Administered by The HTC (PTY) LTD (Reg No.2004/033029/07) otherwise referred to as "HUB"
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CLAIMS MANAGEMENT FRAMEWORK

HUB FINANCIAL SERVICES

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Authorised Financial Services Provider
Registration Number: 2004/033029/07
License number:38683

1. Introduction

The HUB (Pty) Ltd is a Retail company and Authorised Financial Services provider who care about the wellbeing of our Policyholders and beneficiaries. We have a duty to provide services which are transparent, honest, fair and ethical at all times.

2. Objective

In the best interest of our Policyholders, our Claims Management Framework must ensure that:

2.1 It is appropriate for the Business model, policies, services and policy holders and beneficiaries:

2.2 Take reasonable steps to gather and investigate all relevant and appropriate information and circumstances, with due regard to the fair treatment of claimants, and

2.3 Does not impose unreasonable barriers to claimants

3. Important Definitions:

- **"Beneficiary"** in respect of a –
  registered insurer means –
  a person nominated by the Policyholder as the person in respect of whom the Insurer should meet policy benefits; or licensed Insurer, has the meaning assigned to it in Schedule 2 of the Insurance Act;

- **"Business Day"** means any day excluding a Saturday, Sunday or public holiday.

- **"Claim"** means, unless the context indicates otherwise, a demand for any policy benefits by a Claimant in relation to a policy, irrespective of whether or not the Claimant's demand is valid;

- **"Claimant"** means a person who makes a claim;
  a) **"Claim Outcome"** shall relate to the following: **"Accepted"** shall mean that the claim has been finalised in such a manner that the Claimant has either explicitly accepted that the policy benefits have been fully paid or in such a manner that is reasonable for the Hub to assume that the Claimant has so accepted. A Claim should only be regarded as accepted once any and all undertakings made by Guardrisk to provide policy benefits wholly or in part have been met.
  b) **"Repudiated"** shall mean that the Claim has been wholly or partly rejected (or repudiated) and Guardrisk regards the Claim as finalised after advising the Claimant (both verbally and in writing) that it does not intend to take any further action to pay the Claim. This can arise either where a Claim is rejected without

offering to take steps to pay it because Guardrisk regards the Claim as invalid, or where the Claimant does not accept or respond to proposals to pay the Claim and Guardrisk then advises the Claimant that it does not intend to take any further action to attempt to pay the Claim.

c) **"Disputed"** shall mean the Claim is neither accepted nor rejected, but Guardrisk disputes the Claim or the quantum of the Claim.

- **"Customer Query"** means a request to the Hub by or on behalf of a policyholder/beneficiary for information regarding a Claim or a policy, including policy benefits, no-claim bonus, loyalty benefit, waiting period or related service in relation to such policy. This shall also include a progress update on a request previously made or a progress update on a Claim.

- **"Escalated Claim"** shall refer to the following:
  a) an extension of a Claim relating to the outcome of the initial Claim;
  b) the Claim is complex or unusual that it requires intervention by an impartial senior functionary appointed to deal with escalated claims;
  c) the referral of the Claim to the appointed Reinsurer (where applicable) or to the Insurer for further review and feedback;
  d) the referral of the Claim to a Claims Committee mandated and authorized to review the Claim and provide an outcome;
  e) where the resolution of the initial Claim is not to the Claimant's satisfaction and is then treated as a complaint and dealt with in terms of the Guardrisk Complaints Management Framework.

- **"Exclusion"** means the losses or risk events not covered under a policy;

- **"Existing policy"** means a policy entered into before the date on which the relevant rule takes effect;

- **"Goodwill Payment"** means a payment, whether in monetary form or in the form of a benefit or service, by or on behalf of an Insurer to a Claimant as an expression of goodwill aimed at resolving a claim, where the Insurer does not accept liability for any financial loss to the Claimant as a result of the matter complained about;

- **"Insurer"** means Guardrisk Life Limited, a company duly incorporated in terms of the laws of the Republic of South Africa, a registered insurer and an authorized financial services provider.

