Insurance Claims Management Framework

for

RCS Cards Proprietary Limited

An authorised Financial Services Provider

FSP44481

Table of Contents:

1. Introduction……3
2. Purpose……4
3. General information about RCS and the Insurer……4-5
4. RCS Insurance Claims Management Mission……5
5. Key Definitions…… 5-8
6. Treating Customers Fairly……8-9
7. Process to lodge an insurance claim……9
8. Claims management process……9-10
9. Communication process with claimants……10
10. Escalation process……11-12
11. Prohibited claims practices……12
12. Valid claims received during grace period……12
13. Unclaimed Benefit……12-13
14. Sanction screening……13
15. Recordkeeping and reporting ……13-14
16. Monitoring and analysis of claims in line with TCF……14
17. Consequences of non-Compliance……14
18. Review……14

1. Introduction:

The claims management framework is a key component of RCS Cards Proprietary Limited's commitment to fair customer outcomes, ethical conduct, and regulatory compliance. RCS is an authorized Financial Services Provider (FSP 44481) licensed under the Financial Advisory and Intermediary Services Act, 2002 (FAIS), and is committed to conducting its business with honesty, integrity, fairness, dignity, and professionalism in the interests of its customers and stakeholders.

In accordance with Section 62 of the Long-term Insurance Act, the Insurance Act, 2017, and Rule 17 of the Policyholder Protection Rules (PPRs), RCS is required to establish, maintain, and operate an effective claims management framework that promotes the fair treatment of policyholders and claimants. The framework must:

- Be proportionate to the nature, scale, and complexity of the insurer's business and associated risks;
- Be appropriate to the insurer's business model, products, services, policyholders, and beneficiaries;
- Ensure claims are assessed after reasonable steps have been taken to gather and investigate all relevant information and circumstances;
- Facilitate fair, objective, and timely claims decisions;
- Avoid creating unreasonable barriers for claimants;
- Address all minimum requirements prescribed by legislation and regulatory standards.

RCS further recognizes the importance of Treating Customers Fairly (TCF), an outcome-based regulatory framework embedded in Rule 1 of the Policyholder Protection Rules. TCF requires financial institutions to consistently deliver fair outcomes to customers throughout the product life cycle. RCS is committed to embedding the six TCF outcomes into its operations and claims management practices to ensure customers receive transparent, efficient, and equitable treatment.

This Claims Management Framework outlines the principles, governance requirements, and processes that RCS follows when administering, assessing, and resolving insurance claims and is aligned to the internal procedure and control documents. The framework aims to ensure compliance with applicable legislation, consistency in decision-making, and the fair treatment of all policyholders and claimants.

2. Purpose:

The purpose of this framework is to:

- clarify key claim terminology;
- explain how a financial customer can lodge an insurance claim;
- explain the claims management process;
- outline the communication process with claimants;
- provide an escalation process for claimants who are not satisfied with the outcome of an insurance claim;
- document the necessity for record keeping, monitoring and analysis of insurance claims.

3. General information about RCS and the Insurers:

RCS Cards Proprietary Limited (RCS), company registration number 2000/017891/07 is an authorized financial services provider, FSP license no 44481.
Physical Address:
Mutual Park, Jan Smuts Drive
Pinelands, 7430
Postal Address: PO Box 111, Goodwood, 7459
Telephone Number: 021-597 4000 & 0861 729 727
External Compliance Officer: 021-555 4121 (Mr P Kotze, Masthead)

RCS performs binder and intermediary services (non-mandated intermediary) as contemplated in the Short-Term and Long-Term Insurance Acts and the Financial Advisory and Intermediary Services Act, in respect of the following product categories:

- Long Term Insurance sub-category A
- Long Term Insurance sub-category B1
- Long Term Insurance sub-category B1-A
- Short Term Insurance Personal Lines
- Short Term Insurance Personal Lines A1

RCS has a binder and intermediary agreement with Guardrisk Insurance Co Limited (Guardrisk), a licensed non-life insurer FSP75, and Guardrisk Life Limited (Guardrisk), a licensed life insurer FSP76 – both are authorized financial services providers. RCS earns binder and intermediary fees as per regulation. Guardrisk and RCS have concluded a shareholder and subscription agreement that entitles RCS to place insurance business with Guardrisk. The shareholder and subscription agreement entitles RCS to share in the profits and losses generated by the insurance business. Guardrisk may distribute dividends, at the sole discretion of its Board of Directors, to RCS during the existence of the policy.

