STAMP DUTY PAID

Generali Insurance Malaysia Berhad
(formerly known as AXA Affin General Insurance Berhad)
Reg No: 197501002042 (23820-W)

GROUP HOSPITAL & SURGICAL INSURANCE POLICY

This Policy is issued in consideration of the payment of premium to **Generali Insurance Malaysia Berhad** ('the company') as specified in the Policy Schedule and pursuant to the answer when you applied for this insurance and any other disclosures made by you between the time of submissin and the time this contract is entered into. The answer and any other disclosures given by you shall form part of this contract of insurance between you and us. In the eventof any pre-contactual misrepresentation made in relation to your answer or in any disclosures made by you, it may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of term or termination of your contract of insurance.

Provided that no Benefits will be payable unless the entire hospital confinement had been recommended and approved by a legally qualified medical practitioner. The due observance and fulfillment by the Insured Person of the terms and conditions contained herein or endorsed hereon, which terms and conditions shall form part of this Policy, shall insofar as the context permits, be deemed to be conditions precedent to any liability under this Policy.

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

GENERAL POLICY DEFINITIONS

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

1. **POLICYHOLDER** shall mean a person or a corporate body to whom the Policy has been issued in respect of cover for persons specifically identified as Insured Persons in this Policy.
2. **INSURED PERSON** shall mean the person described in the Policy Schedule including his/her Dependant (if applicable).
3. **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.
4. **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.
5. **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.
6. **INJURY** shall mean bodily injury caused solely by Accident.
7. **SICKNESS, DISEASE OR ILLNESS** shall mean a physical condition marked by a pathological deviation from the normal healthy state.
8. **DISABILITY** shall mean a Sickness, Disease, Illness or the entire Injuries arising out of single or continuous series of causes.
9. **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.
10. **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.
11. **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 students at a recognized educational institution.
12. **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 is still on full-time higher education, and who are not gainfully employed.

13. **ELIGIBLE EXPENSES** shall mean Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the schedule.

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

15. **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.

16. **PRE-EXISTING ILLNESS** shall mean disabilities that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:-
    (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.

17. **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, cancers, cysts, nodules, polys, stones of the urinary system and biliary system
    (c) All ear, nose (including sinuses) and throat conditions
    (d) Hernias, haemorrhoids, fistulae, hydrocele, varicocele
    (e) Endometriosis including disease of the Reproduction system
    (f) Vertebro-spinal disorders (including disc) and knee conditions.

18. **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.

19. **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.

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

21. **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.

22. **DAY SURGERY** A patient who needs the use of a recovery facility for a surgical procedure on a pre-plan basis at the hospital/ specialist clinic (but not for overnight stay).

23. **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 hour 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.

24. **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.

25. **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.

26. **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.

27. **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.

28. **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.

29. **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

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

31. **MEDICAL PRACTITIONER** shall mean a person legally authorized in the geographical area of his practice to render medical care and treatment.

APPLICABLE AGE

This Policy shall cover each eligible adult Insured Person up to age of 60 or 65 years (or for applicable and relevant age limit refer to the Schedule of Benefits and Annual Premium Table, or attached Endorsement whichever applicable) unless prior consent has been granted by the Company for any person above this age.

PARTICIPATION

ELIGIBILITY

The Insured Persons eligible for this scheme are the present and future full-time employees of the Employer who are actively engaged at their usual work on the date the Insured Persons are eligible to join the Scheme and are below 60 years on last birthday and renewal is allowed up to 65 years of age.
Present employees will be eligible to participate in the scheme at the commencement date of the scheme. Future employees will be eligible to participate in the scheme according to the date mentioned in the attached application form.
If an employee is not actively engaged at his/ her usual work on the date that he/ she would otherwise be eligible in accordance with the abovementioned requirements, his/ her eligibility date will be deferred to the first (1st.) day of the month immediately following his/ her return to active full-time work.
Dependants of the employees are also eligible in accordance to the requirements stated in the Application Form for the same quantum of benefit as the employees on the dates the employees themselves become eligible. If a dependant is disabled by sickness or injury on the date he/ she would otherwise be eligible, his/ her eligibility date shall be deferred to the day following his/ her complete recovery from the disability.

