

# Application Form

Fax: 0866 126 595  
Email: applications@alllife.co.za

Post: Applications  
AllLife (Pty) Ltd  
PO Box 787159  
Sandton, 2146



Underwritten by Centriq Life Insurance Company Limited

Customer Service: 0861 255 5433

**Instructions**

- Please complete in ink, print clearly, mark selections with X, and sign on every page where indicated
- Please include a signed copy of the identity document (or residence permit) of the life insured with this application

## A. Insurance Requirements

What amount of cover are you applying for?  e.g. R100 000

What benefits are you applying for?  Life cover only  Life and Permanent Disability\* cover

What product are you applying for?  10 Yr Loan Protector  20 Yr Loan Protector  10 Yr Level Cover  20 Yr Level Cover  Whole Life Level Premium  Whole Life Escalating Premium

\* The Advantage Life Permanent Disability product accelerates the death benefit in the event of permanent disability of the Life Insured, as defined in AllLife's published terms and conditions. Acceleration means that payment of a permanent disability claim terminates the life policy and that no further benefits will be payable.  
The benefit payable in the case of permanent disability is 75% of the insured value in the case of the level term cover, and whole life products, or 100% of the (declining) insured value in the case of the loan protector products.

I accept the monthly premium quoted by AllLife:  **INITIAL HERE**

## B. Client Details

**Life Insured:**

Title:  Initials:  Surname:

First name(s):

Maiden name:  Marital status:

ID No.:  Date of birth:  /  /  -  -  -

Age (years):  Gender:  M  F Can we communicate with you via SMS?  Y  N

Telephone (h):  Cell:  -  -  -  -  -

Telephone (w):  (required) Fax:  -  -  -  -  -

Home language:  Race: (optional) Asian  Black  Coloured  White  Indian

Postal address:  Code:  -  -  -

Residential address:  Code:  -  -  -

Email address:

**Policy owner (if other than Life Insured):**

Title:  Full name:

ID/Reg. No.:  Relationship:

Policy Owner Tax Status:  Natural Person  Conforming company/CC  Non-conforming company/CC Contact:

Telephone (h):  Cell:  -  -  -  -  -

Telephone (w):  (required) Fax:  -  -  -  -  -

Postal address:  Code:  -  -  -

Email address:

**Alternative contact person (optional):**

Full name:  Tel/cell:  -  -  -  -  -

Insured's Name:  Insured's Signature:

## B. Client Details (continued)

### Education details (life insured):

Highest tertiary qualification (please indicate with an 'X')  Not Matriculated  Matriculated  Diploma  Degree  Post Graduate

Please give details of qualification:  Year achieved

### Employer details:

Please indicate whether employment details are for:  Life Insured  Policy Owner (if other than the life insured)

Employer name:

Work address:  Code:

Your position:

Department:  Industry type:

What are your primary duties?

Describe your duties in terms of percentages: Admin % Supervisory % Travel % Manual %

### Salary Information:

Monthly gross income:  R Employee number (if applicable):

Are you paid via Persal (the government payroll)?  Y  N If yes, what is your Persal number:

Where the Life Insured is not employed, please state the insurable interest of the policy owner in the Life Insured:

  


## C. HIV Information

When did you find out that you were HIV positive?  /

Are you on Anti-Retroviral Therapy (ART)?  Y  N If 'YES', when did you start ART?  /

If you are on ART, is this your 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup> or later ART drug regime?  1<sup>st</sup> regime  2<sup>nd</sup> regime  3<sup>rd</sup> (or later) regime

What was your CD4+ count on initiation of ART? (cells/mm<sup>3</sup>)  (if known) What was your viral load on initiation of ART? (copies/ml)  (if known)

What Anti-Retroviral medication are you currently taking?

