



**Generali Insurance Malaysia Berhad**

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Member of PIDM

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Generali Insurance Malaysia Berhad is licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia.

## MULTI MEDICAL PROTECTOR POLICY

This Policy is issued in consideration of the payment of premium to Generali Insurance Malaysia Berhad ("the Company") as specified in the Policy Schedule and pursuant to the answer given in your Proposal Form and any other disclosures made by you between the time of submission of your Proposal Form and the time this contract is entered into. The answers and any other disclosures given by you shall form part of this contract of insurance between you and us. However, in the event of any pre-contractual misrepresentation made in relation to your answers or in any disclosures given by you, only the remedies in Schedule 9 of the Financial Services Act 2013 will apply.

Provide always that:

a) For Part I – Basic Med:

If during the Period of Insurance, any sickness, disease, illness or accidental injury necessitates that it is medically necessary for the Insured Person to be confined to a hospital for treatment, the Company will subject to the terms, provisions, exclusions and conditions of and endorsed on this Policy, pay to the Insured or his legal personal representatives the sum or sums stated in the Schedule of Benefits.

b) For Part II – Major Med

1. the Insured Person has been diagnosed and confirmed as suffering from any of the Major Disabilities as defined in this Policy;
2. the Major Disability suffered by the Insured Person is the first incident or occurrence of that medical condition;
3. as for Benefit of "Major Disabilities Relief",
  - i) the diagnosis of the Major Disability is confirmed after the Waiting Period of thirty (30) days;
  - ii) for the payment of the Lump Sum Benefit, the Insured Person has survived for a period of at least thirty (30) days from the date of the diagnosis and confirmation of the Major Disability.

Provided also always that:

- a) the liability of the Company shall not exceed the Overall Annual Limit or the Benefit Limits, whichever applicable, as set out in the Schedule of Benefits for any one period of insurance.
- b) This Policy shall become effective as of the stated Effective Date in the Policy Schedule. This Policy shall be issued for one year and at the end of each period of insurance may be renewed for another year subject to the consent of the Company.

This Policy reflects the terms and conditions of the contract of insurance as agreed between you and us.

### DEFINITIONS

Certain words or group of words have been defined in this Policy and these have the same meaning wherever they are used and which shall form the basis on which a claim may be insured. Where the context requires, masculine form shall apply to feminine and singular term shall include the plural.

1. **INSURED** shall mean the Applicant in the Proposal Form, to whom the Policy has been issued in respect of cover for person(s) specifically identified as Insured Person(s) in this Policy and is aged sixty (60) years and below. In respect of renewals of policies purchased before the Insured attained sixty (60) years, the Insured may be covered until the age as specified in the Table of Benefits, if applicable, subject to yearly review and satisfactory health declarations.
2. **INSURED PERSON** shall mean the person described in the Policy Schedule including his/her Dependent (if applicable)
3. **EFFECTIVE DATE** shall mean the date from which the Insured Person is insured under this Policy.
4. **POLICY YEAR** shall mean the one-year period including the effective date of commencement of Insurance and immediately following that date, or the one-year period following the Renewal or Renewed Policy.
5. **RENEWAL OR RENEWED POLICY** shall mean a Policy which has been renewed without any lapse of time upon expiry of a preceding Policy with the same content.
6. **ACCIDENT** shall mean a sudden, unintentional, unexpected, unusual, and specific event that occurs at an identifiable time and place which shall, independently of any other cause, be the sole cause of bodily injury.
7. **INJURY** shall mean bodily injury caused solely by Accident.
8. **SICKNESS, DISEASE OR ILLNESS** shall mean a physical condition marked by a pathological deviation from the normal healthy state.
9. **DISABILITY** shall mean a Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes.
10. **ANY ONE DISABILITY** shall mean all of the periods of disability arising from the same cause including any and all complications there from except that if the Insured Person completely recovers and remain free from further treatment (including drugs, medicines, special diet or injection or advice for the condition) of the disability for at least ninety (90) days following the latest date of discharge, and subsequent disability from the same cause shall be considered as though it were a new disability.
11. **CONGENITAL CONDITIONS** shall mean any medical or physical abnormalities existing at the time of birth, as well as neonatal physical abnormalities developing within six (6) months from the time of birth. They will include hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the insured was continuously covered under this Policy.
12. **CHILD** shall mean any person who has attained the age of fifteen (15) days and is an unmarried person, is financially dependent upon the Insured and is under the age of nineteen (19), or up to the age of twenty-three (23) for those registered as full time students at a recognized educational institution.
13. **DEPENDENTS** shall mean any of the following persons:
  - a) A spouse aged sixty (60) years and below. In respect of renewals of policies purchased before the spouse attained sixty (60) years, the spouse may be covered until the age as specified in the Schedule of Benefits, if applicable, subject to yearly review and satisfactory health declarations.
  - b) unmarried children fifteen (15) days or higher but under nineteen (19) years of age or twenty-three (23) years of age if still on full-time higher education at a recognized local institution, and who are not gainfully employed.
14. **ELIGIBLE EXPENSES** shall mean Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the Schedule of Benefits.
15. **MEDICALLY NECESSARY** shall mean a medical service which is:
  - a) consistent with the diagnosis and customary medical treatment for a covered Disability, and
  - b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits, and
  - c) not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient), and
  - d) not of an experimental, investigational or research nature, preventive or screening nature,
  - e) for which the charges are fair and reasonable and customary for the Disability.