- **"New Policy"** means a policy entered into on or after the date on which the relevant rule takes effect;

- **"Ombud"** has the meaning assigned to it in the –
  a) Financial Services Ombud Schemes Act, 2004 (Act No. 37 of 2004) up until such time as such Act is repealed through Schedule 4 of the Financial Sector Regulation Act; and
  b) Financial Sector Regulation Act, from the date on which such Act repeals the Financial Services Ombud Schemes Act, 2004 (Act 37 of 2004) through Schedule 4 of such Act;

- **"Plain Language"** means communication that –
  a) is clear and easy to understand;
  b) avoids uncertainty or confusion; and
  c) is adequate and appropriate in the circumstances,

  taking into account the factually established or reasonably assumed level of knowledge of the person or average persons at whom the communication is targeted;

- **"Policy"** means a long-term policy where the Policyholder is a
  a) natural person

- **"Policyholder"** has the meaning assigned to it in the Act, and includes any person in respect of whom a fund, under a fund member policy, insurers its liability to provide benefits to such person in terms of its rules;

- **"Repudiate"** in relation to a Claim means any action by which an Insurer rejects or refuses to pay a Claim or any part of a Claim, for any reason, and includes instances where a Claimant lodges a Claim –
  a) in respect of a loss event or risk not covered by a Policy; and
  b) in respect of a loss event or risk covered by a Policy, but the premium or premiums payable in respect of that policy was not paid

  and "Repudiation" shall have a corresponding meaning;

- **"Service Provider"** means any person (whether or not that person is the agent of the Insurer) with whom an Insurer has an arrangement relating to the marketing, distribution, administration or provision of policies or related services;

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- ***"Waiting Period"*** means a period during which a Policyholder (or any affected Insured) is not entitled to Policy benefits and includes any deferred period to determine permanency of disability;

- **"Reports (or reporting)"** means any periodic or ad-hoc reports (and related documents) obtained from the Claims management system and other sources in the business which shall be used for analysis, monitoring, submissions to regulatory authorities, and the making of recommendations to the business in respect of Claims management.

4. Allocation of duties

The Supervisor is responsible to ensure that the claims process is in line with this framework. Thus ensuring that the person responsible for dealing with the claims is,

4.1 Trained and with the appropriate experience;
4.2 Not be subject to Conflict of interest;
4.3 Have the ability to make impartial decisions

5. Claims Process:

In the event of a claim, the beneficiaries / claimants have the following channels available at which to submit a claim. Claims can be **E-mailed** to HubFinancialServices@hub.co.za, **Faxed** to 086 6096918, **Posted** to Private Bag x03, Mount Edgecombe, Durban, 4302 or **Hand delivered** at a nearest HUB branch. Claims must be lodged within 120 days after the date of the insured event arising with the following documentation:

5.1 Standard Claim Documents

- Fully completed Claim form
- Certified ID copy

5.2 Supporting Documents,

5.2.1 In respect of DEATH,

- Certified copy of computerized death certificate
- Certified copy of ID document of the deceased
- Certified copy of the ID document of the claimant
- Copy of the DHA-1663
- Copy of the Police report if death is due to unnatural causes

Confirmation of banking details (where applicable)

5.2.2 In respect of a CRITICAL ILLNESS,

- Proof of Critical illness that must be confirmed by a doctor with the appropriate specialist knowledge

5.2.3 In respect of HOSPITALIZATION,

- Proof of hospitalization

5.2.4 In respect of RETRENCHMENT,

- Notice of Retrenchment
- Retrenchment letter
- Certificate of Service
- UI19
- IRP5
- CV (optional)

5.3 For information;

Certification of documents must be done at a **South African Police Station** OR by a **Commissioner of Oaths**.

