BERJAYA SOMPO INSURANCE

Policy

SOMPO Health

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
E-mail: customer@bsompo.com.my
Website: www.berjayasompo.com.my

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SH0324

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IMPORTANT NOTICE

This is Your **SOMPO Health** 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

SECTION I - RELATING TO CONTRACTUAL DETAILS

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 PERSONS OR INSUREDS** shall mean the person described in the Policy Schedule including his/her Dependant (if applicable).

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

4. **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.

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

SECTION II - RELATING TO INSURANCE COVER

1. **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.

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

3. **SICKNESS, DISEASE OR ILLNESS** shall mean a physical condition marked by a pathological deviation from the normal healthy state.

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

5. **CONGENITAL CONDITIONS** shall mean any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within 6 months from the time of birth. They will include hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the Insured was continuously covered under this Policy.

6. **CHILD** shall mean any person who has attained the age of 30 days and is an unmarried person, is financially dependent upon the Insured and is under the age of 19, or up to the age of 23 for those registered as full time student at a recognised educational institution in Malaysia.

7. **DEPENDANT** shall mean any of the following persons:
   a) a legally married spouse

b) unmarried children over 30 days old but under nineteen (19) years of age or twenty-three (23) years of age and is still on full-time higher education and who are not gainfully employed.

8. **ELIGIBLE EXPENSES** shall mean Medically Necessary expenses incurred during the Period of Insurance due to a covered Disability but not exceeding the limits in the schedule.

9. **DEDUCTIBLE** shall mean the amount specified in the Schedule of Benefits payable by the Insured Person before any incurred eligible medical expenses are payable under this Policy.

   The Policyholder has the option to choose a Deductible in return for a reduction of premium. The Deductible shall be deducted from the eligible medical expenses incurred, per Insured Person per Policy Year. The Policyholder may choose to increase or decrease the Deductible upon annual Renewal of the Policy which shall not be subject to the Upgraded Policies Condition. No variation of the Deductible amount is allowed throughout the duration of each Policy Year.

   The Deductible does not apply to Outpatient Kidney Dialysis and Outpatient Cancer Treatment.

10. **MEDICALLY NECESSARY** shall mean a medical service which is: -
    a) consistent with the diagnosis and customary medical treatment for a covered Disability, and
    b) in accordance with standards of good medical practice, consistent with the current standard of professional medical care, and of proven medical benefits, and
    c) not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient), and
    d) for which the charges are fair and reasonable and customary for the Disability.

11. **REASONABLE AND CUSTOMARY CHARGES** shall mean charges for medical care which is medically necessary shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individual of the same sex and of comparable age for a similar sickness, disease or injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured Person's medical condition.

12. **PRE-EXISTING ILLNESSES** shall mean disabilities that existed before the Effective date of Insurance that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:-
    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. **SPECIFIED ILLNESSES** shall mean the following disabilities and its related complications, occurring within the first 120 days of Insurance of the Insured Person:
    a) Hypertension, diabetes mellitus and Cardiovascular disease
    b) All tumours, cancer, cysts, nodules, polyps, stones of the urinary system and biliary system
    c) All ear, nose (including sinuses) and throat condition
    d) Hernias, haemorrhoids, fistulae, hydrocele, varicocele
    e) Endometriosis including disease of the Reproduction System
    f) Vertebro-spinal disorders (including disc) and knee conditions.

14. **HOSPITALISATION** shall mean admission to a Hospital as a registered in-patient for Medically Necessary treatments for a covered Disability upon recommendation of a physician. A patient shall not be considered as an in-patient if the patient does not physically stay in the hospital for the whole period of confinement.

15. **INTENSIVE CARE UNIT** shall mean a section within the 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.

16. **COSMETIC SURGERY** shall mean any surgery performed primarily to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction.

17. **ANY ONE DISABILITY** shall mean all of the periods of disability arising from the same cause including any and all complications there from except that if the Insured Person completely recovers and remain free from further treatment (including drugs, medicines, special diet or injection or advice for the condition) of the disability for at least ninety (90) days following the latest date of discharge and subsequent disability from the same cause shall be considered as though it were a new disability.

18. **OUT-PATIENT** shall mean the Insured Person is receiving medical care or treatment without being hospitalised and includes treatment in a Daycare centre.

