Generali Insurance Malaysia Berhad
Reg No: 197501002042 (23820-W)
Generali Customer Service Centre
Level 1, Menara Generali,
27 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia.
Tel: 1 300 13 2121 or +603 3007 2121 Email: customer.service.gi@generali.com.my
www.generali.com.my

Member of PIDM
The benefit (s) payable under eligible product is protected by PIDM up to limits. Please refer to PIDM's TIPS Brochure or contact Generali Insurance Malaysia Berhad or PIDM (visit www.pidm.gov.my).

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

MULTI MEDIC POLICY
HEALTH INSURANCE POLICY

This Policy document is a legal contract between You and Us, and therefore reflects the terms and conditions of the contract of insurance agreed mutually.

For Consumer Insurance Contracts
Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if You are applying for this Insurance wholly for Yourself/family/dependants, You have a duty to take reasonable care not to make a misrepresentation in answering the questions in Your Proposal Form. You must answer the questions in Your Proposal Form fully and accurately. Failure to take reasonable care in answering the questions may result in avoidance of Your contract of insurance, refusal or reduction of Your claim(s), change of terms or termination of Your contract of insurance. This duty of disclosure shall continue until the time Your contract of insurance is entered, varied or renewed with us. In addition to answering the questions in Your Proposal Form, You are required to disclose any other matter that You know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied. You also have a duty to tell us immediately if at any time after Your contract of insurance has been entered, varied or renewed with us any of the information given in Your Proposal Form is inaccurate or has changed. You should satisfy Yourself that this plan will best serve Your needs and that the premium payable under the Policy is the amount that You can afford.

Observation and Fulfilment of Terms and Conditions
This Policy is issued in consideration of the payment of premium to Generali Insurance Malaysia Berhad ('the Company", "Us", "We") on terms as specified in this Policy. While the Policy provides the description of all the services and benefits offered under our insurance plans, the list of services and benefits relevant to Your coverage is stated in the attached Schedule of Benefits ("SOB"). We provide coverage to You under this Policy based on the answers You provided when You applied for this insurance and any other disclosures made by You between the time of submission and the time Your Policy takes effect. The answers and any other disclosures given by You shall form part of this contract of insurance between You and Us. In the event of any pre-contractual misrepresentation made in relation to Your answer or in any disclosures made by You, it will result in avoidance of Your contract of insurance, refusal or reduction of Your claim(s), change of term or termination of Your contract of insurance.
The due observance and fulfilment by the Insured Person of the terms and conditions contained in this Policy and any further endorsements, shall in its entirety form part of this Policy and will be the conditions precedent to any liability or payment of claims under this Policy.

Right to Return Policy Within 15 Days on Your First New Application with Us

If this is the first time that You are applying for this Policy, and if You are not satisfied, for any reason, with the terms of this Policy You may return it to Us within fifteen (15) days from the Issuance Date of this Policy, where We will then cancel Your coverage from the Policy Effective Date and promptly refund any premium You have paid, provided no claims have been made and subject to the cancellation terms of the Policy. Once cancelled, Your Policy will be null and void.

Contact Us
If You wish to correspond with Us for any other reason including the above notice to return the Policy, please write/call Us at the contact details below. You should also inform Your agent/intermediary, if any.

Generali Customer Service Centre
Level 1, Menara Generali,
27 Jalan Sultan Ismail, 50250 Kuala Lumpur, Malaysia.
Tel: 1 300 13 2121 or +603 3007 2121
Email: customer.service.gi@generali.com.my
www.generali.com.my

If You are 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

(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

PROVISIONS

1. Policy Structure

This Policy comprises the following Sections:

Section 1 – Medical Expenses Insurance (MEI)
Section 1 provides insurance on an indemnity basis for the cost of medical treatment. There are six (6) plans. Each plan has various options of Deductible. Section 1 is mandatory. All other Sections cannot be purchased without purchasing Section 1.

Section 2 – Emergency Medical Evacuation & Repatriation of Mortal Remains (EMER)
Section 2 provides for Emergency Medical Evacuation & Repatriation of Mortal Remains. This Section is optional and cannot be purchased without Section 1.

Section 3 – Hospital Cash Benefit Insurance (HCI)
Section 3 provides for the payment of cash benefit in the event of hospitalisation. This Section is optional and cannot be purchased without Section 1.

Section 4 – Outpatient Insurance (OPI)
Section 4 provides insurance on an indemnity basis for the outpatient treatment. This Section is optional and cannot be purchased without Section 1.

Section 5 – Dental Insurance (DI)
Section 5 provides insurance on an indemnity basis for the dental treatment. This Section is optional and cannot be purchased without Section 1.

Section 6 – Critical Illnesses Insurance (CI)
Section 6 provides critical illnesses insurance on a fixed benefit basis. This Section is optional and cannot be purchased without Section 1.

Section 7 – Personal Accident Insurance (PA)
Section 7 provides personal accident insurance on a fixed benefit basis. This Section is optional and cannot be purchased without Section 1.

2. Eligible Policyholder

This Policy may be purchased by an individual who is legally residing in Malaysia at the time of purchasing a policy.

3. Eligible Insured Person

Persons eligible to be covered under this Policy are:
(a) Policyholder and
(b) Dependant

4. Period of Cover and Renewal

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) year after the Effective Date and annually thereafter. On each such Policy Anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company.

Section 1 is renewable at the option of the Policyholder until the occurrence of any of the following:
(a) non-payment of premium or premium not made on time
(b) fraud or misrepresentation of material fact during application
(c) the Policy is cancelled at the request of the Policyholder
(d) total claims of the Policy have reached the Lifetime Limit specified and/or on the death of the Insured Person
(e) the Insured Person ceases to qualify as a Dependant based on the definition of the Policy
(f) the Insured Person attains the coverage age limit specified
(g) termination of coverage for all policies in a certain market and the Company withdraws this Policy completely from the market in accordance with the Portfolio Withdrawal Condition.

This means the Policyholder decides whether to renew the insurance coverage when the Policy expires on each Policy Anniversary, except if any of the above occurs.

Section 2 to Section 7 are renewable at the option of the Company. This means that the insurance company decides whether to renew the insurance coverage when the Policy expires on each Policy Anniversary.

5. Currency

All amounts stated in the Schedule of Benefits and all parts of this Policy are in RM (Ringgit Malaysia) unless stated otherwise.

6. Entry Age

The entry age for an Insured Person is as follows:

(a) Age of thirty (30) days to age of sixty-five (65) years for Section 1
(b) Age of six (6) years to age of sixty-five (65) years for Section 2
(c) Age of twenty-one (21) years to age of sixty-five (65) years for Section 3
(d) Age of six (6) years to age of sixty-five (65) years for Section 4 to Section 7

7. Age Limit

An Insured Person shall cease to be an Insured Person upon the specified period or the attainment of the respective ages, whichever relevant, for the respective Sections as stipulated below:

(a) For Section 1, the insurance is renewable until the Insured Person attains the age of one-hundred (100).
(b) The attainment of the age of seventy (70) years for Section 2 to Section 7.

8. Succeeding Policyholder (applicable only to family plans)

(a) In the event of death of the Policyholder while this Policy is in force, the Policyholder's legally married spouse shall automatically become the Policyholder and all references in this Policy to the Policyholder shall thereafter mean such spouse.
(b) When an Insured Person ceases to be a Dependant Child, the Insured Person may continue to renew the Policy in the Insured Person’s own name as a policyholder and all references in this Policy to the Policyholder shall thereafter mean such Insured Person.
(c) In the event that the Policyholder's legally married spouse who automatically becomes the Policyholder fail to qualify as having insurable interest in an Insured Person, the said Insured Person may continue to renew the Policy in the Insured Person’s own name as a policyholder and all references in this Policy to the Policyholder shall thereafter mean such Insured Person.

9. Geographical Territory

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

DEFINITIONS

Certain words or group of words have been defined in this Policy and these have the same meaning wherever they are used and shall form the basis on which a claim may be covered. The following definitions apply to all Sections of this Policy.

1. You/Your

The Policyholder

2. We/Our/Us

The Insurer, Generali Insurance Malaysia Berhad, the Company

3. Policyholder

A person to whom the Policy has been issued in respect of cover for persons specifically identified as Insured Persons in this Policy. The Policyholder shall also be referred to as the Insured.

4. Insured

The Policyholder described in the Policy Schedule.

5. Insured Person

The Insured Person means the person who is named as the insured in the Schedule of this Policy and for whom premium has been paid.

A Policyholder may insure up to ten (10) Eligible Insured Persons per family policy. However, the Policyholder must have insurable interest in the Insured Person.

A Policyholder has insurable interest in the Dependants.

6. Dependant

Any of the following persons:

(a) the Policyholder’s legally married spouse
(b) Child
(c) Parent or Parent-in-law or Grandparent on who is wholly or partly dependent on the Policyholder for maintenance.

7. Child

The Policyholder's unmarried child who is over thirty (30) days old but under nineteen (19) years of age or twenty-three (23) years of age if still on full-time higher education at a recognised educational institution and who is not gainfully employed.

8. Parent

The Policyholder's mother or father who is wholly or partly dependent on the Policyholder for maintenance.

9. Parent-in-law

The Policyholder's mother-in-law or father-in-law who is wholly or partly dependent on the Policyholder for maintenance.

10. Grandparent

The Policyholder's grandparent who is wholly or partly dependent on the Policyholder for maintenance.

11. Policy Year

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.

12. Commencement Date/Original First Effective Date

This is the date that Your Policy is first written with Us. In the event of any lapse in Your Policy, the Commencement Date will start as new with the relevant new Policy conditions being applied.
We must first receive Your premium for this Policy before Your Policy coverage starts.

13. Effective Date

Your Policy coverage starts from 12:01 a.m. (Malaysian time) on the Effective Date stated in the Policy period/Period of Cover/Insurance Period of Your Policy/Renewal Schedule.

14. Issue Date

The date that Your Policy is issued to You. This may be different from the Effective Date if, for some unforeseen reason, there is an administrative time lag/operational lag in the issuance of Your Policy.

15. Expiry Date

Your Policy coverage ends at midnight 12:00 a.m. (Malaysian time) of this Expiry Date stated in the Policy period/Period of Cover/Insurance Period of Your Policy/Renewal Schedule.

16. Renewal Date

Renewal Date is the date immediately following Your Policy Expiry Date.

17. Renewal or Renewed Policy

A Policy which has been renewed without any lapse of time upon expiry of a preceding Policy with the same content. Your Policy ends at midnight 12:00 a.m. (Malaysian time) of the Policy Expiry Date.
You will receive a Renewal notice at least thirty (30) days prior to Your Policy Expiry Date.

18. Reinstatement Date

Reinstatement is not allowed for this Policy. This means that there is no grace period within which You can reinstate Your Policy if You had not paid Your Renewal premium before Your Policy Expiry Date.

19. Singular/Plural

Singular terms shall imply the plural and the plural terms shall imply the singular where applicable.

20. Benefit

Benefit(s) refers to the coverage provided under this Policy. The Benefits applicable to You are based on the Plan You select at application and accepted by Us on the terms of this Policy. Please refer to the Schedule of Benefits for a summary of the Benefits available under this Policy.

21. Age

Age reference points are on age last birthday basis as of the Policy Effective Date (unless stated otherwise).

22. Co-Insurance

A cost sharing arrangement under which You are obliged to bear a specified percentage of the Eligible Expenses as specified in the Schedule of Benefits with the balance to be reimbursed under this Policy.

23. Congenital Conditions

Any medical or physical abnormalities existing at the time of birth, as well as neo-natal 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 Person was continuously covered under this Policy.

24. Diagnosis

Diagnosis shall mean the definitive diagnosis made by a Physician based upon such specific evidence as required for the benefits defined in this Policy. In the absence of such specific evidence, diagnosis shall be based upon clinical, laboratory, radiological and histological

evidence acceptable to Us. Such diagnosis must be supported by Our medical doctor who may base his/her opinion on the medical evidence submitted by the Insured Person and/or any additional evidence which the Our medical doctor may require.
In the event of any dispute or disagreement regarding the appropriateness or correctness of the diagnosis, We 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 acknowledged expert in the field of medicine concerned as selected by Us, and the opinion of such expert as to such diagnosis shall be binding on both the Insured Person and Us.

25. Doctor or Physician or Surgeon

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 himself is the Insured Person.

26. Dentist

A person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided but excluding a dentist who is himself is the Insured Person.

27. General Practitioner

A Medical Practitioner qualified and licensed to practice western medicine. He must be registered in the locality of practice and must practice within the scope of his licensing and training. A General Practitioner who is himself or herself is the Insured Person of the Policy shall not be considered a General Practitioner for this Policy when making a claim.

28. Hospital

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:

(a) has facilities for diagnosis and major surgery,
(b) provides twenty-four (24) hours a day nursing services by registered and graduate nurses,
(c) is under the supervision of a Physician, and
(d) is not primarily a clinic; a rehabilitation centre for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.

29. Hospitalisation

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.

30. Intensive Care Unit

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.

31. Malaysian Government Hospital

A hospital which charges of services are subject to the Fee Act 1951 Fees (Medical) Order 1982 and/or its subsequent amendments if any.

32. Medical Practitioner

Shall mean a person legally authorised in the geographical area of his practice to render medical care and treatment.

33. Mental, Emotional or Functional Nervous Disorders

Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

34. Outpatient

The Insured Person who is receiving medical care or treatment without being hospitalised and includes treatment in a Day-care Centre.

35. Registered Pharmacist

A medical professional who is registered and licensed to give out medicine as prescribed by a Physician/Doctor/Surgeon.

36. Prescribed Medicines

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.

37. Reimbursement

Means the Policyholder must pay for the claims first and then seek reimbursement from Us, subject to Our terms and conditions of a Benefit claim payment.

38. Specialist

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 dentist or surgeon who himself is the Insured Person.

39. Language

In the event of any inconsistencies or discrepancies between the English version and the Bahasa Malaysia version of this Policy, the English version shall prevail.

40. Tax

The premiums You pay on Your Policy may qualify You for a personal tax relief, subject to the final decision of the Inland Revenue Board of Malaysia. We do not provide tax advice. It is Your responsibility to consult Your tax advisor(s) about whether Your Policy qualifies for any tax benefits.

41. Panel Network/ Panel

Panel or Panel Network shall mean a provider of health services (clinic, Specialist or Hospital) appointed by Us or Our legal representative / third party administrator to provide health services to Insured Persons. The Panel Network is where You can utilise the Cashless Facility provided that You have elected for this Facility for Your Plan**.**

42. Participating Providers

Refers to providers of health services that are participating in Our defined Panel Network. You can utilise the Cashless Facility at Participating Providers provided that You have elected for this Facility for Your Plan.

43. Non-Participating Providers

Refers to providers of health services that are not within Our defined Panel Network. Cashless Facility is not applicable at Non-Participating Providers. You will need to pay first at these Non-Participating Providers and then seek reimbursement from Us for the Eligible Expenses.