Products underwritten by Guardrisk Insurance Company Limited:

- Card Protection Plan

Products underwritten by Guardrisk Life Limited:

- Customer Protection Insurance Plan
- Funeral Plan
- Personal Accident Plan
- Comprehensive Protection Plan
- Critical Illness Plan
- Income Protection Plan
- Accidental Death Insurance

4. RCS Insurance Claims Management Mission

RCS undertakes to provide financial customers with quality service, integrity, and commitment and in addition, RCS undertakes to:

- Empower and train the people in our business who processes insurance claims and ensure they have the appropriate claims management experience;
- Manage insurance claims in a timely and fair manner, with every claim receiving proper consideration in a process that is managed appropriately and effectively by the responsible, appointed staff member(s) without any conflict of interest;
- Undertake to ensure easy access for a claimant to the RCS insurance claims process and claim forms;
- Ensure that an internal process exists for challenging claims and that regular feedback is provided to the claimant;
- Ensure that the RCS insurance claims handling process is reviewed on a regular basis by senior management and that overall improvement/s are actioned because of feedback received from policyholders;
- Inform claimants of their right to refer their insurance complaints resulting from a claim to Guardrisk or to the relevant OMBUD;
- Maintain records of all insurance claims received for a minimum period of 5 years, which will specify the outcome of all the claims lodged.

5. Key Definitions:

The following key definitions are important to note:

Beneficiary
For Life, Risk and Health classes of business:
means the person nominated by the Principal Insured to receive the benefits of this Policy on the death of the principal insured. Where a beneficiary nomination is not received, the benefit will be payable to the deceased's estate. Should there be no estate, the benefit will be payable to the deceased's spouse. If no spouse, the benefit will be payable to the claimant provided the claimant can prove insurable interest exists and he/she was dependent on the principal insured for financial assistance. The principal insured is the nominated beneficiary in respect of the death of a spouse;

For Credit Life insurance:
RCS is the beneficiary;

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 the claimant's demand is valid;

Claimant
means a person who makes a claim;

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 Guardrisk to assume that the claimant has so accepted. A claim should only be regarded as accepted once all undertakings made by Guardrisk to provide policy benefits wholly or in part have been met;

Compensation payment
A payment, whether in monetary form or in the form of a benefit or service, by or on behalf of RCS to a complainant to compensate the complainant for a proven or estimated financial loss incurred as a result of RCS's contravention, non -compliance, action, failure to act, or unfair treatment forming the basis of the complaint, where RCS accepts liability for having caused the loss concerned, but excludes any -

- Goodwill payment;
- payment contractually due to the complainant in terms of the financial product or financial service concerned; or
- refund of an amount paid by or on behalf of the complainant to the provider where such payment was not contractually due;

And includes any interest on past due payment of any amount referred to above;

Customer Query
means a request to Guardrisk 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:

- an extension of a claim relating to the outcome of the initial claim;
- the claim is complex or unusual that it requires intervention by an impartial senior functionary appointed to deal with escalated claims;
- the referral of the claim to the appointed reinsurer for further review and feedback;
- the referral of the claim to a Claims Committee mandated and authorised to review the claim and provide an outcome;

- 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 RCS Complaints Management Framework;

Exclusion
means the losses or risk events not covered under a policy. Should a claim arise from an exclusion, no benefit will be payable;

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

Goodwill payment
A payment, whether in monetary form or in the form of a benefit or service, by or on behalf of RCS to a complainant as an expression of goodwill aimed at resolving a complaint, where RCS does not accept liability for any financial loss to the complainant as a result of the matter complained about;

Grace Period
means a period of 60 (sixty) days after the premium payment date where the cover is still in force, but the Premium has not been paid. If any claim event occurs during this period which results in a valid claim, the unpaid premium/s will be deducted from any benefit paid. Failure to pay the premium/s by the expiry of this period will result in the policy lapsing and all benefits will cease.
A claim event that arises in the period after the policy has lapsed will not be covered.
The grace period does not apply to payment of the first premium;

