BERJAYA SOMPO INSURANCE

Policy

Living Care

The benefits payable under eligible policy are protected by PIDM up to limits.
Please refer to PIDM's TIPS Brochure or contact Berjaya Sompo Insurance Berhad or PIDM (visit www.pidm.gov.my).

Berjaya Sompo Insurance Berhad
Registration No. 198001008821 (62605-U)
Level 36, Menara Bangkok Bank,
105, Jalan Ampang, 50450 Kuala Lumpur.
Toll Free: 1-800-889-933
Tel.: 03-2170 7300
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Website: www.berjayasompo.com.my

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LC0324

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IMPORTANT NOTICE

This is Your **Living Care** Policy. You should satisfy yourself that this Policy will best serve Your needs. You should read and understand the Policy terms, conditions and warranties and discuss with Your agent and/or with Us directly for more information and/or to clarify any doubts You may have, before You purchase this Policy.

You must fully observe and fulfill the terms, conditions and warranties of this Policy to enjoy the coverage provided. If You have any questions after reading these documents or if there are any change in Your circumstances that may affect the insurance provided, please notify Us immediately, otherwise You may not receive the benefits of this Policy.

If You have any complaints relating to this Policy, please contact

COMPLAINTS UNIT – CUSTOMER SERVICE CENTRE
Berjaya Sompo Insurance Berhad
Registration No. 198001008821 (62605-U)
Level 36, Menara Bangkok Bank
105 Jalan Ampang
50450 Kuala Lumpur

Tel	: 03-2170 7300
Tol Free	: 1-800-889-933
Fax	: 03-2170 4800
Email	: customer@bsompo.com.my

If You are not happy with Our response, You may opt to contact either:

OMBUDSMAN FOR FINANCIAL SERVICES
Level 14, Main Block
Menara Takaful Malaysia
4, Jalan Sultan Sulaiman
50000 Kuala Lumpur

Tel.	: 03-2272 2811
Fax	: 03-2272 1577
E-mail	: enquiry@ofs.org.my
Website	: www.ofs.org.my

LAMAN INFORMASI NASIHAT DAN KHIDMAT (LINK)
Bank Negara Malaysia
Ground Floor, Blok D
Jalan Dato Onn
50480 Kuala Lumpur

Tel	: 603-2698-8044 / 2698 9044 / 9179 2888
Tol free	: 1-300-88-5465
Fax	: 03-2174 1515
Email	: bnmtelelink@bnm.gov.my
eLINK	: telelink.bnm.gov.my
SMS	: 15888

OUR AGREEMENT

The Policy, Schedule and any Endorsements must be read together as they form Your insurance contract with Us. These documents reflect the Terms and Conditions of the contract of insurance as agreed between You and Us and is issued in consideration of the payment of premium as specified in the Schedule and pursuant to the answers given in the Proposal Form completed by You (or on Your behalf by Your intermediary) and any other disclosures made by You between the time of submission of Your Proposal Form and the time this Contract is entered into.

DUTY OF DISCLOSURE

You have a duty to take reasonable care not to make any misrepresentation in answering the questions in the Proposal Form i.e. You should answer the questions 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. In the event of any pre-contractual misrepresentations made in relation to Your answers and in any disclosures given by You, only remedies in Schedule 9 of the Financial Services Act 2013 will apply.

You have a duty to tell Us immediately if at any time after Your contract of insurance has been entered into, varied or renewed with Us, any of the information given in the Proposal Form is inaccurate or has changed.

At the point of purchasing this insurance and at any point during the validity of this insurance contract, You must immediately inform Us of any other insurance that You have bought which provides like or similar type of coverage to the items insured under this contract of insurance.

DEFINITIONS

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

1. **POLICYHOLDER/YOU/YOUR** shall mean a person or a corporate body to whom the Policy has been issued in respect of cover for persons specifically identified as Insured Persons in this Policy.