SECTION 1
MEDICAL EXPENSES INSURANCE (MEI)

LIMITS OF COVERAGE

BENEFITS	**Multi Medic Base**			**Multi Medic Prime**		
PLAN	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 1**	**Plan 2**	**Plan 3**
Overall Annual Limit (OAL) (Section 1)	110,000	165,000	330,000	550,000	825,000	1,100,000
SECTION 1- PART A, B, C, D (MANDATORY)						
PART A - HOSPITALISATION & SURGERY						
Room & Board daily limit, incurred during the policy period	165	275	385	550	1,100	3,300
Intensive Care Unit Hospital Supplies and Services Pre-Surgical Consultation & Diagnosis (one consultation) Pre-Hospitalisation Specialist Consultation Pre-Hospital Diagnostic Tests Second Surgical Opinion In-Hospital Physician Visit (2 visit per day) Post-Hospitalisation Treatment (up to 90 days from discharge) Surgical Fees (post-surgery care up to 90 days from the date of surgery) Anaesthetist Fee Operation Theatre Ambulance Fee Medical Report Fee Service Tax	Actual charges incurred during the policy period for reasonable, necessary and customary medical care provided in the treatment of an insured disability					
Organ Transplant, once per lifetime						
Daily Guardian Benefit	165	275	385	550	1,100	3,300
Malaysian Government Hospital Cash Allowance per day	55	110	165	275	550	550
PART B – OUTPATIENT CARE FOLLOWING HOSPITALISATION OR SURGERY						
Post-Hospitalisation Outpatient Physiotherapy Treatment, Per Disability Limit	5,500	5,500	5,500	16,500	16,500	16,500
Post-hospitalisation Home Nursing Care						
(a) Daily Limit	110	110	110	220	220	220
(b) Per Disability Limit	5,500	5,500	5,500	5,500	5,500	5,500
Outpatient Cancer Treatment	Actual charges incurred during the policy period for reasonable, necessary and customary medical care provided in the treatment of an insured disability					
Outpatient Kidney Dialysis						
Outpatient Long Term Injections for Specified Disabilities	N/A	N/A	N/A	5,500	11,000	22,000
PART C – EMERGENCY AND TRADITIONAL & COMPLEMENTARY MEDICAL TREATMENT						
Emergency Sickness Treatment (between 10pm to 7am) Emergency Outpatient Treatment for Accident (including 31 days follow up treatment) Emergency Dental Treatment for Accident (including 31 days follow up treatment)	Actual charges incurred for reasonable, necessary and customary medical care provided in the treatment of an insured disability					
Traditional & Complementary Medicine (TCM), limit per year subject to 20% co-payment	1,100	2,200	3,300	5,500	8,250	11,000
PART D – ENHANCED CARE BENEFIT						
External Prostheses						
(a) Limit Per Disability	N/A	N/A	N/A	5,500	11,000	22,000
(b) Sub-Limit for Wheelchair	N/A	N/A	N/A	550	1,100	1,650
Inpatient Treatment for Mental Illness, limit per disability	N/A	N/A	N/A	5,500	11,000	22,000
Plastic Surgery, limit per disability	N/A	N/A	N/A	5,500	11,000	22,000
DEDUCTIBLE PER DISABILITY (applicable to Part A Only)						
Option 1	0	0	0	0	0	0
Option 2	5,500	8,250	11,000	16,500	22,000	33,000
Option 3	11,000	16,500	22,000	27,500	33,000	55,000

Note:
The Limits of Coverage (Room and Board Limit, Overall Annual Limits, Sub-Limits and Deductibles) will increase automatically every three (3) years by 10% of effective Limits of Coverage at the time of the launch of this product, subject to the following:

a. The respective new Deductible and limits will only apply to new policies issued or policies renewed after the Effective Date of the respective increase in limits.
b. The Deductible and limits applicable for claims shall be the Deductible and limits applicable to the Policy during the first intimation of the respective claim and the increased Deductible and limits will not be applicable to claims already reported.

SUMMARY OF COVERAGE

PART A – HOSPITALISATION

If the Insured Person is confined to a Hospital for treatment or is surgically treated as a day case during the Period of Insurance stated in the Policy Schedule, this Section of the Policy shall indemnify the Policyholder reasonable, customary and Medically Necessary expenses incurred for the following, subject to the limits specified in the Limits of Coverage and the Description of Benefits:

1.1. Hospital Room and Board Benefit, incurred during the period of insurance
1.2. Intensive Care Unit, incurred during the period of insurance
1.3. Hospital Supplies and Services, incurred during the period of insurance
1.4. Pre-Surgical Consultation & Diagnosis, limited to one (1) consultation prior to surgery
1.5. Pre-Hospital Specialist Consultation, limited to one (1) consultation prior to hospitalisation
1.6. Pre-Hospital Diagnostic Tests, related to one (1) consultation prior to hospital admission
1.7. Second Surgical Opinion, limited to one (1) consultation prior to surgery
1.8. In-Hospital Physician Visit, subject to two (2) visits a day
1.9. Post-Hospitalisation Treatment incurred within ninety (90) days following discharge from hospital.
1.10. Surgical Fees, with post-surgery care up to ninety (90) days from the date of surgery
1.11. Anaesthetist Fees
1.12. Operating Theatre Fees
1.13. Ambulance Fees, incurred during the Policy period of insurance
1.14. Organ Transplant (once per lifetime)
1.15. Services Tax, where applicable
1.16. Medical Report Fee
1.17. Daily Guardian Benefit
1.18. Malaysian Government Hospital Cash Allowance per day up to one-hundred (100) days Per Disability

PART B – OUTPATIENT CARE FOLLOWING HOSPITALISATION OR SURGERY

After the Insured Person is confined to a Hospital for treatment or is surgically treated as a day case during the Period of Insurance stated in the Policy Schedule, this Section of the Policy shall indemnify the Policyholder reasonable, customary and Medically Necessary expenses incurred for the following, subject to the limits specified in the Limits of Coverage and the Description of Benefits:

1. Post-Hospitalisation Outpatient Physiotherapy Treatment (limited to twice per week incurred within ninety (90) days following discharge from hospital)
2. Post-hospitalisation Home Nursing Care (incurred within ninety (90) days following discharge from hospital)
3. Outpatient Cancer Treatment
4. Outpatient Kidney Dialysis
5. Outpatient Long Term Injections for Specified Disabilities

PART C – EMERGENCY AND TRADITIONAL & COMPLEMENTARY MEDICAL TREATMENT

If the Insured Person received outpatient treatment for an injury due to an accident as defined in the Policy, this Section of the Policy shall indemnify the Policyholder reasonable, customary and Medically Necessary expenses incurred for the following, subject to the limits specified in the Limits of Coverage and the Description of Benefits. Payment will only be made upon receipt and approval of proofs of expenses incurred.

1. Emergency Sickness Treatment (between 10pm to 7am)
2. Emergency Outpatient Treatment for Accident (including thirty-one (31) days follow up treatment)
3. Emergency Dental Treatment for Accident (including thirty-one (31) days follow up treatment)
4. Traditional & Complementary Medicine (TCM) Benefit (80% of incurred amount - up to annual limit stipulated)

PART D – ENHANCED CARE BENEFIT

If the Insured Person is provided with the following enhanced medical care stipulated in Schedule of Benefits during the Period of Insurance stated in the Policy Schedule, this Section of the Policy shall indemnify the Policyholder reasonable, customary and Medically Necessary expenses incurred for the following as part of the Overall Annual Limit, subject to the limits specified in the Limits of Coverage and the Description of Benefits. Payment will only be made upon receipt and approval of proofs of expenses incurred.

1. External Prostheses, subject to the limit per disability and Sub-Limit for Wheelchair
2. Inpatient Treatment for Mental Illness, subject to the limit per disability
3. Plastic Surgery, subject to the limit per disability

All expenses payable under all Parts of this Section shall add to and form part of the Overall Annual Limit stipulated in the Policy.

Where the Plan is purchased with a Deductible, such Deductible shall apply to each Disability and shall form part of the Overall Annual Limit.

SPECIFIC PROVISIONS (applicable to Section 1)

1. Eligibility

Only the following Insured Persons are eligible for insurance in relation to new policies:

(a) The Policyholder between the age of twenty-one (21) years and sixty-five (65) years
(b) The Policyholder's legally married spouse age sixty-five (65) years and below
(c) Child
(d) Parent or Parent-in-law age sixty-five (65) years and below
(e) Grandparent age sixty-five (65) years and below

2. Period of Cover and Renewal

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) year after the Effective Date and annually thereafter. On each such Policy Anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company.

This Policy will be renewable at the option of policyholder subject to the terms, conditions and termination at each of the anniversary of the Policy date. This policy is renewable at the option of policyholder until the occurrence of any of the following:

(a) non-payment of premium or premium not made on time
(b) fraud or misrepresentation of material fact during application
(c) the Policy is cancelled at the request of the Policyholder
(d) total claims of the Policy have reached the per Disability limit or Lifetime Limit specified, where applicable. This applies to the respective sub-limits only and the Policy will still be renewable to cover benefits that have not exceed the respective per Disability limit or lifetime limit
(e) on the death of the Insured Person
(f) the Insured Person attains the coverage age limit specified
(g) the Insured Person ceases to qualify as a Dependant based on the definition of the Policy

The renewal premiums payable is not guaranteed, and the Company shall revise the premium rate and the respective revised premium shall be applicable at the time of renewal. Such changes, if any, shall be applicable to all policyholders irrespective of their claim experience according to the Company's risk assessment.

The Company will give thirty (30) days written notice prior to Policy renewal in the event of premium revision.

3. Increase in Limits of Coverage

This product is launched on 10 December 2020 and the Limits of Coverage (Room and Board Limit, Overall Annual Limits, Sub-Limits and Deductibles) for Section 1 shall increase automatically every three (3) years by 10% of effective Limits of Coverage at the time of the launch of the product.

4. Premium Pricing

The premium applicable to Section 1 shall be revised automatically every three (3) years on the same Effective Dates of the increase in Limits of Coverage.

The pricing of the premium and all subsequent revisions shall be done on a portfolio basis. New applications will be subjected to individual underwriting and premium loadings applicable at the first inception date will be applicable to the standard premium rates as well as all subsequent revisions.

SPECIFIC DEFINITIONS (applicable to Section 1)

1. Accident

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.

2. Any One Disability

All of the periods of disability arising from the same cause including any and all complications therefrom 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.

3. As Charged

Actual charges incurred for reasonable, necessary and customary medical care provided in the treatment of an insured disability.\

4. Day Surgery

A surgical procedure on a pre-plan basis at the hospital / specialist clinic where a patient uses a recovery facility (but not for overnight stay).

5. Deductible

The specified eligible amount as specified in Schedule of Benefits that You are liable before any benefits are payable under this Policy. Deductible applies to the Hospitalisation Benefit only on a per Disability claim basis, as listed in the Schedule of Benefits.

6. Disability

A Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes.

7. Eligible Expenses

Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the Schedule.

8. Injury

Bodily injury caused solely by Accident.

9. Lifetime Limit

The maximum amount of total Benefits We will pay under this Policy over Your lifetime. The Policy shall terminate automatically once the total claims paid reach or exceed the Lifetime Limit.

There is no overall Lifetime Limit on this Policy. However certain specific Benefits in this Policy are subject to a once in a lifetime coverage condition depending on the Plan and Add-on Rider Benefits that You purchase, and the Benefits covered under that Plan and Add-on Rider Benefit. Please read the Schedule of Benefits in conjunction with this Policy Contract wordings carefully, to note the Benefits that have a lifetime limit condition.

10. Medically Necessary

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 Person 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, and
(e) for which the charges are fair and reasonable and customary for the Disability, and
(f) providing treatment directly related to the covered Disability.

11. 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 the type/types of Disability. In the event the Overall Annual Limit having been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining Policy Year.

12. Pre-existing Illness

Disabilities that the Insured Person has reasonable knowledge of during application. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:

(a) the Insured Person had received or is receiving treatment;
(b) medical advice, diagnosis, care or treatment has been recommended;
(c) clear and distinct symptoms are or were evident; or
(d) Its existence would have been apparent to a reasonable person in the circumstances.

13. Reasonable and Customary Charges

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. Reasonable and customary charges for services rendered in Malaysia shall not exceed the charges stipulated in the 13th Schedule of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013 and its subsequent amendments if any.

14. Sickness, Disease or Illness

A physical condition marked by a pathological deviation from the normal healthy state.

15. Surgery

Any of the following medical procedures:

(a) to incise, excise or electro-cauterize 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.

16. TCM Practitioner

Shall mean a registered and licensed traditional and complementary medicine (TCM) practitioner under the Malaysian Traditional and Complementary Medicine Act 2016 and/or its subsequent amendments if any.

17. Treatment

Treatment shall mean the actual receiving of medical or surgical care or attention from a Medical Practitioner and for all Medically Necessary diagnostic services directly associated with the covered Disability.

18. Waiting Period

Waiting period is the first thirty (30) days between the beginning of an Insured Person's Disability and the commencement of this Policy date/ reinstatement 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.

DESCRIPTION OF BENEFITS (applicable to Section 1)

1. Hospital Room and Board

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 any one 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.

2. Intensive Care Unit

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.

3. Hospital Supplies and Services

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.

4. Pre-Surgical Consultation and Diagnosis

Specialists' fees for consultation, pathology and radiography following referral from a general practitioner, for each Illness or Injury requiring surgery. Benefit is not payable for outpatient treatment (including medications and any subsequent consultations after the Illness is diagnosed), nor if the Insured Person is not subsequently surgically treated after such diagnostic services have been performed. If the Insured Persons is subsequently confined in a Hospital for treatment, the reimbursement shall be paid under Pre-Hospital Specialist Consultation and Pre-Hospital Diagnostic Tests.

5. Pre-Hospital Specialist Consultation

Reimbursement of the Reasonable and Customary Charges for the first-time consultation by a Specialist in connection with a Disability within sixty (60) days 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 Person does not result in Hospital confinement for the treatment of the medical condition diagnosed.

6. Pre-Hospital Diagnostic Tests

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 within sixty (60) days preceding hospitalisation and amount as set forth in the Schedule of Benefits in a Hospital and which are recommended by a qualified Medical Practitioner. No payment shall be made if upon such diagnostic services, the Insured Person 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.

7. Second Surgical Opinion

Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary consultation or opinion with the second specialist within sixty (60) days prior to surgery to determine whether a surgical operation is necessary or required in view of the Insured Person's medical condition up to maximum amount as set forth in the Schedule of Benefits. Payment is limited to one (1) consultation prior to surgery. Payment will not be made if the Insured Person does not undergo surgery for the medical condition diagnosed.

While claiming under this Benefit and deciding to obtain a Second Surgical Opinion, Policyholder and each Insured Person expressly agree that:

(a) It is entirely for the Insured Person to decide whether to obtain such opinion, from which Medical Practitioner to take the Second Surgical Opinion, and the use (if any) to which the Second Surgical Opinion obtained is put.
(b) We do not provide any Second Surgical Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other persons' reliance on the same, or the use to which the Second Surgical Opinion is put.

We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations whatsoever made by any Medical Practitioner or in any Second Surgical Opinion or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

8. In-Hospital Physician Visit

Reasonable and Customary Charges for Medically Necessary ward visits by the attending Physician while the Insured Person is confined in the Hospital as an inpatient for a non-surgical Disability. This benefit is limited to a maximum of two (2) visits per day not exceeding the maximum number of days as set forth in the Schedule of Benefits.

9. Post Hospitalisation Treatment

Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up treatment by the same attending Physician, within ninety (90) 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. Reimbursement is only applicable for post-hospitalisation treatment costs incurred during the period of insurance and only for eligible hospitalisation occurring during the period of insurance.

