BERJAYA SOMPO INSURANCE

Policy

SOMPO Medic*Now*

Berjaya Sompo Insurance Berhad
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Table of Contents

IMPORTANT NOTICE....3
OUR AGREEMENT.... 4
DUTY OF DISCLOSURE 4
DEFINITIONS.... 4
DESCRIPTION OF BENEFITS 6
CONDITIONS.... 8
EXCLUSIONS 11
HOW YOUR POLICY MAY BE CANCELLED....12
CLAIMS PROCEDURES 12

IMPORTANT NOTICE

This is **Your SOMPO MedicNow** 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 **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 – DEFINITIONS RELATING TO POLICY CONTRACT

1. **YOU / YOUR** shall mean the **Policyowner** .

2. **WE / OUR / US** shall mean the Insurer.

3. **POLICYOWNER** shall mean the person named in the Policy as the owner. It can be an individual or a corporate body. The **Policyowner** controls the Policy, unless the Policy has been assigned.

4. **INSURED PERSON / PARTICIPANT / COVERED PERSON** shall mean the person who is named in the Policy as the life being insured/covered. The **Insured Person/Participant/ Covered Person** is entitled to the benefits under this Policy.

SECTION II – DEFINITIONS RELATING TO POLICY TERMINOLOGY

1. **ACCIDENT** shall mean a sudden, unforeseen and unplanned event that results in bodily **Injury**.

2. **INJURY** shall mean damage to the body as a result of an **Accident.**

3. **CONGENITAL DISORDER/DISEASE** 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 Person/Participant/Covered Person** was continuously covered under this Policy.

4. **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.

5. **DAY SURGERY/DAYCARE PROCEDURE** shall mean a surgical procedure performed at a **Hospital** or Day **Surgery**/Daycare **Specialist** Centre which requires the use of a recovery facility, but without an overnight stay at the **Hospital** or Day **Surgery**/Daycare **Specialist** Centre.

6. **DENTIST** shall mean a healthcare practitioner that specializes in the diagnosis, prevention and treatment of **Diseases** or conditions of the oral cavity.

   He/she must be registered in the geographical area of practice and holds a valid practicing certificate.

   A **Dentist** who is himself or herself the **Policyowner** or the **Insured Person/Participant/Covered Person** under the Policy shall not be considered a **Dentist** for this Policy when making a claim.

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

8. **GENERAL PRACTITIONER (GP)** shall mean a medical practitioner qualified and licensed to practice western medicine. He must be registered in the locality of practice and must practice within the scope of his licensing and training.

A **General Practitioner** who is himself or herself the **Policyowner** or the **Insured Person/Participant/Covered Person** of the Policy shall not be considered a **General Practitioner** for this Policy when making a claim.

9. **HOSPITAL** shall mean a registered institution established for the purpose of providing treatment and care of bed-paying sick or injured patients, and has facilities for:

   - 24-hour nursing services by registered and graduate nurses;
   - Diagnostic and major **surgery**; and
   - Under the supervision of a **physician**.

   A **Hospital** is expressly NOT:
   - Primarily a clinic;
   - A convalescent, nursing or rest home;
   - A rehabilitation centre for alcoholics or drug addicts; or
   - A home for the elderly or infirmed.

10. **INTENSIVE CARE UNIT** shall mean a section within a **Hospital** which is designated as an **Intensive Care Unit** by the **Hospital**, and which is maintained on a twenty-four (24) hour basis solely for treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the **Hospital.**

11. **OUTPATIENT** shall mean a person who visits the **Hospital**, clinic or other healthcare facility for diagnosis or treatment but is not **Hospitalised**.

12. **MALAYSIAN GOVERNMENT HOSPITAL** shall mean a **Hospital** established, maintained, operated or provided by the Malaysian Government but excludes privatised or corporatised **Malaysian Government Hospitals**.

13. **PRESCRIBED MEDICINES** shall mean medicines dispensed by a **Physician** or Registered Pharmacist for the treatment of a covered **Disability**.

14. **SPECIALIST** shall mean a medical practitioner who specialises in a specific field of medicine and who is recognised by the appropriate health authority as an expert in that field. A **Specialist** shall include a **Physician** or a **Surgeon.**

    A **Specialist** who is himself or herself the **Policyowner** or the **Insured Person/Participant/Covered Person** of the Policy shall not be considered a **Specialist** for this Policy when making a claim.