2. **INSURED PERSON** shall mean the person described in the Policy Schedule including his/her Dependants (if applicable)

3. **WE/OUR/US/THE COMPANY** shall mean Berjaya Sompo Insurance Berhad

4. **DEPENDANT** shall mean a Spouse or Child(ren). A Spouse is either one's husband or wife in a legally recognized marriage who is below the age of 66 years. A Child is one who has attained 30 days, is unmarried and financially dependent upon the Insured Person and is under age 19 years or up to 23 years of age and is registered as a full time student in a recognized tertiary institution.

5. **POLICY YEAR OR PERIOD OF INSURANCE** shall mean the one year period including the effective date of commencement of Insurance and immediately following that date, or the one year period following the Renewal or Renewed Policy

6. **RENEWAL OR RENEWED POLICY** shall mean a Policy which has been renewed without any lapse of time upon expiry of a preceding Policy with the same content.

7. **ACCIDENT** shall mean a sudden, unintentional, unexpected, unusual, and specific event that occurs at an identifiable time and place which shall, independently of any other cause be the sole cause of bodily Injury.

8. **DISEASE** shall mean a change in the state of the body or some of its organs which leads to the interruption or disturbance of the bodily functions and causing pain and weakness or physical or mental disorder as certified by a medical practitioner.

9. **ILLNESS** shall mean a physical condition marked by a pathological deviation from the normal healthy state leading to the impairment of normal physiological function which manifests itself during the Period of Insurance and requires medical treatment.

10. **INJURY** shall mean bodily damage caused solely by Accident.

11. **DISABILITY** shall mean a Sickness, Disease, Illness or the entire bodily injuries arising out of single or continuous series of causes.

12. **CONGENITAL DEFECT OR DISEASE** shall mean any medical or physical abnormalities existing at the time of birth and which is abnormal or anomalous with reference to form, structure or position, as well as neo-natal physical abnormalities developing within 6 months from the time of birth.

13. **PRE-EXISTING ILLNESSES** shall mean disabilities that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing illness 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.

14. **PHYSICIAN OR SURGEON OR SPECIALIST** shall mean a registered medical practitioner qualified and licensed to practice western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice and who is classified by the appropriate health authorities as a person with superior and special expertise in specified fields of medicine.

15. **NEUROLOGIST** shall mean a medical practitioner qualified as an expert in neurology or in the treatment of disorders of the nervous system and duly licensed to practice in his geographical area of practice.

16. **PATHOLOGIST** shall mean a medical practitioner qualified as a pathologist and duly licensed to practice within the scope of accredited pathology in his geographical area of practice.

17. **MEDICAL PRACTITIONER** shall mean a person legally authorized in the geographical of his practice to render medical care and treatment, and includes a Physician, Surgeon, Neurologist, Pathologist and any other Medical Specialist who is not the Insured Person himself or of his family.

18. **DIAGNOSIS** shall mean a definitive diagnosis made by a medical practitioner based upon such specific evidence, as referred to in the definition of the Critical Illness concerned, or in the absence of such specific evidence, based upon the radiological, clinical, histological or laboratory evidence acceptable to the Company. Such diagnosis must be supported by the Company's Medical Officer who may base his opinion on the medical evidence submitted by the claimant and/or any additional evidence he may require.

19. **IRREVERSIBLE** shall mean cannot be reasonably improved upon by medical treatment and/or surgical procedures consistent with the current standard of the medical services available in Malaysia.

20. **PERMANENT** shall mean expected to last throughout the lifetime of the Insured Person.

21. **PERMANENT NEUROLOGICAL DEFICIT** shall mean 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, delirium and coma.

22. **TREATMENT** shall mean the actual receiving of medical or surgical care or attention either as an inpatient or outpatient from a medical practitioner and for all medically necessary diagnostic services directly associated with the covered Disability under treatment.