When last did you have an HIV monitoring blood test?  /

What was your CD4+ count in this test? (cells/mm<sup>3</sup>)  (if known) What was your viral load in this test? (copies/ml)  (if known)

Where was this test done? (Laboratory name)

## D. Adherence Requirement

I understand that this policy requires that I remain adherent in terms of the AllLife Adherence Policy and the AllLife Adherence Monitoring Policy in the document referenced ADXALSTF05. In general this requires that I go for blood tests every 6 months (*only CD4+ count prior to starting Anti-Retroviral Therapy ("ART") and both CD4 count and Viral Load tests after starting ART*) and forward the results to AllLife. I will need to start appropriate ART within 60 days of having recorded a CD4+ count of below 200 cells/mm<sup>3</sup> and, after starting ART, I must not have 2 consecutive blood tests showing a reduction in CD4+ count and/or a Viral Load above 1000 copies/ml. To prevent becoming non-adherent, I will be required to initiate anti-retroviral therapy as prescribed by my healthcare practitioner and/or managed healthcare company and take the correct ART dose, at the correct time daily, every day.

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Insured's Name:

Insured's Signature:



## J. My Medical History

### Do you or have you ever suffered from:

1. Any disorder of the heart, e.g. heart attack, rheumatic fever, shortness of breath, valve problems, palpitations, arrhythmias, chest pain, heart failure etc.?  Y  N
2. Any disease of circulation or blood vessels, e.g. high blood pressure, high cholesterol, stroke, cramps in the legs, aneurysms etc.?  Y  N
3. Any disease of the lungs (including, but not limited to): chronic cough, TB, pneumocystis carinii pneumonia, candidiasis of the trachea and/or bronchi and/or lungs etc.?  Y  N
4. Any disorder of the digestive system (including, but not limited to): chronic diarrhea (i.e. >1month), difficulty and/or pain on swallowing, pancreas, candidiasis of the oesophagus etc.?  Y  N
5. Any disorder of the kidneys, reproductive organs or bladder, e.g. blood/protein in the urine, infertility, kidney stones, recurrent prostatitis or cystitis, ovarian cysts, vaginal/rectal fistulae, testicular problems, nephritis etc.?  Y  N
6. Any disorder of the muscle, bones, joints or skin e.g. back problems (including neck), osteoporosis, gout, arthritis, fibromyalgia, rheumatism, muscle weakness, polio, paralysis, Paget's disease, porphyria, psoriasis, dermatitis etc.?  Y  N
7. Any endocrine disorder, e.g. diabetes, thyroid problems, female hormone disorders, infertility, adrenal disorders, pituitary disorders, parathyroid disorders, glandular disorders etc.?  Y  N
8. Any disorder of the spleen, liver, or blood system (including, but not limited to): Hodgkin's disease, Hepatitis B or C or any other Hepatitis other than Hepatitis A etc.?  Y  N
9. Any cancers, growths or tumours of any kind (including, but not limited to): Kaposi's sarcoma, lymphoma, oral hairy leukoplakia, enlarged lymph nodes (glands) etc.?  Y  N
10. Any disorders of the neurological system or any psychiatric complaint (including, but not limited to): epilepsy, blackouts, paralysis, weakness, migraine, depression, anxiety, phobias, meningiomas, ongoing headaches, brain aneurysms, progressive multifocal leukoencephalopathy, toxoplasmosis of the brain, HIV encephalopathy, early dementia etc.?  Y  N
11. Any disorder of the ears, eyes or throat, e.g. hearing loss, defective vision (other than short or long sightedness), retinal detachment, hoarseness, chronic sinusitis etc.?  Y  N
12. Any connective tissue diseases, e.g. systemic lupus erythematosus, scleroderma, Raynaud's disease, rheumatoid arthritis, sarcoidosis, polymyositis etc.?  Y  N
13. Any of the following systemic conditions and/or diseases: unexplained weight loss of >10% of body weight, unexplained prolonged fever >1month (intermittent or constant), extrapulmonary TB (TB other than in lungs), oral and/or vulvovaginal candidiasis (thrush), severe bacterial infections, HIV wasting syndrome, cryptosporidiosis with diarrhea >1month, isosporiasis with diarrhea >1month, extrapulmonary cryptococcosis, cytomegalovirus disease of an organ other than liver, spleen or lymph node, herpes simplex viral infection (mucocutaneous>1month or systemic any duration), any disseminated endemic mycosis (fungal infection), atypical mycobacteriosis, non-typhoid Salmonella septicaemia, shingles?  Y  N
14. Any other diseases, operations, disabilities or accidents not mentioned above?  Y  N

Please provide details for any questions you answered 'yes' to above (including question number, date of last symptoms, treating doctor and doctor's telephone number):