10. Surgical Fees

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 the maximum of ninety (90) days from the date of surgery, but within the maximum indicated in the Schedule of Benefits. If more than one (1) 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.

11. Anaesthetist Fees

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.

12. Operating Theatre Fees

Reasonable and Customary Operating Room charges incidental to the surgical procedure not exceeding the limits as set forth in the Schedule of Benefits.

13. Ambulance Fees

Reasonable and Customary Charges incurred for (inclusive of attendant's fee) for the Medically Necessary use of a ground ambulance service 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.

14. Organ Transplant

Reimburses Reasonable and Customary Charges incurred on transplantation surgery for the Insured Person being the recipient of the transplant of a kidney, heart, lung, liver or bone marrow. Payment for this Benefit is limited to one (1) organ transplant per lifetime whilst the Policy is in force and shall be subject to the limit as set forth in the Schedule of Benefits. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

In the event of a transplant rejection, complications due to the Insured Person's body rejection of the transplanted organ will not be payable. The Insured Person's insurance Policy must be valid throughout the course of the treatment and this benefit is not payable if the Policy has lapsed or is terminated partway through the treatment.

15. Service Tax

Reimburses the actual amount of government services tax payable in respect of treatment received for Illnesses or conditions covered under the Policy.

16. Medical Report Fee

Reimbursement of the actual fee charged for Medical Report up to the maximum limit as stated in the Schedule of Benefits.

17. Daily Guardian Benefit for Child

The actual expenses incurred for daily food and lodging for a parent or guardian while accompanying the stay of an Insured Person (who is below the age of sixteen (16) years) in the Hospital. The maximum daily amount for this Benefit is as specified in the Schedule of Benefits. The maximum number of days for the reimbursement of this Benefit follows the maximum days as per the Hospital Room and Board Benefit.

18. Daily Cash Allowance for Full Treatment at a Malaysian Government Hospital

Pays a daily cash allowance as stated in the Schedule of Benefits to You for each complete day of the Insured Person's stay in a Malaysian Government Hospital provided the Daily Room and Board Charge is not more than the Hospital Room and Board Benefit limit. The Daily Cash Allowance will only be payable if Your the Disability is treated continuously in full at a Malaysian Government Hospital, without any transfer to or from any Private Hospital.

19. Post-hospitalisation Outpatient Physiotherapy Treatment

Reimbursement of Reasonable and Customary Charges for outpatient physiotherapy treatment referred in writing by a licensed Specialist or Physician after Surgery or In-Hospitalisation treatment, within ninety (90) days and amount specified in the Schedule of Benefits, immediately following discharge from the Hospital/Surgery. A copy of the referral letter must be submitted as proof of recommendation.

No payment will be made for medication/treatment and subsequent consultations with the same Specialist or Physician. This is payable under the Post-Hospitalisation Treatment Benefit.

20. Post-hospitalisation Home Nursing Care

Reimbursement of Reasonable and Customary daily charges of full-time services of a registered Nurse for services rendered to the Insured Person who is bed-bound, which are Medically Necessary and prescribed by the attending Physician or Surgeon for the continued treatment at the Insured Person's home of the specific medical condition for which the Insured Person was hospitalised.

The Insured Person is required to provide evidence, at his/her own cost and expense, of the necessity of home nursing care. The Benefit shall be payable up to the maximum amount and maximum period stated in the Schedule of Benefits and is limited to nursing expenses only. No payment will be made for custodial care, meal, general housekeeping services, companion and personal comfort items.

21. Outpatient Cancer Treatment

If an Insured Person is diagnosed with Cancer as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for radiotherapy or chemotherapy treatment of cancer performed at the outpatient department of a Hospital or a registered cancer treatment centre immediately following discharge from Hospital confinement or surgery, subject to the limit of this Disability as specified in the Schedule of Benefits.

Reasonable and Customary Charges for doctor's consultation and related examination, laboratory or diagnostic tests or any drugs prescribed under this Benefit is also reimbursable.

Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist 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 Person who had been diagnosed as a cancer patient and/or is receiving cancer treatment prior to the Effective Date of Insurance.

22. Outpatient Kidney Dialysis

If an Insured Person 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 the outpatient department of a Hospital or a legally registered dialysis treatment centre immediately following discharge from Hospital confinement or surgery, subject to the limit of this Disability as specified in the Schedule of Benefits.

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.

Reasonable and Customary Charges for doctor's consultation and related examination, laboratory or diagnostic tests or any drugs prescribed under this Benefit is also reimbursable.

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 Person who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the Effective Date of Insurance.

23. Outpatient Treatment for Specified Long Term Injections

Reimbursement of Reasonable and Customary Charges for Medically Necessary long-term injections on the Insured Person done is an outpatient setting of a Hospital for the following Disability:

(a) retinopathy and/or macular degeneration (up to three (3) injections per year)
(b) rheumatoid arthritis (up to two (2) injections per year)

24. Emergency Sickness Treatment

Reimbursement of Reasonable and Customary Charges for treatment of emergency Sickness rendered in a Hospital or 24-hour clinic and received as an outpatient between the hours shown in the Schedule of Benefits. If no time/hours are shown in the Schedule of Benefits, the accepted time of emergency for this Benefit is from 10pm till 7am. The time of the treatment as certified by the attending Doctor shall be part of the conditions for the payment of a claim. The maximum amount reimbursable for this Benefit is specified in the Schedule of Benefits.

25. Emergency Accidental Outpatient Treatment Benefit

Reimbursement of Reasonable and Customary Charges up to the maximum amount specified in the Schedule of Benefits for treatment of Injury to the Insured Person as an outpatient in any registered Clinic or Hospital. Such treatment must be done within 24 hours from the time of Accident. Reasonable and Customary Charges incurred for subsequent follow-up treatments for the same Injury by the same Specialist, Clinic or Hospital is reimbursable up to thirty-one (31) days from the date of first consultation.

26. Emergency Accidental Dental Treatment Benefit

Reimbursement of the Reasonable and Customary Charges charged by a legally registered dentist or at a dental clinic or Hospital to the Insured Person as an outpatient, within 24 hours of the Accident for the treatment of accidental injuries to sound natural teeth. Reasonable and Customary Charges incurred for subsequent follow-up treatment by the same dentist or same registered dental clinic or Hospital for the same accidental injuries to sound natural teeth will be reimbursable up to thirty-one (31) days from the date of first consultation. Subsequent restorative works such as periodontal, orthodontal, prosthodontal services, crowning, bridging, root canal treatment, are not covered.

27. Traditional & Complementary Medicine (TCM)

Reimbursement of 80% of charges incurred for Medically Necessary services and treatment provided by legally authorised and registered TCM practitioners and facilities in Malaysia. Prescribed medicine is included. TCM benefit can be used as complementary to treatment under the Hospitalisation and Surgery Benefit, or on its own as an Outpatient Benefit.

Referral from Malaysian Government Hospital is required to have TCM as conservative management. (Conservative management refers to medical treatment defined by the avoidance of invasive measures such as surgery or other invasive procedures, usually with the intent to preserve function or body parts.) With the referral, TCM treatment can be administered either be within the Malaysian Government Hospital facility or at any legally registered TCM centre.
This Benefit is for claims Reimbursement only. Cashless Facility is not applicable for TCM Benefit. Each claim is subject to 20% co-insurance and the total amount reimbursable is capped up to a limit per year as stated in the Schedule of Benefits.

TCM Benefits include alternative treatments which means alternative forms of treatments other than “Allopathy” or “modern medicine” but is limited only to the following:

(a) Acupuncture
(b) Chiropractor
(c) Homeopathy - Herbal Therapy as an Adjunct Treatment for Cancer

Reimbursement is limited to one (1) visit per day and is subject to the following Specific Exclusions

(a) All preventive and rejuvenation treatments (non-curative in nature) including without limitation, treatments that are not Medically Necessary are excluded.
(b) Pre-hospitalisation Medical Expenses, Post-hospitalisation Medical Expenses, Day Care Treatment and Outpatient Medical Expenses are excluded from claim under this TCM Benefit.

28. External Prostheses

If You have selected a Plan that covers for this Benefit, cost and expenses incurred for the following is reimbursable, subject to the limits stated in the Schedule of Benefits:

(a) External prosthetic appliances or devices including artificial limbs
(b) Hearing aids, cochlear implants
(c) Pacemakers (device)
(d) Wheelchair (subject to sub-limit under the limit for this Benefit)
(e) Spine brace

Only cost of the initial prosthesis needed as part of a treatment and which is required at the time of, or subsequent to a covered surgical procedure is reimbursable. Replacement of pre-existing prosthesis is not reimbursable.

This Benefit, if included in the insured Plan, overrides the standard Exclusions (defined in the Exclusions Section of this Policy) to the extent of the items covered under this Benefit.

29. Inpatient Treatment for Mental Illness

If You have selected a Plan that covers for this Benefit, Reasonable and Customary Charges incurred for Medically Necessary Inpatient treatment of the Mental Illnesses/disorders (defined below) in a recognised psychiatric unit of a Hospital is reimbursable. All treatment must be administered under the direct supervision of a consultant psychiatrist. The maximum amount reimbursable for this Benefit is as specified in the Schedule of Benefits.

The Mental Illnesses/disorders covered under this Benefit include:

(a) Post-traumatic stress disorder (PTSD)
(b) Adolescent mental health (below the age of sixteen (16) years)
(c) Schizophrenia (below the age of seventy (70) years)
(d) Bipolar Disorder (below the age of seventy (70) years)
(e) Tourette Syndrome (below the age of twenty-one (21) years)

Admission for attempted suicide is excluded. Pre-existing mental illnesses are not covered.
The above list may be reviewed and changed from time to time. Further details of the above conditions currently covered are available on request. This Benefit, if included in the insured Plan, overrides the standard Exclusions (defined in the Exclusions Section of this Policy) to the extent of the items covered under this Benefit.

30. Plastic Surgery

If You have selected a Plan that covers for this Benefit, the cost and expenses incurred for plastic surgery that are non-cosmetic and surgical correction that significantly impacts the function of the body part in question is reimbursable up to the maximum amount specified in the Schedule of Benefits.

Treatment may be received as Inpatient or as Day patient only covers the following Plastic Surgery/procedures:

(a) Breast
   i. Breast reconstruction with breast prosthesis after a mastectomy (not breast implant), for an Insured Person who is female by birth. Breast reconstruction means reconstruction of a breast incident to mastectomy or lumpectomy to restore or achieve breast symmetry.
   ii. Breast reduction in cases where the patient develops moderate to severe complications as a result of having very large breasts, subject to certified medical diagnosis.

(b) Ear
   i. Otoplasty procedure to correct deformed ears by Illness or Injury.

(c) Eye
   i. A severely hooded eyelid that partially obscures a patient's vision (up to age sixty (60) years)
   ii. Eye prosthesis, in event of loss of an eye (up to age sixty (60) years)

(d) Facial
   i. Facial disorders that are caused by paralysis, deformities of the facial muscles, the head or the neck.

(e) Hand
   i. Hyperhidrosis surgery for the palms and/or underarm (up to age twenty-one (21) years)

The above list may be reviewed and changed from time to time. Further details of the above procedures currently covered are available on request. This Benefit, if included in the insured Plan, overrides the standard Exclusions (defined in the Exclusions Section of this Policy) to the extent of the items covered under this Benefit.

31. Cashless Facility

If an Insured Person requires inpatient treatment or surgery in a Hospital listed in the Company's approved panel hospitals in Panel Network, the Company's Appointed Service Provider or third-party administrator ("TPA") shall assist in the hospital admission and settlement of the payment to the hospital.

The Policyholder shall pay to the hospital for all uninsured expenses. The Company's Appointed Service Provider or TPA shall only be responsible for arranging the settlement of amounts exceeding the uninsured expenses. In the event of overpayment by the Appointed Service Provider or TPA, the Company's Appointed Service Provider / TPA reserves the right to recover the excess payment from the Policyholder.

Cashless Facility is only valid at the Company's Panel Network in Malaysia. For non-panel providers, the Insured Person would need to pay first and seek reimbursement, subject to the Policy terms and conditions.

SPECIFIC EXCLUSIONS (applicable to Section 1)

1. Pre-existing illness.

2. Any medical or physical conditions arising within the first thirty (30) days of the Insured Person's cover or date reinstatement whichever is latest except for accidental injuries.

3. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of near-sightedness (including Radial Keratotomy or Lasik) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.

4. Dental conditions including dental treatment or oral surgery except as necessitated by Injuries to sound natural teeth occurring wholly during the Period of Insurance.

5. Private nursing, rest cures or sanitaria 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.

6. Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.

7. Pregnancy, childbirth (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.

8. 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 not Medically Necessary is, and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for weight reduction or gain.

9. Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.

10. 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.

11. Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.

12. 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.

13. Investigation and treatment of sleep and snoring disorders, hormone replacement therapy and alternative therapy such as treatment, medical service or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bone-setting, herbalist treatment, massage or aroma therapy or other alternative treatment.

14. 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 Person and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.

15. Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestations).

16. 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.

17. Sickness or Injury arising from racing of any kind (except foot racing), hazardous sports such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter sports, professional sports and illegal activities.

18. Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes.

19. Expenses incurred for sex changes.

SPECIFIC CONDITIONS (applicable to Section 1)

1. ALTERATIONS

No alteration to this Policy shall be valid unless mutually agreed upon by the Company and the Policyholder, and such approval is endorsed thereon. If, however, an alteration or amendment is a regulatory requirement, this may take effect immediately without mutual consent.

2. CANCELLATION OF POLICY

This Policy may be cancelled by the Policyholder 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 Policyholder shall be entitled to a refund of the premium as follows: -

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

3. CONTRIBUTION

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

4. CONVERSION POLICIES *(applicable only if specified in the Policy Schedule)*

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 Person 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.

5. FULL REIMBURSEMENT IN A GOVERNMENT HOSPITAL

Charges for eligible medical expenses are covered in full for treatment in a Malaysian Government Hospital for each Illness or Injury, provided the claimant does not transfer from or to a private hospital for treatment and the room and board charge is not greater than that provided under the chosen Plan applicable to the claimant.

6. LOCAL TREATMENT CLAUSE

Notwithstanding anything contained herein to the contrary, if the Insured Person is not a Malaysian, the coverage and benefits provided by this Policy shall be limited to treatment in Malaysia only.

7. OVERSEAS TREATMENT

If the Insured Person seeks treatment overseas, benefits in respect of the treatment shall be covered subject to the exclusions, limitations and conditions 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 Medical Emergency

(b) an Insured Person upon recommendation of a Physician and must 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 return to Malaysia are excluded.

8. RESIDENCE OVERSEAS

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

9. UPGRADED POLICIES *(applicable only if specified in the Policy Schedule)*

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.

10. UPGRADED ROOM AND BOARD CO-PAYMENT

If the Insured Person is hospitalised 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. For expenses incurred in Malaysia, the eligible benefits stipulated in the Private Healthcare Facilities and Services Act 1998 shall not be subject to 20% co-payment but shall be limited to the maximum amount stipulated in the applicable Schedule of Fees.

11. 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.

Section 2
EMERGENCY MEDICAL EVACUATION & REPATRIATION (EMER)

Section 2 provides for Emergency Medical Evacuation & Repatriation of Mortal Remains. This Section is optional and cannot be purchased without Section 1.