23. **SURGERY OR SURGICAL PROCEDURE** shall mean manual or operative procedures(s) required for treatment of a disease or injury, correction of deformity or defect, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

24. **ACTIVITIES OF DAILY LIVING** are:-
    a) Transfer - Getting in and out of a chair without requiring physical assistance.
    b) Mobility - The ability to move from room to room without requiring any physical assistance.
    c) Continence - The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
    d) Dressing - Putting on and taking off all necessary items of clothing without requiring assistance of another person.
    e) Bathing/Washing - The ability to wash in 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.

25. **WAITING PERIOD** shall mean the first specific days between the beginning of an Insured Person's Disability and the risk commencement date or reinstatement date of this Policy, whichever is later, 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.

26. **ASSESSMENT PERIOD** shall mean the period during which the Company will assess a condition before deciding whether or not 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 evidence has been submitted).

27. **SURVIVAL PERIOD** shall mean the duration of fourteen (14) days from and including the date of diagnosis of the Critical Illness after the Waiting Period of the Insured Person.

COVERAGE

During the Period of Insurance**,** subject to the terms, conditions, exclusions and definitions as stated in this policy, policy schedule and any endorsements herein, We will pay to the Policyholder the Benefits as a Lump Sum Payment stated in the policy schedule

Provided always that no Benefits will be payable unless all of the following conditions have been satisfied: -

i) the Insured Person has been diagnosed and confirmed as suffering from a Critical Illness as defined in the Policy;
ii) the Critical Illness suffered by the Insured Person is the first incident or occurrence of that disease or condition;
iii) the diagnosis of the Critical Illness is made after the Waiting Period;
iv) the Insured Person has survived for a period of at least fourteen (14) days from the date of definitive diagnosis and confirmation of the Critical Illness.

The due observance and fulfilment by the Insured Person of the terms and conditions contained herein or endorsed hereon shall be deemed to be conditions precedent to any liability under this Policy.

DEFINITION OF CRITICAL ILLNESS

The Critical Illness covered in this Policy shall be as follows, and shall make reference to the standard guidelines adopted by the Life Insurance Association of Malaysia (LIAM) and The General Insurance Association of Malaysia (PIAM) :

1. **Alzheimer's Disease/Severe Dementia**
   Deterioration or loss of intellectual capacity confirmed by clinical evaluation and imaging tests arising from Alzheimer's Disease or Severe Dementia as a result of irreversible organic brain disorders. The covered event must result in significant reduction in mental and social functioning requiring continuous supervision of the Insured Person. The diagnosis must be clinically confirmed by a neurologist.

   From the above definition, the following are not covered:
   (i) Non organic brain disorders such as neurosis
   (ii) Psychiatric illnesses
   (iii) Drug or alcohol related brain damage

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.

   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 Contract, thereby reducing the amount of the Lump Sum Payment which may be payable.

3. **Bacterial Meningitis - resulting in permanent inability to perform Activities of Daily Living**
   Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord 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 diagnosis must be confirmed by:
   (i) an appropriate specialist; and
   (ii) the presence of bacterial infection in the cerebrospinal fluid by lumbar puncture.

   For the above definition, other forms of meningitis, including viral meningitis are not covered

4. **Benign Brain Tumor – of specified severity**
   A benign tumour in the brain or meninges within the skull, where all of the following conditions are met:

   (i) It is life threatening.
   (ii) It has caused damage to the brain.
   (iii) It has undergone surgical removal or has caused permanent neurological deficit with persisting clinical symptoms; and
   (iv) 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:
   (i) Cysts
   (ii) Granulomas
   (iii) Malformations in or of the arteries or veins of the brain
   (iv) Hematomas
   (v) Tumours in the pituitary gland
   (vi) Tumours in the spine

(vii) Tumours of the acoustic nerve.

5. **Blindness - Permanent and Irreversible**
Permanent and irreversible loss of sight as a result of accident or illness to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in both eyes using a Snellen eye chart or equivalent test and the result must be certified by an ophthalmologist.

6. **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:
(i) Burr hole procedures
(ii) Transsphenoidal procedures
(iii) Endoscopic assisted procedures or any other minimally invasive procedures
(iv) Brain surgery as a result of an accident.