EFFECTIVE DATE OF INSURED PERSONS

The insurance of each eligible Insured Person shall take effect on his/her eligible date provided that the Insured Person applies to enroll for insurance by completing and returning an enrolment form provided by the Company within thirty (30) days from his eligibility date, otherwise the insurance of the Insured Person will take effect on a date to be specified by the Company after the Insured Person has submitted the enrolment form and produced satisfactory medical evident of insurability which the Company may require at no expenses to the Company.

AUTOMATIC TERMINATION

The Insurance for the Insured person shall terminate in the earliest happening of the following events:
- ❑ on the death of the Insured Person; or
- ❑ on the Policy Anniversary immediately following the 65th birthday of the Insured Person; or
- ❑ for a dependent child, on his/ her 19th birthday or his/ her 23rd, birthday if in full-time tertiary institution in Malaysia; or
- ❑ if the total Benefits paid under the Policy since the last Policy Anniversary exceeds the Overall Annual Limit for the respective Policy Year; or
- ❑ at midnight standard Malaysian 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: -

1. the time the Insured Person is discharged from Hospital; or
2. the time the Overall Annual Limit shall have been exhausted.

- ❑ On the date of termination of employment; or
- ❑ On the date in which an Employee is retired or pensioned.

BENEFITS

Extent
The Benefits provided under this Policy are applicable without geographical limitation for 24 hours a day. Certain Benefits described below **need not necessary available** in this Policy. **The actual scope of Benefits provided is set forth in the attached Schedule of Benefits.**

Description
Upon receipt of due proof that any Insured Person while insured under this Policy shall have been disabled and by reason of such disability is confined to hospital upon the recommendation and approval of a duly qualified medical practitioner on account of a covered illness, bodily injury or disease, the Company agrees subject to the other provisions of this Policy to pay the Benefits provided below (if applicable):

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.

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

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.

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

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

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

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 the maximum number of days and amount as set forth in the Schedule of Benefit in a Hospital and which are recommended by a qualified medical practitioner. No payment shall be made if upon such diagnostic services, the Insured does not result in hospital confinement for the treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.

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 the maximum number of days as set forth 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 does not result in hospital confinement for the treatment of the medical condition diagnosed.

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

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

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 the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

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

AMBULANCE FEES
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.

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.

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) Carcinorma in situ including of the cervix;
(b) Ductal Carcinorma in situ of the breast;
(c) Papillary Carcinorma 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.

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.

INSURED CHILD'S DAILY GUARDIAN BENEFIT
Reimburses (up to stipulated limits set forth on the Schedule of Benefits the expenses for meals and lodging incurred to accompany an insured Child (aged below fifteen (15) years) in the hospital up to the maximum number of days set forth in the Schedule of Benefit.

OUT-PATIENT PHYSIOTHERAPY TREATMENT
Reimbursement of Reasonable and Customary Charges for out-patient physiotherapy treatment referred in writing by a licensed specialist Physician after Surgery or in-Hospital treatment, within the maximum number of days and amount as set forth in the Schedule of Benefits immediately following discharge from Hospital/ Surgery. However no payment will be made for medication/treatment and subsequent consultations with the same specialist Physician. A copy of the referral letter must be submitted as proof of recommendation.

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

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.

GOVERNMENT SERVICE TAX
Reimbursement of charges imposed by the Malaysian Government for tax levied on the Room & Board Charges, subject to the amount not exceeding the percentage of the eligible Room & Board charges as stated in the Schedule of Benefits.