This Section of the Policy provides that in the event of an Insured Person named in the Policy Schedule suffering a serious medical condition,

(a) the Company's appointed Assistance Provider shall provide to the Insured Person the assistance services described in this policy;

(b) the Company shall pay directly to the Appointed Assistance Provider all expenses incurred in providing such assistance services; and

(c) the maximum liability of the Company shall be limited to the Annual Overall Limit stated in the following Table of Benefits.

The maximum amount payable is standalone and does not form part of the Overall Annual Limit or the Deductibles of Section 1 of this Policy.

LIMITS OF COVERAGE

	Plan 1	Plan 2
Emergency Medical Evacuation & Repatriation, Overall Annual Limit	500,000	1,000,000

DESCRIPTION OF COVERAGE

A. DOMESTIC EMERGENCY MEDICAL ASSISTANCE PROGRAMME

Services by TPA are available twenty-four (24) hours a day, every day to You/Insured Person if travelling anywhere within Malaysia. You can call the TPA's alarm centre in Malaysia twenty-four (24) hours a day to request the services below.

(a) Despatch of Medication Not Available Locally

TPA will despatch the necessary medication not available locally in case of emergency and when local laws, rules and regulations allow such a despatch. Cost of medicine shall be borne by the Insured Person and We will pay for cost of despatch up to RM1,000 only per event, subject to the EMER overall expense limit.

(b) Medical Evacuation

Following medical emergency, when hospitalised and local medical facility is inadequate, TPA will arrange for medical evacuation under constant medical supervision to the nearest adequate medical facility.

(c) Medically Supervised Repatriation

If TPA doctor, in consultation with the local attending physician, determines that treatment should continue at a medical facility nearer home following stabilisation of the medical condition of the Insured Person, TPA will arrange for repatriation under constant medical supervision.

For Medical Evacuation (b) and Medically Supervised Repatriation (c), all decisions as to the medical fitness of transfer, means of transportation and the final destination will be made by TPA or its authorised representative and will be based solely upon medical necessity.

The Medical Evacuation and Medically Supervised Repatriation services shall be up to the EMER overall expense limit as stated in the Schedule of Benefits, on per person per event per year.

B. INTERNATIONAL MEDICAL ASSISTANCE PROGRAMME

Services here are provided twenty-four (24) hours a day, every day to Insured Persons travelling anywhere outside Malaysia with each trip not exceeding ninety (90) consecutive days subject to maximum of one-hundred and eighty (180) days per year. Insured Persons can call the TPA call centre in Malaysia twenty-four (24) hours a day to request the services described below:

(a) Tele-medical Consultation and Evaluation of the Insured Person's Condition

When medical advice is needed during travels outside Malaysia, the Insured Person is to call the TPA for assistance and advice. TPA doctor on duty will provide help over the phone. It is important that the telephone conversation does not permit the establishment of a diagnosis and must be considered as an advice only.

(b) Medical Referral and Arrangement of Medical Appointments

Upon request, the TPA shall provide the name, address and telephone number of physicians (including both general practitioners and specialists), hospitals, dentists and dental clinics. TPA will attempt upon request to confirm the availability of the applicable medical or dental professional to make an appointment for treatment. Any third-party cost incurred shall be borne directly by the Insured Person.

(c) Despatch of Medication Not Available Locally

TPA will despatch the necessary medication not available locally in case of emergency and when local laws, rules and regulations allow such a despatch. Cost of medicine shall be borne by the Insured Person and We will pay for cost of despatch up to RM3,800 only per event, subject to the EMER overall expense limit.

(d) Medical Evacuation

Following medical emergency when Hospitalised and local medical facility is inadequate, TPA will arrange for medical evacuation under constant medical supervision to the nearest adequate medical facility.

(e) Medically Supervised Repatriation

If TPA doctor, in consultation with the other local attending physician, determines that treatment should continue at a medical facility nearer home following stabilisation of the medical condition of the Insured Person, TPA will arrange for the repatriation under constant medical supervision.

For Medical Evacuation (d) and Medically Supervised Repatriation (e), all decisions as to the medical fitness of transfer, means of transportation and the final destination will be made by TPA or its authorised representative and will be based solely upon medical necessity. The Medical Evacuation and Medically Supervised Repatriation services shall be up to the EMER overall expense limit as stated in the Schedule of Benefits, on per person per event per year.

(f) Medical Monitoring & Emergency Message Transmission

TPA will monitor the Insured Person's condition if the Insured Person is Hospitalised and will keep the Insured Person's employer / family informed, with prior agreement of the Insured Person in writing.

(g) Repatriation of Mortal Remains

If Insured Person dies while on the trip due to sickness or an accident, TPA or its authorised representative will organise for the return of the body or remains to the Insured Person's country of origin. We will pay for cost of such repatriation up to RM25,000 only per event, subject to the EMER overall expense limit.

(h) Visit to Bedside by a Friend / Relative

Should the Insured Person's Hospitalisation outside Malaysia be expected to last more than seven (7) consecutive days and TPA doctor on duty agrees that it is Medically Necessary for a relative / friend to be by the Insured Person's bedside provided no travel companion is with the Insured Person, TPA will arrange for one (1) economy class transportation for the relative / friend to visit the Insured Person. We will pay for the cost for one (1) economy class return transportation, subject to the EMER overall expense limit.

(i) Return of Child Travelling with the Insured Person

In event that the Insured Person is hospitalised and the Insured Person's medical condition prevents the Insured Person from caring for the Insured Person's minor children travelling with the Insured Person and no relative is on the spot able to take care of them, TPA will arrange one-way economy class transportation for the children to be sent back to Malaysia. We will pay for the cost incurred for the one-way economy class ticket for the children who are minor(s), subject to the EMER overall expense limit.

The following items below from (j) to (n) are purely assistance services rendered by TPA to Insured Person purely on referral arrangement basis. TPA / We will not be responsible for any expenses, which shall be incurred in connection to such rendering of services.

(j) Visa, Passport and Innoculation Requirements

TPA will provide information concerning Visa, inoculation, passport or immunization requirements of the foreign countries in which the Insured Person will be travelling.

(k) Location of Lost Items

TPA will assist the Insured Person in the location of lost luggage, documents and personal items. Airlines, government authorities and credit card issuers are among those who will be contacted, if necessary.

(l) Legal referral

Should the Insured Person seek legal assistance in the event of a medical emergency while on a trip, TPA will refer the Insured Person to our local advisors (where available).

(m) Referral to Interpreter / Translator

Should the Insured Person need translation assistance for an emergency in the course of the Insured Person's trip, TPA will refer the Insured Person to a local translator (where available).

n) Emergency Message Relay

In the case of a medical emergency, TPA will establish a national or international message relay to a designated addressee nominated by the Insured Person via telecommunication services.

SPECIFIC PROVISIONS (applicable to Section 2)

1. Eligibility

Only the following Insured Persons are eligible for insurance in relation to new policies:

(a) The Policyholder between the age of twenty-one (21) years and sixty-five (65) years
(b) The Policyholder's legally married spouse age sixty-five (65) years and below
(c) The Policyholder's Dependant Child age six (6) years and above
(d) The Policyholder's Dependant Parent or Parent-in-law age sixty-five (65) years and below
(e) The Policyholder's Dependant Grandparent age sixty-five (65) years and below

2. Period of Cover and Renewal

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) 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.

The renewal premium payable is not guaranteed, and the Company reserves the right to determine the premium applicable specifically to each Insured Person at the time of renewal.

3. Premium Pricing

The pricing of the premium and all subsequent revisions shall be done on a portfolio basis. New applications will be subjected to individual underwriting and premium loadings applicable at the first inception date will be applicable to the standard premium rates as well as all subsequent revisions.

SPECIFIC DEFINITIONS (applicable to Section 2)

1. Approved Assistance Provider

Emergency Assistance company appointed by the Company to provide the emergency assistance services.

2. Place of Residence

The permanent residence of the Insured Person in Malaysia as declared by the Policyholder.

3. Serious Medical Condition

A condition, which in the opinion of the Company and the Approved Assistance Provider, constitutes a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to the Insured Person's immediate or long-term health prospects. The seriousness of the medical condition shall be judged within the context of the Insured Person's geographical location, the nature of the medical emergency and the local availability of appropriate medical care or facilities.

4. Emergency Medical Condition

A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(b) serious impairment to bodily functions; or
(c) serious dysfunction of any bodily organ or part.

5. Ambulance Service

Services rendered by a registered ambulance services provider from the site of happening of a serious medical condition to an appropriate local medical care facility.

SPECIFIC EXCLUSIONS (applicable to Section 2)

1. Any event occurring when the Insured Person is within the territory of Malaysia (International Assistance) or is in the Place of Residence in Malaysia (Domestic Assistance).

2. Any expense, if the Insured Person is not suffering from a Serious Medical Condition or if the treatment can be reasonably delayed until the Insured Person returns to Malaysia (International Assistance) or his/her Place of Residence within Malaysia (Domestic Assistance).

3. Any expense, if the emergency assistance is not provided by the Company's Appointed Assistance Provider.

4. An Insured Person who is physically able to return to his/her country of residence as a seated passenger and without medical escort (unless excepted by the Company's Appointed Assistance Provider's duty doctor).

5. Any expense, if the Insured Person is travelling outside Malaysia (International Assistance) or travelling from the Place of Residence within Malaysia (Domestic Assistance) contrary to the advice of a Medical Practitioner or for the purpose of obtaining medical treatment or for rest and recuperation following any prior accident or illness.

6. Any treatment or expense related to childbirth, pregnancy, (except abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn children) and in any event childbirth, miscarriage (spontaneous abortion) or pregnancy after sixth (6th) month thereof.

7. Any expense incurred for emotional, mental illness and psychiatric disorder as opposed to physical and strictly medical reason.

8. Self-inflicted injury, suicide, drug addiction or abuse, alcohol abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS) or any AIDS related conditions or diseases.

9. Any expense resulting from participation in war, riot or civil commotion, strikes, rebellion or any illegal act resulting in imprisonment or while engaging in or participating in any police, naval, military or air force operations of an offensive nature planned or conducted by the Civil or Military Authorities against bandits, terrorist, or other elements

10. Any expense in respect of the Insured Person who is more than seventy (70) years old at the date of the intervention unless otherwise agreed by endorsement in the Policy Schedule.

11. Any expense in respect of an Insured Person who is under the influence of drugs other than those prescribed by a doctor as well as consequence of alcohol abuse.

12. Any expense related to accident or injury occurring while the Insured Person is engaged in mountaineering or rock climbing necessitating the use of guides or ropes, potholing, skydiving, parachuting, ballooning, hang-gliding, deep sea diving utilising hard helmet with air hose attachments, racing of any kind other than on foot and all professional sports unless otherwise agreed by endorsement in the Policy Schedule.

13. Any expense incurred in the conduct of a burial.

14. Direct or indirect effects of nuclear reactions.

SPECIFIC CONDITIONS (applicable to Section 2)

1. Alteration

The Company reserves the right to amend the terms and provisions of this Section of this Policy by giving a 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 Section of this Policy shall be valid unless authorised 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. If, however, an alteration or amendment is a regulatory requirement, this may take effect immediately without prior notice.

2. Cancellation

The Policyholder may cancel this Section of this Policy by giving written notice to the Company, such notice to state when thereafter cancellation shall become effective. If no claim has been made prior to the cancellation, premium may be refunded to the Policyholder after deducting the following short period premium:

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

The Company may cancel the Policy by giving written notice to the Policyholder at the address shown in the Policy Schedule or endorsed herein, stating when, not less than fourteen (14) days thereafter, such cancellation shall become effective. Pro-rata refund of premium will be made to the Policyholder for this cancellation. Cancellation shall be without prejudice to any claim originating prior to the Effective Date of cancellation.

SECTION 3
HOSPITAL CASH BENEFIT INSURANCE (HCI)

Section 3 provides for the payment of cash benefit in the event of hospitalisation. This Section is optional and cannot be purchased without Section 1.

The maximum amount payable is standalone and does not form part of the Overall Annual Limit or the Deductibles of Section 1 of this Policy.

LIMITS OF COVERAGE

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Daily Cash Benefit	100	200	300	400	500
Maximum Number of Days Per Year	60	60	60	60	60

DESCRIPTION OF BENEFITS (applicable to Section 3)

1. Insured Event

In the event the Insured Person requires Hospitalisation as a result of an Accident or Illness.

2. Insured Benefit

This Section of the Policy provides that in the event of hospitalisation of Insured Person named in the Policy Schedule for the treatment of an insured Disability, this Section of this Policy shall pay the Policyholder the eligible daily Cash Benefit subject to the following:

(a) The daily Cash Benefit payable is a fixed daily amount stipulated in Schedule of Benefits for the chosen plan, and
(b) Cash benefits will be paid in total after discharge from hospital, and
(c) The maximum amount payable shall not exceed the maximum number of days per year of the chosen plan.

3. Time Excess

There is a time excess of five (5) days. This means that the daily cash benefit is only payable from the sixth day of hospitalisation.

4. Waiting Period

This Section of this Policy is subject to thirty (30) days Waiting Period for Illness. This benefit will not be payable for hospitalisation resulting from an Illness within the first thirty (30) days from the Commencement Date/Original First Effective Date. Waiting Period does not apply to hospitalisation due to Accident.

SPECIFIC PROVISIONS (applicable to Section 3)

1. Eligibility

Only the following Insured Persons are eligible for insurance in relation to new policies:

(a) The Policyholder between the age of twenty-one (21) years and sixty-five (65) years

(b) The Policyholder's spouse between the age of twenty-one (21) years and sixty-five (65) years

2. Period of Cover and Renewal

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) 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.

The renewal premium payable is not guaranteed, and the Company reserves the right to determine the premium applicable specifically to each Insured Person at the time of renewal.

3. Premium Pricing

The pricing of the premium and all subsequent revisions shall be done on a portfolio basis. New applications will be subjected to individual underwriting and premium loadings applicable at the first inception date will be applicable to the standard premium rates as well as all subsequent revisions.

SPECIFIC EXCLUSIONS (applicable to Section 3)

1. Claim for hospitalisation that is not payable under Section 1 of this Policy.

2. Claims arising out of hospitalisation for an illness during the first thirty (30) days from the Commencement Date/Original First Effective Date.

3. No benefit will be payable for the first five (5) days of each eligible hospitalisation. This is the time excess period applicable to this Section of this Policy.

SPECIFIC CONDITIONS (applicable to Section 3)

1. Alteration

The Company reserves the right to amend the terms and provisions of this Section of this Policy by giving a 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 Section of this Policy shall be valid unless authorised 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. If, however, an alteration or amendment is a regulatory requirement, this may take effect immediately without prior notice.

2. Cancellation

The Policyholder may cancel this Section of this Policy by giving written notice to the Company, such notice to state when thereafter cancellation shall become effective. If no claim has been made prior to the cancellation, premium may be refunded to the Policyholder after deducting the following short period premium:

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

The Company may cancel the Policy by giving written notice to the Policyholder at the address shown in the Policy Schedule or endorsed herein, stating when, not less than fourteen (14) days thereafter, such cancellation shall become effective. Pro-rata refund of premium will be made to the Policyholder for this cancellation. Cancellation shall be without prejudice to any claim originating prior to the Effective Date of cancellation.

SECTION 4
OUTPATIENT INSURANCE (OPI)

Section 4 provides insurance on an indemnity basis for the outpatient treatment. This Section is optional and cannot be purchased without Section 1.