16. **REASONABLE AND CUSTOMARY CHARGES** shall mean charges for medical care which is medically necessary shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individual of the same sex and of comparable age for a similar sickness, disease or injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured Person's medical condition.
17. **PRE--EXISTING ILLNESSES** shall mean disabilities that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:
- the Insured Person had received or is receiving treatment;
  - medical advice, diagnosis, care or treatment has been received;
  - clear and distinct symptoms are or were evident; or
  - its existence would have been apparent to a reasonable person in the circumstances.
18. **SPECIFIED ILLNESSES** shall mean the following disabilities and its related complications, occurring within the first 120 days of Insurance of the Insured Person:
- Hypertension, diabetes mellitus and cardiovascular disease.
  - All tumours, cancers, cysts, nodules, polyps, stones of the urinary system and biliary system.
  - All ear, nose (including sinuses) and throat conditions.
  - Hernias, haemorrhoids, fistulae, hydrocele, varicocele.
  - Endometriosis including disease of the reproduction system.
  - Vertebro-spinal disorders (including disc) and knee conditions.
19. **HOSPITALISATION** shall mean admission to a Hospital as a registered in-patient for Medically Necessary treatments for a covered Disability upon recommendation of a physician. A patient shall not be considered as an in-patient if the patient does not physically stay in the hospital for the whole period of confinement.
20. **INTENSIVE CARE UNIT** shall mean a section within a Hospital which is designated as an Intensive Care Unit by the Hospital, and which is maintained on a twenty-four (24) hour basis solely for treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.
21. **OUT-PATIENT** shall mean the Insured Person is receiving medical care or treatment without being hospitalized and includes treatment in a Daycare centre.
22. **WAITING PERIOD** shall mean the first thirty (30) days between the beginning of an Insured Person's disability and the commencement of this Policy date and is applied only when the person is first covered. This shall not be applicable after the first year of cover. However, if there is a break in insurance, the Waiting Period will apply again. For Major Disabilities, the Waiting Period is thirty (30) days.
23. **DAY SURGERY** shall mean a patient who needs the use of a recovery facility for a surgical procedure on a pre-plan basis at the hospital/specialist clinic (but not for overnight stay).
24. **HOSPITAL** shall mean only an establishment duly constituted and registered as a hospital for the care and treatment of sick and injured persons as paying bed-patients, and which:
- has facilities for diagnosis and major surgery,
  - provides twenty-four (24) hour a day nursing services by registered and graduate nurses,
  - is under the supervision of a Physician, and
  - is not primarily a clinic; a place for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.
25. **MALAYSIAN GOVERNMENT HOSPITAL** shall mean a hospital which charges of services are subject to the Fee Act 1951 Fees (Medical) Order 1982 and/or its subsequent amendments if any.
26. **PRESCRIBED MEDICINES** shall mean medicines that are dispensed by a Physician, a Registered Pharmacist or a Hospital and which have been prescribed by a Physician or Specialist in respect of treatment for a covered Disability.
27. **DOCTOR or PHYSICIAN or SURGEON** shall mean a registered medical practitioner qualified and licensed to practice western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice, but excluding a doctor, physician or surgeon who is the insured himself.

28. **DENTIST** shall mean a person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided but excluding a physician or surgeon who is the insured himself.
29. **SPECIALIST** shall mean a medical or dental practitioner registered and licensed as such in the geographical area of his practice where treatment takes place and who is classified by the appropriate health authorities as a person with superior and special expertise in specified fields of medicine or dentistry but excluding a physician or surgeon who is the insured himself.
30. **PATHOLOGIST** shall mean a medical practitioner qualified as a pathologist and duly licensed to practice within the scope of an accredited pathology laboratory pursuant to the laws of the country in which such practice is maintained.
31. **NEUROLOGIST** shall mean a medical practitioner qualified as an expert in neurology or in the treatment of disorders of the nervous system and duly licensed to practice within the laws of the country in which such practice is maintained.
32. **SURGERY** shall mean any of the following medical procedures:
- a) To incise, excise or electrocauterize any organ or body part, except for dental services.
  - b) To repair, revise, or reconstruct any organ or body part.
  - c) To reduce by manipulation a fracture or dislocation.
  - d) Use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or urethra.
33. **TREATMENT** shall mean the actual receiving of medical or surgical care or attention either as an inpatient or outpatient from a medical practitioner and for all medically necessary diagnostic services directly associated with the covered Disability under treatment.
34. **MEDICAL PRACTITIONER** shall mean a person legally authorised in the geographical area of his practice to render medical care and treatment.
35. **DIAGNOSIS** shall mean the definitive diagnosis made by a Physician, Surgeon, Neurologist or Pathologist based upon such specific evidence, as referred to below in the definition of the particular Major Disability concerned, or in the absence of such specific evidence based upon radiological, clinical, histological or laboratory evidence acceptable to the Company. Such diagnosis must be supported by the Company's Medical Officer or appointed medical practitioner who may base his opinion on the medical evidence submitted by the claimant and/or any additional evidence he may require.

In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to call for an examination, of either the Insured Person or the evidence used in arriving at such diagnosis, by an independent expert medical practitioner acknowledged in the field of medicine concerned and the opinion of such expert as to such diagnosis shall be binding on both the Insured Person and the Company.

36. **MAJOR DISABILITY** means illness or injury, the signs or symptoms of which commenced after the Waiting Period and shall include either the diagnosis of any of the following illnesses, injuries or performance of any of the covered surgeries included herein if the Major Disability is diagnosed within the Waiting Period, no benefit shall be payable.

The Major Disability covered in this Policy shall be defined as follows:

**I. Bacterial Meningitis**

This means bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit persisting for at least six (6) consecutive months, such diagnosis to be confirmed by a consultant neurologist.

**II. Brain Surgery**

This means the actual undergoing of surgery to the brain during general anaesthesia during which the scalp is opened.

**III. Cancer**

This means any malignant tumour characterised by the uncontrolled growth and spread of the malignant cells and invasion of tissue that requires treatment by surgery, radiotherapy, chemotherapy, biological response modifiers or any other major Interventional treatment and includes cancers that are completely untreatable. Inconvertible evidence of such invasion of tissue or definitive histology of the malignant tumour must be produced. The following are included:

- Leukemia;
- Hodgkin's disease;
- Malignant Lymphoma;
- Malignant bone marrow disorders; and
- Melanomas which have a depth of invasion of Clark Level 3 or 1.5mm or more in thickness.

The following are excluded:

- chronic Lymphocytic Leukemia Rai Stage 0-2;
- tumours treated by endoscopic procedures alone;
- all skin cancers including malignant melanomas less than Clark Level 3 or 1.5mm in thickness;
- carcinoma in situ unless leading to radical breast surgery;
- all AIDS related malignancies.

**IV. Chronic Liver Disease**

This means end-stage liver failure which is permanent, together with permanent jaundice, ascites and encephalopathy. Disease excluded.

**V. Chronic Lung Disease**

This means permanent respiratory failure with FEV1 test results of consistently less than 1 litre requiring permanent oxygen therapy.

**VI. Coma**

This means a state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously with the use of life support systems for at least four (4) consecutive days and resulting in a neurological deficit which is of a permanent nature.

**VII. Coronary Artery Disease Requiring By-pass Surgery**

This means the actual undergoing of by-pass surgery (including saphenous vein or internal mammary graft/s) for the treatment of coronary artery disease. Any other operations are specifically excluded from this definition.

**VIII. Encephalitis**

This means severe inflammation of brain substance which results in significantly permanent neurological sequelae. The permanent neurological deficit must be documented for at least four (4) weeks. Encephalitis occurring in patients in HIV infection is excluded.