Ombud
has the meaning assigned to it in the –

- 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
- 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;

NFO (National Financial Ombud Scheme) will have a corresponding meaning where the context so allows;

Plain Language means communication that:

- is clear and easy to understand;
- avoids uncertainty or confusion; and
- as adequate and appropriate in the circumstances'

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

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:

- in respect of a loss event or risk not covered by a policy; and
- 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;

Sanction Screening
means the process to identify if a beneficiary or claimant is on a Sanctions List in which instance the benefit payable cannot be paid to such person. It also means the identification of a beneficiary or claimant as a:

- PIP – Prominent Influential Person;
- PEP – Politically Exposed Person;
- FPPO – Foreign Prominent Public Official; or
- DPIP – Domestic Prominent Influential Person,

in which instance the internal Compliance process must be followed to determine if the benefit can still be paid to such person.

Unclaimed Benefit
means a benefit in terms of an approved claim where the benefit cannot be paid to the nominated beneficiary within 3 (three) years of the claim having been approved because the nominated beneficiary is not contactable. In other words, the nominated beneficiary cannot be located, his/her emails are undelivered, his/her post is returned to the Binder Holder and/or his/her contact number is no longer in in use. **Unclaimed benefits** shall have a corresponding meaning;

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;

6. Treating Customers fairly

Treating Customers Fairly (TCF) is an outcomes based regulatory and supervisory approach designed to ensure that regulated financial institutions deliver specific, clearly set out fairness outcomes for financial customers. Regulated entities are expected to demonstrate that they deliver the following six TCF Outcomes to their customers throughout the product life cycle, from product design and promotion, through advice and servicing, to complaints and claims handling:

- Policyholders can be confident they are dealing with firms where TCF is central to the corporate culture;
- Products & services marketed and sold in the retail market are designed to meet the needs of identified financial customer groups and are targeted accordingly;
- Policyholders are provided with clear information and kept appropriately informed before, during and after point of sale;

- Where advice is given, it is suitable and takes account of financial customer's circumstances;
- Products perform as firms have led customers to expect, and service is of an acceptable standard and as they have been led to expect;
- Policyholders do not face unreasonable post-sale barriers imposed by firms to change product, switch providers, submit a claim or make a complaint.

7. Process to lodge an insurance claim with RCS:

Policyholders/claimants can lodge insurance claims through the following channels, however, if lodged telephonically the claimant will be requested to provide the information in writing thereafter:

- Consult the RCS website for the process on "How to claim" and download the claim forms from the product landing page - www.rcs.co.za;
- Request a claim form or email documents to claims@rcsgroup.co.za;
- Telephone – contact the RCS Insurance team on 0861 729 727.

8. Claims management process:

Step 1	RCS will receive claim documents from a claimant and will acknowledge receipt of a claim immediately after registering the claim on the system.
Step 2	The insurance inbound agent who registers the claim on the system will follow a checklist to see if all the required documents were submitted, and if not, inform the claimant that there is outstanding documentation required to proceed with the claim process.
Step 3	Should all the documentation be available to assess the claim it will go through an assessment process conducted by the first assessor. The first assessor will: • Follow a checklist relative to documentation required; • Check that all premiums have been paid and that the policy is still active; • Check that the claim event is not excluded in terms of the policy wording; • Arrive at a preliminary decision; • Where the preliminary decision is an approval, the first assessor will calculate the settlement amount where applicable; • The first assessor will then send the claim for final assessment; • Where the preliminary decision is a repudiation, the first assessor will send the claim for final assessment; • Where there are still documents outstanding for the first assessor to complete the assessment, the claimant will be contacted to provide the documents that is still outstanding.
Step 4	The final assessor will review the recommended decision of the first assessor by: • Reviewing the documentation received; • Reviewing policy status and premiums paid; • Reviewing claim event and circumstances in line with the policy wording; • Reviewing settlement calculation for approved claims;