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

16. **SURGERY** shall mean a procedure that involves the cutting of a patient's tissues or closure of a previously sustained wound. Other procedures may be considered **Surgery** if they involve surgical procedures or settings, such as the use of an operating theatre, anaesthesia, antiseptic conditions, typical surgical instruments, suturing or stapling.

17. **WAITING PERIOD** shall mean the first 30 days from the Commencement Date or the Reinstatement Date of the Policy whichever is later.

SECTION III – DEFINITIONS RELATING TO POLICY CONDITION

1. **ANY ONE DISABILITY** refers to all of the periods of **Disability** arising from the same cause including any and all complications except that if the **Insured Person/Participant/Covered Person** completely recovers and remain free from further treatment (including drugs, medicines, special diet, injection or advice for the condition) of the **Disability** must not exceed 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**.

2. **HOSPITALISATION / HOSPITALISED** shall mean the admission to a **Hospital** as a registered inpatient for **Medically Necessary** treatments for a covered **Disability** upon recommendation of a **Physician**. A patient shall not be considered as an inpatient if the patient does not physically stay in the **Hospital** for the whole period of confinement.

3. **DEDUCTIBLE** shall mean the specified eligible amount as specified in Schedule of Benefits that **You** are liable before any benefits are payable under this Policy.

   The **Insured Person/Participant/Covered Person** can choose to increase or decrease the **Deductible** upon annual **Renewal** of the cover. No midterm amendment to the **Deductible** is allowed.

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

4. **MEDICALLY NECESSARY** shall mean a medical service which is:
   a) consistent with the diagnosis and customary medical treatment for a covered **Disability**;
   b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits;
   c) not for the convenience of the **Insured Person/Participant/Covered Person** or the medical practitioner, and unable to be reasonably rendered out of **Hospital** (if admitted as an inpatient);
   d) not of an experimental, investigational or research nature, preventive or screening nature, medical technology/procedure, which has not been proven to be effective, based on established medical practice, or which has not been approved by a recognized body in Malaysia ;
   e) for which the charges are fair, reasonable and customary for the covered **Disability**; and
   f) provide treatment directly related to the covered **Disability.**

5. **ELIGIBLE EXPENSES** shall mean **Medically Necessary** expenses incurred for the treatment of the **Disability** during the period of Insurance but not exceeding the limits specified in the Schedule.

6. **PRE-EXISTING ILLNESS** shall mean Disabilities that the **Insured Person/Participant/Covered Person** has reasonable knowledge of before the effective date of insurance. An **Insured Person/Participant/Covered Person** may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:-
   a) the **Insured Person/Participant/Covered 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 circumstance.

7. **OVERALL ANNUAL LIMIT** shall mean benefits payable in respect of expenses incurred for treatment provided to the **Insured Person/Participant/Covered Person** during the period of insurance shall be limited to **Overall Annual Limits** as specified 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/Participant/Covered Person** hereunder shall immediately cease to be payable for the remaining **Policy Year**.

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

9. **RENEWAL OR RENEWED POLICY** shall mean a Policy that has been renewed without any lapse of time from the expiry of the earlier Policy.

10. **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 within Malaysia according to 13th Schedule of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013 and its subsequent amendments if any.

    Such charges when incurred, taking into consideration similar or comparable treatment, services or supplies to individual of the same gender and of comparable age of 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/**Participant**'s/**Covered Person**'s medical condition.

11. **SPECIFIED ILLNESS** shall mean the following Disabilities or any complications caused by such Disabilities occurring within the first 120 days of commencement date or reinstatement date whichever is the later:

    a. Hypertension, diabetes mellitus or cardiovascular **Disease;**
    b. Growths of any kind including tumours, cancers, cysts, nodules, polyps;
    c. Stones of the urinary system and biliary system;
    d. Any **Disease** of the ear, nose (including sinuses) or throat;
    e. Hernias, haemorrhoids, fistulae, hydrocele or varicocele;
    f. Any **Disease** of the reproductive system including endometriosis; or
    g. Any disorders of the spine (including a slipped disc) or any knee conditions.