**IX. Fulminant Viral Hepatitis**

This means a submissive to massive necrosis of the liver caused by the hepatitis virus leading to precipitously to live, failure all the following diagnostic criteria must be met:

- a rapidly decreasing liver size;
- necrosis involving entire lobules, leaving only a collagen reticular framework;
- rapidly degenerating liver function tests; and
- deepening jaundice.

**X. Heart Attack (Myocardial Infarction)**

This means the death of part of the heart muscle (myocardium) as a result of inadequate blood supplies. The diagnosis is based on clinical electrocardiogram (ECG) and biochemical assessments with the following criteria being present:

- a current history of typical chest pain;
- an electrocardiogram showing changes resulting from this occurrence; and
- a pathology test, which confirms that cardiac enzymes have been elevated above generally accepted laboratory levels. Simple angina pectoris is excluded.

**XI. Heart Valve Replacement**

This means the actual undergoing of open-heart surgery replace or repair heart valves as a consequence of heart valve defects or abnormalities.

**XII. Kidney Failure**

The terminal stage of renal disease resulting in the loss of function of both kidneys requiring permanent renal dialysis. Medullary cystic Disease is covered under this definition. Medullary Cystic Disease is a condition involving polycystic kidney formation of multiple cysts the medulla region of both kidneys and involving the collecting ducts as unequivocally diagnosed by a medical consultant.

**XIII. Major Burns**

This means tissue injury caused by thermal, electrical or chemical agents causing third degree burns to at least:

- twenty (20%) percent or more of the body surface as measured by 'The Rule of 9' of the Lund & Browder Body Surface Chart; or
- both hands or the face requiring surgical debridement and/or grafting.

**XIV. Major Organ Transplant**

This means the human to human organ transplant from a donor to the Insured Person of one or more of the following organs: kidney, lung, pancreas, heart, liver or bone marrow.

The transplantation of all other organs or parts of organs or any other tissue transplant is excluded.

**XV. Multiple Sclerosis**

This means the unequivocal diagnosis of Multiple Sclerosis by a consultant neurologist. There must be more than one episode of well-defined neurological deficit with persistent neurological abnormalities resulting in a permanent loss of at least twenty-five (25%) percent impairment of whole body function or the inability to perform three (3) or more of Activities of Daily Living, as defined below:

**Loss of Daily Living**

1. Dressing - the ability to put on and take off clothing without assistance
2. Toileting - the ability to use the toilet, including getting in and off without assistance
3. Mobility - the ability to get in and out of bed and a chair without assistance
4. Continence - the ability to control bowel and bladder function
5. Feeding - the ability to get food from a plate into the mouth without assistance

**XVI. Open Heart Surgery**

This means open heart surgery for treatment of cardiac defect(s), cardiac aneurysm or benign cardiac tumour(s).

**XVII. Paralysis/Paraplegia**

This means complete and permanent loss of use of two (2) or more limbs through neurological damage for the remainder of the Insured Person's life. The following events are covered:

- **Paraplegia:** The permanent loss of use of both legs, or both arms, resulting from spinal cord sickness or injury.
- **Quadriplegia:** The permanent loss of use of both arms and both legs resulting from spinal cord sickness or injury.
- **Hemiplegia:** The total loss of function of one side of the body due to sickness or injury where such loss of function is permanent.
- **Diplegia:** The total loss of function of both sides of the body due to sickness or injury where such loss of function is permanent.
- **Tetraplegia:** The total and permanent loss of use of both arms and both legs, together with loss of head movement, due to brain sickness or injury or spinal cord sickness or injury.

**XVIII. Stroke or Cerebrovascular accident**

This means cerebrovascular accident or incident producing neurological sequelae, lasting more than twenty-four (24) hours. This includes infarction of brain tissue, intracranial and/or subarachnoid haemorrhage, or embolisation from an extracranial source. Evidence of permanent neurological deficit must be produced. Transient ischemic attacks, reversible ischemic neurological defect and cerebral symptoms due to migraine are excluded.

**XIX. Total Blindness**

The permanent loss of sight in both eyes due to sickness or injury to the extent of 6/60 or less, or to the extent that the visual field is reduced to 20 degrees or less. The diagnosis must be clinically confirmed by a qualified eye specialist.

**XX. Total Loss of Hearing / Deafness**

This means complete and irrecoverable loss of hearing, both natural and assisted, from both ears as a result of sickness or injury as certified by an appropriate medical (Ear, Nose & Throat) specialist and must include audiometric and sound-threshold tests.

## DESCRIPTION OF BENEFITS

### EXTENT

The Benefits provided under this Policy are applicable without geographical limitation for twenty-four (24) hours a day in respect of the eligibility of the Insured Person.

### PART I – BASIC MED

#### 1. INPATIENT BENEFITS

##### (a) HOSPITAL ROOM & BOARD

Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Person's confinement, but in no event shall the benefit exceed, for anyone day, the rate of Room and Board Benefit, and the maximum number of days as set forth in the Schedule of Benefits. The Insured Person will only be entitled to this benefit while confined to a Hospital as an in-patient.

##### (b) NURSING CARE AND SERVICE

Reimbursement of the Reasonable and Customary Charges Medically Necessary for the daily general nursing care and services rendered whilst the Insured Person is confined to a Hospital as bed patient in a Hospital.

##### (c) LODGER FEES

Reimbursement of the expenses for meals and lodging incurred to accompany an insured Child (aged below fifteen (15) years) in the hospital up to the maximum limit and number of days as set forth in the Schedule of Benefits.

##### (d) ALL ELIGIBLE INPATIENT MEDICAL EXPENSES

Reimbursement of Reasonable and Customary Charges actually incurred for all eligible medical expenses incurred by the Insured Person when confined to a Hospital. This shall include charges or fees of:

- **Intensive Care Unit**

Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an in-patient in the Intensive Care Unit of the Hospital. This benefit shall be payable equal to the actual charges made by the Hospital subject to the maximum benefit for any one day, and maximum number of days, as set forth in the Schedule of Benefits. Where the period of confinement in an Intensive Care Unit exceeds the maximum set forth in the Schedule of Benefits, reimbursement will be restricted to the standard Daily Hospital Room and Board rate. No Hospital Room and Board Benefits shall be paid for the same confinement period where the Daily Intensive Care Unit Benefits is payable.