Question No.	Date of last symptoms	Doctor	Contact number	Details

Insured's Name:

Insured's Signature:

## J. My Medical History (continued)

15. Are you currently pregnant (answer only if female)?  Y  N
16. Have there been any problems with previous pregnancies (answer only if female)?  Y  N
17. Have any of your children suffered from any birth defects or congenital abnormalities?  Y  N
18. Have you ever been tested for Hepatitis or any sexually transmitted disease (**excluding** HIV) or have you ever received medical advice, counseling or treatment in respect thereof?  Y  N
19. Did you receive any medication or other treatment uninterruptedly for longer than 6 (six) days within the past 5 (five) years, or is this the case now, for conditions NOT mentioned already? Please include dose and diagnosis.  Y  N


20. Height (metres):  Weight (kilograms):  **FOR OFFICE USE:**

21. Has your weight changed by more than 5 kg in the last 12 months?  Y  N

22. Alcohol – quantity and type consumed per week:

23. Tobacco (including the past 12 months) – quantity and type per day:

24. Have you ever or do you use recreational drugs e.g. cannabis, mandrax etc. Have you ever received medical advice to reduce or discontinue liquor, drug or tobacco consumption?  Y  N

25. Have you ever been charged with drunken driving?  Y  N

26. Has a proposal for life, medical, disability, dread disease or impairment insurance on your life ever been declined, postponed, withdrawn or accepted on special terms or at special premium rates (except as a result of your HIV status)?  Y  N

27. Have you ever submitted a disability, accident, dread disease or impairment claim to any insurer or fund?  Y  N

28. Have your parents or siblings ever suffered from diabetes, stroke, heart complaint, high blood pressure, porphyria, mental disorders, haemophilia or any other hereditary disease? Please specify which person and what disease.  Y  N

29. Do you participate in or are you involved in any pursuit, avocation or occupational activity that might be considered hazardous e.g. racing (speed contests), diving, aviation, parachuting, mining, mountaineering etc.?  Y  N

30. Are you intending, or are you aware of a need to seek medical advice from a medical practitioner within the next 8 weeks for any condition or operation?  Y  N

31. Any congenital or birth defect, including, but not limited to mental insufficiency, essential defect of memory/concentration, minimal brain dysfunction etc.?  Y  N

32. Do you live outside the borders of the RSA or do you plan to do so continuously for a period in excess of 3 months within the following 12 months?  Y  N

33. Are you aware of any other health or other factors (past or present), not disclosed above, which may influence medical risk and/or the risk attached to this policy?  Y  N

Please provide details for any questions you answered 'yes' to above (including question number, date of last symptoms, treating doctor and doctor's telephone number):

Question No.	Date of last symptoms	Doctor	Contact number	Details

Insured's Name:

Insured's Signature:

**K. Broker / Agent Details (only to be filled in if applicant has been assisted by a Broker / Agent)**

Brokerage Name:	<input type="text"/>	Brokerage Code:	<input type="text"/>
Agent / Broker Name:	<input type="text"/>	Agent / Broker Code:	<input type="text"/>

**Disclosure of commission earned on this policy:**

I acknowledge that I have been informed by the above Broker/Agent that (s)/he (or his/her Brokerage) will receive a percentage of the sum of all my anticipated monthly premium payments (no more than 3%) in the form of a commission associated with the sale of this insurance policy. I understand that the commission will be paid by AllLife to the Broker/Agent out of the proceeds of my monthly premiums.

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**L. Declaration and Signature**