	• Arrive at a decision and check if decision aligns with the recommended decision received from the first assessor; • Where the decisions are aligned and the claim is approved, the final assessor will approve the claim, and documentation will be sent to the claimant to inform him/her of the decision.
Step 5	The final assessor will refer complex claims to the Admin Manager for assistance. Should the Admin Manager not be able to assist, the claim will be referred to the Head: Insurance who will recommend a decision that must be approved by the Insurer
Step 6	The final assessor will send claims that must be repudiated to the Insurer for review and approval • The Insurer will review all the documents and circumstances of the claim on the system and either approve or decline the repudiation; • Where the repudiation is approved the final assessor will send a repudiation letter to the claimant to explain the reason for repudiation; • Should the Insurer disagree with the repudiation the repudiation will be overturned and the claimant will be informed that the claim has been approved.
Step 7	Payment of the claim • Once the claim has been approved a claims settlement will be made; • The claimant will be informed of the payment once the claims settlement has been made; • The claim will then be closed on the system.
Step 8	Complaints that follow from repudiated claims • The claimant will be informed of the escalation process to follow should they not be happy with the claims outcome. This information is in the repudiation letter sent to the claimant.

9. Communication process with claimants:

There are several communication points during the claims process as per RCS internal Insurance Claims Management procedure, as follows:

- Acknowledge receipt of claim;
- Requesting additional information from claimant and documents to enable the processing of the claim with regular reminders;
- Providing claimant with feedback during the claims process;
- Approval letter;
- Repudiation letter which will include the Escalation process and:
    - The reason for the decision;
    - Include the facts that informed the decision;
    - That the claimant may within a period of not less than 90 days after the date of receipt of the notice make representation to the Insurer;
    - That the claimant has the right to lodge a complaint to the Insurer or to the relevant OMBUD and provide the contact details and time limitation of the applicable OMBUD scheme;
- Confirmation of claim payment and closure.

10. Escalation process:

Should a claimant be dissatisfied with the outcome of a claim, RCS will use the following process for the escalation and review of complaints emanating from claims outcomes:

- Where the complaint is of a complex or unusual nature, the initial complaint handler will escalate this to a senior person, namely the Insurance Administration Manager;
- Where the Insurance Administration Manager is unable to reach a determination, the complaint will be escalated to the Head of Insurance (HOI). The Administration Manager will provide the HOI with a summary of the complaint as well as supporting documents;
- The HOI will review the circumstances and provide feedback to the Insurance Administration Manager – in some instances the HOI will request that the complaint be escalated to the Insurer for guidance;
- Once the HOI reaches a determination based either on their own investigation or from guidance received from the Insurer, the complaint handler will communicate the decision to the complainant.

Should a complainant not accept the outcome of the complaint, there is a further escalation avenue available to them to follow:

Should RCS not resolve the complaint to the satisfaction of the complainant, the complainant can then approach the Insurer. Contact details of the Insurers involved are below:

Guardrisk Insurance Company Limited and Guardrisk Life Limited, on email address complaints@guardrisk.co.za, or by phoning 011-6691000

Should the Insurer not resolve the complaint to the satisfaction of the complainant, the complainant can then approach the applicable OMBUD.

The objective of the applicable OMBUD is to consider and dispose of complaints in a procedurally fair, informal, economical, and expeditious manner and by reference to what is equitable. The applicable OMBUD is independent and impartial.

The following contact information is relevant for each OMBUD and Regulatory authority:

National Financial OMBUD Scheme – for claims and service related matters

Physical Address Cape Town:	6th Floor Claremont Central Building 6 Vineyard Road Claremont, 7708
Physical Address Johannesburg:	110 Oxford Road Houghton Estate Illovo 2198
Tel:	0860-800-900
Email:	info@nfosa.co.za
Website:	www.nfosa.co.za

The FAIS Ombudsman – for product/advice related matters

Postal Address:	P.O. Box 41 Menlyn Park, 0063
Tel:	(012) 762 5000
Share call:	0860 663 274
E-mail:	info@faisombud.co.za
Website:	www.faisombud.co.za

Financial Sector Conduct Authority – for market conduct related matters

Postal Address:	P.O. Box 35655, Menlo Park, 0102
Tel:	(012) 428 8000
Fax:	(012) 346 6941
Email:	info@fsca.co.za
Website:	www.fsca.co.za

The Information Regulator – for complaints relating to the use of personal information

Postal Address:	P.O. Box 31533 Braamfontein Johannesburg, 2017
Tel:	+27-10-023-5200
Email:	POPIAComplaints@inforegulator.com

11. Prohibited Claims practices:

RCS and the Insurer may not:

1.1 Dissuade a claimant from obtaining the services of an attorney or adjustor;
1.2 Deny a claim without performing a reasonable investigation; or
1.3 Deny a claim based on the outcome of a polygraph, lie detector or truth verification or similar test.

