STAMP DUTY PAID

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

MEDIC 101
HOSPITALISATION & SURGICAL POLICY

The Insured / Policyholder, by a proposal and declaration, has applied to GENERALI INSURANCE MALAYSIA BERHAD (hereinafter called "the Company") for the insurance contained in this Policy, Schedule and Endorsements incorporated herein, and has paid the premium as stated in the Schedule as consideration for such insurance. The Company, subject to the terms, definitions, conditions, limitations and exclusions contained in this Policy, Schedule and any Endorsements herein, will indemnify the Insured for Eligible Expenses incurred during the Period of Insurance if an Insured Person is confined to Hospital during the Period of Insurance as a direct result of an Injury or Sickness in respect of treatment or services undertaken by or on the recommendation of a Physician or Surgeon in the manner and to the extent hereinafter provided.

The proposal and declaration made by the Insured / Policyholder, Insured Person and this Policy, Schedule and any Endorsements incorporated herein or thereafter and issued by the Company shall be read jointly as one insurance document and shall form the basis of this contract.

IMPORTANT NOTICE

The Insured / Policyholder shall read this Policy carefully, and if any error or differences be found herein, or if the cover be not in accordance with the wishes of the Insured, advice should be given to the Company immediately and the Policy returned for alteration.

The following are some of the common important Definitions, Conditions and Exclusions appearing in the Policy:

1. Definitions & Exclusions of 'Pre-existing Condition' and 'Specified Illnesses'.
2. Definition and application of DEDUCTIBLE.
3. Definitions of 'Reasonable & Customary Charges' and 'Medically Necessary'.
4. Condition for Overseas Treatment
5. Notification of Claims within 30 days and Claims Procedures

TABLE OF BENEFITS

The Benefits & Limits insured herein shall be any one of the following Benefit Plans as indicated in the Policy Schedule. Details of Benefit items are described in 'Description of Benefits'.

Schedule of Benefits	**TU750**	**TU600**	**TU450**	**TU330**	**TU220**
Hospital Room & Board (daily limit)	750	600	450	330	220
Intensive Care Unit	As Charged subject to 'Reasonable & Customary Charges' and Overall Annual Limit				
Surgical Fees					
Anesthetist Fees					
Operation Fees					
In-Hospital Physician Visits					
Hospital Services & Supplies					
Organ Transplant (Kidney, Heart, Lung, Liver or Bone Marrow only)					
Pre-Hospital Diagnosis Tests					
Pre-Hospital Specialist Consultation					
Home Nursing Care					
Post-Hospitalisation Treatment					
Outpatient Physiotherapy Treatment					
Outpatient Cancer Treatment					
Outpatient Kidney Dialysis Treatment					
Deductible per *Disability per policy year*	10,000	10,000	10,000	10,000	10,000
Overall Annual Limit	300,000	250,000	200,000	150,000	100,000
Overall Annual Limit (applicable under policy condition No. 10)	390,000	325,000	260,000	195,000	130,000
Accidental Death Benefit	10,000	10,000	10,000	10,000	10,000

DESCRIPTION OF BENEFITS

The amount indemnified by the Company shall not exceed the actual costs of the treatment and services rendered and the maximum liability of the Company shall be based on the actual, Medically Necessary, Reasonable and Customary charges incurred but not to exceed the Limits in accordance with the Benefit Plan set out in the Table of Benefits. No benefits whatsoever shall be payable for charges, fees or expenses of every kind and description which are not specifically mentioned hereunder.

1. HOSPITAL ROOM & BOARD

Reimburses the daily charges made by the hospital for room accommodation and meals incurred by the Insured Person for each day of confinement as a registered bed-paying patient in a Hospital.

2. INTENSIVE CARE UNIT

Reimburses daily charges for confinement in an Intensive Care Unit or Cardiac Care Unit where prescribed by attending Physician or Surgeon.

3. SURGEON FEES

Reimburses professional fees charged by the Surgeon for a Surgery performed. This includes the Surgeon's ward visits, pre-surgical assessment and all normal post-surgical care up to 60 days before and after the operation.

Surgeon Fee shall also include first professional fees charged by a second Physician or Surgeon who may be consulted prior and during Hospitalisation of the Insured Person for the Surgery.

4. ANAESTHETIST FEE

Reimburses professional fees charged by the Anaesthesiologist for the supply and administration of anaesthesia incidental to the performance of a Surgery.

5. OPERATING THEATRE

Reimburses Operating Room charges incidental to the performance of a Surgery.

6. IN-HOSPITAL PHYSICIAN VISITS

Reimburses professional fees charged by a Physician for visiting a bed-paying patient while confined for a non-surgical Disability.