- **Hospital Supplies & Services**

Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, laboratory examinations, electrocardiograms, physiotherapy, basal metabolism tests, intravenous injections and solutions, administration of blood and blood plasma but excluding the cost of blood and plasma whilst the Insured Person is confined as an in-patient in a Hospital, up to the amount stated in the Schedule of Benefits.

- **Operating Theatre Fees**

Reimbursement of the Reasonable and Customary Operating Room charges incidental to the surgical procedure.

- **Anaesthetist Fees**

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia not exceeding the limits as set forth in the Schedule of Benefits.

- **Surgical Fees**

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary surgery by the Specialists, including pre-surgical assessment Specialist's visits to the Insured Person and post-surgery care up to a maximum of sixty (60) days from the date of surgery, but within the maximum indicated in the Schedule of Benefits. If more than one surgery is performed for Any One Disability, the total payments for all the surgeries performed shall not exceed the maximum stated in the Schedule of Benefits.

- **In-Hospital Physician Visit**

Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visiting a in-paying patient while confined for a non-surgical disability subject to a maximum of one (1) visit per day not exceeding the maximum number of days as set forth in the Schedule of Benefit.

- (e) **MALAYSIAN GOVERNMENT HOSPITAL DAILY CASH ALLOWANCE**

Pays a daily allowance for each day of confinement for a covered Disability in a Malaysian Government Hospital, provided that the Insured shall confine to a Room and Board rate that does not exceed the amount shown in the Schedule of Benefit. No Payment will be made for any transfer to or from any Private Hospital and Malaysian Government Hospital for the covered disability.

- (f) **MEDICAL REPORT FEE**

Reimbursement of the fee actually charged for the completion of the Medical Report by the attending Physician or Surgeon up to the maximum limit as stated in the Schedule of Benefits.

- (g) **MALAYSIAN TAX**

Reimbursement of the charges imposed by the Malaysian tax authorities (if applicable) levied by the clinics/hospitals on taxable Benefits described herein (if any) as provided by the Insured Person that are payable under this Policy is subject to the Overall Annual Limit.

## 2. **OUTPATIENT BENEFITS**

- (a) **PRE-HOSPITALISATION SPECIALIST CONSULTATION**

Reimbursement of the Reasonable and Customary Charges for the first-time consultation by a Specialist in connection with a Disability within the maximum number of days as set forth in the Schedule of Benefits preceding confinement in a Hospital and provided that such consultation is Medically Necessary and has been recommended in writing by the attending general practitioner.

Payment will not be made for clinical treatment (including medications and subsequent consultation after the illness is diagnosed) or where the Insured does not result in hospital confinement for the treatment of the medical condition diagnosed.

- (b) **PRE-HOSPITALISATION DIAGNOSTIC SERVICES**

Reimbursement of the Reasonable and Customary Charges for Medically Necessary ECG, X-ray and laboratory tests which are performed for diagnostic purposes on account of an injury or illness when in connection with a Disability preceding hospitalisation within the maximum number of days and amount as set forth in the Schedule of Benefit in a Hospital and which are recommended by a qualified medical practitioner. No payment shall be made if upon such diagnostic services, the Insured does not result in hospital confinement for the treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.

- (c) **DAYCARE SURGERY**

Reimbursement of the Reasonable and Customary Charges for all professional fees, including all incidental costs, services and supplies, for minor Daycare Surgical Procedures performed as an outpatient without hospitalisation. The surgical procedures shall include all invasive (diagnostic) or endoscopic procedures and minor operations but exclude treatment or procedures for long term illness like cancer, kidney failure and the like.

- (d) **POST-HOSPITALISATION PHYSICIAN TREATMENT**

Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up treatment by the same attending Physician, within the maximum number of days and amount as set forth in the Schedule of Benefits immediately following discharge from Hospital for a non-surgical disability. This shall include medicines prescribed during the follow-up treatment but shall not exceed the supply needed for the maximum number of days as set forth in the Schedule of Benefits.

- (e) **EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT**

Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily injury arising from an Accident for Medically Necessary treatment as an outpatient at any registered clinic or hospital within twenty-four (24) hours of the Accident causing the covered bodily Injury. Follow up treatment by the same doctor or same registered clinic or Hospital for the same covered bodily injury will be provided up to the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

- (f) **EMERGENCY ACCIDENTAL OUTPATIENT DENTAL TREATMENT**

Reimbursement of the Reasonable and Customary Charges charged by a legally registered dentist or at a dental clinic or hospital within twenty-four (24) hours of the Accident for the treatment of accidental injuries to sound natural teeth. Subsequent restorative, periodontal, orthodontic and prosthodontal services are not covered. Follow-up treatment by the same dentist or same registered clinic or Hospital for the same accidental injuries to sound natural teeth will be provided up to the period as set forth in the Schedule of Benefits.

**(g) AMBULANCE FEES**

Reimbursement of the Reasonable and Customary Charges incurred for medically necessary domestic ambulance services inclusive of attendant to and/or from the Hospital of confinement. Payment will not be made if the Insured Person is not hospitalised and subject to the limits set forth in the Schedule of Benefits.

**(h) OUTPATIENT PHYSIOTHERAPY TREATMENT**

Reimbursement of Reasonable and Customary Charges for out-patient physiotherapy treatment referred in writing by a licensed Specialist/Physician after Surgery or in-Hospital treatment, within ninety (90) days from the date of Hospital discharge/Surgery. However, no payment will be made for medication/treatment and subsequent consultations with the same Specialist/Physician. A copy of the referral letter must be submitted as proof of recommendation.

**(i) HOME NURSING CARE**

Reimbursement of Reasonable and Customary Charges of full-time services of a registered Nurse for services rendered to the Insured Person who is medically necessary and prescribed by the attending Physician or Surgeon for the continued treatment at the Insured Persons home of the specific medical condition for which the Insured Person was hospitalised Services for activities of daily living that are not medically necessary will not be payable. The benefit shall be payable up to a maximum period as stated in the Schedule of Benefits. The Insured Person, however, is required to provide evidence, at its cost and expense, of the continuance of such necessity if required by the Company.

**OVERALL ANNUAL LIMIT**

Benefits payable in respect of expenses incurred for treatment provided to the Insured Person during the Period of Insurance shall be limited to Overall Annual Limits as stated in the Schedule of Benefits irrespective of a type/types of disability In the event the Overall Annual Limit having been paid, all insurance and Benefits for the Insured Person hereunder shall immediately cease to be in force, unless Part II - Major Disability is available subject to its terms and conditions.

**PART II - MAJOR MED**

If the Insured Person suffers from one of the Major Disabilities, as defined, he is eligible to be covered under the Part II – Major Med with benefits as defined herein subject to Policy terms and conditions.