DESCRIPTION OF BENEFITS

The limits of eligible Benefits are set forth in the Policy Schedule of Benefits and described below (if applicable). Certain Benefits described below may not necessarily be applicable to **Your** Policy.

HOSPITAL ROOM AND BOARD – The actual daily Charge by the **Hospital** for the use of the Room and Board during the **Insured Person**'s/**Participant**'s/**Covered Person**'s stay in the **Hospital** up to the maximum daily Charge for this Benefit specified in the Schedule of Benefits.

The maximum number of days **We** will reimburse for this Benefit is specified in the Schedule of Benefits.

INTENSIVE CARE UNIT – The actual daily Charge by the **Hospital** for the **Insured Person**'s/ **Participant**'s/**Covered Person**'s stay in the **Intensive Care Unit** up to the maximum daily Charge for this Benefit specified in the Schedule of Benefits.

The maximum number of days **We** will reimburse for this Benefit is specified in the Schedule of Benefits.

We will not reimburse for any **Hospital** Room and Board Charge for the days the **Insured Person/Participant/Covered Person** stayed in the **Intensive Care Unit**.

OPERATING THEATRE - The **Reasonable and Customary Charges** for the use of the Operating Theatre or Operating Room up to the maximum amount for this Benefit as specified in the Schedule of Benefits.

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, intravenous injections and solutions, administration of blood and blood plasma but excluding the cost of blood and plasma whilst the **Insured Person/Participant/Covered Person** is confined as an inpatient in a **Hospital**, up to the amount stated in the Schedule of Benefits.

DAILY CASH ALLOWANCE AT GOVERNMENT HOSPITAL - Pay a daily cash allowance to **You** for each complete day of the **Insured Person/Participant/Covered Person** stay in a **Malaysian Government Hospital** provided the Daily Room and Board Charge is not more than that stated in the Schedule of Benefits.

PRE-HOSPITALISATION 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 the maximum number of days and amount as specified in the Schedule of Benefit in a **Hospital** and which are recommended by a qualified medical practitioner.

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

PRE-HOSPITAL SPECIALIST CONSULTATION FEE - Reimbursement of the **Reasonable and Customary Charges** for the first time consultation by a **Specialist** in connection with a **Disability** within the maximum number of days as specified in the Schedule of Benefit preceding confinement in a **Hospital** and provided that such consultation is **Medically Necessary** and has been recommended in writing by the attending **General Practitioner**.

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

SURGEON FEE - The **Reasonable and Customary Charges** for **Surgery** performed on the **Insured Person/Participant/Covered Person** in the **Hospital** and shall include Charges for pre-surgical assessment, in-**Hospital** visits by the **Surgeon** or **Specialist** and post-surgical care.

The maximum number of days and the maximum amount **We** will reimburse for this Benefit is specified in the Schedule of Benefits subject to regulated fees.

If more than one **Surgery** is performed for **Any One Disability**, the total amount for all Surgeries performed shall not exceed the maximum amount for this Benefit as specified in the Schedule of Benefits.

ANAESTHETIST FEE - The **Reasonable and Customary Charges** for the administration of anaesthesia on the **Insured Person/Participant/Covered Person** by an anaesthetist up to the maximum amount for this Benefit as specified in the Schedule of Benefits.

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 Person**'s/**Participant**'s/**Covered Person**'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 60 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 Person/Participant/Covered Person** does not result in **Hospital** confinement or the treatment of the medical condition diagnosed.

IN-HOSPITAL PHYSICIAN VISIT (for non-surgical Hospitalisation) - The **Reasonable and Customary Charges** for ward visits by the attending **Physician** while the **Insured Person/Participant/Covered Person** is being admitted as a non-surgical patient in the **Hospital**. **We** will reimburse the **Reasonable and Customary Charges** up to 2 visits per day, irrespective of the number of visiting doctors.

The maximum number of days for such visits for this Benefit is specified in the Schedule of Benefits.

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

AMBULANCE FEE – The **Reasonable and Customary Charges** (inclusive of attendant's fee) for the use of a ground ambulance service by the **Insured Person/Participant/Covered Person** to and/or from the **Hospital.**

We will not reimburse this fee if the **Insured Person/Participant/Covered Person** was not admitted to a **Hospital.**

The maximum amount for this Benefit is stated in the Schedule of Benefits.