7. HOSPITAL SERVICES & SUPPLIES

Reimburses charges for general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, diagnostic tests, laboratory examinations, electrocardiograms, physiotherapy, rental of appliances, surgical implants, basal metabolism tests, intravenous injections and solutions, administration of blood and blood plasma, oxygen and its administration, and taxes (if applicable) whilst the Insured Person is confined as a bed-paying patient in a Hospital.

8. ORGAN TRANSPLANT

Reimburses medical 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 of an Insured Person whilst the Policy is in force. The costs of acquisition of the organ and all costs incurred by the donors are not covered.

9. PRE-HOSPITAL DIAGNOSTIC TESTS

Reimburses charges for ECG, X-ray, laboratory and diagnostic tests which are performed for diagnostic purposes and when in connection with a Disability preceding Hospitalisation within sixty (60) days and which are recommended by a Physician. No benefit shall be made if upon such diagnostic services, the Insured Person does not result in Hospitalisation for the treatment of the medical condition diagnosed. Cost incurred for any medications and consultation will not be payable under this benefit.

10. PRE-HOSPITAL SPECIALIST CONSULTATION

Reimburses the professional fees charged for the first-time consultation by a Specialist in connection with a Disability within sixty (60) days preceding Hospitalisation and provided that such consultation has been recommended in writing by a Doctor. No benefit shall be made for clinical treatment (including medications and subsequent consultation after the Disability is diagnosed) or where the Insured Person does not result in Hospitalisation for the treatment of the medical condition diagnosed.

11. HOME NURSING CARE

Reimburses the daily professional fees for the services rendered by a medically qualified and licensed Nurse in the Insured Person's home and incurred within sixty (60) days immediately following discharge from the Hospital provided that such services are deemed to be Medically Necessary by the attending Physician in writing. The plan and schedule of the treatment for this Home Nursing Care must be established and prescribed in writing by the attending Physician. No payment will be made for custodial care, meal, general housekeeping services, companion, rest cure or personal comfort items.

12. POST-HOSPITALISATION TREATMENT

Reimburses medical charges for follow-up treatment by the same attending Physician and incurred within sixty (60) days immediately following discharge from the 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 said sixty (60) days period.

13. OUTPATIENT PHYSIOTHERAPY TREATMENT

Reimburses the daily professional fees charged by a legally and medically qualified Physiotherapist for outpatient physiotherapy treatment and incurred within one hundred (100) days immediately following discharge from the Hospital provided that such service is deemed to be Medically Necessary by the attending Physician in writing.

14. OUTPATIENT CANCER & / or KIDNEY DIALYSIS TREATMENT

If an Insured Person is diagnosed with Cancer or Kidney Failure as defined herein, the Company will reimburse medical charges incurred for the treatment of Cancer or Kidney Failure provided that such treatment (radiotherapy &/or chemotherapy for Cancer and Dialysis for Kidney Failure) is received at the outpatient department of a Hospital or a legally registered Cancer treatment centre or Kidney Dialysis centre immediately following discharge from Hospital confinement or surgery.

It is a specific condition of this Benefit that notwithstanding the exclusion of Pre-Existing Conditions, this Benefit will not be payable for any Insured Person who has been diagnosed as a Cancer patient or developed chronic renal diseases and / or is receiving dialysis treatment prior to the effective date of Insurance.

15. ACCIDENTAL DEATH BENEFIT

Pays the Insured a stated lump sum benefit in the event of Accidental Death of an Insured Person if death occurs within six (6) months from the date of the Accident.

DEFINITIONS

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

2. **CHILD** means any person whose age has attained the age of thirty (30) days, is under the age of nineteen (19) years, or up to the age of twenty (23) years for any one registered as a full-time student at a recognized educational institution; is unmarried and financially dependent upon the Policyholder.

3. **COMPANY** means Generali Insurance Malaysia Berhad.

4. **CONGENITAL ABNORMALITY** means any medical or physical abnormality 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 was continuously covered under this Policy.

5. **DEDUCTIBLE** means a monetary sum that shall be deducted from the Eligible Expenses incurred by an Insured Person, and on per Disability per Policy Year basis. The Deductible is stated under the insured Benefit Plan.

6. **DENTIST** means 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 or Insured Person himself.

7. **DEPENDANT** means any of the following persons:
a) Legally married spouse,
b) unmarried Child as defined herein.

8. **DISABILITY** means a Sickness or the entire Injuries arising out of a single or continuous series of causes.

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

10. **ELIGIBLE EXPENSES** mean Medically Necessary expenses incurred by an Insured Person due to a covered Disability and provided that the expenses incurred fall within the 'Description of Benefits' and benefit limits of the insured Benefits Plan.

11. **HOSPITAL** means 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:

i) have facilities for diagnosis and major surgery
ii) provides 24 hours daily nursing service by registered and graduate nurses
iii) is under the supervision of a Physician, and

iv) is not primarily a clinic, a place for alcoholics or drugs addicts, a nursing, rest or convalescent home or a home for the aged or similar establishment.

