) provided by You or which is collected from You is processed in accordance with the provisions of the Protection of Personal Information Act 4 of 2013 and further, is stored in a safe and secure manner.

You hereby agree to give honest, accurate and up-to-date Personal Information and to maintain and update such information when necessary.

You accept that Your Personal Information collected by Us may be used for the following reasons:

- to establish and verify Your identity in terms of the Applicable Laws;
- to enable Us to fulfil Our obligations in terms of this Policy;
- to enable Us to take the necessary measures to prevent any suspicious or fraudulent activity in terms of the Applicable Laws; and reporting to the relevant Regulatory Authority/Body, in terms of the Applicable Laws.

We may share Your information for further processing, with the following third parties, which third parties have an obligation to keep Your Personal Information secure and confidential:

- Payment processing service providers, merchants, banks and other persons that assist with the processing of Your payment instructions;
- Law enforcement and fraud prevention agencies and other persons tasked with the prevention and prosecution of crime;
- Regulatory authorities, industry ombudsmen, governmental departments, local and international tax authorities, and other persons that We, in accordance with the Applicable Laws, are required to share Your Personal Information with;
    - Credit Bureaus;
    - Our service providers, agents and sub-contractors that We have contracted with, to offer and provide products and services to any Policyholder in respect of this Policy; and
    - Persons to whom We cede Our rights or delegate Our authority to, in terms of this Policy.

You acknowledge that any Personal Information supplied to Us in terms of this Policy is provided according to the Applicable Laws. Unless consented to by Yourself, We will not sell, exchange, transfer, rent or otherwise make available Your Personal Information (such as Your name, address, email address, telephone or fax number) to any other parties and You indemnify Us from any claims resulting from disclosures made with Your consent.

You understand that if We have utilised Your Personal Information contrary to the Applicable Laws, You have the right to lodge a complaint with GENRIC and Sirago, should GENRIC and Sirago not resolve the complaint to Your satisfaction, You have the right to escalate the complaint to the Information Regulator.

You also similarly give consent to the sharing of information in regards to past insurance policies and claims that you have made. You also acknowledge that information provided by yourself or your representative may be verified against any legally recognised sources or databases.

By insuring or renewing your insurance you not only consent to such information sharing, but also relinquish any rights of confidentiality with regards to underwriting or claims information that you have provided or that has been provided by another person on your behalf.

In the event of a claim, the information you have supplied with your application together with the information you supply in relation to the claim, will be included on the system and made available to other insurers participating in the prevention of fraudulent and any criminal behaviour or activity.