19. **WAITING PERIOD** shall mean the first 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.

SECTION III - RELATING TO MEDICAL SUPPLIERS

1. **DAY-SURGERY** shall mean a patient who needs the use of a recovery facility for a surgical procedure on a pre-planned basis at the hospital/specialist clinic (but not for an overnight stay).

2. **HOSPITAL** shall mean only an establishment duly constituted and registered as a hospital for the care and treatment of sick and injured persons as paying bed-patients, and which:-
   a) has facilities for diagnosis and major surgery,
   b) provides 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 place for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.

3. **MALAYSIAN GOVERNMENT HOSPITAL** shall mean a hospital which charges of services are subject to the Fee Act 1951 Fees (Medical) Order 1982 and/or its subsequent amendments, if any.

4. **PRESCRIBED MEDICINES** shall mean medicines that are dispensed by a Physician, a Registered Pharmacist or a Hospital and which have been prescribed by a Physician or Specialist in respect of treatment for a covered Disability.

5. **DOCTOR OR PHYSICIAN OR SURGEON** shall mean a registered medical practitioner qualified and licensed to practice western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice, but excluding a doctor, physician or surgeon who is the Insured himself.

6. **DENTIST** shall mean a person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided, but excluding a physician or surgeon who is the Insured himself.

7. **SPECIALIST** shall mean a medical or dental practitioner registered and licensed as such in the geographical area of his practice where treatment takes place and who is classified by the appropriate health authorities as a person with superior and special expertise in specified fields of medicine or dentistry, but excluding a physician or surgeon who is the Insured himself.

8. **SURGERY** shall mean any of the following medical procedures:
   a) To incise, excise or electrocauterize any organ or body part, except for dental services.
   b) To repair, revise, or reconstruct any organ or body part
   c) To reduce by manipulation a fracture or dislocation
   d) Use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or urethra.

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 indemnify the Policyholder for eligible medical expenses incurred if any Insured Person is confined to hospital as a direct result of an accidental bodily injury, illness or disease in respect of treatment or services undertaken by or on the recommendation of a physician or surgeon

DESCRIPTION OF BENEFITS

The limits of eligible Benefits are set forth in the Policy Schedule of Benefits and described below.

HOSPITAL ROOM AND BOARD - Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Person's confinement, but in no event shall the benefit exceed, for 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.

INTENSIVE CARE UNIT - Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an in-patient in the Intensive Care Unit of the Hospital. This benefit shall be payable equal to the actual charges made by the Hospital subject to the maximum benefit for any one day, and maximum number of days, as set

forth in the Schedule of Benefits. Where the period of confinement in an Intensive Care Unit exceeds the maximum set forth in the Schedule of Benefits, reimbursement will be restricted to the standard Daily Hospital Room and Board rate.

No Hospital Room and Board Benefits shall be paid for the same confinement period where the Daily Intensive Care Unit Benefits is payable.

LODGER – Reimburses the actual lodger fees charged for accompanying an Insured Child (aged below 18 years) while in hospital confinement not exceeding the limits or the maximum number of days as set forth in the Schedule of Benefits.

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

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

SURGICAL IMPLANT OF PACEMAKER AND DEFIBRILLATOR – Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary Surgical Implants of Pacemaker and defibrillator and prescription thereof during surgery subject to the limits as set forth in the Schedule of Benefits. Pacemaker and defibrillator will be covered for first time implantation and exclude its subsequent replacement, including any parts thereof.

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

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 preceding hospitalisation within 60 days preceding confinement in a Hospital.

No payment shall be made if upon such diagnostic services, the Insured does not result in hospital confinement for the treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.

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 60 days preceding confinement in a Hospital and provided that such consultation is Medically Necessary.

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

SURGEON FEE - Reimbursement of the Reasonable and Customary Charges for a Medically Necessary surgery by the Specialists, including pre-surgical assessment Specialist's visits to the Insured Person and post-surgery care up to 90 days inclusive both before and after the date of surgery, but within the maximum indicated in the Schedule of Benefits. If more than one surgery is performed for Any One Disability, the total payments for all the surgeries performed shall not exceed the maximum stated in the Schedule of Benefits.