LIMITS OF COVERAGE

	Plan 1	Plan 2	Plan 3
1. General Practitioner Consultation Reasonable, customary and medical necessary clinical charges incurred as charged but subject to the combined limit for Each Consultation	50	75	100
2. Specialist Consultation Reasonable, customary and medical necessary Outpatient Specialist Consultation as specified in the Description of Coverage	80% of As Charged Amount Incurred	80% of As Charged Amount Incurred	80% of As Charged Amount Incurred
3. Overall Annual Limit	2,000	3,000	5,000

DESCRIPTION OF COVERAGE

1. General Practitioner Consultation

Reimbursement of Outpatient General Practitioner Consultation for common sicknesses and bodily injuries as specified below at the Company's panel of clinics:

(a) Routine consultation
Cost of Consultations provided by a legally registered Doctor at a General Practitioner Clinic.

(b) Medication
Cost of Medication relevant to the treatment of the Disability for which consultation is being provided by a legally registered Doctor at a General Practitioner Clinic.

(c) Injection
Cost of Injection which requires a Physician's or Physician Assistant's administration at a General Practitioner's Clinic for the treatment of illnesses or injury.

(d) Diagnostic Laboratory Tests and X-Ray Procedures
Cost of Diagnostic Laboratory Tests and X-Ray Procedures done at a General Practitioner's Clinic for the determination and diagnosis of a Disability. Such tests must be related to the clinical Disability and shall not include routine check-ups.

The amount is reimbursable subject to the Overall Limit Per Consultation and Overall Annual Limit stated in the Limits of Coverage and is limited to one (1) visit per day.

2. Specialist Consultation

Reimbursement of Outpatient Specialist Consultation as specified below upon the referral of a General Practitioner:

(a) Consultation Fees with the Specialist
Cost of Outpatient Consultations provided by a legally registered Medical Specialist.

(b) Medication
Cost of Medication prescribed by the attending Specialist relevant to the treatment of the Disability for which consultation is being provided by the attending Specialist.

(c) Injection
Cost of injection administered by a Specialist or Specialist's assistant.

(d) Diagnostic Laboratory Tests and X-Ray Procedures
Cost of non-invasive diagnostic procedures, laboratory and imaging by a Specialist.

(e) Outpatient Physiotherapy Treatment
Cost of outpatient physiotherapy treatment, subject to written recommendation by the treating Specialist.

(f) Outpatient Nursing Care
Nursing care charges, subject to written recommendation by the treating Specialist.

The amount reimbursable shall be subject to 20% co-insurance, is reimbursable up to Overall Annual Limit stated in the Limits of Coverage and is limited to one (1) visit per day.

SPECIFIC PROVISIONS (applicable to Section 4)

1. Eligibility

Only the following Insured Persons are eligible for insurance in relation to new policies:

(a) The Policyholder between the age of twenty-one (21) years and sixty-five (65) years
(b) The Policyholder's spouse age sixty-five (65) years and below
(c) The Policyholder's Dependant Child age six (6) years and above
(d) The Policyholder's Dependant Parent or Parent-in-law age sixty-five (65) years and below
(e) The Policyholder's Dependant Grandparent age sixty-five (65) years and below

2. Period of Cover and Renewal

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) 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.

The renewal premium payable is not guaranteed, and the Company reserves the right to determine the premium applicable specifically to each Insured Person at the time of renewal.

3. Premium Pricing

The pricing of the premium and all subsequent revisions shall be done on a portfolio basis. New applications will be subjected to individual underwriting and premium loadings applicable at the first inception date will be applicable to the standard premium rates as well as all subsequent revisions.

SPECIFIC EXCLUSIONS (applicable to Section 4)

This Policy does not cover claims arising out of hospitalisation for the treatment of an illness or injury.

This Policy does not cover any Clinical, General Practitioner, Doctor and Specialist charges and costs caused directly or indirectly, wholly or partly, by any one (1) of the following occurrences:

1. Purchase or acquisition of all types of external and internal appliances or devices (i.e. wheelchairs, implants, hearing aids, walking aids, equipment for nebulizing, orthopedic pads).
2. Dental conditions including dental treatment or surgery except as a result of an accident. Restorative procedures such as crowning, bridging, implant and root canal treatment are not covered.
3. Plastic/cosmetic treatment and its complication thereafter, except as necessitated by accidental injury.
4. Eye examination, refractive errors of the eyes and its correction, supply of corrective glasses or contact lens.
5. Alternative therapies including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bone setting, herbalist treatment, massage or aroma therapy, non-western medicine and other alternative treatment.
6. Surgical, mechanical or chemical contraceptive methods of birth control, and Hormone therapy.
7. Sexual dysfunction, sex transformation whether by surgical or chemical.
8. Sexually transmitted diseases and its sequel, AIDS or HIV and its related complications, any communicable diseases requiring quarantine by law.
9. Pregnancy, childbirth (including delivery), pre-natal, postnatal care, abortion, infertility and miscarriage.
10. Suicide, attempted suicide, self-inflicted injury or overdose of any kind intentional or otherwise while sane or insane.
11. Routine health check-ups, routine physical examination, including gynaecological checkups.
12. Outpatient physical therapy or physiotherapy except upon written referral of a Specialist.
13. Speech and occupational therapy, Blood and topical allergy testing.
14. Treatment for congenital abnormalities, deformities and disabilities.
15. Vitamins, food supplements, soaps, shampoos, toiletries items, herbal cures, weight reduction or induction agents, off the counter medications, and preventive vaccinations /immunization except as mentioned in Description of benefits,
16. Treatment of Injuries sustained while under the influence of alcohol or narcotics or whilst in participation in any illegal or dangerous activities.
17. Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestations).
18. Private nursing care or services for rest cures or sanitaria care provided by rest/nursing home, and house calls by doctors for any reason.
19. Purchase of treatment of rehabilitation drugs (i.e. smoking patches and etc.).
20. Facial or treatment for Acne, any circumcision unless Medically Necessary.
21. Dispense of member's current medication for a period of more than two (2) weeks except for member with chronic conditions e.g. diabetes, hypertension, etc. where one (1) month supply is allowed.
22. Treatment/dispense of medication which are not consistent with diagnosis and costs/expenses of services of a non-medical nature.
23. 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 Person and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.
24. More than one (1) consultation per day to a General Practitioner, doctor or Specialist.
25. Outpatient rehabilitation therapy, chemotherapy, radiation therapy and kidney dialysis.

SPECIFIC CONDITIONS (applicable to Section 4)

1. Alteration

The Company reserves the right to amend the terms and provisions of this Section of this Policy by giving a 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 Section of this Policy shall be valid unless authorised 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. If, however, an alteration or amendment is a regulatory requirement, this may take effect immediately without prior notice.

2. Cancellation

The Policyholder may cancel this Section of this Policy by giving written notice to the Company, such notice to state when thereafter cancellation shall become effective. If no claim has been made prior to the cancellation, premium may be refunded to the Policyholder after deducting the following short period premium:

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

The Company may cancel this Section of this Policy by giving written notice to the Policyholder at the address shown in the Policy Schedule or endorsed herein, stating when, not less than fourteen (14) days thereafter, such cancellation shall become effective. Pro-rata refund of premium will be made to the Policyholder for this cancellation. Cancellation shall be without prejudice to any claim originating prior to the Effective Date of cancellation.

SECTION 5
DENTAL INSURANCE (DI)

Section 5 provides insurance on an indemnity basis for the dental treatment. This Section is optional and cannot be purchased without Section 1.

LIMITS OF COVERAGE

	Plan 1	Plan 2	Plan 3
1. Dental Benefits Reasonable, customary and medical necessary dental treatment as specified in the Description of Coverage	70% of As Charged Amount Incurred	70% of As Charged Amount Incurred	70% of As Charged Amount Incurred
2. Overall Annual Limit	1,000	1,500	2,000

DESCRIPTION OF COVERAGE

1. DIAGNOSTIC AND PREVENTIVE DENTAL SERVICES

(a) PA (Periapical) and Bitewing X-rays (routine)

i. PA (Periapical) and Bitewing x-rays refers to a type of x-ray image taken by a Dentist to assess oral health or to look at a particular area of the mouth. They are commonly used to examine for interdental caries and recurrent caries under existing restorations.

ii. Reimburses only one (1) set in any consecutive 12-month period and limited to a maximum of four (4) films per set.

iii. Not subject to any waiting period.

(b) Dental check-up & maintenance

i. Clinical Oral Evaluation, reimburses only one (1) per consecutive 6-month period.
ii. Prophylaxis (Cleaning) or periodontal maintenance procedure, reimburses only one (1) prophylaxis or periodontal maintenance procedure per consecutive 6-month period.
iii. Not subject to any waiting period.

(c) X-rays (non-routine), subject to 6 months waiting period

i. Complete mouth survey or panoramic x-rays - reimburses only one (1) in any consecutive 60-month period.
ii. For Benefit determination purposes, a full mouth series will be determined to include bitewings and 10 or more periapical x-rays (provides clear image of an entire tooth from crown to root, which cannot be found with a bitewing x-ray).
iii. Individual periapical x-rays - A maximum of four (4) periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period.
iv. Intraoral occlusal x-rays - Limited to two (2) films in any consecutive 12-month period.
v. Subject to six (6) months waiting period.

(d) Fillings

i. Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.
ii. Silicate Restorations - Benefits for the replacement of an existing silicate restoration are only payable if at least 12 consecutive months have passed since the existing filling was placed.
iii. Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed.
iv. Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one (1) time per restoration regardless of the number of pins used.
v. Subject to six (6) months waiting period.

2. ORAL SURGERY

(a) Simple extractions

i. Routine Extraction - Includes local anaesthesia and routine postoperative care.
ii. Root Removal - Exposed Roots - Includes local anaesthesia and routine postoperative care.
iii. Subject to six (6) months waiting period.

(b) Examinations

i. Histopathologic exams - payable only if the surgical biopsy is also covered.
ii. Subject to twelve (12) months waiting period.

(c) Endodontic procedures (root canal therapy)

Commonly known as "root canal therapy" (inside tooth). Concerns the etiology (investigation of cause), prevention, diagnosis, and treatment of conditions that affect the tooth pulp, root, and periapical tissues.

i. Root Canal Therapy:
   a. Root Canal Therapy, Primary Tooth (excluding final restoration) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anaesthesia and routine follow-up care.
   b. Root Canal Therapy - Permanent Tooth - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anaesthesia and routine follow-up care.
   c. Root Canal Therapy, Retreatment - by Report - Covered only if more than twenty-four (24) consecutive months have passed since the original endodontic therapy and only if necessity is confirmed by professional review.
ii. Apexification (procedure to close the end of open tooth root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anaesthesia and routine follow-up care. A maximum of three (3) visits per Policy Year are payable.
iii. Apicoectomy (root end surgery often performed after failed root canal treatment) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anaesthesia and routine follow-up care.
iv. Retrograde Filling (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anaesthesia and routine follow-up care. Not separately payable on the same date and tooth as an Apicoectomy.
v. Root Amputation (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anaesthesia and routine follow-up care.
vi. Hemi section - Fixed bridgework replacing the extracted portion of a hemisected tooth is not covered. Procedure includes local anaesthesia and routine postoperative care.
vii. Subject to twelve (12) months waiting period.

(d) Oral surgery procedures

i. Surgical Extraction - (except for the removal of impacted teeth) - Includes local anaesthesia and routine postoperative care.
ii. Surgical Removal of Residual Tooth Roots (Cutting Procedure) - Includes local anaesthesia and routine postoperative care.

iii. Tooth Transplantation (includes reimplantation from one site to another and splinting and/or stabilisation) - Includes local anaesthesia and routine postoperative care.
iv. Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption - Includes local anaesthesia and routine postoperative care.
v. Biopsy of Oral Tissue, including brush biopsy technique - Includes local anaesthesia and routine postoperative care.
vi. Alveoloplasty (a pre-prosthetic procedure performed to smoothen or reshape the jawbone) - Includes local anaesthesia and routine postoperative care.
vii. Vestibuloplasty (procedures to restore alveolar ridge height by lowering attaching muscles) - Includes local anaesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.
viii. Radical Excision of Reactive Inflammatory Lesions (Scar Tissue or Localized Congenital Lesions) - Includes local anaesthesia and routine postoperative care.
ix. Removal of Odontogenic Cyst or Tumour (jaw cyst) - Includes local anaesthesia and routine postoperative care.
x. Removal of Exostosis (bone spur) - Maxilla or Mandible - Includes local anaesthesia and routine postoperative care.
xi. Incision and Drainage - Includes local anaesthesia and routine postoperative care.
xii. Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Facial bones - Autogenous or Nonautogenous, by Report - Includes local anaesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.
xiii. Frenectomy (Frenulectomy, Frenotomy), Separate Procedure - Includes local anaesthesia and routine postoperative care.
xiv. Excision of Hyperplastic Tissue - Per Arch - Includes local anaesthesia and routine postoperative care.
xv. Excision of Pericoronal Gingiva - Includes local anaesthesia and routine postoperative care.
xvi. Synthetic Graft - Mandible or Facial Bones, by Report - Includes local anaesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.
xvii. Removal of Impacted Tooth:
    a. Surgical Removal of Impacted Tooth - Soft Tissue - The Benefit includes local anaesthesia and routine postoperative care.
    b. Surgical Removal of Impacted Tooth - Partially Bony - The Benefit includes local anaesthesia and routine postoperative care.
    c. Surgical Removal of Impacted Tooth - Completely Bony - The Benefit includes local anaesthesia and routine postoperative care.
    d. Removal of Impacted Tooth; Completely Bony, with Unusual Surgical Complications - The Benefit includes local anaesthesia and routine postoperative care.
xviii. Subject to twelve (12) months waiting period.

(e) Periodontic procedures

Concerns the supporting structures of teeth (around tooth), and diseases and conditions that affect them. The supporting tissues include periodontium, which includes the gingiva (gums), alveolar bone, cementum (root cells), and the periodontal ligament.

i. Periodontal Scaling and Root Planning (if not related to periodontal surgery) - Per Quadrant - Limited to 1 time per quadrant of the mouth in any consecutive 36-month period. Not separately payable if performed on the same treatment plan as prophylaxis.
ii. Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only one (1) periodontal maintenance procedure or adult prophylaxis is payable in any consecutive 6-month period. This procedure includes an exam and scaling and root planning.
iii. Gingivectomy - Only one (1) periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
iv. Gingival Flap Procedure Including Root Planning - Only one (1) periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
v. Clinical Crown Lengthening - Hard Tissue - No limitation.
vi. Mucogingival Surgery - Per Quadrant - only one (1) periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
vii. Osseous Surgery - only one (1) periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.
viii. Bone Replacement Graft - First Site Quadrant.
ix. Bone Replacement Graft - Each Additional Site in Quadrant.
x. Guided Tissue Regeneration - Resorbable Barrier - per Site, per Tooth - Only one (1) periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery.
xi. Pedicle Soft Tissue Graft - No limitation.
xii. Free Soft Tissue Graft (including donor site surgery) - No limitation.
xiii. Subepithelial Connective Tissue Graft Procedure (including donor site surgery) - No limitation.
xiv. Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - No limitation.
xv. Subject to twelve (12) months waiting period.