12. **HOSPITALISATION** means admission to a Hospital as a registered bed-patient for Medically Necessary treatment of a covered Disability upon recommendation of a Physician. A patient shall not be considered as a bed-paying patient if the patient does not physically stay in the Hospital for the whole period of confinement. In the event of surgery, the requirement of Hospitalisation is waived.

13. **INJURY** means bodily damage caused solely by Accident.

14. **INSURED PERSON** means a person named as the Insured Person in the Policy Schedule or whose name is added by Endorsement.

15. **LIFETIME LIMIT** means the maximum aggregate liability of the Company per Lifetime of an Insured Person. Once the Lifetime Limit is reached, the liability of the Company in respect of that Insured Person is automatically terminated (if applicable).

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

17. **MEDICALLY NECESSARY** means a medical service which is:

i) consistent with the diagnosis and customary medical treatment for a covered Disability, and
ii) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits, and
iii) not for the convenience of the Insured Person or the Physician, and unable to be reasonably rendered out of Hospital (if admitted as a bed-paying patient),
iv) not of an experimental, investigational or research nature, preventive or screening nature, and
v) and for which the charges are fair and Reasonable and Customary for the treatment of Disability.

18. **OUT-PATIENT** means an Insured Person is receiving medical care or treatment without being hospitalized and this shall include treatment in a day care centre.

19. **OVERALL ANNUAL LIMIT** means Benefits payable in respect of Eligible Expenses incurred by an Insured Person during the Policy Year shall be limited to Overall Annual Limit irrespective of the type / types of Disability. In the event the Overall Annual Limit having been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining Policy Year.

20. **PHYSICIAN OR SURGEON OR DOCTOR** means 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 or Insured Person himself.

21. **POLICYHOLDER / INSURED** 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.

22. **POLICY YEAR** means 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 of the Policy.

23. **PRE-EXISTING CONDITION** means Disability that the Insured Person has reasonable knowledge of on or before the effective date of insurance of the Insured Person. An Insured Person may be considered to have reasonable knowledge of a Pre-existing Condition where the condition is one for which:

i) the Insured Person had received or is receiving treatment;
ii) medical advice, diagnosis, care or treatment has been recommended;
iii) clear and distinct symptoms are or were evident; or
iv) its existence would have been apparent to a reasonable person in the circumstances.

24. **PRESCRIBED MEDICINES** 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.

25. **REASONABLE AND CUSTOMARY CHARGES** 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 Disability and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured Person's medical condition.

26. **RENEWAL OR RENEWED POLICY** means a Policy which has been renewed without any lapse of time upon expiry of a preceding Policy.

27. **SICKNESS, DISEASE OR ILLNESS** means a physical or medical condition marked by a pathological deviation from the normal healthy state.

28. **SPECIFIED ILLNESSES** mean the following Disabilities and its related complications, occurring within the first one hundred and twenty (120) days of Insurance of the Insured Person:

i) Hypertension, cardiovascular disease and diabetes mellitus.
ii) All tumours, cancers, cysts, nodules, polyps, stones of the urinary and biliary system.
iii) All ear, nose (including sinuses) and throat conditions.
iv) Hernias, haemorrhoids, fistulae, hydrocele, varicocele.
v) Endometriosis including disease of the reproduction system.
vi) Vertebro-spinal disorders (including disc) and knee conditions.

29. **SPECIALIST** means a Physician or Dentist 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 or Insured Person himself.

30. **SURGERY** means any of the following medical procedures:

i) to incise, excise or electrocauterize any organ or body part.
ii) to repair, revise, or reconstruct any organ or body part.
iii) to reduce by manipulation a fracture or dislocation.
iv) use of endoscopy to remove a stone or object from the larnyx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or urethra.

31. **CANCER** means 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:

i) Carcinorma in situ including of the cervix;
ii) Ductal carcinorma in situ of the breast;
iii) Papilary carcinorma of the bladder & Stage 1 prostate cancer;
iv) All skin cancers except malignant melanoma;
v) Stage 1 Hodgkin’s disease;
vi) Tumours manifesting as complications of AIDS.

32. **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.

CONDITIONS

1. **AGE LIMIT**: No person shall be included for cover under this Policy who has yet to attain the age of 30 days or over the age of sixty-Five (65) years, unless the Insured Person has been continuously insured under this Policy prior to the age of sixty–six (66) years, in which case continuous insurance up to the date when the Insured Person turns one hundred and one (101) years old may be allowed.

2. **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 Insured'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 Company should give 30 days prior written notice to the Insured according to the last recorded address for any alterations made.