7. **Cancer - of specified severity and does not cover very early cancers**
Any malignant tumour positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukemia, lymphoma and sarcoma.

For the above definition, the following are not covered:

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

(ii) All tumours of the prostate histologically classified as T1N0M0 (TNM classification)
(iii) All tumours of the thyroid histologically classified as T1N0M0 (TNM classification)
(iv) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM classification)
(v) Chronic Lymphocytic Leukemia less than RAI Stage 3
(vi) All cancers in the presence of HIV
(vii) Any skin cancer other than malignant melanoma.

8. **Chronic Aplastic Anemia - resulting in permanent Bone Marrow Failure**
Irreversible permanent bone marrow failure which results in anemia, neutropenia and thrombocytopenia requiring at least two (2) of the following treatments:

(i) Regular blood product transfusion;
(ii) Marrow stimulating agents;
(iii) Immunosuppressive agents; or
(iv) Bone marrow transplantation.

The diagnosis must be confirmed by a bone marrow biopsy.

9. **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, 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.

The following is not covered:
(i) Coma resulting directly from alcohol or drug abuse.

10. **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.

For the above definition, the following are not covered:
(i) angioplasty;
(ii) other intra-arterial or catheter based techniques;
(iii) keyhole procedures;
(iv) laser procedures.

11. **Deafness - Permanent and Irreversible**
Permanent and irreversible loss of hearing as a result of accident or illness to the extent that the loss is greater than 80 decibels across all frequencies of hearing in both ears. 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.

12. **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.

Encephalitis in the presence of HIV infection is not covered.

13. **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.

14. **End-Stage Liver Failure**
End-stage liver failure as evidenced by all of the following:
- Permanent jaundice;
- Ascites (excessive fluid in peritoneal cavity); and,
- Hepatic encephalopathy.

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

15. **End-Stage Lung Disease**
End-stage lung disease causing chronic respiratory failure.

All of the following criteria must be met:
(i) The need for regular oxygen treatment on a permanent basis;
(ii) Permanent impairment of lung function with a consistent Forced Expiratory Volume (FEV) of less than 1 liter during the first second;
(iii) Shortness of breath at rest; and
(iv) Baseline Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less.

16. **Full-blown AIDS**
The clinical manifestation of AIDS (Acquired Immuno-deficiency Syndrome) must be supported by the results of a positive HIV (Human Immuno-deficiency Virus) antibody test and a confirmatory test. In addition, the Insured Person must have a CD4 cell count of less than two hundred (200)/µL and one or more of the following criteria are met:

(i) Weight loss of more than 10% of body weight over a period of six (6) months or less (wasting syndrome)
(ii) Kaposi Sarcoma
(iii) Pneumocystis Carinii Pneumonia
(iv) Progressive multifocal leukoencephalopathy
(v) Active Tuberculosis
(vi) Less than one-thousand (1000) Lymphocytes/µL
(vii) Malignant Lymphoma.

17. **Fulminant Viral Hepatitis**
A sub-massive to massive necrosis (death of liver tissue) caused by any virus as evidenced by all of the following diagnostic criteria:

(i) A rapidly decreasing liver size as confirmed by abdominal ultrasound;
(ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework;
(iii) Rapidly deteriorating liver functions tests; and
(iv) Deepening jaundice.

Viral hepatitis infection or carrier status alone (inclusive but not limited to Hepatitis B and Hepatitis C) without the above diagnostic criteria is not covered.

18. **Heart Attack - 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:

(i) A history of typical chest pain;
(ii) 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
(iii) 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:
- occurrence of an acute coronary syndrome including but not limited to unstable angina.

- a rise in cardiac biomarkers resulting from a percutaneous procedure for coronary artery disease.

19. **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.