SECOND SURGICAL OPINION
Reimbursement of Reasonable and Customary charges for consultation and opinion with a second specialist to determine whether a surgical operation is necessary or required in view of the Insured Person's medical condition up to the maximum limit per disability as stated on the Schedule of Benefits. Payment is made only if the Insured Person is subsequently hospitalised for surgery and if charges are incurred within a period as stated in the Schedule of Benefits prior to such hospitalisation.

ACCIDENTAL DEATH BENEFIT
Pays the amount as shown in the Schedule of Benefits for the loss of life of the Insured employee due to accident. An official death certificate shall establish the death of the Insured employee.

EMERGENCY SICKNESS TREATMENT
Reimbursement of Reasonable and Customary charges for emergency of sickness rendered in a hospital or 24 hours clinic and received as an outpatient between the hours shown in the Schedule of Benefits. The time of the treatment as certified by the attending doctor shall be a condition precedent to liability. Such payment shall in no event the maximum stated in the Schedule of Benefits.

IN-PATIENT TREATMENT IN GOVERNMENT HOSPITAL
Reimbursement of the medical expenses and other eligible services incurred when confine in a Malaysian Government Hospital for medical treatment or surgery up to the maximum limit as stated in the Schedule Of Benefits provided that the daily room and board charges incurred are not higher than the entitled plan limit.

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.

GENERAL EXCLUSIONS

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

1. All Pre-existing Illness for the first twelve (12) months of issue date, unless declared and accepted by the Company.
2. Specified Illness 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. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy)and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.
5. 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.
6. Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilization, venereal disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC(AIDS Related Complex) and HIV related diseases, and any communicable diseases required quarantine by law.
7. Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions
8. Pregnancy, child birth (including surgical delivery), miscarriage, abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility. Erectile dysfunction and tests or treatment related to impotence or sterilization.
9. Hospitalisation primarily for investigatory purposes, diagnosis, X-ray examination, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for weight reduction or gain.
10. Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.

11. 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.

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

13. 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.

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

15. 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.

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

17. 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

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

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

20. Expenses incurred for sex changes.

CLAIMS PROCEDURES

1. CLAIMS PROCEDURES

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

ii) 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.

GENERAL PROVISIONS AND CONDITIONS

1. PERIOD OF COVER AND RENEWAL

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

This Policy is renewable at the option of the Company. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.

The company shall give the Policyholder 30days written notice in the event of revision of premium or portfolio withdrawal.

2. GEOGRAPHICAL TERRITORY

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

3. OVERSEAS TREATMENT

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

i) an Insured Person travelling aboard for a reason other than for medical treatment, needs to be confined to a Hospital outside Malaysia as a consequence of a Medically Emergency;

ii) an Insured Person upon recommendation of a Physician and has to be transferred to a Hospital outside Malaysia because the specialised nature of the treatment, aid, information or decision required can neither be rendered nor furnished nor taken

in Malaysia.

Overseas treatment of a disease, sickness or injury which is diagnosed in Malaysia and non-emergency or chronic conditions where treatment can reasonably be postponed until return to Malaysia are excluded.

4. ALTERATIONS

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

5. CANCELLATION

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

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

The company may by notice in writing to the Policyholder under registered letter to his last known address give (7) days notice of their intention to terminate this Policy and refund of a proportion of the premium corresponding to the unexpired period of insurance.

6. 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.

7. GOVERNING LAW

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

8. 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.

9. CHANGE IN RISK

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

10. SUBROGATION

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

11. 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.

12. UPGRADED ROOM AND BOARD CO-PAYMENT

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

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. COOLING-OFF PERIOD

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

19. PORTFOLIO WITHDRAWAL CONDITION

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

20. CONDITION PRECEDENT TO LIABILITY

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

21. 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.

22. MISREPRESENTATION / FRAUD

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

23. 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.

24. 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.

25. PREMIUM WARRANTY

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

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

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

26. THE POLICY

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

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

27. POLICY NOT ASSIGNABLE

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

28. GENDER

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

29. SUITS AGAINST THIRD PARTIES

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