**1. IN-EXCESS OF REIMBURSEMENT FROM PART I**

All eligible, necessary and reasonable medical expenses rendered whilst the Insured Person is confined in a Hospital for one of the Major Disabilities. Amount payable shall be in excess of the amount reimbursable under Part I – Basic Med up to the maximum amount per annum per Insured Person as stated in the Schedule of Benefits of Part II – Major Med.

**2. OUTPATIENT CANCER TREATMENT**

If an Insured is diagnosed with Cancer as defined below, the Company will reimburse the Reasonable and Customary Charges Incurred for the Medically Necessary treatment of cancer performed at a legally registered cancer treatment centre subject to the limit of this disability as specified in the Schedule of Benefits.

Such treatment (radiotherapy or chemotherapy excluding consultation, examination tests, take home drugs) must be received at the outpatient department of a Hospital or a registered cancer treatment centre immediately following discharge from Hospital confinement or surgery.

Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major intervention treatment or surgery (excluding endoscopic procedures alone) is considered necessary.

The cancer must be confirmed by histological evidence of malignancy. The following conditions are excluded:

- a) Carcinoma in situ including of the cervix;
- b) Ductal Carcinoma in situ of the breast;
- c) Papillary Carcinoma of the bladder & Stage 1 Prostate Cancer;
- d) All skin cancers except malignant melanoma;
- e) Stage 1 Hodgkin's disease;
- f) Tumours manifesting as complications of AIDS.

It is a specific condition of this Benefit that, notwithstanding the exclusion of pre-existing conditions, this Benefit will not be payable for any Insured who had been diagnosed as a cancer patient and/or is receiving cancer treatment prior to the Effective Date of Insurance.

**3. OUTPATIENT KIDNEY DIALYSIS TREATMENT**

If an Insured is diagnosed with Kidney Failure as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of kidney dialysis performed at a legally registered dialysis centre subject to the limit of this disability as specified in the Schedule of Benefits.

Such treatment (dialysis excluding consultation, examination tests, take home drugs) must be received at the outpatient department of a Hospital or a registered dialysis treatment centre immediately following discharge from Hospital confinement or surgery.

**Kidney Failure** means end stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis is initiated.

It is a specific condition of this Benefit that, notwithstanding the exclusion of pre-existing conditions, this Benefit will not be payable for any Insured who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the Effective Date of Insurance.

**4. RECUPERATIVE ALLOWANCE**

A lump sum payment as stated in the Schedule of Benefits shall be payable to the Insured Person provided the Insured Person was hospitalisation for more than five (5) consecutive days due to one of the Major Disabilities.

**5. HOSPITALISATION INCONVENIENCE**

A daily cash allowance is payable if the Insured Person was hospitalised in a Private Hospital for more than five (5) consecutive days due to one of the Major Disabilities. Payment will be made from the 6th day onwards up to a maximum period of fifteen (15) days.

**6. MAJOR DISABILITIES RELIEF**

In the event of the Insured Person's survival for a period of at least thirty (30) days following the definitive Diagnosis and confirmation of the Major Disability, as defined, a lump sum payment with amount stated in the Schedule of Benefits shall be payable to the Insured Person. No payment shall be made

- a) if the definitive Diagnosis is confirmed within the waiting period of thirty (30) days from the Effective Date of Insurance;
- b) if the Diagnosis does not match or fit the definitions of the Major Disabilities.

This benefit shall also be payable regardless whether the Insured Person was hospitalised or not, and payment of benefit is valid for once per lifetime only.

## EXCLUSIONS

The contract does not cover any hospitalisation, surgery or charges caused directly or indirectly, wholly or partly, by any one (1) of the following occurrences:

1. Pre-Existing Conditions, as defined.
2. Specified Illnesses occurring during the first one hundred and twenty (120) days of continuous cover.
3. Illnesses that commenced or contracted within the Waiting Period of thirty (30) days, except for accidental injuries in respect of Part I – Basic Med.
4. Major Disabilities, as defined, that commenced or diagnosed within the Waiting Period of thirty (30) days in respect of Part II – Major Med – Benefit 5.
5. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.
6. Dental conditions including dental treatment or oral surgery except as necessitated by Accidental Injuries to sound natural teeth occurring wholly during the Period of Insurance.
7. Private Nursing, rest cures or sanatoria care, illegal drugs, intoxication, sterilization, venereal disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related diseases and any communicable diseases required quarantine by law.
8. Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.

9. Pregnancy, child birth (including surgical delivery), miscarriage, abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility. Erectile dysfunction and tests or treatment related to impotence or sterilization.
10. Hospitalisation primarily for investigatory purposes, diagnosis, X-ray examination, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for weight reduction or gain.
11. Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.
12. War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes, riots and civil commotion or insurrection.
13. Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.
14. Expenses incurred for donation of any body organ by an Insured Person and costs of acquisition of the organ including all costs incurred by the donor during organ transplant and its complications.
15. Investigation and treatment of sleep snoring disorders, hormone replacement therapy and alterative therapy such as treatment, medical service or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bone setting, herbalist treatment, massage or aromatherapy or other alternative treatment.
16. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured and Disabilities arising out of duties of employment or profession that is covered under a Workmen's Compensation Insurance Contract.
17. Psychotic, mental or nervous disorders (including any neuroses and their physiological or psychosomatic manifestations).
18. Costs/expenses of services of a non-medical nature, such as television, telephones, telex services, radios or similar facilities, admission kit/pack and other ineligible non-medical items.
19. Sickness or Injury arising from racing of any kind (except foot racing), hazardous sport such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter sports, professional sport and illegal activities.
20. Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes.
21. Expenses incurred for sex change.

## CLAIM PROCEDURES

### 1. EVENTS LEADING TO CLAIMS

- a) The Insured shall within thirty (30) days of a Disability that incurs claimable expenses, give written notice to the Company stating full particulars of such event, including all original bills and receipts, and a full Physician's report stipulating the diagnosis of the condition treated and the date the Disability commenced in the Physician's opinion and the Physician's summary of the cost of treatment including medicines and services provided.

Failure to furnish such notice within the time allowed shall not invalid any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

- b) The Insured shall immediately procure and act on proper medical advice and the Company shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured to do so.

### 2. INCOMPLETE CLAIMS

All claims must be submitted to the Company within thirty (30) days of completion of the events for which the claim is being made. Claims are not deemed complete and Eligible Benefits are not payable unless all bills for such claims have been submitted and agreed upon by the Company. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing shall be at the Company's sole discretion.