6. Internal Claims Process:

6.1 On receipt of a claim the following happens;

Claims are allocated to the assessor

- Claims are then captured on the Central spreadsheet
- Claims in respect of death, and where the Policyholder is the bearer of the account, the certified death certificate will be sent to the administrator Nedbank to flag the HUB account as estate late
- Claims are captured on the Valerie system and a unique claim number is generated
- Acknowledgement of receipt of claim is sent to the claimant by sms / post with the unique claim number
- Claims assessor will check if all the required documentation is received, using a document checklist and documents linked against ID number on the system

6.2 Additional documents at the request of the Administrator:

- Supporting proof of relationship if Principal member and spouse are not legally married
- Surname of deceased (spouse or child) is different to that of the principal member, with an explanation of difference in surname together with supporting documents

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6.3 Document Checklist

- Computerised death certificate must be certified by South African Police services or Commissioner of Oaths
- ID document of the deceased (must be stamped "DECEASED") and be certified by South African Police OR Commissioner of Oaths
- ID document of the claimant and must be certified as per certification listed above.
- DHA-1663
- Proof of relationship if Principal member and spouse are not legally married
- Police report if death due to unnatural causes
- Proof of hospitalization
- Confirmation of banking details
- Certificate of Service
- Notice of Retrenchment
- Retrenchment letter
- UI19
- IRP5
- Proof of Banking Account

BENEFITS PAYABLE:

6.4 Life Cover and Critical Illness Cover

If the Insured passes away or becomes diagnosed with a covered Critical Illness during the period of insurance, the Insurer will settle the Balance of Indebtedness on the HUB account at the date of the Claim Event up to a maximum of R15,000-00. A Claim that is accepted by us as valid will be paid within 30 days.

6.4.1 Retrenchment Cover

If during the period of insurance an Insured is retrenched due to new technology, re-organisation by the employer, liquidation of the company or staff reductions and the Insured remains unemployed for more than 90 continuous days, the Insurer shall pay a benefit equal to the Balance of Indebtedness on the HUB account at the date of the Claim Event up to a maximum of R15,000-00. Only 1 retrenchment Claim will be considered in any 12 month period. Once a Claim has been paid for retrenchment, an Insured will only be covered again once he/she has been employed for more than 12 months with another employer. A claim that is accepted by us as valid will be paid within 90 days.

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6.4.2 Hospitalisation Cover

If during the period of insurance an Insured is hospitalised and the admission is for 3 consecutive days, the Insurer shall pay a benefit equal to the Balance of Indebtedness at the date of the Claim Event up to a maximum of R15,000-00. In order to claim for this benefit, the Insured must:

- have been employed at the date of admission
- be under the continuous care of a doctor in respect of the admission
- be prevented from working as a result of this admission
  provide evidence in support of a valid claim. A claim that is accepted by us as valid will be settled within 30 days.

6.4.3 Funeral Cover

If during the period of cover, an insured passes away, a claim that is accepted by us as valid will be paid in 2 working days.

6.5 Internal Complaints Handling Process

6.5.1 How to submit a complaint

A complaint must be submitted by a complainant to HubFinancialServices@hub.co.za , Fax: 086 6096918 or call at 0861 888 899 or FSP Complaints 20 Marshall Drive, Mount Edgecombe, Durban, 4302. The complaint must be addressed for the attention of the Complaints Representative. The complainant must give a detailed description (either in writing or orally) of the event that caused them to suffer any prejudice. Where applicable, the complainant will need to attach documentation in support of allegations made against the FSP or service provider and the service received.

6.5.2 Complaints Resolution Process

A complaint will be received by the customer services consultant who will acknowledge receipt to the complainant within 24 hours providing the details of the person handling the complaints and their contact details. A complaint should be resolved within 15 business days of receipt of the complaint.

As soon as the complaint is acknowledged to the complainant the Complaints representative will start the investigation process which will include determining the nature of the complaint or the category under which the complaint falls in order to follow the correct process for that complaint.