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

20. **HIV Infection Due To Blood Transfusion**
Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:

(i) The blood transfusion was medically necessary or given as part of a medical treatment;
(ii) The blood transfusion was received in Malaysia or Singapore after the commencement of the policy;
(iii) The source of the infection is established to be from the institution that provided the blood transfusion and the institution is able to trace the origin of the HIV tainted blood;
(iv) The Insured Person does not suffer from hemophilia; and
(v) The Insured Person is not a member of any high risk groups including but not limited to intravenous drug users.

21. **Loss of Speech**
Total, permanent and irreversible loss of the ability to speak as a result of injury or illness. A minimum Assessment Period of six (6) months applies. Medical evidence to confirm injury or illness to the vocal cords to support this disability must be supplied by an Ear, Nose, and Throat specialist.

All psychiatric related causes are not covered.

22. **Third Degree Burns - of specified severity**
Third degree (i.e. full thickness) skin burns covering at least twenty percent (20%) of the total body surface area.

23. **Major Head Trauma - resulting in permanent inability to perform Activities of Daily Living**
Physical head injury resulting in permanent functional impairment verified by a neurologist. 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 three (3) months applies.

24. **Major Organ / Bone Marrow Transplant**
The receipt of a transplant of:

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

Other stem cell transplants are not covered.

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

26. **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.

27. **Multiple Sclerosis**
A definite diagnosis of multiple sclerosis by a neurologist. The diagnosis must be supported by all of the following:

- Investigations which confirm the diagnosis to be Multiple Sclerosis;
- Multiple neurological deficits resulting in impairment of motor and sensory functions occurring over a continuous period of at least six (6) months; and
- Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

28. **Muscular Dystrophy**
The definite diagnosis of a Muscular Dystrophy by a Neurologist which must be supported by all of the following:

(i) Clinical presentation of progressive muscle weakness
(ii) No central/peripheral nerve involvement as evidenced by absence of sensory disturbance
(iii) Characteristic electromyogram and muscle biopsy findings

No benefit will be payable under this Covered Event before the Insured Person has reached the age of 12 years next birthday.

29. **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 or not any form of coronary artery surgery has been performed.

30. **Paralysis of limbs**
Total, permanent and irreversible loss of use of both arms or both legs, or of one arm and one leg, through paralysis caused by illness or injury. A minimum Assessment Period of six (6) months applies.

31. **Parkinson's Disease - resulting in permanent inability to perform Activities of Daily Living**
A definite diagnosis of Parkinson's Disease by a neurologist where all the following conditions are met:

(i) Cannot be controlled with medication;
(ii) Shows signs of progressive impairment; and
(iii) Confirmation of the permanent inability of the Insured Person to perform without assistance three (3) or more of the Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinsonism are not covered.

32. **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 catheterization, resulting in permanent physical impairment to the degree of at least Class III of the New York Heart Association (NYHA) classification of cardiac impairment.

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

33. **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 classification of cardiac impairment. The diagnosis has to be supported by echocardiographic findings of compromised ventricular performance.

The NYHA Classification of Cardiac Impairment for Class III and Class IV means the following:
Class III: Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes symptoms.
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.

34. **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:
(i) Transient ischemic attacks
(ii) Cerebral symptoms due to migraine
(iii) Traumatic injury to brain tissue or blood vessels
(iv) Vascular disease affecting the eye or optic nerve or vestibular functions.

35. **Surgery to Aorta**
The actual undergoing of surgery via 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:
(i) angioplasty;
(ii) other intra-arterial or catheter based techniques;
(iii) other keyhole procedures;
(iv) laser procedures

36. **Systemic Lupus Erythematosus With Severe Kidney Complications**
A definite diagnosis of Systemic Lupus Erythematosus 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 hematological or joint involvement are not covered.

WHO Lupus Classification:
Type III - Focal Segmental glomerulonephritis
Type IV - Diffuse glomerulonephritis
Type V - Membranous glomerulonephritis

CONDITIONS

1. **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 Persons 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 authorized 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.