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

EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT - The **Reasonable and Customary Charges** for treatment of **Injury** to the **Insured Person/Participant/Covered Person** as an **Outpatient** in any registered clinic or **Hospital**. Such treatment must be done within 24 hours from the time of **Accident**.

We will also reimburse for the **Reasonable and Customary Charges** incurred for subsequent follow up treatments for the same **Injury** by the same **Specialist**, clinic or **Hospital**.

The maximum amount and the maximum number of days **We** will reimburse for this Benefit is specified in the Schedule of Benefits.

EMERGENCY ACCIDENTAL DENTAL TREATMENT – The **Reasonable and Customary Charges** for treatment of **Injury** to the **Insured Person/Participant/Covered Person** arising from an **Accident** occurring to wholly sound natural teeth, and received as an **Outpatient** within 24 hours from the time of **Accident**. The **Reasonable and Customary Charges** for follow-up treatment will be provided up to 60 days of the **Accident** causing the **Injury** and where such treatment is administered in a legally registered dental clinic or **Hospital**.

MALAYSIAN GOVERNMENT SERVICES TAX - Reimbursement of the 6% Government Services Tax levied by the Malaysian Government on charges actually incurred for benefits as stated in the Schedule of Benefits.

OUT-PATIENT CANCER TREATMENT - The **Reasonable and Customary Charges** for radiotherapy or chemotherapy for the treatment of cancer on the **Insured Person/Participant/Covered Person** as an **outpatient** in a legally registered cancer treatment centre or a **Hospital**.

We will pay the **Reasonable and Customary Charges** for doctor's consultation and related examination, laboratory or diagnostic tests or any drugs prescribed under this Benefit.

The maximum amount **We** will reimburse for this Benefit is specified in the Schedule of Benefits.

OUT-PATIENT KIDNEY DIALYSIS TREATMENT - The **Reasonable and Customary Charges** incurred for kidney dialysis on the **Insured Person/Participant/Covered Person** as an **Outpatient** performed in a registered dialysis centre or **Hospital.**

We will pay the **Reasonable and Customary Charges** for doctor's consultation and related examination, laboratory or diagnostic tests or any drugs prescribed under this Benefit.

The maximum amount **We** will reimburse for this Benefit is specified in the Schedule of Benefits.

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

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 yet attained the age of 19 years. This Policy does not cover **Insured Person/Participant/Covered Person** over the age of 49 years, unless such a person has been continuously insured under this Policy prior to the age of 49, in which case continuous insurance up to the end of the Policy Year in which such **Insured Person/Participant/Covered Person** attains 69 years of age is allowed under this Policy.

2. **PERIOD OF COVER AND RENEWAL**
The Policy is issue for the term of one year starting on the Commencement Date and terminate on the Expiry Date as specified in the Schedule. **You** can renew the Policy on each Policy Anniversary at the prevailing premium rate calculated based on the **Insured Person's/Participant's/Covered Person**'s age on the **Renewal** Date.

The premium rates are not guaranteed. **We** reserve the right to change the premium rates. Any change in premium rates shall apply to all **Policyowners** purchasing the same plan and shall commence from the next **Renewal** Date. **We** shall write to inform **You** of the change in the premium rates by giving **You** 30 days' notice.

If **You** want to upgrade **Your** Policy to a higher plan, **You** can do that on the **Renewal** Date. Please write to inform **Us** of **Your** intention to upgrade **Your** plan a month before the **Renewal** Date. **We** shall re-underwrite **Your** new plan and shall write to confirm **Our** acceptance.

3. **WORLDWIDE COVERAGE**
This Policy provides **You** with 24-hour worldwide cover.

4. **OVERSEAS TREATMENT (where Elective Treatment Overseas is allowed)**
We will reimburse the **Reasonable and Customary Charges** incurred for overseas treatment if:

- the **Insured Person/Participant/Covered Person** was **Hospitalised** for a medical emergency while travelling out of Malaysia. Such verss travel must not be for treatment of any medical condition.
- the **Insured Person/Participant/Covered Person** was recommended by a **Physician** to seek treatment outside of Malaysia because there is no other treatment available in Malaysia for that **Disability**.

We reserve the right to determine whether such treatment outside of Malaysia is necessary, in consultation with **Our** appointed medical doctor.