6.5.3 Complaints received should be categorised according to the following:

6.5.3.1 Outcome 2: Complaints relating to the design of a product or service

This category includes complaints indicating that the service towards the customer was unfair, inadequate, confusing or overly complex, or unsuitable for the customers at which they have been targeted. Complaints regarding unfair or confusing pricing, costs or charges will be dealt with under this category.

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6.5.3.2 Outcome 3: Complaints relating to information provided

This includes complaints that any documentation provided to customers or prospective customers, or other communications with customers or prospective customers is inaccurate, unsuitable, misleading, incomplete, confusing, unclear, etc. It covers both advertising and marketing material as well as specific product or service-related communications. It also covers information provided at all stages of the product life cycle. Such complaints could apply to either the content of the information, or the manner or medium in which it is provided. It will also include complaints regarding a failure to provide information, or complaints that information was provided at an inappropriate time.

6.5.3.3 Outcome 4: Complaints relating to advice

This category relates to complaints that advice provided did not take adequate account of the customer or prospective customer's needs and circumstances (including affordability), was factually incorrect or misleading, or that advice was not provided when the complainant believes it should have been provided. Complaints indicating that the consultant was subject to a conflict of interest, or was lacking in knowledge, skill, experience or integrity are dealt with under this category.

6.5.3.4 Outcome 5(a): Complaints relating to product performance

This category includes complaints indicating a customer's disappointment in becoming aware of limitations relating to the product or service that are not in line with their expectations. Where applicable, this would include (but is not limited to) complaints indicating that the customer was not kept adequately informed during the life of the product of matters that affect the product's ability to meet expectations. Complaints regarding a product supplier's exercise of any contractual right to terminate a product or amend its terms are dealt with in this category.

6.5.3.5 Outcome 5(b): Complaints relating to customer service

Customer service complaints are those expressing dissatisfaction with FSP's administration of requests and transactions (including complaints regarding FSP's technological support) and complaints relating to the way in which FSP's staff have dealt with the customer (for eg. complaints of rudeness, incompetence or non-responsiveness). This would include complaints regarding the administrative processing of payments to or by the customer. Included are complaints relating to breaches of privacy or confidentiality. It is important to note that complaints relating to the customer service standards of third party or outsourced service providers are included in this category. Complaints arising from alleged fraudulent activity by the FSP or a service provider, where the customer is dissatisfied with the manner in which the FSP has handled the matter or with the assistance provided by the FSP in attempting to resolve the matter.

6.5.3.6 Outcome 6(a): Complaints relating to product accessibility, changes or switches

This category relates to complaints in respect of barriers or limitations on access to funds, or in the ability to transfer products or services to another provider, or on the ability to make changes to the product or service. Types of barriers or limitations covered would include penalties, termination charges, lengthy notice periods, complex "red tape" administrative hurdles when trying to access funds, etc.

6.5.3.7 Outcome 6(b): Complaints relating to complaints handling

This includes complaints regarding the administration of the complaints process, such as delays, poor communication regarding processes and decisions, cumbersome or inaccessible processes, failure to inform complainants of their rights regarding escalation or Ombud mechanisms, etc. It does not include dissatisfaction regarding the outcome of a complaint, which would be regarded as a continuation of the original complaint.

6.5.3.8 Outcome 6(c): Complaints relating to insurance risk claims

These complaints would include:
(i) complaints relating to the administration of the claim process (such as delays, poor communication regarding processes and decisions, cumbersome or inaccessible processes, etc.)
(ii) complaints relating to actual non-payment of claims

In the case of non-payment of claims, reporting requirements in relation to this category are likely to require further sub-categories in respect of the reasons for non-payment, such as:

- Required claim documentation / evidence not submitted
- Criteria for insured event not met
- Waiting period not expired
- Exclusion applies
- Non-disclosure or misrepresentation
- Policy / benefit not in force
- Claimant is not the person entitled to the benefits (beneficiary disputes)
- Dispute re quantum of claim
- Other reasons.

6.5.3.9 Other complaints

A catch-all category for any complaints not falling within one of the above TCF aligned complaints categories or sub-categories. This category should however not be treated as a "default" reporting category.