- I understand that I am applying for a life insurance policy underwritten by Centriq Life insurance Company Ltd, and administered by AllLife.
- I hereby confirm that I have not been advised to replace any existing policies by AllLife.
- **I hereby confirm that I have given consent that my bank account may be debited for the payment of the premium amount and any administration fees.**
- I understand that my cover will only be initiated on receipt of the first premium and issuance of the policy and that the premium and any administration fees are subject to change with 30 days notice at any time throughout the duration of the policy.
- I understand that, if I do not inform AllLife of any material change in circumstances between submitting this application form, payment of my first premium, and inception of my policy, I will not be covered.
- I understand that my policy is governed by AllLife's standard business practices.
- I hereby confirm that **I have read, understood and agree** with all the points in both the AllLife Adherence Policy and the AllLife Adherence Monitoring Policy in the document referenced ADXALSTF05.
- I understand that to be adherent I must comply with the AllLife Adherence and Monitoring Policies (document referenced ADXALSTF05). In general this requires that I go for blood tests every 6 months (only CD4 count prior to starting ART and both CD4 count and Viral Load tests after starting ART) and forward the results to AllLife. I will need to start appropriate ART within 60 days of having recorded a CD4 count of below 200 cells/mm<sup>3</sup> and, after starting ART, I must not have 2 consecutive blood tests showing a reduction in CD4+ count and/or a Viral Load above 1000 copies/ml. To prevent becoming non-adherent, I will be required to initiate anti-retroviral therapy as prescribed by my healthcare practitioner and/or managed healthcare company, take the correct dose, at the correct time daily, every day.
- I understand that **I am responsible for funding all medical costs** associated with meeting the AllLife Adherence Policy and the AllLife Adherence Monitoring Policy including, but not limited to, the costs associated with blood tests and obtaining Anti-retroviral therapy.
- I hereby confirm that I have consented to AllLife obtaining my historical and future blood and other medical test results.
- I hereby confirm that I have consented to AllLife sharing my answers on this application and any data that they may receive with the appropriate regulatory authorities and for the purpose of appropriately assessing risk, this includes, but is not limited to, the product's reinsurer and Centriq Life Insurance Company Ltd.
- I hereby confirm that I have consented to AllLife transferring this policy to any underwriter if, in their opinion, it is appropriate to do so.
- I understand that there will be an administrative charge should I rescind/cancel this policy after the first instalment has been deducted from my bank account.
- I indemnify AllLife (Pty) Ltd, Centriq Life Insurance Company Ltd, any disclosing parties, their shareholders, their directors, agents and employees against any claims arising from the above disclosure.
- I understand that if I miss two or more payments I will no longer be covered by this policy and will need to re-apply for cover.
- I understand that this policy has **no surrender value** (there is no savings component).
- I understand that, if I have selected a combined Life and Permanent Disability policy, the disability benefit is an accelerated death benefit in the event of permanent disability of the life insured, as defined in AllLife's published terms and conditions. Acceleration means that payment of a permanent disability claim terminates the policy, and no further benefits will be payable. I understand that the benefit payable in the case of permanent disability of the life insured is 75% of the insured value in the case in the case of the 10- and 20 year level cover, the whole life level premium, and the whole life escalating premium products, or 100% of the (declining) insured value in the case of the loan protector products.
- **I understand that if I have selected a finite term policy and there is no claim within the term of the policy, there is no surrender value or payout at the end of the term.**
- Any policy granted and the interpretation of such policy shall be governed by the laws of the Republic of South Africa and be subject to the jurisdiction of the High Court of the Republic of South Africa.

**I warrant that the information supplied by me to AllLife is true and correct**

Signature of applicant:

d	d	/	m	m	/	y	y	y	y
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**CONSENT TO LIMITED DISCLOSURE OF MEDICAL INFORMATION AND TEST RESULTS**

I, the undersigned

(full names)

(ID number)

of  (address)

hereby state as follows:

1. I am aware that AllLife (Pty) Ltd ("AllLife") is a life insurance broker and administration company.
2. I am aware that AllLife may or may not be able, on account of my health condition, to obtain life insurance for me. I also understand that AllLife cannot give me any guarantee that it will succeed in obtaining affordable insurance for me.
3. I fully understand that every insurance company, before deciding whether or not to offer life insurance to a person ("the applicant") and to eventually consider the making of any payments or benefits under an insurance policy, regards it as absolutely necessary to assess its financial risk(s). In order to make such an assessment an insurance company will as a matter of routine require the applicant to furnish the company with full details regarding his or her medical history and state of health. An insurance company may also require the applicant to submit himself/herself to such medical tests as are regarded essential.
4. I further understand that an insurance company may require an applicant to fill in a questionnaire in which the applicant is required to answer a series of questions on his/her general lifestyle, including diet, use of alcohol, tobacco, medicines and other substances.
5. I have already been medically examined and treated by one or more doctors or other healthcare providers.
6. I hereby authorise AllLife to obtain from any doctor, healthcare provider or organisation (such as a managed healthcare organisation) which has particulars of medical or clinical tests or examinations performed on me or will obtain particulars in performing such tests or examinations at any stage in future. I understand that such authorisation given by me will be irrevocable, i.e. that I will not be entitled at any stage to inform AllLife that they may no longer obtain or have access to such particulars.
7. I hereby further authorise AllLife to furnish or disclose any or all details of the medical information regarding myself, which they have obtained in terms of this authorisation, to any insurance company with which they decide to negotiate at any stage in order to endeavour to secure an insurance policy which will provide cover to me.
8. I acknowledge and agree that my consent and authorisation contained in this document in particular also applies to my HIV status and/or any diagnosis of and/or treatment for AIDS or HIV. This authorisation will cover the results of any past or future medical or clinical tests, including (but not limited to) blood tests known as CD4+ count and RNA viral load blood tests and related monitoring tests, which AllLife may regard as necessary to obtain or require at the application stage or on an ongoing basis.
9. This authorisation by me specifically also covers pathology laboratories which at any stage in the past tested and reported on or will in future test and report on blood, urine or other bodily substance or tissue obtained from me.
10. I am aware of the fact that, in general, disclosures made by doctors, laboratories, hospitals, other healthcare providers and organisations such as medical schemes, medical scheme administrators and managed healthcare organisations, of personal, medical details of patients to other parties without the patient's consent is not only illegal but may also be professionally unethical. I am aware that, amongst other remedies available, an aggrieved person may claim damages for such unauthorised disclosures.
11. I realise, however, that by giving the irrevocable consent and authorisation contained in this document, I shall have no claim whatsoever against AllLife or any doctor, pathology laboratory, hospital, other healthcare providers and/or organisations mentioned in this document who or which will furnish AllLife with the type of medical or clinical information mentioned in this document. I clearly understand that I hereby waive, i.e. abandon, any claim for damages or compensation that I might otherwise have had against such a person or organisation. In particular I also waive any claim that I might otherwise have had against employees, directors, agents, shareholders or members of AllLife as well as of any doctors or other bodies or organisations mentioned in this paragraph or their employees.
12. I acknowledge that before signing this document I was given the opportunity by AllLife or a person acting on its behalf, to discuss the content of this document, its implications and effect, and that all questions I have had were answered to my satisfaction.
13. The provisions of this document constitute the whole of the agreement between me and AllLife in respect of the matters referred to in this document and the said provisions may only be waived, varied or amended in terms of another written document signed by me and by an authorised representative of AllLife.
14. I acknowledge that I have read and fully understood, and freely consent to, the provisions of this document.

Signature:

Signed at:  (Place)

Date:  /  /

## STATUTORY NOTICE TO LONG-TERM INSURANCE POLICYHOLDERS

### IMPORTANT: PLEASE READ CAREFULLY – DISCLOSURE & OTHER LEGAL REQUIREMENTS

As a long-term insurance policyholder, or prospective policyholder, you have the right to the following information:

**1. The intermediary (insurance broker or representative) dealing with you must at the earliest reasonable opportunity disclose:**

- a) Name, physical & postal address and telephone no.
- b) Legal capacity: independent or representative for brokerage
- c) Concise details of relevant experience
- d) Insurance products that may be sold
- e) Insurers whose products may be marketed
- f) Indemnity cover held – Yes/No
- g) Shareholdings in insurers if 10% or more
- h) Name of insurers from which the intermediary received 30% or more of total commission and remuneration during past calendar year

The intermediary must be able to produce proof of contractual relationship with and accreditation by the insurers concerned

**2. Your right to know the impact of the decision you elect to make:**

- a) The intermediary or insurer dealing with you must inform you of (1) The premium you may be paying and (2) The nature and extent of benefits you may receive
- b) If the benefits are linked to the performance of certain assets: (1) How much of the premium will go towards the benefit, & (2) To what portfolio your benefits will be linked
- c) The possible impact of this purchase on your finances
- d) The possible impact of this purchase on your other policies (affordability)
- e) The possible impact of this purchase on your investment portfolio (affordability)
- f) The flexibility of changes you may make to the proposed contract
- g) The contract terms of the product you intend to purchase

(It is very important that you are quite sure that the product or transaction meets your needs and that you feel you have all the information you need to make a decision)

**3. Your right when being advised to replace an existing policy:**

You may not be advised to cancel a policy to enable you to purchase a new policy or amend an existing policy unless:

- a) The intermediary identifies the policy as a replacement policy
  - b) The implications of cancellation of the policy are disclosed to you such as: (1) The influence on your benefits under the old policy (2) The additional costs incurred with the replacement
  - c) The insurer that issued the original policy will contact you.
- You are advised to discuss the matter with its representative.