We will reimburse the actual Charge according to the terms and conditions and the limits of this Policy and the amount shall be calculated at the exchange rate published by the largest local bank (determined by asset size) in Malaysia on the day of discharge from the **Hospital.**

We will not reimburse the costs of transportation of the **Insured Person/Participant/Covered Person** (or any other person) to or from the place of treatment.

5. **RESIDENCE OVERSEAS**
We will not reimburse the Charge incurred for overseas treatment if the **Insured Person/Participant/Covered Person** has travelled or resides out of Malaysia for a continuous period of more than 90 days.

6. **ALTERATION (for yearly renewable Policy)**
We reserve the right to change the terms and conditions of this Policy. Such changes shall take effect from the next **Renewal** Date.
We will write to **You** to inform of any change of terms and conditions 30 days before the next **Renewal** Date.

7. **CERTIFICATION, INFORMATION AND EVIDENCE**
We may ask **You** to provide **Us** with information and evidence such as certificates and medical reports. This will be provided at **Your** expense and shall be in the form required by **Us**.

We reserve the right to request that the **Insured Person/Participant/Covered Person** be subjected to a medical examination by a doctor of **Our** choice, as and when **We** require. **We** will bear the cost of the medical examination.

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

9. **MISSTATEMENT OF AGE AND GENDER**
If the age or gender of the **Insured Person/Participant/Covered Person** has been misstated, any benefits payable will be pro-rated on the ratio of the actual premium paid to the correct premium which should have been paid based on the correct age and gender. **We** will refund any excess premium paid without interest.

If **We** do not have the rates for the corrected age or gender and **We** are therefore unable to issue the Policy, the Policy will be void. **We** will refund the premiums paid without interest.

Example:
If the premium paid is RM800 but the correct premium is RM1,000.

When a claim arises and the amount of eligible claims reimbursed is RM10,000, then **We** will pay
$\frac{800}{1,000} \times 10,000 = RM8,000$

10. **CHANGE IN RISK**
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 (or when **You** applied for this insurance) is inaccurate or has changed. This includes any change in occupation, hobby or sporting activities of the **Insured Person/Participant/Covered Person** that may increase the risk.

We reserve the right to alter the terms and conditions (including premium rates) of this Policy if warranted by the occupation or sporting activities change.

11. **SUBROGRATION**
If **You** suffer a **Disability** as a result of another party's actions or inactions, and **We** incur a loss under this Policy, then **You** agree to:

1. Authorise **Us** to sue in **Your** name to seek recovery of the loss, and other remedies; and
2. Provide **Us** with all necessary assistance in performing the above.

We shall pay for all expenses incurred in the recovery of the loss.

12. **COORDINATION OF BENEFITS**
We reserve the right to reduce the amount of Benefit reimbursed to **You** or the **Insured Person/Participant/Covered Person** if **You** or the **Insured Person/Participant/Covered Person** has been reimbursed for the medical expenses incurred for the same **Hospitalisation** from other sources.

The total amount of claim reimbursed shall not exceed the expenses actually incurred for the same **Hospitalisation**.

13. **WAITING PERIOD (for individual Policy)**
We will not reimburse **You** for any Charges incurred by the **Insured Person/Participant/Covered Person** if he or she is **Hospitalised** within the first 30 days from the Commencement Date or Reinstatement Date whichever is the later, unless the **Hospitalisation** is the result of an **Accident.**

14. **TAKE-OVER POLICIES**
We will continue to provide cover to the **Insured Person/Participant/ Covered Person** for existing **Disability** that he has suffered before the commencement of this Policy provided:

- the earlier Policy terminates immediately before the Commencement of this Policy,
- the Benefits of the earlier Policy covers the **Insured Person/Participant/Covered Person** for this **Disability**, and
- a copy of the earlier Policy was given to **Us**.

We will reimburse the **Reasonable and Customary Charges** for the treatment of the **Disability** up to the limit of the earlier Policy or the limit of this Policy whichever is the lower.

15. **UPGRADED POLICIES**
If **You** increase the Benefit of this Policy and **the Insured Person/Participant/Covered Person** has suffered a **Disability** before the Benefit has been increased, **We** will only reimburse the **Reasonable and Customary Charges** for the treatment of such **Disability** up to the limits of the earlier Benefit.