(f) Restorative procedures, subject to twelve (12) months waiting period

i. Crowns:
    a. There is no coverage for core build-ups (support for crown).

b. There is no coverage for porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
c. There is no coverage for precious or semi-precious metals for crowns, bridges, pontics and abutments.
d. There is no coverage for diagnostic casts, diagnostic models, or study models.
e. For Insured Persons under age sixteen (16) years old, crowns are limited to resin or stainless steel only.
f. Subject to twelve (12) months waiting period

ii. Repairs to Crowns and Inlays:
a. Recement Inlays - No limitation.
b. Recement Crowns - No limitation.
c. Repairs to Crowns - Limited to repairs performed more than twelve (12) consecutive months after initial insertion.
d. Subject to twelve (12) months waiting period

iii. Repairs to Dentures and Bridges:
a. Repairs to Full and Partial Dentures - Limited to repairs performed more than twelve (12) consecutive months after initial insertion.
b. Recement Fixed Partial Denture - Limited to repairs performed more than twelve (12) consecutive months after initial insertion.
c. Fixed Partial Denture Repair, by Report - Limited to repairs performed more than twelve (12) consecutive months after initial insertion.
d. Inlays and Onlays - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than eighty-four (84) consecutive months have elapsed since the last placement.
e. Crowns - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than eighty-four (84) consecutive months have elapsed since the last placement.
i. For Insured Persons under sixteen (16) years of age, Benefits for crowns on vital teeth are limited to Resin or Stainless-Steel Crowns.
ii. Benefits for crowns are based on the amount payable for nonprecious metal substrate.
iii. For Insured Persons under the age of sixteen (16) years, Stainless Steel Crowns or Resin Crowns are covered only when the tooth cannot be restored by filling and then only one (1) time in a consecutive 36-month period.
f. Post and Core (in conjunction with a crown or inlay) - Covered only for endodontically treated teeth with total loss of tooth structure.
g. Subject to twelve (12) months waiting period.

(g) Prosthodontic procedures

i. Bridges:
a. Post and core in conjunction with a fixed bridge covered only for endodontically treated teeth with total loss of tooth structure.
b. Benefits for the replacement of an existing bridge are payable only if the existing bridge is at least 84 consecutive months old, is not serviceable, and cannot be repaired.
c. Benefits for Cast Metal Retainer for Resin Bonded Fixed Bridge will be considered for the initial replacement of a necessary functioning natural tooth extracted while the Insured Person was covered under this Benefit.
d. There is no coverage for the placement for the initial placement of a fixed bridge, unless it includes the replacement of a functioning natural tooth extracted while the Insured Person is covered under this Benefit. If a bridge replaces teeth that were missing prior to the date the Insured Person's coverage became effective (Commencement Date/Original First Effective Date) and teeth that are extracted after the Insured Person's Effective Date, Benefits are payable only for the pontics replacing those teeth which are extracted while the Insured Person was insured under this Benefit. The removal of only a permanent third molar (wisdom tooth) will not qualify a fixed bridge for Benefit under this provision.
e. Subject to twelve (12) months waiting period.

ii. Full Dentures:
a. There are no additional Benefits for personalised dentures or overdentures or associated procedures.
b. We will not pay for any denture until it is accepted by the Insured Person.
c. Limited to one (1) time per arch per eighty-four (84) consecutive months. There is no coverage for the initial placement of a full denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this Benefit.
d. The removal of only a permanent third molar will not qualify a full or partial denture for Benefit under this provision.
e. Subject to twelve (12) months waiting period.

iii. Partial Dentures:
a. There are no additional Benefits for precision or semi-precision attachments.
b. The Benefit for a partial denture includes any clasps and rests and all teeth.
c. We will not pay for any denture until it is accepted by the Insured Person.
d. Limited to one (1) partial denture per arch per 84 consecutive months unless there is a necessary extraction of an additional functioning natural tooth.
e. There is no coverage for the initial placement of a partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this Benefit.
f. The removal of only a permanent third molar will not qualify a full or partial denture for Benefit under this provision.

g. Subject to twelve (12) months waiting period.

iv. Fixed Partial Dentures (Nonprecious Metal Pontics, Retainer Crowns and Metallic Retainers):
   a. Benefits will be considered for the initial replacement of a necessary functioning natural tooth extracted while the person was covered under the plan.
   b. Benefits for retainer crowns and pontics are based on the amount payable for nonprecious metal substrates.
   c. Subject to twelve (12) months waiting period.

v. Add tooth to existing Partial Denture:
   a. To replace newly extracted functional natural tooth
   b. Only if more than 12 consecutive months have elapsed since the insertion of the partial denture.
   c. Subject to twelve (12) months waiting period.

vi. Complete and Partial Overdentures:
   a. There are no additional Benefits for precision or semi-precision attachments.
   b. The Benefit for a partial denture includes any clasps and rests and all teeth.
   c. We will not pay for any denture until it is accepted by the Insured Person.
   d. Limited to one (1) partial denture per arch per eighty-four (84) consecutive months unless there is a necessary extraction of an additional functioning natural tooth.
   e. Subject to twelve (12) months waiting period.

vii. Replacement:
   a. Benefits are based on the amount payable for nonprecious metal substrates. Benefits for the replacement of an existing resin bonded bridge are payable only if the existing resin bonded bridge is at least eighty-four (84) consecutive months old, is not serviceable, and cannot be repaired. There is no coverage for the replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth or for any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
   b. There is no replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
      i. replacement occurs at least eighty-four (84) consecutive months after the initial date of insertion of the current full or partial denture; or
      ii. the partial denture is less than eighty-four (84) consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this Benefit (alternate Benefits of adding a tooth to an existing appliance may be applied); or
      iii. replacement occurs at least eighty-four (84) consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than eighty-four (84) consecutive months old, and replacement is needed due to an additional Necessary extraction of a functioning natural tooth while the person is covered under this Benefit. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
   c. Subject to twelve (12) months waiting period.

(h) Anaesthetics

i. General Anaesthesia - Paid as a separate Benefit only when Medically or Dentally Necessary and when administered in conjunction with complex oral surgical procedures which are covered under this Benefit.

ii. V. (Intravenous) Sedation - Paid as a separate Benefit only when Medically or Dentally Necessary and when administered in conjunction with complex oral surgical procedures which are covered under this Benefit.

iii. Subject to twelve (12) months waiting period.

3. ORTHODONTICS

Reimbursable Treatment are:

(a) Cephalometric x-rays
(b) Full mouth or panoramic x-rays taken in conjunction with an orthodontic treatment plan
(c) Diagnostic casts (i.e., study models) for orthodontic evaluation
(d) Surgical exposure of impacted or unerupted tooth for orthodontic purposes
(e) Fixed or removable orthodontic appliances for tooth movement and/or tooth guidance.
(f) Subject to twelve (12) months waiting period.

SPECIFIC PROVISIONS (applicable to Section 5)

1. Eligibility

Only the following Insured Persons are eligible for insurance in relation to new policies:

(a) The Policyholder between the age of twenty-one (21) years and sixty-five (65) years
(b) The Policyholder's legally married spouse age sixty-five (65) years and below
(c) The Policyholder's Dependant Child age six (6) years and above
(d) The Policyholder's Dependant Parent or Parent-in-law age sixty-five (65) years and below
(e) The Policyholder's Dependant Grandparent age sixty-five (65) years and below

2. Period of Cover and Renewal

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) 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.

The renewal premium payable is not guaranteed, and the Company reserves the right to determine the premium applicable specifically to each Insured Person at the time of renewal.

3. Premium Pricing

The pricing of the premium and all subsequent revisions shall be done on a portfolio basis. New applications will be subjected to individual underwriting and premium loadings applicable at the first inception date will be applicable to the standard premium rates as well as all subsequent revisions.

SPECIFIC EXCLUSIONS (applicable to Section 5)

1. Cost of replacement of teeth that are already missing before an Insured Person first becomes insured.
2. Dental treatment and replacement of prosthodontic appliances for cosmetic purpose.
3. Replacement of mislaid, loss or stolen, denture or bridgework.
4. Dental treatments required due to wilful injury.
5. Fees charged by the dentist for any services other than the oral treatment.
6. Congenital defects.
7. Temporomandi-bular Joint (TMJ) Dysfunction, unless it is determined that such treatment is dental in nature.
8. Any others highlighted in the listed items.

SPECIFIC CONDITIONS (applicable to Section 5)

1. Alteration

The Company reserves the right to amend the terms and provisions of this Section of this Policy by giving a 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 Section of this Policy shall be valid unless authorised 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. If, however, an alteration or amendment is a regulatory requirement, this may take effect immediately without prior notice.

2. Cancellation

The Policyholder may cancel this Section of this Policy by giving written notice to the Company, such notice to state when thereafter cancellation shall become effective. If no claim has been made prior to the cancellation, premium may be refunded to the Policyholder after deducting the following short period premium:

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

The Company may cancel this Section of this Policy by giving written notice to the Policyholder at the address shown in the Policy Schedule or endorsed herein, stating when, not less than fourteen (14) days thereafter, such cancellation shall become effective. Pro-rata refund of premium will be made to the Policyholder for this cancellation. Cancellation shall be without prejudice to any claim originating prior to the Effective Date of cancellation.

Section 6
CRITICAL ILLNESS INSURANCE (CI)

Section 6 provides critical illnesses insurance on a fixed benefit basis. This Section is optional and cannot be purchased without Section 1.

The maximum amount payable is standalone and does not form part of the Overall Annual Limit or the Deductibles of Section 1 of this Policy.

LIMITS OF COVERAGE

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Sum Insured	50,000	100,000	150,000	200,000	250,000	300,000
Waiting Period	90 days	90 days	90 days	90 days	90 days	90 days
Survival Period	30 days	30 days	30 days	30 days	30 days	30 days

DESCRIPTION OF COVERAGE

1. Cancer of specified severity and does not cover very early cancers

Any malignant tumour positively diagnosed with histological confirmation (confirmed by a pathologist) and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.
For the above definition, the following are not covered:

a) All cancers which are histologically classified as any of the following:
   - pre-malignant
   - non-invasive
   - Carcinoma in situ
   - having borderline malignancy
   - having malignant potential

b) All tumours of the prostate histologically classified as T1N0M0 (TNM classification);
c) All tumours of the thyroid histologically classified as T1N0M0 (TNM classification);
d) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM classification);
e) Chronic Lymphocytic Leukaemia less than RAI Stage 3;
f) All cancers in the presence of HIV;
g) Any skin cancer other than malignant melanoma.

2. Angioplasty and Other Invasive Treatments for Coronary Artery Disease

The actual undergoing for the first time of Coronary Artery Balloon Angioplasty, artherectomy, laser treatment or the insertion of a stent to correct a narrowing or blockage of one or more coronary arteries as shown by angiographic evidence and advice of the cardiologist. Intra-arterial investigative procedures are not covered. Payment under this clause is limited to ten percent (10%) of the Critical Illness coverage under this Policy subject to a maximum of RM25,000. This covered event is payable once only and shall be deducted from the amount of this benefit rider, thereby reducing the amount of the lump sum payment which may be payable.

3. Cardiomyopathy – of specified severity

A definite diagnosis of cardiomyopathy by a cardiologist which results in permanently impaired ventricular function and resulting in permanent physical impairment of at least Class III of the New York Heart Association's (NYHA) classification of cardiac impairment. The diagnosis must be supported by echocardiographic findings of compromised ventricular performance, LVEF (left ventricular ejection fraction) of forty percent (40%) or less.
The NYHA Classification of Cardiac Impairment for Class III and Class IV means the following:

a) Class III: Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes symptoms.
b) Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Cardiomyopathy directly related to alcohol or drug abuse is **not covered**.

4. Coronary Artery By-Pass Surgery

Refers to the actual undergoing of open-chest surgery to correct or treat Coronary Artery Disease (CAD) by way of coronary artery by-pass grafting. The diagnosis must be supported by a coronary angiography and the realisation of the surgery must be confirmed by a cardiologist.
For the above definition, the following are not covered:

a) angioplasty;
b) other intra-arterial or catheter-based techniques;
c) keyhole procedures;
d) laser procedures.

5. Heart Attack

Heart Attack must be of specified severity.
Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:
A history of typical chest pain;

a) New characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block; and
b) Elevation of the cardiac biomarkers, inclusive of CPK-MB above the generally accepted normal laboratory levels or Troponins recorded at the following levels or higher:
- Cardiac Troponin T or Cardiac Troponin I > / = 0.5 ng/ml

The evidence must show the occurrence of a definite acute myocardial infarction which should be confirmed by a cardiologist or physician.

For the above definition, the following are not covered:
a) occurrence of an acute coronary syndrome including but not limited to unstable angina.
b) a rise in cardiac biomarkers resulting from a percutaneous procedure for coronary artery disease.
c) Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T.

6. Heart Valve Surgery

The actual undergoing of open-heart surgery to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities. The diagnosis of valve abnormality must be supported by echocardiography and the realisation of surgery must be confirmed by a cardiologist.

For the above definition, the following are not covered:
a) Repair via intra-arterial procedure;
b) Repair via key-hole surgery or any other similar techniques.

7. Primary Pulmonary Arterial Hypertension – of specified severity

A definite diagnosis of primary pulmonary arterial hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterisation (cardiac catherization proving the pulmonary pressure above 30mm of Hg), resulting in permanent physical impairment to the degree of at least Class III of the New York Heart Association (NYHA) classification of cardiac impairment, confirmed by a cardiologist or specialist in respiratory medicine.

Pulmonary arterial hypertension resulting from **other causes** shall be **excluded** from this benefit.

The NYHA Classification of Cardiac Impairment for Class III and Class IV means the following:
a) Class III: Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes symptoms.
b) Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

8. Serious Coronary Artery Disease

The narrowing of the lumen of Right Coronary Artery (RCA), Left Anterior Descending Artery (LAD) and Circumflex Artery (not inclusive of their branches) occurring at the same time by a minimum of sixty percent (60%) in each artery as proven by coronary arteriography (non-invasive diagnostic procedures are not covered). A narrowing of sixty percent (60%) or more of the Left Main Stem will be considered as a narrowing of the Left Anterior Descending Artery (LAD) and Circumflex Artery. This covered event is payable regardless of whether any form of coronary artery surgery has been performed.

9. Surgery for Aortic Aneurysm

The actual undergoing of surgery for a thoracotomy or laparotomy (surgical opening of thorax or abdomen) to repair or correct an aortic aneurysm, an obstruction of the aorta or a dissection of the aorta. For this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

For the above definition, the following are not covered:
a) angioplasty;
b) other intra-arterial or catheter-based techniques;
c) other keyhole procedures;
d) laser procedures;
e) surgery to treat peripheral vascular disease of the aortic branches even if a portion of the aorta is repaired or corrected or removed during the operative procedure.

10. End-Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in the following:
a) Permanent jaundice;
b) Uncontrolled Ascites (excessive fluid in peritoneal cavity); and
c) Hepatic encephalopathy.

Liver failure secondary to alcohol or drug abuse is **not covered**.

11. Fulminant Viral Hepatitis

A sub-massive to massive necrosis (death of liver tissue) caused by hepatitis virus as evidenced by all the following diagnostic criteria:
a) Confirmatory test of hepatitis infection;
b) A rapidly decreasing liver size as confirmed by abdominal ultrasound;
c) Necrosis involving entire lobe, leaving only a collapsed reticular framework;
d) Rapidly deteriorating liver functions tests;
e) Increasing bilirubin levels persistently; and
f) Hepatic encephalopathy.