### 3. CURRENCY OF PAYMENT

All payments under this Policy shall be made in the legal currency of Malaysia. Should any payment be requested by the Insured to be payable in any other currency, then such amount shall be payable in the demand currency as may be purchased in Malaysia at the prevailing currency market rates on the date of the claim settlement.

## SPECIAL PROVISIONS

### 1. PERSONS ELIGIBLE

Person eligible to be covered under this Policy are:

- a) Anyone between the ages of fifteen (15) days and sixty (60) years and renewal extension may be allowed up to age as stated in the Schedule of Benefits subject to application and satisfactory declaration of health status on yearly review basis. There is no automatic acceptance for person above sixty (60) years old.
- b) Malaysians who reside in Malaysia only.

### 2. ADDITION OF INSURED PERSONS

Dependents of the Insured who are eligible to be insured shall, from time to time Policy is in force, be included as an Insured Person(s) of this Policy if:

- a) the Insured requests such inclusion of dependents is similarly received by the Company at the time of his or her application of cover;
- b) the dependents are eligible to be insured in accordance with the terms and standards of acceptance by the Company; and
- c) the required additional premium is paid

The addition of dependent is only allowed during the Policy Anniversary, or within thirty (30) days from the date of marriage in the case of spouse, or within thirty (30) days from the date of birth of the dependent child.

Fresh Application Form must be completed for such addition. Such application is subject to satisfactory health declaration and documentation proof, and acceptance by the Company.

### 3. AUTOMATIC TERMINATION

The insurance of an Insured Person shall automatically terminate on the earliest happening of the following events:

- a) on the death of an Insured Person; or
- b) on the Policy Anniversary, of which premium is not paid within fourteen (14) days from the expiry; or
- c) exceed the maximum eligible age of an Insured Person; or
- d) for a dependent child, on his/her nineteenth (19th) birthday on his/her twenty-third (23rd) birthday if in full-time tertiary institution in Malaysia; or
- e) if the total benefits paid under the Policy since the last Policy Anniversary exceeds the Overall Annual Limit for the respective Policy Year; or
- f) at mid-night standard Malaysian time on the last day of the Period of Insurance unless an Insured Person is confined to a Hospital at such time. If this being the case, the time of termination shall be extended to:
  - (i) the time the Insured Person is discharged from Hospital; or
  - (ii) the time the Overall Annual Limit shall have been exhausted; whichever is the first to occur.

### 4. PERIOD OF COVER AND RENEWAL

This Policy shall become effective as of the date stated in the Policy Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company according to the age of the Insured Persons.

This Policy is renewable at the option of the Company and there is no automatic renewal acceptance. Application for change of benefits to a higher plan can only be made on renewal and is subject to application and satisfactory health declaration and acceptance by the Company upon renewal.

### 5. GEOGRAPHICAL TERRITORY

All benefits provided in this policy are applicable worldwide for twenty-four (24) hours a day.

### 6. RESIDENCE OVERSEAS

No benefit whatsoever shall be payable for any medical treatment received by the Insured outside Malaysia, if the Insured resides or travels outside Malaysia for more than ninety (90) consecutive days.

**7. OVERSEAS TREATMENT**

If the Insured Person seeks treatment overseas, benefits in respect of the treatment shall be covered subject to the exclusions, limitations, conditions, reasonable and customary charges specified in this Policy and all benefits will be payable based on the official exchange rate ruling on the last day of the Period of Confinement and shall exclude the cost of transport to the place of treatment provided:

- a) an Insured Person travelling abroad for a reason other than for medical treatment, needs to be confined to a Hospital outside Malaysia as a consequence of a Medically Emergency;
- b) an Insured Person, upon recommendation of a Physician, has to be transferred to a Hospital outside Malaysia because the specialised nature of the treatment, aid, information or decision required can neither be rendered nor furnished nor taken in Malaysia.

Overseas treatment of a disease, sickness or injury which is diagnosed in Malaysia and non-emergency or chronic conditions where treatment can reasonably be postponed until returning to Malaysia are not covered under the Policy.

**8. LOCAL TREATMENT CLAUSE**

If the Insured Person(s) is a non-Malaysian and his application has been approved, the coverage and benefit provided in respect of this Insured Person, including his family members if insured, are applicable within Malaysia.

A non-Malaysian shall be defined as a person who is not a Malaysia citizen and is residing in Malaysia for not less than twelve (12) months.

**9. SUCCEEDING POLICYHOLDER**

This Policy may be automatically endorsed to effect a change in the name of the Insured in the following event:

- a) Upon the death of the Insured while this Policy is in force, the Insured's legal spouse
  - i) If at the time is an Insured Person, shall automatically become the Insured. All references in this Policy to the Insured shall thereafter mean such spouse;
  - ii) Shall automatically become the Insured for a dependent child who is an Insured Person. All reference in this Policy to the Insured shall thereafter mean such spouse.
- b) Upon the death of both the Insured and the Insured's legal spouse, while this Policy is in force, the legally appointed trustee for the dependent child who is an Insured Person, shall automatically become the Insured until the expiry of the policy.

**GENERAL CONDITIONS**

This Policy and the Schedules shall be read together as one contract and any words or expressions to which a specific meaning has been attached in any part of this Policy or of the Schedules shall bear such specific meaning wherever it may appear.

**1. NOTICE**

Every notice or communication to the Company shall be in writing and sent to the Company. No alterations in the terms of this Policy or any endorsement thereon will be held valid unless the same is signed or initialed by an authorised representative of the Company.

**2. CONDITION PRECEDENT TO LIABILITY**

The due observance and the fulfillment of the terms, provisions and conditions of this Policy by the Insured Person and in so far as they relate to anything to be done or complied with by the Insured Person shall be conditions precedent to any liability of the Company.

**3. MISREPRESENTATION / FRAUD**

If the proposal or declaration of the Insured Person is untrue in any respect or if any material fact affecting the risk be incorrectly stated herein or omitted there from, or if this insurance, or any renewal thereof shall have been obtained through any misstatement, misrepresentation or suppression, or if any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support thereof, then in any of these cases, this Policy shall be void.

**4. MISSTATEMENT OF AGE**

If the age of the Insured Person has been misstated and the premium paid as a result thereof is insufficient, any claim payable under this Policy shall be prorated based on the ratio of the actual premium paid to the correct premium which should have been charged for the year. Any excess premium, which may have been paid as a result of such misstatement of age, shall be refunded without interest.