16. **CONVERSION POLICIES**
If **You** have converted the Policy from an 'Inner Limits' Policy to an 'As Charged/Full Reimbursement' Policy and the **Insured Person/Participant/Covered Person** has suffered a **Disability** before such conversion, **We** will reimburse the **Reasonable and Customary Charges** for the treatment of such **Disability** according to the Schedule of Benefits before the conversion.

17. **UPGRADED ROOM & BOARD CO-PAYMENT**
If **You** are **Hospitalised** at a published Room & Board rate which is higher than **Your** eligible benefit, **You** shall bear the difference in the **Hospital** Room & Board charges as well as 20% of the other eligible benefits described in the Schedule of Benefits.

18. **FREE LOOK PERIOD (for premium paying Policy)**
You have the right to return this Policy within 15 days after **We** deliver it to **You**, if, for any reason, **You** are not satisfied with this Policy.

If returned, the Policy will be considered void from the beginning and any Premium paid will be refunded to **You** less any medical examination fee incurred.

19. **PORTFOLIO WITHDRAWAL CONDITION**
We reserve the right not to continue with the underwriting of this insurance product.

In doing so, **We** will stop accepting any new Policies and will not offer **renewal** of **Your** Policy once it has expired.

We will write to inform **You** of **Our** intention by giving **You** at least 30 days notice.

20. **TERMINATION**

The Policy shall automatically terminate:

a) If any premium remains unpaid at the expiry of the Policy
b) if the Policy expires, lapses or is cancelled, surrendered or converted to extended term insurance
c) on the Expiry Date of Policy as stated in the Schedule;
d) upon the written request of the **Policyowner** to terminate this Policy;
e) on the death of the **Insured Person/Participant/Covered Person**; or
f) the total claim of the Policy has reached or exceeded the **Overall Annual Limit**.

21. **TERMINATION OF BENEFITS**

The Benefits under the 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 Cover** unless the **Insured Person/Participant/Covered Person** is confined to a **Hospital** at such time, in which case the time of termination shall be extended to the time the **Insured Person/Participant/Covered Person** is discharged from **Hospital**.

Follow up treatment shall not be covered under this Benefit.

EXCLUSIONS

RISK EXCLUDED

We shall not reimburse Charges incurred for **Hospitalisation** resulting directly or indirectly from any of the following risks:

1. **Specified Illnesses** within 120 days from the Commencement Date or Reinstatement Date whichever is the later;
2. Any **Disability** (except for **Injury**) and its signs or symptoms that appear within 30 days from the Date of Commencement or Date of Reinstatement whichever is the later;
3. Self-inflicted injuries or suicide or attempted suicide, while sane or insane;
4. **Injuries** or **Hospitalisation** as a result of drug abuse, addictive disorders from substance misuse or while under the influence of alcohol;
5. 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;
6. Ionizing radiation or contamination by radioactivity from any nuclear fuel or nuclear waste;
7. **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; or
8. Participation in any form of aviation (except as a fare-paying passenger or crew member on a regular route operated by a licensed commercial airline), or aerial sports such as (but not limited to) skydiving, parachuting, bungee jumping, hang gliding or ballooning.

HOSPITALISATION EXCLUDED

We shall also not reimburse for Charges incurred for **Hospitalisation**, directly or indirectly resulting from any of the following medical conditions or situations:

1. Pre-Existing **Illness**.
2. Plastic or **Cosmetic Surgery** and related treatments.
3. Circumcision or any **Surgery** on the foreskin.
4. Eye examination and surgical correction for visual impairments due to nearsightedness, farsightedness or astigmatism or radial keratotomy or Lasik.
5. Dental conditions including dental treatment by **Dentist** or oral **Surgery** except as necessitated by accidental injuries to sound natural teeth occurring wholly during the period of Insurance.
6. Private nursing care, non-**Hospital** nursing care, rest cures, sanitaria care, hospice care and care or treatment that do not lead to a recovery, conservation of **Your** condition or restoration to **Your** previous state of health.
7. Veneral **Disease** and its sequelae.
8. HIV, AIDS or AIDS related **Disease**.
9. Communicable **Diseases** requiring quarantine by law.
10. **Congenital Disorders/Diseases** or deformities including hereditary and developmental conditions.
11. Pregnancy or pregnancy related conditions including childbirth (whether surgical or otherwise), complications arising from pregnancy such as miscarriage, abortion, pre-or post-natal care, contraceptive methods for birth control, infertility treatments and its complications.
12. Impotence, infertility sterilization, erectile dysfunctions and its complications.
13. Sleep apnea or snoring disorder.
14. Hyperhidrosis.
15. Hormone Replacement Therapy.
16. Mental or nervous disorders (including psychosis, neurosis and their physiological or psychosomatic manifestations).
17. Sex changes.
18. Donations of body parts or organs by the **Insured Person/Participant/Covered Person**.