2. **AGE LIMITS**
No person shall be included for cover under this Policy who has not as yet attained the age of 30 days. This Policy does not cover Insured Persons over the age of 60 years, unless such person has been continuously insured under this Policy prior to the age of 60, in which case continuous insurance up to the end of Policy Year in which such Insured turns 66 years old is allowed under this Policy.

3. **ADDITION OF INSURED PERSON**
Dependents of the Policyholder who are eligible to be insured shall, from time to time this Policy is in force, be included as an Insured Person(s) of this Policy if: -

a) the Policyholder requests such inclusion.
b) the Dependents are eligible to be insured in accordance with the terms and standards of acceptance by the Company; and
c) the required additional premium is paid.

4. **AUTOMATIC TERMINATION**
The insurance for the Insured Person shall terminate in the earliest happening of the following events:

a) on the death of the Insured Person;
b) on the Policy Anniversary immediately following the 66th birthday of the Insured Person;
c) for a dependent Child, on his/her 19th birthday or on his/her 23rd birthday if in full-time tertiary institution;
d) after the full amount of the Lump Sum Benefit under this Policy had been paid;
e) on the date the dependant is no longer a dependant as defined in the Policy

5. **PERIOD OF COVER AND RENEWAL**
This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company.

This Policy is renewable at the option of the Company. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal. The Company shall give the Policyholder 30 days written notice in the event of revision of premium or portfolio withdraw.

6. **ALTERATIONS**
The Company reserves the right to amend the terms and provisions of this Policy by giving a 30 day prior notice in writing by ordinary post to the Policyholder's last known address in the Company's records, and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless authorized by the Company and such approval is endorsed thereon.

7. **CANCELLATION**
The Policyholder may cancel this Policy at any time by giving notice in writing to the Company. Such notification shall become effective from the date the Company receives the notice or on the date specified in the notice, whichever is later. The Company

will refund the pro-rated premium to the Policyholder for the unexpired Period of Insurance, provided no claims have been made under the Policy and subject to a minimum premium of RM60.

The Company may cancel this Policy by giving the Policyholder 14 days' notice in writing to the Policyholder's address known to the Company, and refund the pro-rated premium to the Policyholder for the unexpired Period of Insurance

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

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

10. **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.

11. **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 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.

12. **OWNERSHIP**
Unless otherwise expressly provided for 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 recognize any equitable or other claim to or interest in the Policy, and the receipt of the Policy or a Benefit by the Policyholder or by his legal or authorized representative alone shall be an effective discharge of all obligations and liabilities of the Company. The Policyholder shall be deemed to be a responsible Principal or Agent of the Insured Persons covered under this Policy.

13. **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.

14. **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.

15. **JUVENILE LIEN**
Upon diagnosis of critical illness prior to the Insured Person covered attaining the age of 5 years old, the benefit payable shall be reduced by the percentage of the juvenile lien in accordance with the following table:

Age attained at diagnosis	**Percentage of claims payable**
0 to less than 2 years	20%
2 to less than 3 years	40%
3 to less than 4 years	60%
4 to less than 5 years	80%

16. **MISREPRESENTATION/FRAUD**
If the proposal or declaration of the Insured Person is untrue in any aspect 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.

17. **PREMIUM WARRANTY**
It is a fundamental and absolute Special Condition of this contract of insurance that the premium due must be paid and received by the Company within sixty (60) days from the inception date of this Policy/Endorsement/Renewal Certificate.

If this condition is not complied with then this contract is automatically cancelled and the Company shall be entitled to the pro-rata premium for the period they have been on risk.

Where the premium payable pursuant to this Warranty is received by an authorized agent of the Company, the payment shall be deemed to be received by the Company for the purposes of this warranty and the onus of proving that the premium payable was received by a person, including an insurance agent, who was not authorized to receive such premium shall lie on the Company.