Acute viral hepatitis or carrier status alone is **not covered**.

12. Chronic Aplastic Anaemia – resulting in permanent Bone Marrow Failure

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring at least two (2) of the following treatments:
a) Regular blood product transfusion;

b) Marrow stimulating agents;
c) Immunosuppressive agents; or
d) Bone marrow transplantation.

The diagnosis and suggested line of treatment must be confirmed by a Haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than twenty-five percent (25%) which is evidenced by any two (2) of the following:

1. Absolute Neutrophil count of less than 500 per cubic millimetre;
2. Absolute Reticulocyte count less than 20,000 per cubic millimetre; or
3. Platelet count of less than 20,000 per cubic millimetre.

13. Systemic Lupus Erythematosus with Severe Kidney Complications

A definite diagnosis of Systemic Lupus Erythematosus with severe kidney complications confirmed by a rheumatologist.

For this definition, the covered event is payable only if it has resulted in Type III to Type V Lupus Nephritis as established by renal biopsy. Other forms such as discoid lupus or those forms with only haematological or joint involvement are not covered.

WHO Lupus Classification:

a) Type III - Focal Segmental glomerulonephritis
b) Type IV - Diffuse glomerulonephritis
c) Type V - Membranous glomerulonephritis

14. Alzheimer's Disease (Presenile Dementia)

The unequivocal diagnosis of Alzheimer's disease (presenile dementia) before age sixty (60) years that must be confirmed by a specialist Medical Practitioner (Neurologist) and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT Scan, MRI, PET of the brain).

The disease must also result in a permanent inability to perform independently three or more Activities of Daily Living or must result in need of supervision and the permanent presence of care staff due to the disease. These conditions must be medically documented for at least ninety (90) days.

From the above definition, the following are not covered:

a) Non-organic brain disorders such as neurosis;
b) Psychiatric illnesses;
c) Drug or alcohol related brain damage;
d) Any other type of irreversible organic disorder/dementia;

Diagnosis of Alzheimer's disease on or after age sixty (60) years.

15. Bacterial Meningitis – resulting in permanent functional impairment

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least six (6) weeks.

The diagnosis must be confirmed by:

a) The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b) A consultant Neurologist
c) Bacterial Meningitis in the presence of HIV infection is excluded
d) It should result in a permanent inability to perform at least three (3) of the Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons.

A minimum Assessment Period of **thirty (30) days** applies.

16. Benign Brain Tumour – of specified severity

A benign tumour in the brain or meninges within the skull, where all the following conditions are met:

a) it is life threatening
b) it has caused damage to the brain
c) it has undergone surgical removal or, if inoperable, has caused a Permanent neurological deficit such as (but not restricted to) characteristic symptoms of increased intracranial pressure such as papilloedema, mental seizures and sensory impairment; and for the purpose of this benefit, the word "Permanent" shall mean beyond the hope of recovery with current medical knowledge and technology
d) its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on MRI, CT or other reliable imaging techniques.

The following are not covered:

a) cysts;
b) granulomas;
c) malformations in or of the arteries or veins of the brain;
d) haematomas;
e) tumours in the pituitary gland;
f) tumours in the spine;
g) tumours of the acoustic nerve.

17. Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy (surgical opening of skull) is performed.

For the above definition, the following **are not covered**:

a) Burr hole procedures;
b) Transphenoidal procedures;

c) Endoscopic assisted procedures or any other minimally invasive procedures;
d) Brain surgery as a result of an accident;
e) Surgery for removal of Benign Brain Tumour / Cyst / Nodule.

18. Coma – resulting in permanent neurological deficit with persisting clinical symptoms

A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously for at least ninety-six (96) hours (4 days), requiring the use of life support systems and resulting in a Permanent Neurological Deficit with Persisting Clinical Symptoms. A minimum Assessment Period of thirty (30) days applies. Confirmation by a neurologist must be present.
Coma resulting directly from alcohol or drug abuse is **not covered**.

19. Encephalitis – resulting in permanent inability to perform Activities of Daily Living

Severe inflammation of brain substance, resulting in permanent functional impairment. The permanent functional impairment must result in an **inability** to perform **at least three (3)** of the Activities of Daily Living. A minimum Assessment Period of thirty (30) days applies. The covered event must be certified by a neurologist.
The following are not covered:
a) Encephalitis due to alcohol and substance abuse,
b) Encephalitis in the presence of HIV infection.

20. Major Head Trauma – resulting in permanent inability to perform Activities of Daily Living

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than three (3) months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
The Accidental Head injury must result in an inability to perform at least three (3) of the Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

21. Motor Neuron Disease – permanent neurological deficit with persisting clinical symptoms

A definite diagnosis of motor neuron disease by a neurologist with reference to either spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be Permanent Neurological Deficit with Persisting Clinical Symptoms.
A minimum Assessment Period of three (3) months applies.

22. Multiple Sclerosis

A definite diagnosis of multiple sclerosis by a neurologist. The diagnosis must be supported by all the following:
a) Investigations including typical MRI (Magnetic Resonance Imaging) and CSF (Cerebrospinal Fluid) findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
b) Multiple neurological deficits resulting in impairment of motor and sensory functions occurring over a continuous period of at least six (6) months; and
c) Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

Other causes of neurological damage such as SLE (Systemic Lupus Erythematosus) and HIV (Human Immunodeficiency Viruses) are excluded.

23. Muscular Dystrophy

The definite diagnosis of a Muscular Dystrophy by a neurologist which must be supported by all the following:
a) Clinical presentation of progressive muscle weakness;
b) No central/peripheral nerve involvement as evidenced by absence of sensory disturbance;
c) Confirmed with the appropriate laboratory, biochemical, histological, and electromyographic evidence.

No benefit will be payable under this covered event before the Insured Person/You has/have reached the age of twelve (12) years.

24. Paralysis of Limbs

The total, permanent and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A Specialist Medical Practitioner must be of the opinion that paralysis will be permanent with no hope of recovery. A minimum Assessment Period of six (6) months applies.

25. Parkinson's Disease – resulting in permanent inability to perform Activities of Daily Living

The unequivocal diagnosis of idiopathic or primary Parkinson’s Disease (all other forms of Parkinsonism are excluded) before age sixty (60) years that must be confirmed by a specialist Medical Practitioner (Neurologist). The disease must also result in a permanent inability to perform independently three (3) or more Activities of Daily Living or must result in a permanent bedridden situation and inability to get up without outside assistance and where the following conditions are met:
a) Cannot be controlled with medication;
b) Shows signs of progressive impairment; and
c) These conditions must be medically documented for at least ninety (90) days.

26. Stroke – resulting in permanent neurological deficit with persisting clinical symptoms

Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolization from an extra cranial source resulting in permanent neurological deficit with persisting clinical symptoms. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist. A minimum Assessment Period of **three (3) months** applies.

For the above definition, the following are not covered:

a) Transient ischemic attacks;
b) Cerebral symptoms due to migraine;
c) Traumatic injury to brain tissue or blood vessels;
d) Vascular disease affecting the eye or optic nerve or vestibular functions.

27. Blindness – Total and Irreversible

The total and irreversible loss of sight in both eyes as a result of Illness or Injury. The blindness must be confirmed by an Ophthalmologist. The blindness must not be able to be corrected by medical procedure.

28. Deafness – Total and Irreversible

Total and irreversible loss of hearing as a result of accident or illness to the extent that the loss is greater than 90 decibels across all frequencies of hearing in both ears, persisting for at least six (6) months. Medical evidence in the form of an audiometry and sound-threshold tests result must be provided and certified by an Ear, Nose, and Throat (ENT) specialist. The deafness must not be correctable by aides or surgical procedures.

Congenital deafness is **not covered**.

29. Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a **continuous period of twelve (12) months**. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist. No benefit will be payable if, in general medical opinion, a device, or implant could result in the partial or total restoration of speech.

All **psychiatric related** causes are **not covered**.

30. End-Stage Lung Disease

End-stage lung disease causing chronic respiratory failure. All the following criteria must be met:

a) The need for regular oxygen treatment on a permanent basis;
b) Permanent impairment of lung function with a consistent FEVI (Forced Expiratory Volume) test results which are consistently less than one (1) litre measured on three (3) occasions, three (3) months apart;
c) Shortness of breath at rest; and
d) Baseline Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less.

31. End-Stage Kidney Failure – requiring dialysis or kidney transplant

End-stage kidney failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular dialysis is initiated or kidney transplantation is carried out.

32. Medullary Cystic Disease

A progressive hereditary disease of the kidney characterised by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anaemia, polyuria and renal loss of sodium, progressing to chronic kidney failure. Diagnosis must be supported by a renal biopsy.

33. Major Organ / Bone Marrow Transplant

The actual undergoing of a transplant of:

a) Human **bone marrow** using haematopoietic stem cells preceded by total bone marrow ablation; or
b) One of the following human organs: **heart, lung, liver, kidney, pancreas** that resulted from irreversible end-stage failure of the relevant organ.

The following are excluded:

a) Other stem cell transplants
b) Where only islets of Langerhans are transplanted

SPECIFIC DEFINITIONS (applicable to Section 6)

1. Assessment Period

Means period during which We will assess a condition before deciding whether the condition qualifies as being permanent. The assessment period will be for the **minimum period** time frame stated in the relevant definition and **will not be longer than twelve (12) months** (provided all required evidences have been submitted).

A minimum Assessment Period of **six (6) months** applies to these Critical Illnesses:

a) Paralysis of limbs

A minimum Assessment Period of **three (3) months** applies to these Critical Illnesses:

a) Stroke – resulting in permanent neurological deficit with persisting clinical symptoms
b) Motor Neuron Disease – permanent neurological deficit with persisting clinical symptoms

A minimum Assessment Period of **thirty (30) days** applies to these Critical Illnesses:

a) Bacterial Meningitis – resulting in permanent functional impairment
b) Coma – resulting in permanent neurological deficit with persisting clinical symptoms
c) Encephalitis – resulting in permanent inability to perform Activities of Daily Living

For other Covered Critical Illnesses, other specific terms and conditions apply.

2. Waiting Period

Ninety (90) days Waiting Period for all Covered Critical Illnesses.

3. Covered Surgery(ies)

Shall mean the various surgical operations or procedures defined or specified in the **Description of Coverage** Section

4. Reversible

Means **can be improved** upon or return to normal by medical treatment and/or surgical procedures consistent with the current standard of the medical services available in Malaysia. **Reversible** conditions are **excluded** from this Benefit.

5. Irreversible

Means **cannot be improved** upon nor return to normal by medical treatment and/or surgical procedures consistent with the current standard of the medical services available in Malaysia.

6. Permanent

Means expected to last throughout the lifetime of the Insured Person.

7. Permanent Neurological Deficit with Persisting Clinical Symptoms

Means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Insured Person. Symptoms that are covered include numbness, paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia and coma.

8. Survival period

The **Survival Period**, in order to be eligible to receive the Critical Illness Benefit, if diagnosed, is **thirty (30) days**. This means that the Insured Person will need to survive this length of time after being diagnosed with a Covered Critical Illness (including after any assessment period to confirm a condition or diagnosis), in order for the Benefit to be payable. If the Insured Person dies within the Survival Period, the family / beneficiaries will not receive a Critical Illness Benefit pay-out.

Example, if Insured Person is diagnosed with a Covered Critical Illness on 10 June 2019 (the confirmed / definitive diagnosis date), he needs to survive the next 30 days until 10 July 2019. If he is alive on 11 July 2019 at 12.01 am, he can receive the Critical Illness Benefit.

9. Payment Condition

We pay You/Insured Person the Critical Illness Sum Insured in lump sum ("Lump Sum Payment"). The Lump Sum Payment is payable once only. This Benefit Rider shall terminate upon payment of the Lump Sum Payment. **Thereafter** this Benefit Rider cover **cannot be renewed**.

Only in the event of "Angioplasty and Other Invasive Treatments for Coronary Artery Disease", Our liability is limited to ten percent (10%) of the Lump Sum Payment (the "Limited Payment") subject to a maximum of RM25,000. This Limited Payment is **payable only once**. The Sum Insured of this Benefit Rider shall then continue with the reduced Sum Insured (and carried through each Renewal until the remaining Sum Insured is paid out upon occurrence of other Covered Critical Illness).

10. Payment Basis

Fixed lump sum amount.

11. Activities of Daily Living (ADL)

Activities of Daily Living (ADL) are as follows:

a) **Transferring**
The ability to move from a bed to an upright chair or wheelchair and vice versa.

b) **Mobility**
The ability to move from place to place without requiring any physical assistance.

c) **Continence**
The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.

d) **Dressing**
The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.

e) **Bathing/Washing**
The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.

f) **Eating**
All tasks of getting food into the body once it has been prepared.

SPECIFIC PROVISIONS (applicable to Section 6)

1. Eligibility

Only the following Insured Persons are eligible for insurance in relation to new policies:

(a) The Policyholder between the age of twenty-one (21) years and sixty-five (65) years

(b) The Policyholder's legally married spouse age sixty-five (65) years and below

(c) The Policyholder's Dependant Child age six (6) years and above
(d) The Policyholder's Dependant Parent or Parent-in-law age sixty-five (65) years and below
(e) The Policyholder's Dependant Grandparent age sixty-five (65) years and below

2. Period of Cover and Renewal

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) 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.

This Policy is renewable at the option of the Company. However, once the full Sum Insured has been paid out, this Benefit Rider **will terminate** and will **not be made available** to the Insured Person.

The renewal premium payable is not guaranteed, and the Company reserves the right to determine the premium applicable specifically to each Insured Person at the time of renewal.

3. Premium Pricing

The pricing of the premium and all subsequent revisions shall be done on a portfolio basis. New applications will be subjected to individual underwriting and premium loadings applicable at the first inception date will be applicable to the standard premium rates as well as all subsequent revisions.

SPECIFIC EXCLUSIONS (applicable to Section 6)

1. Any illness or surgery other than a diagnosis of or surgery for a **Covered Critical Illness** as defined in this Section of this Policy.
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2. Critical Illnesses for which the signs or symptoms first occurred within the specified Waiting Periods of the Covered Critical Illnesses.

3. Any Critical Illness diagnosed due, directly or indirectly, to a **congenital** defect or disease which has manifested or was diagnosed before the Insured Person attains seventeen (17) years of age.

4. Any Pre-existing conditions prior to the Commencement Date/Original First Effective Date of this insurance.

5. The diagnosis of Fulminant Viral Hepatitis, Cancer, Encephalitis, Bacterial Meningitis or Alzheimer's Disease/Severe Dementia of You/Insured Person, where in Our opinion, was directly or indirectly due to an Acquired Immune Deficiency Syndrome (AIDS) or infection by any HIV. We reserve the right to require the Insured Person to undergo a blood test for HIV as a condition precedent to any acceptance of any claim. For the purpose of this Policy:
   a. The definition of AIDS shall be that used by the World Health Organisation (WHO) in 1987, or any subsequent revision by the World Health Organisation of that definition.
   b. Infection shall be deemed to have occurred where blood or other relevant test(s) indicate in Our opinion either the presence of any HIV or Antibodies to such a Virus.

6. Any of the Covered Critical Illnesses or Covered Surgeries defined in this Section which is caused by a self-inflicted injury.