6.6. Investigation and Resolution of the Complaint

The complaints representative must conduct an investigation using all the information received from the complainant and from consultation with the employee(s) or the department that the complaint is laid against. The process must also take into account the customer services charter and commitments to customer service in order to arrive at a decision that may be favourable to all affected parties.

When necessary, the complaints officer may delegate this function to an employee who is adequately trained and has appropriate mix of experience and skill in handling complaints and has good understanding of the business and TCF outcomes. Should the process take longer than six weeks, the complainant must be advised of the extended period.

After having consulted with the relevant personnel and considered the evidence received from all parties, the Complaints Representative must make a decision which will be communicated to Management first who will review the process followed in resolving the

complaint and test its objectivity. On the feedback from Management, the complaints representative will then communicate the decision to the complainant.

6.6.1 Decision to dismiss the complaint

If after the investigation it appears that the service was rendered according to the adopted processes and procedures within the organization, and no fault on the conduct of an employee or the FSP was found, the decision will be to dismiss the complaint.

The complainant will be advised in writing of the decision arrived at during the investigation process and reasons for arriving to that decision and be advised of further available recourse within the business.

The appeal process will involve the review of the evidence submitted and the processes followed when arriving at the decision to reject the complaint. Should the decision of the appeal board still be to reject or dismiss the complaint, the complainant will be advised in writing of the decision of the appeal board and be advised to submit a complaint to the Ombudsman who is available to assist the complainant.

Should the appeal board arrive at a decision to grant the complaint. This decision will be communicated to the complainant together with the commitment to make the compensation payment.

6.6.2 Decision to uphold the Complaint

Where a complaint is upheld, the complainant will be advised of the decision by the FSP and of the commitment, if any, to make a compensation payment, goodwill payment.

6.7. Feedback to the Complainant

The complainant must be given feedback on the progress on the complaint resolution process. The feedback referred to here could be in a form of a SMS or a telephone call advising the complainant of the status of the complaint.

7. Record keeping

7.1. All claims are kept for a minimum of 5 years.
7.2. Hard copies of the documents are filed physically and scanned electronically on the internal network drives. A complaint must be recorded in the complaints register, supporting documents must be scanned and be kept for a period of five years. The complaints register must be made available for monitoring purposes.

8. CLAIMS ESCALATION AND APPEALS PROCESS

8.1 The contact details for Guardrisk Life Limited are as follows:

Postal : PO Box 786015, Sandton, 2146
Tel : 086 033 3361
Email : complaints@guardrisk.co.za

8.2 The contact details for the Administrator are as follows:

Postal : Private Bag x03; Mount Edgecombe; Durban; 4300
Tel : 0861 888 899
Fax : 0866 096 918
Email : hubfinancialservices@hub.co.za

8.3 The contact details for the Long Term Insurance Ombudsman are as follows:

Postal : Private Bag X45, Claremont, 7735
Tel : (021) 657 5000
Sharecall : 0860 103 236

Fax : (021) 674 0951
Email : info@ombud.co.za

8.4 The contact details for the FAIS Ombudsman are as follows:

Postal : PO Box 74571, Lynwood Ridge, 0040
Tel : (012) 762 5000
Fax : (012) 348 3447
Email : info@faisombud.co.za

Complaints escalation process: (Please follow the steps below)

STEP 1 Please liaise directly with The HUB on the details provided above.

STEP 2 Should you still feel dissatisfied with the outcome of step 1, you may contact Guardrisk Life Limited on the details above.

STEP 3 Should you still feel dissatisfied with the outcome of step 2, you may refer the matter to the Ombudsman for Long-Term Insurance, who

provides a free service to consumers who are not happy with responses they receive from an Insurance company. Contact details are above.

9. Prohibited Claims Practices

The Hub and the Insurer may not;

9.1. Deny the claimant the right to submit a claim,

9.2. Dissuade a claimant from making use of the internal complaints process.

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