12. Valid claims received during period of grace:

If a claimant submits a claim in respect of an event that occurred during a grace period, the value of the claim may be reduced by the sum of the unpaid premium.

13. Unclaimed Benefit:

If a benefit under a policy is an unclaimed benefit, RCS must take action to determine if the nominated beneficiary is alive and/or aware of the benefit payable to him/her under the policy. Specifically, in the 3 (three) year period after the unclaimed benefit arises, RCS must:

- attempt to contact the nominated beneficiary telephonically and electronically to advise them of the unclaimed benefit; or

- determine the last known contact information of the nominated beneficiary by comparing internal and external databases, including the use of internet search engines and/or social media; or

- appoint an external tracing company to locate the nominated beneficiary.

Before the end of the 3 (three) year period referred to above, RCS must confirm the unclaimed benefit and transfer the amount of the unclaimed benefit to an account in the name of the Insurer, and the Insurer will accept liability for the unclaimed benefit.

14. Sanction screening:

RCS, as an accountable institution under the Financial Intelligence Center Act (FICA), is obligated to perform sanction screening on the beneficiary of a claim prior to the claim settlement being made, to ensure that the beneficiary is not a sanctioned person in terms of the definition provided under sanction screening in Section 6 above.

RCS is committed to a culture of compliance and as such has procedures and controls in place designed to comply with sanction requirements. In addition, RCS ensures that ongoing training is provided to all employees relative to sanctions and sanction screening, anti-money laundering, and counter-terrorism activities and how to identify and report on any suspicious transaction.

RCS is prohibited to transact with a sanctioned person or entity. Any suspicious transaction or should a claimant or beneficiary be identified as a sanctioned person, must be reported through the channels identified in the internal policies and procedures document.

15. Record keeping and reporting:

RCS must maintain a register of claims received and records must be kept for a minimum of 5 (five) years in terms of requirements of legislation. Records to be kept:

- customer's name and surname
- ID and/or account number
- claim type
- all relevant evidence, correspondence and decisions must be retained
- progress and update status of claims

The following data must be maintained and reported on:

- number of claims received;
- number of claims approved;
- number of claims rejected;
- number of claims pending outstanding documents;
- number of claims closed;
- number of claims decisions escalated by customers to the internal complaints escalation process;

- number of claims referred to a Regulator/OMBUD and their outcome;
- number and amounts of compensation payments made;
- number and amounts of goodwill payments made.

16. Monitoring and analysis of claims in line with TCF:

Claims information that has been recorded, must be scrutinised and analysed by RCS on an ongoing basis. RCS must use this information to manage conduct risks and implement improved outcomes and processes for its clients, and to prevent recurrences of poor outcomes and errors.

RCS must on a monthly basis analyse claims by looking at:

- number of claims received by claim type;
- number of claims received by product;
- number of claims approved;
- number of claims repudiated;
- number of claims where documents is outstanding;
- number of claims close;
- average turnover time by claim type.

The person responsible for conducting the claims analysis is the Insurance Administration manager who will report on this to the Head of Insurance (HOI) on a monthly basis.

The report will include:

- information on the categorisation of claims;
- what trends have been identified;
- what the average turnaround time is of claims by claim type;
- what actions will be taken to manage risks and implement improved outcomes.

The HOI will analyse the results and request the Insurance Administration Manager to execute the actions identified in the report to improve the outcome.

17. Consequences of Non-Compliance

RCS will follow its relevant performance management and/or disciplinary processes for non-compliance to this procedure.

RCS could also be subject to regulatory fines should legislative requirements not be complied with.

18. Review

This framework will be reviewed every 24 (twenty-four) months for relevance. This framework can, however, be reviewed on an ad-hoc basis when considered necessary by management or when required by changes in legislation.