If at the correct age, the Insured Person would not have been eligible for cover under this Policy, no benefit shall be payable.

**5. CHANGE IN RISK**

The Insured Person shall give immediate notice in writing to the Company of any material change in his or her occupation, business, duties or pursuits and pay any additional premium that may be required by the Company.

**6. CONTRIBUTION**

If an Insured Person carries other insurance covering any injury or illness insured by this Policy, the Company shall not be liable for a greater proportion of such illness or injury than how the amount applicable hereto under this Policy bears to the total amount of all valid insurance covering such illness or injury.

**7. SUBROGATION**

If the Company shall become liable for any payment under this Policy, the Company shall be subrogated to the extent of such payment to all the rights and remedies of the Insured Person against any party and shall be entitled at its own expense to sue in the name of the Insured Person. The Insured Person shall give or cause to be given to the Company all such assistance in his/her power as the Company shall require to secure the rights and remedies and at the Company's request shall execute or cause to be executed all documents necessary to enable the Company to effectively to bring suit in the name of the Insured Person.

**8. CERTIFICATION, INFORMATION AND EVIDENCE**

All certificates, information, medical reports and evidence as required by the Company shall be furnished at the expense of the Insured, and in such a form that the Company may require in any event all notices which the Company shall require the Policyholder to give must be in writing and addressed to the Company. An Insured shall, at the Company's request and expense, submit to a medical examination whenever such is deemed necessary.

**9. GOVERNING LAW**

This Policy is issued under the laws of Malaysia and is subject and governed by the laws prevailing in Malaysia.

**10. UPGRADED ROOM AND BOARD CO-PAYMENT**

If the Insured Person is hospitalized at a published Room & Board rate which is higher than his/her eligible benefit, the Insured Person shall bear 20% of the other eligible benefits described in the Schedule of Benefits.

**11. OWNERSHIP OF POLICY**

Unless otherwise expressly provided for by Endorsement in the Policy, the Company shall be entitled to treat the Policyholder as the absolute owner of the Policy. The Company shall not be bound to recognise any equitable or other claim to or interest in the Policy, and the receipt of the Policy or a Benefit by the Policyholder (or by his legal or authorized representative) alone shall be an effective discharge of all obligations and liabilities of the Company.

The Policyholder shall be deemed to be the responsible Principal or Agent of the Insured Persons covered under this Policy.

**12. TAKE-OVER POLICIES**

If this policy shall have commenced immediately upon termination of a preceding policy and if an Insured shall have been afflicted with a medical disability prior or at the time this policy started (and benefits under the preceding policy would have been available to him), such Insured shall continue to be covered for the existing disability, but not to exceed the limits of the previous policy on condition the Company has secured a copy of the preceding policy.

**13. UPGRADED POLICIES**

If the Eligible Benefits to any Insured under the terms of this Policy be increased while it is in force or at the time of Renewal or replacement and if such Insured shall have been afflicted with a Disability prior or at the time the Benefits were increased, the Limits of Benefits payable in respect of such Disability shall not exceed the Limit of Benefits prior to the date the Benefits were upgraded.

**14. CONVERSION POLICIES**

If the Eligible Benefits provided under this Policy shall have been converted from an existing coverage of an 'Inner Limits' to an 'As Charged/Full Reimbursement' coverage, and if such Insured shall have been afflicted with a Disability prior or at the time the Benefits were converted the benefits payable in respect of the Disability shall be in accordance with the Schedule of Benefits prior to the date the Eligible Benefits were converted.

**15. COOLING-OFF PERIOD**

If this Policy shall have been issued and for any reason whatsoever the Insured Person shall decide not to take up the Policy, the Insured Person may return the Policy to the Company for cancellation provided such request for cancellation is delivered by the Insured Person to the Company within fifteen (15) days from the date of delivery of the Policy. The Insured Person is entitled to the return of the full premium paid less deduction of medical expenses incurred by the Company in the issued of the Policy.

**16. PORTFOLIO WITHDRAWAL CONDITION**

The Company reserves the right to cancel the portfolio as a whole if it decides to discontinue underwriting this insurance product. Cancellation of the portfolio as a whole shall be given by written notice to the policyholder and the Company will run off all policies to expiry of the period of cover within the portfolio.

**17. CANCELLATION**

This policy may be cancelled by the Insured at any time by giving a written notice to the Company; and provided that no claims have been made during the current policy year, the Insured shall be entitled to a refund of the premium as follows:

<b>Period Not Exceeding</b>	<b>Refund of Annual Premium</b>
15 days	90% (applicable for renewal only)
1 month	80%
2 months	70%
3 months	60%
4 months	50%
5 months	40%
6 months	30%
7 months	25%
8 months	20%
9 months	15%
10 months	10%
11 months	5%
Period exceeding 11 months	No Refund

**18. ALTERATIONS**

The Company reserves the right to amend the terms and provisions of this Policy by giving a thirty (30) day prior notice in writing by ordinary post to the Owner's last known address in the Company's records, and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless Authorized by the Company and such approval is endorsed thereon. The insurer should give thirty (30) days prior written notice to the policyholder according to the last recorded address for any alterations made.

**19. LEGAL PROCEEDINGS**

No action at law or in equity shall be brought to recover on this Policy prior to expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. If the Insured Person shall fail to supply the requisite proof of loss as stipulated by the terms, provisions and conditions of the Policy, the Insured Person may, within a grace period of one calendar year from the time that the written proof of loss to be furnished, submit the relevant proof of loss to the Company with cogent reason(s) for the failure to comply with the Policy terms, provisions and conditions. The acceptance of such proof of loss shall be at the sole and entire discretion of the Company. After such grace period has expired, the Company will not accept, for any reason whatsoever, such written proof of loss.

**20. SUIT AGAINST THIRD PARTIES**

Nothing in this Policy shall render the Company liable to be held responsible to or to be added as a party in any way whatsoever to any legal suit for damages which may be instituted by the Insured Person or his representatives against any provider of medical, surgical, dental or emergency medical assistance services or treatment which may arise for reasons of neglect, malpractice or other causes resulting from any act or omission in the treatment, examination or services rendered to the Insured Person covered under this Policy.

**21. ARBITRATION**

All differences arising out of this Policy shall be referred to an Arbitrator who shall be appointed in writing by the parties in difference. In the event they are unable to agree on who is to be the Arbitrator within one (1) month of being required in writing to do so then both parties shall be entitled to appoint an Arbitrator each who shall proceed to hear the differences together with an Umpire to be appointed by both Arbitrators. However, this is provided that any disclaimer of liability by the Company for any claim hereunder must be referred to an Arbitrator within twelve (12) calendar months from date of such disclaimer.