7. Further Critical Illnesses once the full Sum Insured has been paid out.

SPECIFIC CONDITIONS (applicable to Section 6)

1. Alteration

The Company reserves the right to amend the terms and provisions of this Section of this Policy by giving a 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 Section of this Policy shall be valid unless authorised 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. If, however, an alteration or amendment is a regulatory requirement, this may take effect immediately without prior notice.

2. Cancellation

The Policyholder may cancel this Section of this Policy by giving written notice to the Company, such notice to state when thereafter cancellation shall become effective. If no claim has been made prior to the cancellation, premium may be refunded to the Policyholder after deducting the following short period premium:

Period Not exceeding 15 days	-	90% Refund of Annual Premium (applicable to renewal only)
Period Not exceeding 1 month	-	80% Refund of Annual Premium
Period Not exceeding 2 months	-	70% Refund of Annual Premium
Period Not exceeding 3 months	-	60% Refund of Annual Premium
Period Not exceeding 4 months	-	50% Refund of Annual Premium
Period Not exceeding 5 months	-	40% Refund of Annual Premium

Period Not exceeding 6 months	-	30% Refund of Annual Premium
Period Not exceeding 7 months	-	25% Refund of Annual Premium
Period Not exceeding 8 months	-	20% Refund of Annual Premium
Period Not exceeding 9 months	-	15% Refund of Annual Premium
Period Not exceeding 10 months	-	10% Refund of Annual Premium
Period Not exceeding 11 months	-	5% Refund of Annual Premium
Period exceeding 11 months	-	No refund of Premium

The Company may cancel this Section of this Policy by giving written notice to the Policyholder at the address shown in the Policy Schedule or endorsed herein, stating when, not less than fourteen (14) days thereafter, such cancellation shall become effective. Pro-rata refund of premium will be made to the Policyholder for this cancellation. Cancellation shall be without prejudice to any claim originating prior to the Effective Date of cancellation.

Section 7
PERSONAL ACCIDENT INSURANCE (PA)

Section 7 provides personal accident insurance on a fixed benefit basis. This Section is optional and cannot be purchased without Section 1.

The maximum amount payable is standalone and does not form part of the Overall Annual Limit or the Deductibles of Section 1 of this Policy.

LIMITS OF COVERAGE

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Accidental Death	50,000	100,000	150,000	200,000	250,000	300,000
Permanent Disablement	50,000	100,000	150,000	200,000	250,000	300,000

DESCRIPTION OF COVERAGE

If during the Period of Insurance, the Insured Person shall sustain any Bodily Injury caused by Accidental means which within twelve (12) months such injury shall, solely and independently of any other cause, result in the Insured Person's death or permanent disablement as defined below, We will, subject to the Conditions and Exclusions of this Policy pay to:

(a) Policyholder; or

(b) in the event of his death to pay:

i. to his nominee as executor according to the direction of the nomination (Paragraphs 4 and 6, Schedule 10 of the Financial Services Act 2013 (FSA)); or

ii. to trustee of the trust created over such nomination in accordance with Paragraph 5, Schedule 10 of the FSA; or

iii. to assignee, as the case may be (Paragraph 7, Schedule 10 of the FSA); or

iv. according to Paragraph 8, Schedule 10 of the FSA in the event there is no nomination (e.g. lawful executor or administrator of Insured Person’s estate); the compensation (sum insured, SI) as specified in the Schedule of Benefits, and in accordance with the Table of Compensation below, depending on extent of the Injury/Disability.

We will not make any payment in excess of the Sum Insured stated in the Schedule of Benefits for any one Policy Year.

The events upon which the PA Benefit is payable is summarised as follows:

Event	Benefit Payable as Per	Payment Basis
Death occurring within twelve (12) calendar months of the Accident date.	Table of Compensation Part A	Lump Sum
Permanent Disablement occurring within twelve (12) calendar months of the Accident date.	Table of Compensation Part B	Lump Sum (% Scale)

Loss means in the case of limbs and digits loss by physical severance or permanent total loss of use.

Loss of Speech shall mean total inability to communicate verbally.

The degree of shortening of arm/leg is to be certified in medical report from Specialist.

Where the Injury is not specified, We reserve the right to adopt a percentage of disablement consistent with the provisions of the Table of Compensation (TOC).

The aggregate of all percentages payable in respect of any one Accident shall not exceed 100% of the Sum Insured. In the event of a total of 100% having been paid during the period of this Policy, this Personal Accident Insurance shall immediately cease to be in force. All other losses lesser than 100% if having been paid shall reduce the coverage by the amount paid from the date of Accident until the expiry of this Benefit.

The aggregate payable in respect of any one Accident shall not exceed 100% of the Sum Insured in a Policy Year.

TABLE OF COMPENSATION		**Percentage of Sum Insured**
A	**Death** (occurring within twelve (12) calendar months of the Accident)	100%
B	**Permanent Disablement** (occurring within twelve (12) calendar months of the Accident):	
	Permanent total loss of sight of both eyes	100%
	Permanent total loss of sight of one eye and physical separation of or the loss of ability to use **either** one hand or foot	100%
	Permanent total loss and physical separation of or the loss of ability to **use both** hands or both feet	100%
	Permanent total loss and physical separation of or the loss of ability to use one hand **and** foot	100%
	Permanent paralysis of limbs	100%
	Injuries resulting in being permanently bedridden	100%
	Loss of an arm at the shoulder joint	75%
	Loss of arm above the elbow joint	70%
	Loss of arm beneath the elbow joint	60%
	Loss of a hand at the wrist	50%
	Loss of a thumb	25%
	Loss of an index finger	10%
	Loss of any other finger	5%
	Loss of a leg above mid-thigh	75%
	Loss of a leg up to mid-thigh	60%
	Loss of a leg up to beneath the knee	50%
	Loss of a leg up to mid-calf	45%
	Loss of a foot at the ankle	40%
	Shortening of a leg by at least 5%	7%
	Loss of a large toe	5%
	Loss of any other toe	2%
	Permanent loss of sight of one eye	50%
	Loss of hearing of both ears	75%
	Loss of hearing of one ear	25%
	Loss of speech	25%
	Loss of sense of smell	10%
	Loss of sense of taste	5%
C	**Burns as calculated on Rule of Nines** for each area of body affected:	
	Burns at least 18% of the body surface area	30%
	Burns at least 27% of the body surface area	50%
	Burns at least 45% of the body surface area	100%

Double Indemnity: We will pay **double the Sum Insured** if the Insured Person suffers either Death or Permanent total paralysis from the neck down or Permanent total loss or Permanent loss of use of at least two (2) limbs due to an Accident while travelling as **a fare-paying passenger on any mode of public transport.**

SPECIFIC PROVISIONS (applicable to Section 7)

1. Eligibility

Only the following Insured Persons are eligible for insurance in relation to new policies:

(a) The Policyholder between the age of twenty-one (21) years and sixty-five (65) years

(b) The Policyholder's legally married spouse age sixty-five (65) years and below

(c) The Policyholder's Dependant Child age six (6) years and above
(d) The Policyholder's Dependant Parent or Parent-in-law age sixty-five (65) years and below
(e) The Policyholder's Dependant Grandparent age sixty-five (65) years and below

2. Period of Cover and Renewal

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) 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.

This Policy is renewable at the option of the Company. However, once the full Sum Insured has been paid out, this Benefit **will terminate** and will **not be made available** to the Insured Person.

The renewal premium payable is not guaranteed, and the Company reserves the right to determine the premium applicable specifically to each Insured Person at the time of renewal.

3. Premium Pricing

The pricing of the premium and all subsequent revisions shall be done on a portfolio basis. New applications will be subjected to individual underwriting and premium loadings applicable at the first inception date will be applicable to the standard premium rates as well as all subsequent revisions.

SPECIFIC DEFINITIONS (applicable to Section 7)

1. Accident

Accident for this Benefit also covers Death or Permanent Disablement arising out of or resulting from accidental gas (e.g. smoke, poisonous gas or fumes) inhalation, suffocation, drowning, food and drink poisoning, and other similar misfortune with or without any sign of external or violent visible injury. It is mandatory for submission of post-mortem report indicating the cause of death due to the respective incidents of accidental gas inhalation, suffocation, drowning or poisoning.

2. Sum Insured (SI)

The Sum Insured (SI) for the respective Insured Person is specified in the Policy Schedule.
You can only change the Sum Insured before the start of a Renewed Policy Year, subject to the terms and conditions of this Policy.

3. Accidental Death (AD)

Death within twelve (12) months of Accident. 100% of the Sum Insured specified in Your/Insured Person's Schedule of Benefits is payable. Refer to Part A of the Table of Compensation.

4. Permanent Disablement (PD)

Permanently disabled within twelve (12) months of Accident or permanent loss of certain body parts. Payment is based on the % scale listed in the Table of Compensation (Part B) multiplied by the Sum Insured specified in Your/Insured Person's Schedule of Benefits.

5. Burns

If during the Policy Year, the Insured Person sustains Injury which results in Second Degree Burns or Third-Degree Burns, then We agree to pay the percentage of the Sum Insured shown in the Table of Compensation above based on the Rule of Nines.
The Rule of Nines is a system used by Medical Practitioners for assessing the percentage of the body surface affected by Burns. In this system, each of the head and each arm cover nine percent (9%) of the body; each the front of the body and the back of the body and each leg covers eighteen percent (18%) of the body; and the groin covers the remaining one percent (1%) of the body.
Second Degree Burns refer to burns which penetrate beyond the epidermis, causing formation of blisters.
Third Degree Burns must involve scarring that cover at least twenty percent (20%) of the body's surface area. The diagnosis must confirm the total area involved using standardised, clinically accepted body surface area charts showing coverage of at least twenty percent (20%) of the body surface area.
Specific exclusion: We will not pay for liability arising directly or indirectly from sunburn, in-door tanning, cosmetic tanning, or aesthetic procedures.

6. Disappearance

We shall pay the death compensation if during the period of insurance, the Insured Person disappears following an accident involving aircraft or at sea or in a natural calamity and the Insured Person's body is not found within one (1) year after his disappearance and sufficient evidence is produced to Our satisfaction that leads Us inevitably to the conclusion that the Insured Person died as a result of an event within the scope of this Benefit. However, if at any time after payment has been made the Insured Person is found to be living, any sum(s) paid by Us in settlement of the claim shall be refunded to Us.

SPECIFIC EXCLUSIONS (applicable to Section 7)

Unless specifically included in the Schedule of Benefits or endorsed in the Policy Schedule, this 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. Death, Injuries or Hospitalisation as a result of drug abuse, addictive disorders from substance misuse or while under the influence of alcohol

2. Self-inflicted injuries or suicide or attempted suicide, while sane or insane

3. 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

4. Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.

5. Death, Sickness or Injury arising from racing of any kind (except foot racing) hazardous sports such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter sports, professional sports and illegal activities.

6. Participation in any form of aviation (except as a fare-paying passenger or crew member on a regular route operated by a licensed commercial airline), or aerial sports such as (but not limited to) skydiving, parachuting, bungee jumping, hang gliding or ballooning.

7. Riding/driving without a valid driving licence.

8. While participating in unlawful activities or committing or attempting to commit any unlawful act.

9. Provoked murder or assault, wilful exposure to needless peril except to save human life.

CONDITIONS

1. PERIOD OF COVER AND RENEWAL

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one (1) 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.

Each Section of this Policy has its own renewal condition as stipulated in the Specific Provisions applicable to the respective Sections.

2. GEOGRAPHICAL TERRITORY

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

3. ALTERATIONS

Each Section to this Policy has its specific alteration condition which may differ.

4. CANCELLATION OF POLICY

Each Section to this Policy has its specific cancellation condition which may differ.

5. 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.

6. GOVERNING LAW

This Policy shall be interpreted and governed by the laws of Malaysia. Any action or suit against Us shall only be instituted in a Malaysian court.

7. 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.

8. 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.

9. 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 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.

10. 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 authorised representative) alone shall be an effective discharge of all obligations and liabilities of the Company. The Policyholder shall be deemed to be responsible Principal or Agent of the Insured Persons covered under this Policy.

11. 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 issue of the Policy, provided no claims have been made.

12. CONDITION PRECEDENT TO LIABILITY

The due observance and the fulfilment 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.

13. 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 initialled by an authorised representative of the Company.

14. 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 therefrom, 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.

15. 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 insurance cover is effective.

16. GRACE PERIOD

Notwithstanding the Cash Before Cover Condition, a Grace Period of fourteen (14) days following the expiry date shall be allowed to the Policyholder for the payment of any premiums after the first Policy Year. If any premium is not paid in respect of this Policy or any supplementary contracts before the end of the Grace Period, this Policy and the relevant supplementary contracts shall be deemed as terminated at the expiry date of the Policy. Even if payment is made during the grace period any Disability occurring during the period from the expiry date to the payment date shall not be payable.

17. 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 (1) 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.

18. 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.

19. THE POLICY

This Policy, any riders or endorsements and the Application constitute the entire contract between the parties hereto. All statements made by or on behalf of the Insured Person shall, in the absence of fraud, be deemed representations and no such statements shall void this Policy or continue it in force or be used in defence of a claim unless they are contained as misrepresentations or omissions of facts which would have ought to be stated in the Application or in any particulars supplementary to such statements.

No agent is authorised to make or modify this Policy or extend the time of payment of premiums, to waive any lapse or forfeiture or waive any of the Company's rights or requirements or to bind the Company by making any promise or by accepting any representation or information not contained in the Application.

20. POLICY NOT ASSIGNABLE

This Policy is not assignable, and the Company shall not be affected 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.

21. GENDER

Words or phrases denoting one gender include all other genders and similarly if denoting the singular include the plural and vice versa.

22. CLAIMS PROCEDURES

(a) The Insured Person 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 Person 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.

23. 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.

24. 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.

25. MISSTATEMENT OR OMISSION OF MATERIAL FACT

If:

(a) any answer, disclosure or representation by You, before this contract of insurance is entered, varied or renewed, in or to any proposal or declaration or query, has been deliberately or recklessly stated in any respect; or

(b) before this contract of insurance is entered, varied or renewed, You have failed to disclose any fact You knew to be relevant to Our decision on whether to accept this risk or not and the rates and the terms to be applied; or

(c) any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support of such claim.

then in any of the above cases, this Policy shall be void.

26. TERMINATION OF INSURED PERSON AND COMPANY LIABILITY

An Insured Person shall cease to be an Insured Person on the happening of the following events:

(a) for Children, on the anniversary following attainment of the 19th birthday or 23rd birthday for those registered as full-time students at a recognised educational institution.
(b) the date of termination of the Policy of any person's coverage.
(c) when the Policyholder ceases to have insurable interest in the Insured Person.
(d) nonpayment of premium or premium not made on time
(e) fraud or misrepresentation of material fact during application
(f) the Policy is cancelled at the request of the Policyholder
(g) total claims of the Policy have reached the Lifetime Limit specified and/or on the death of the Insured Person
(h) the Insured Person ceases to qualify as a Dependant based on the definition of the Policy
(i) the Insured Person attains the coverage age limit specified
(j) termination of coverage for all policies in a certain market and the Company withdraws this Policy completely from the market in accordance with the Portfolio Withdrawal Condition.

In any case the Company's liability shall cease with the date of termination of the Policy or any person's coverage.

27. SUITS 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.

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. 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.