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

SECOND SURGICAL OPINION – Charges for consultation or opinion with a second specialist to determine whether a surgical operation for the same disease or injury is required in view of the Insured's medical condition. When considered medically necessary by the second specialist and such that this reaffirms the opinion expressed by the first specialist, the consultation fee incurred shall be payable but not exceed the maximum limit as stated in the Schedule of Benefits. The second consultation must be rendered within 30 days of the first consultation for this benefit to be payable.

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

IN-HOSPITAL PHYSICIAN VISIT - Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visiting an in-paying patient while confined for a non-surgical disability subject to a maximum of 2 visits per day not exceeding the maximum number of days as set forth in the Schedule of Benefit.

POST-HOSPITALISATION TREATMENT - Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up treatment by the same attending Physician, within 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 31 days as set forth in the Schedule of Benefits.

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

HOSPITAL MISCELLANEOUS FEE – Reimbursement of Admission fee, registration fee, medical record, billing fee, name tag/ID band, dispensing fee and other items deemed fit and necessary for medical purposes up to the maximum limit as stated in the Schedule of Benefits.

MEDICAL REPORT FEE – Reimbursement of the fee actually charged for the completion of the Medical Report up to the maximum limit as stated in the Schedule of Benefits.

EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT - Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily injury arising from an Accident for Medical Necessary treatment as an outpatient at any registered clinic or hospital within 24 hours of the Accident causing the covered bodily Injury. Follow up treatment by the same doctor or same registered clinic or Hospital for the same covered bodily injury will be provided up to 60 days as set forth in the Schedule of Benefits.

EMERGENCY ACCIDENTAL DENTAL TREATMENT - Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits as a result of a bodily injury arising from an ACCIDENT occurring to wholly sound natural teeth, and received as an out-patient within 24 hours of the occurrence of the accident. Follow-up treatment will be provided up to 14 days of the Accident causing the Injury and in a legally registered dental clinic or Hospital.

HOME NURSING CARE - Reimbursement of the Reasonable and Customary Charges incurred for up to 180 days and up to maximum limit as stated in the Schedule of Benefits for services rendered by a qualified and Government licensed Nurse which are medically necessary for the care of an Insured who is totally disabled and who would otherwise have been confined as a bed patient in a Hospital. The plan of treatment for the home nursing care must be established and prescribed by the attending Physician after the Insured has been hospitalised and discharge from the Hospital.

No payment will be made for custodial care, meal, general housekeeping services, companion and personal comfort items.

BEREAVEMENT ALLOWANCE – shall pay an amount as provided in the Schedule of Benefits to the Insured Person's next of kin or legal personal representative in the event of death of the Insured Person caused by illness or accident. The death of the Insured Person shall be established by an official Death Certificate.

ALTERNATIVE MEDICINE – Reimbursement of the charges incurred for any traditional form of treatment rendered by a sinseh, traditional bone-setters or other alternative treatment regime, where such services are provided under a valid Business Licence by relevant authorities, following an accidental bodily injury. Medical Treatments including medicine that must be supported by receipts. Such reimbursement shall be limited to RM100 per visit up to maximum of RM1,000 in respect of anyone accident.

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 applicable only once per lifetime whilst the Policy is in force and shall be subject to the limit as set forth in the Schedule of Benefit. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

OUT-PATIENT PHYSIOTHERAPY / CHIROPRACTIC TREATMENT - Reimburses charges for out-patient physiotherapy / chiropractic treatment referred in writing by a licensed specialist Physician after Surgery or Hospital confinement treatment within 90 days from the date of discharge from Hospital/Surgery. However, no payment will be made for medication / treatment and subsequent consultations with the same attending specialist Physician who treated the Insured.

SERVICE TAX - Reimbursement of the 8% Service Tax levied by the Malaysian Government on charges actually incurred for benefits as stated in the Schedule of Benefits.

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

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

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

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

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

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

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

OVERALL ANNUAL LIMIT - Benefits payable in respect of expenses incurred for treatment provided to the Insured Person during the period of insurance shall be limited to Overall Annual Limits as stated in the Schedule of Benefits irrespective of a type/types of disability. In the event the Overall Annual limit having been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining Policy year.

HOSPITALISATION INCOME (DUE TO COVID-19 VACCINATION SIDE EFFECT) - The Company will pay RM100.00 per day for the period of Hospitalisation not exceeding 10 days as a result of Sickness, Disease or Illness due to side-effects of the COVID-19 vaccination requiring Hospitalisation as advised by a Physician. Any Hospitalisation due to the same cause shall be considered as one Disability.