19. Primarily for investigative purposes, screening, diagnosis, X-rays, scans, general physical or medical examinations that are done routinely or are not incidental to treatment or diagnosis of a **Disability**, treatment or investigation of a **Disability** that are not **Medically Necessary** to be **Hospitalised**, preventive treatments and medicine.
20. Stem cell therapy, except hematopoietic blood disorders.
21. Treatments specifically for weight reduction or gain or bariatic **Surgery**.
22. Of an experimental, investigational or research nature.

TREATMENT AND COSTS OF EQUIPMENT, APPLIANCES AND MEDICINE EXCLUDED
We shall also not reimburse for costs or expenses incurred for the following:

1. Alternative treatments such as chiropractic services, acupuncture, acupressure, reflexology, bone-setting, herbalist treatment, hyperbaric oxygen therapy, massage or aroma therapy or other alternative medicines, except due to **Accident** as defined under Alternative Medicine; or
2. Glasses, multifocal lens or contact lens; or
3. External prosthetic appliances or devices including but not limited to artificial limbs, external fixator, hearing aids, cochlear apparatus; or
4. Pacemakers, implantable cardiac defibrillator (ICD) and cochlear implants; or
5. Items that are not directly related to the medical treatment of the **Disability** including rental of television, telephones, broadband services, electricity charges, admission/registration/record fee, admission kit/pack; or
6. Body parts or organs, blood or blood products and blood surety.

HOW YOUR POLICY MAY BE CANCELLED

You may cancel this Policy at any time by giving **Us** notice in writing. Such notification shall become effective from the date **We** receive the notice or the date specified in **Your** notice, whichever is later. **We** will refund the pro-rated premium to **You** for the unexpired Period of Insurance, provided no claims have been made under the Policy and subject to a minimum premium of RM60.00.

We may cancel this Policy by giving **You** 14 days' notice in writing to **Your** last email address or address known to **Us**, and refund the pro-rated premium to **You** for the unexpired Period of Insurance.

CLAIMS PROCEDURES

1. **HOW TO MAKE A CLAIM**
   You are to submit the following documents within 30 days from the date of discharge from the **Hospital** to speed up the processing of **Your** claim:

   - All original bills and receipts; and
   - A **Physician**'s report with information of diagnosis, scans and tests done, the date of **Disability**, date of Discharge, conclusion and summary of treatment provided and follow ups.

   If **You** were not able to notify **Us** within 30 days from the date of discharge from the **Hospital**, it does not invalidate the claim if **You** can prove that it was not reasonable to do so.

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

3. **CONDITION PRECEDENT TO LIABILITY**
   You must observe and comply with the terms, provisions and conditions of this Policy in order for **Us** to be liable under this Policy.

4. **MISREPRESENTATION**
   Failure to give answers that are fully accurate may result in the avoidance of **Your** Policy, refusal or reduction of **Your** claim(s), change of terms or termination of **Your** Policy.

5. **LEGAL PROCEEDINGS**
   You shall not take any legal action within 60 days from the date **We** receive **Your** letter informing **Us** of a claim under this Policy.

   You shall give **Us** all the necessary documents for the claim within one calendar year from the date **We** received **Your** letter. **We** shall not process the claim if any of the necessary document is received after one calendar year.

6. **FRAUD**
   If any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support of such claim, this Policy shall be void.

7. **NOTICE TO US**
All notices to **Us** must be in writing and email the documents to **Us** at customer@bsompo.com.my or deliver the same to **Our** Customer Service Centre at Level 36, Menara Bangkok Bank, 105 Jalan Ampang, 50450 Kuala Lumpur.

8. **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.