**AllLife does not and has not advised you to replace any existing policy**

**4. Your right to be informed by the insurer:**

The insurer will forward you documentation confirming policy details as discussed in paragraph 2 of this Notice, which will also include:

- a) The name of the insurer
- b) The product being purchased
- c) The cost in Rands of the transaction and specifically:
  - The loadings, if any
  - The initial expense, and
  - The amount of commission and other remuneration being paid to the intermediary
- d) In the case of policies with an investment element, the ongoing expense and any other fees or charges payable
- e) The summary in terms of section 48 of the Long-term Insurance Act, 1998
- f) The contact number and address of the complaints and compliance officers of the insurer.

**5. Your right to cancel the transaction:**

In most cases, you have a right to cancel a policy in writing within 30 days after receipt of the summary contemplated in section 48 from the insurer. The same applies to certain changes you may make to a policy. The insurer is obliged to confirm to you whether you have this right and to explain how to exercise it. Please bear in mind that you may not exercise it if you have already claimed under the policy or if the event, which the policy insures you against, has already happened. If the policy has an investment component, you will carry any investment loss.

**6. Important Warning**

- It is very important that you are quite sure that the product or transaction meets your needs and that you feel you have all the information you need before making a decision
- It is recommended that you discuss with the intermediary or insurer the possible impact of the proposed transaction on your finances, your other policies or your broader investment portfolio. You should also ask for information about the flexibility of any proposed policy.
- Where paper forms are required, it is advisable to sign them only once they are fully completed. Feel free to make notes regarding verbal information, and to ask for written confirmation or copies of documents.
- Remember that you may contact either the Long-term Insurance Ombudsman or the registrar of Long-Term Insurance, whose details are set out below, if you have any concerns regarding a product sold to you or advice given to you.

**7. Particulars of Long-term Insurance Ombudsman**

P O Box 45007  
 Claremont  
 7735  
 Tel: (021) 657-5000  
 Fax: (021) 674-0951

**8. Particulars of Registrar of Long-term Insurance**

Financial Services Board  
 P O Box 35655  
 Menlo Park  
 0102  
 Tel: (012) 428-8000  
 Fax: (012) 347-0221

**FSB registration details:**

AllLife (Pty) Ltd: FSP 4946  
 Centriq Life Insurance Company Ltd: FSP 7370

Insured's  
Name:

Insured's  
Signature:

## **ALLLIFE ADHERENCE AND ADHERENCE MONITORING POLICY**

**Note that this Adherence and Adherence Monitoring Policy can change on 30 days notice at AllLife's sole discretion, based on reasonable medical practice.**

### **A. AllLife Adherence Policy**

The following adherence protocol will need to be met in order to maintain benefit levels under the Advantage Life product range. Please note that, although the AllLife adherence policy requires testing every 6 months, the HIV Clinicians Society recommends testing every 3 months, so please discuss more regular testing with your clinician and/or managed health care company.

You are required to go for regular blood tests and to ensure that AllLife is provided with copies of these test results (**make sure to include "AllLife" as a "copy doctor" when you fill in the form at the testing Laboratory**) as follows:

- a. **Prior to initiating ART**, the insured is required to be tested for, and to provide to AllLife, their **CD4+ count every 6 months**.
- b. **After starting ART**, the insured is required to be tested for and to provide to AllLife their **RNA viral load and CD4+ count every 6 months**.
- c. The insured **must enrol on ART within sixty (60) days after a CD4+ count of 200 cells/mm<sup>3</sup> or below** (the HIV Clinicians Society recommends starting ART at a CD4+ count of 250 cells/mm<sup>3</sup> or below) has been recorded or the insured has contracted an AIDS defining illness. Details of the original ART regimen (all ART regimens must include 3 or more antiretroviral agents, capable of suppressing HIV virus replication and must be as prescribed by a clinician) must be provided to AllLife within 30 days of initiation of ART.
- d. The customer's blood test results after initiating ART must be as specified in the Adherence Monitoring Policy in order to remain adherent.
- e. Although AllLife will endeavour to access all blood test results directly from the testing laboratory or the insured's managed health care company (if any), it will be the responsibility of the insured to provide the data to AllLife on a 6 monthly basis, if we do not receive the blood test results, the customer will be defined as non-adherent.
- f. The insured must provide AllLife with proof that they have started ART by providing a receipt for purchase of anti-retrovirals within 90 days of receiving test results indicating a CD4+ count of below 200 cells/mm<sup>3</sup>. Such proof must:
  - i. be computer generated
  - ii. include the insured name
  - iii. include the name of the selling or providing entity
  - iv. include the date of the sale or provision of the anti-retrovirals
  - v. include the details of the antiretroviral drugs purchased
- g. The process described in (f) above must be repeated at each change of ART regimen.

### **B. AllLife Adherence Monitoring Policy**

Adherence, as defined, is the taking of all appropriate ART medication (defined as medication which prevents viral replication and is approved by the HIV Clinicians Society) in the appropriate dosage at the appropriate time every day. AllLife utilises the following protocol to check adherence after the customer has started ART:

**Either of the RNA viral load condition or the CD4+ count condition shall be sufficient to indicate non-adherence.**

The customer will be deemed to be non-adherent, unless the customer is on their third ART regimen, if either;

- a. the RNA viral load test results do not show a reduction in RNA viral load of at least 1 log (measured against their RNA viral load prior to starting ART), and have a RNA viral load of below 5000 copies/ml, by their second scheduled test post ART initiation, unless the insured has changed their regimen before the second scheduled test (scheduled tests occur once every 6 months, although the life insured may undergo more frequent testing if required by their treating doctor). In the case where the Insured has changed their ART regimen, the Insured must show a reduction in RNA viral load of at least 1 log (measured against their RNA viral load prior to initiating ART), and to a RNA viral Load of below 5000 copies/ml, by their third scheduled test post ART initiation. Proof will need to be submitted regarding change of regimen; **or**
  - b. from 12 (twelve) months after initiating ART, the RNA viral Load is over 1000 copies/ml for any two consecutive scheduled tests.
- OR**
- c. CD4+ count drops by more than 50 cells/mm<sup>3</sup> or 20% of baseline\* whichever is smaller over a 12 month (or shorter) period; **and**
  - d. Two consecutive blood tests have shown a downward trend in the customer's CD4+ count.

Then the insured will be deemed to be non-adherent unless the insured is on their third ART regimen.

**In addition**, if no blood test is conducted within thirty days of the stipulated date (every 6 months), then the insured is deemed to be non-adherent until they provide AllLife with their test results (irrespective of having started ART). If these test results show that CD4+ count has dropped by less than 50 cells/mm<sup>3</sup> or 20% of baseline whichever is smaller, then the insured will be deemed to be adherent and their cover will be restored appropriately. The testing interval will remain that of the original and will not be based off of the new test date.

In cases where laboratory results are unusual or discrepant in the opinion of AllLife, these will be evaluated on a case-by-case basis by AllLife and, if necessary, repeat tests may be required. All CD4+ count and RNA viral Load tests must be done at SANAS or LOA approved laboratories.

AllLife must be informed of any changes in ART regimen and such change may only be with the written approval or instruction of the client's healthcare provider.

The Insured will be defined as adherent should their RNA viral Load be below 500 copies/ml and their CD4+ count be above 500 cells/mm<sup>3</sup>, irrespective of variations in their CD4+ count as described above.

\* Each customer has a baseline CD4+ count determine as the higher of (i-iii) as follows:

- i. CD4+ count at initiation of ART (must initiate at CD4+ count less than or equal to 200); or
- ii. Highest post ART initiation test score; or
- iii. If already on ART at inception of cover, CD4+ count at initiation of AllLife cover or highest test score post initiation of cover, whichever is higher.