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

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

EXCLUSIONS

The Company shall not be liable in respect of any of the Critical Illnesses directly or indirectly contributed by the following, and no Benefit shall be payable if:

1. The signs or symptoms of the Critical Illness is manifested prior to or:
   (a) Within the Waiting Period of sixty (60) days for:
      (i) Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease;
      (ii) Cancer;
      (iii) Coronary Artery By-Pass Surgery;
      (iv) Heart Attack;
      (v) Other Serious Coronary Artery Disease; or

   (b) Within the Waiting Period of thirty (30) days for all other Critical Illnesses.

2. The Critical Illness arises from a Pre-Existing Condition which existed prior to the risk commencement date or reinstatement date of the Insured Person whichever is the later.

3. The Critical Illness, which in the Company's opinion, was caused directly or indirectly by the existence of Acquired Immune Deficiency Syndrome (AIDS) or by the presence of any Human Immunodeficiency Virus (HIV) infection. The Company reserves the right to require the Insured Person to undergo a blood test for HIV as a condition precedent to acceptance of any claim. The exception is when there is Full Blown AIDS or HIV due to Blood Transfusion, as defined in the Policy. For the purpose of this Policy:

   a) the definition of AIDS shall be that used by the World Health Organization in 1987, or any subsequent revision by the World Health Organization of that definition;

   b) infection shall be deemed to have occurred when blood or other relevant test(s) indicate, in the Company's opinion, either the presence of any Human Immunodeficiency Virus or Antibodies to such Virus.

4. Any Critical Illness diagnosed due, directly or indirectly, to a Congenital Defect or Disease.

5. Any Critical Illness caused by self-inflicted injury, while sane or insane.

6. Any Critical Illness resulting directly from alcohol or drug abuse.

7. Death of the Insured Person within the Survival Period following the date of diagnosis of any Critical Illness.

8. Any Critical Illness consequent upon 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.

9. Any Critical Illness caused directly or indirectly by ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.

10. It is condition precedent to the Company's liability that any person covered in this Policy shall not in any way, directly or indirectly, be involved in any of the following occupations or duties:

    a) Airline crew, Army personnel, Ship crew and/or workers on board vessels;
    b) Occupations involving diving, oil-rig platform and/or offshore work (non-administrative);
    c) Occupations involving work at heights exceeding 30 feet above ground or floor level or underground;

d) Occupations involving manual work in hazardous places such as shipyard, dockyard, airplane hangar and oil refinery; and
e) Doctors and/or Nurses

Unless applications for coverage for such occupations from persons insured had been received and approved by the Company in writing.

CLAIMS PROCEDURES

1. EVENTS LEADING TO CLAIMS

(i) Upon the occurrence of a covered condition likely to give rise to a claim under this Policy, the Insured Person shall within 30 days of the occurrence, give written notice to the Company stating full particulars of such event and with a doctor's report stipulating the diagnosis of the condition treated and the date the Disability commenced. The Company will provide the Insured Person with the necessary forms to be completed for the filing of proof of claim.

(ii) All documents or evidence required by the Company for the proof of claim shall be made available by the Insured Person at his/her own expense. Any examination or investigatory procedures required by the Company to verify a claim shall be paid by the Company. The Company shall at its own expense be entitled to have a post-mortem examination performed in the event of the death of the Insured Person where it is not prohibited by law.

(iii) 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.

(iv) The Company shall have the right to obtain further independent opinion on the confirmation of the diagnosis upon which a claim is based from its own panel of medical specialist without any prejudice to the validity of the claim submitted by the Insured Person.

2. INCOMPLETE CLAIMS

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

3. CURRENCY OF PAYMENT

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

4. CONDITION PRECEDENT TO LIABILITY

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

5. 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.

6. LEGAL PROCEEDINGS

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

7. 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.

8. SUITS AGAINST THIRD PARTIES

Nothing in this Policy shall render the Company liable or be responsible or to be added as a party in any way whatsoever to any suit for damages which may be instituted by the Policyholder or an Insured nominated under this Policy against any provider

of Medical or Dental Services or Treatments, wherein such may sue the same for reasons of neglect, malpractice or other causes arising from his/her acts or omissions in the treatment or examination of any Insured under the terms of this Policy.