**22. POLICY NOT ASSIGNABLE**

This Policy is not assignable and the Company shall not be effected by any notice of trust, lien, charge or assignment of the Policy. The receipt by the Insured Person or his authorised representatives shall be deemed to be a valid discharge of the Company's liability under this Policy.

### 23. CURRENT EXCHANGE RATES

In the event of hospitalisation outside Malaysia, bills rendered in terms of currency other than Malaysian Ringgit shall be payable on the basis of the quoted exchange rate (open market rate if a free market, official rate if not a free market) in effect on the date of discharge from hospital of the Insured Person.

### 24. CASH BEFORE COVER

It is fundamental and absolute special condition of this contract of insurance that the premium due must be paid and received by the Company before the insurance cover is effective.

## IMPORTANT

The Insured Person shall read this Policy carefully, and if any error or differences be found herein, or if the cover is not in accordance with the wishes of the Insured Person, advice should at once be given to the Company and the Policy returned for attention.

In the event of any dispute or ambiguity out of the Bahasa Malaysia translation of this Policy, the English version shall prevail.

If, for any reason, You are unhappy with the service You have received from Us, You can take the following steps:

1. In the first instance, please write to Our Customer Service Department at Our current address. Alternatively, You can e-mail Us at: [customer.service.qi@generali.com.my](mailto:customer.service.qi@generali.com.my)
2. If You are still not satisfied with the way any issue has been handled, You can:
  - (a) Refer matters concerning claims to:  
Financial Markets Ombudsman Service (formerly known as Ombudsman for Financial Services)  
Company No: 200401025885  
Level 14, Main Block, Menara Takaful Malaysia, No. 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur.  
Tel: +603 2272 2811 Website: [www.fmos.org.my](http://www.fmos.org.my)
  - (b) Submit your complaints/feedback to:  
BNMLINK  
4th Floor, Podium Bangunan AICB, No. 10, Jalan Dato' Onn, 50480 Kuala Lumpur.  
Tel: 1-300-88-5465  
(Overseas: +603 2174 1717)  
BNMLINK Webpage : [bnm.gov.my/BNMLINK](http://bnm.gov.my/BNMLINK)

### Product Disclosure and Transparency

We would like to inform that if you wish to know more about the key features, the fees and charges payable, and risks associated with our products, you can log on to our website [www.generali.com.my](http://www.generali.com.my).

Should you require a copy of the Product Disclosure Sheet for a particular product, please contact our office nearest to you.

### Service Tax

The Premium payable by you is subject to the Service Tax Act 2018, including any subsidiary legislations, orders or regulations governing the application of such tax, as may be imposed, or amended by the relevant authorities from time to time.

When we pay a claim, the amount of claims paid (including any service tax imposed by the relevant authorities) shall be subject to the sum insured or limits of insurance covered under the Policy.

### Data Privacy Notice

You hereby agree that by using our services and providing your personal data to us, you consent to Generali's collection, use, disclosure and/or processing of your personal data as described in the Data Privacy Notice made available at our website [www.generali.com.my](http://www.generali.com.my). We reserve the right to update and amend our Data Privacy Notice from time to time. We will notify you of any amendments to our Data Privacy Notice via announcement on our website or other appropriate means.

**SCHEDULE OF BENEFITS**

<b>SCHEDULE OF BENEFITS</b>	<b>MP450 RM</b>	<b>MP350 RM</b>	<b>MP220 RM</b>	<b>MP160 RM</b>	<b>MP110 RM</b>
<b>PART I - BASIC MED BENEFITS</b>					
<b>INPATIENT BENEFITS</b>					
1. a) Hospital Room & Board, per day	450	350	220	160	110
b) Nursing Care and Service, per day up to 150 days	100	80	70	70	30
c) Lodger Fees - for Child below 15 years old	450	350	220	160	110
d) All eligible Inpatient Medical Expenses including Intensive Care Unit	Full Reimbursement				
e) Malaysian Government Hospital Daily Cash Allowance, per day, up to 150 days	150	100	75	60	50
f) Medical Report Fee	100	100	100	100	100
<b>OUTPATIENT BENEFITS</b>					
2. a) Pre-Hospitalisation Specialist Consultation & Diagnostic Services within 60 days preceding confinement					
b) Daycare Surgery, inclusive of all incidental services & supplies					
c) Post-Hospitalisation Physician Treatment - within 60 days after discharge from hospital					
d) Emergency Accidental Outpatient Treatment - within 24 hours & up to 30 days follow-up treatment	Full Reimbursement				
e) Emergency Accidental Outpatient Dental Treatment - within 24 hours & up to 14 days follow-up treatment					
f) Ambulance Fees					
g) Outpatient Physiotherapy Treatment - within 90 days after discharge					
h) Home Nursing Care, per day up to 60 days	450	350	220	160	110
<b>OVERALL ANNUAL LIMIT- PART I - Per Insured Person</b>	<b>100,000</b>	<b>70,000</b>	<b>50,000</b>	<b>35,000</b>	<b>25,000</b>

<b>SCHEDULE OF BENEFITS</b>	<b>MP450 RM</b>	<b>MP350 RM</b>	<b>MP220 RM</b>	<b>MP160 RM</b>	<b>MP110 RM</b>
<b>PART II - MAJOR MED BENEFITS</b>					
1. All Eligible, Necessary & Reasonable Medical Expenses rendered as Inpatient for the Defined Major Disability - per Insured Person, Per Annum - in excess of reimbursement from PART I	80,000	60,000	45,000	35,000	35,000
2. Monthly Outpatient Cancer Treatment or Kidney Dialysis - reimbursement within Policy Period only	6,000	5,000	4,000	3,000	2,000
3. Recuperative Allowance in lump sum, upon discharge - hospitalisation for more than 5 consecutive days (max per disability)	2,200	1,750	1,200	1,000	750
4. Hospitalisation Inconvenience per day, up to 15 days - in excess of 5 consecutive days of hospitalisation (max per disability)	125	100	75	60	60

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5.	Major Disabilities Relief - in lump sum payment (once per lifetime) upon diagnosis of Defined Major Disability subject to 30 days waiting period & 30 days survival period	12,000	10,000	7,500	5,000	5,000
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**NOTE:**

If there is conflict or inconsistency between any of the contents of the document and the contents of a version of this same document issued or printed in any other language, the contents of this document issued and printed in English prevail.