CONDITIONS

1. 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 a person has been continuously insured under this Policy prior to the age of 60, in which case continuous insurance up to the end of the Policy Year in which such Insured turns 100 years old is allowed under this Policy.

2. 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.

3. 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. A notice of 30 days will be given should any premium rate be increased.

This Policy is renewable at the option of Policyholder subject to the terms, conditions and termination at each of the anniversary of the Policy date. The renewal premiums payable will increase with age and is not guaranteed and the Company reserves the right to revise the premium rate 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.

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 lifetime limit specified and/or 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.

4. 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 portfolio as a whole shall be given by written notice 30 days before expiry to the Policyholder and the Company will run off all policies to expiry of the period of cover within the portfolio.

5. GEOGRAPHICAL TERRITORY

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

6. OVERSEAS TREATMENT

If the Insured Person elects to or is referred to be treated outside Malaysia by the Attending Physician, and subsequently proceeds with such treatment, benefits in respect of the treatment shall be limited to Reasonable and Customary and Medically Necessary Charges for such equivalent local treatment in Malaysia 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;

Reasonable and Customary charges which are medically necessary shall be deemed to be:

a) fees laid down in the Malaysian Medical Association's Schedule of Fees
b) average charges of medium-cost hospital treatment shall be the basis of payment for all other related charges applied to similar or equivalent severity of the medical condition being treated.

7. ALTERATIONS

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

8. CANCELLATION OF POLICY

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 e-mail address or address known to the Company, and refund the pro-rated premium to the Policyholder for the unexpired Period of Insurance.

9. 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.

10. GOVERNING LAW

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

11. 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.

12. SUBROGATION

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

13. 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.

14. UPGRADED ROOM & 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.

15. 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.

16. SUCCEEDING POLICYHOLDER

In the event of death of the Policyholder while this Policy is in force, the Policyholder's legal spouse if at the time is an Insured Person, shall automatically become the Policyholder and all references in this Policy to the Policyholder shall thereafter mean such spouse.

17. MISREPRESENTATION/FRAUD

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

18. WAITING PERIOD

Eligibility for benefits starts 30 days after the Insured has been included in the Policy, except for a covered Accident occurring after the effective date of coverage.

19. RESIDENCE OVERSEAS

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

20. TAKE-OVER POLICIES

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

21. UPGRADED POLICIES

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

22. CONVERSION POLICIES

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

23. TERMINATION OF BENEFITS

The Benefits under this Policy shall terminate at such time the Benefits covered shall have been exhausted or at mid-night (Malaysia time) on the last day of the Period of Insurance unless the Insured Person is confined to a Hospital at such time. If this being the case, the time of termination shall be extended to the time the Insured Person is discharged from Hospital.

Follow up treatment shall not be covered under this extension.

24. 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 issue 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.

EXCLUSIONS

This Policy does not cover any hospitalisation, surgery or charges caused directly or indirectly, wholly or partly, by any one (1) of the following occurrence:

1. Pre-existing illnesses.

2. Specified Illnesses occurring during the first 120 days of continuous cover.

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

4. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.

5. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of prosthetic appliances or devices such as artificial limbs, hearing aids and prescriptions thereof.

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

7. Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilisation, venereal disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related diseases, and any communicable diseases required quarantine by law.

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

9. Pregnancy, child birth (including surgical delivery), and its related complications, 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 sterilisation.

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

11. Hospitalisation primarily for investigatory purposes, all diagnostic tests including and not limited to Positron Emission Tomography (PET) Scan, Computed Tomography (CT) Scan, Computed Axial Tomography (CAT) Scan, Magnetic Resonance Imaging (MRI), X-ray examination, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for hyperhidrosis, weight reduction or gain.

12. 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.

13. 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.

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

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

16. 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.

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

18. 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.

19. Expenses incurred for sex changes

20. Investigation and treatment of sleep and snoring disorders, hormone replacement therapy and stem cell treatment.

21. Treatment directed towards development delay / or learning disabilities in children (including dyslexia).

CLAIMS PROCEDURES

1. EVENTS LEADING TO CLAIMS

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

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

2. INCOMPLETE CLAIMS

All claims must be submitted to the Company within 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 Arbitra-tors. 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.