3. **CANCELLATION**: This Policy may be cancelled by the Insured 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 Insured shall be entitled to a refund of the premium as follows:

Period not exceeding:	Refund of Annual Premium
15 days	90% (applicable for renewals 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

4. **CONDITION PRECEDENT TO LIABILITY**: The due observance and the fulfilment of Terms and Conditions of this policy by the Insured and Insured Person in so far as they relate to anything to be done or complied with by the Insured and Insured Person shall be conditions precedent to any liability of the Company.

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

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

7. **DEDUCTIBLE**:

i) Only one Deductible shall be applicable to an Insured Person and / or his / her Dependants for injuries arising out of one or same motor vehicle accident provided all such Insured Persons are insured under this Policy.

ii) If an Insured Person is confined in a Malaysian Government Hospital for the entire treatment of a covered Disability, then the Deductible shall be reduced by 50%.

8. **GEOGRAPHICAL TERRITORY:** All benefits provided in this Policy are applicable worldwide for twenty-four (24) hours a day subject to Policy Condition on 'Overseas Treatment'.

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

10. **INCREASE OF OVERALL ANNUAL LIMIT**: If an Insured Person has been continuously covered by an active and enforceable 'Multi Medi-Plus' or 'Multi Medical Protector' policy underwritten by the Company for a period of not less than twenty-four (24) consecutive months at the first date of Hospital admission, then the Overall Annual Limit in respect of that Insured Person shall be automatically increased by thirty percent (30%).

11. **MISREPRESENTATION / FRAUD**: If the proposal or declaration of the Insured or 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.

12. **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 Policy Year. Any excess premium, which may have been paid as 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 whatsoever shall be payable.

13. **OWNERSHIP OF POLICY**: Unless otherwise expressly provided for by Endorsement in the Policy, the Company shall be entitled to treat the Insured as the absolute owner of the Policy. The Company shall not be bound to recognize any equitable or other claim to or interest in the Policy, and the receipt of the Policy or a Benefit by the Insured (or by his legal or authorized representative) alone shall be an effective discharge of all obligations and liabilities of the Company. The Insured shall be deemed to be responsible Principal or Agent of the Insured Persons covered under this Policy.

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

i) An Insured Person travelling abroad for a reason other than for medical treatment needs to be confined to a Hospital outside Malaysia as a consequence of a medical emergency.
ii) An Insured Person upon written recommendation of a Specialist and has to be transferred to a Hospital outside Malaysia because the specialized 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 was diagnosed in Malaysia and non-emergency or chronic conditions where treatment can reasonably be postponed until return to Malaysia are excluded.

15. **PERIOD OF COVER AND RENEWAL**

This Policy shall become effective as of the date stated in the Policy 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 will be renewable at the option of Insured subject to the terms, conditions and termination at each of the anniversary of the Policy date. The renewal premiums payable is not guaranteed, and the Company reserves the right to revise the premium rate applicable at the time of renewal. Such changes, if any shall be applicable to all Insured's irrespective of their claim experience according to the Company's risk assessment.

The Policy is renewable at the option of the Insured until the occurrence of any of the following:

i) non-payment of premium or premium not made on time.
ii) fraud or misrepresentation of material fact during application.
iii) the policy is cancelled at the request of the Insured.
iv) total claims of an Insured Person have reached the Lifetime Limit specified.
v) on the death of the Insured Person.
vi) the Insured Person ceases to qualify as a Dependant.
vii) the Insured Person attains the Age Limit specified.
viii) termination of coverage for all Policies of this insurance product in a certain market and the Company withdraws this insurance product completely from the market in accordance with the Portfolio Withdrawal Condition.

16. **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 Insured and the Company will run off all policies to expiry of the period of cover within the portfolio.

17. **QUALIFYING PERIOD:** Eligibility for benefits starts thirty (30) days after the Insured Person has been included in the Policy, except for a covered Accident occurring after effective date of coverage.

18. **RENEWAL:** The Company shall not be bound to give notice that any premium for renewal is due and such premium shall be deemed to be due on the date on which the Policy expires and must be paid within 14 days thereafter. However, during such 14 days the Company shall remain liable thereunder if by the last of such day the premium is actually paid unless the Company or the Insured shall have given notice that the Insurance would not be renewed.

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

20. **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 & / or Insured Person against any party and shall be entitled at its own expense to sue in the name of the Insured / Insured Person. The Insured / Insured Person shall give or cause to be given to the Company all such assistance in his / her power as the Company shall require securing 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 / Insured Person.

21. **TERMINATION OF BENEFITS**: This policy, its coverage and benefits shall terminate at mid-night (Malaysia time) on the last day of the Period of Insurance. If an Insured Person is confined to Hospital at the time of such termination, then termination shall be extended to the time he is first discharged from Hospital or the time his Overall Annual Limit & / or Lifetime Limit have been exhausted, whichever is the first to occur.

22. **THE POLICY, SCHEDULE AND ENDORSEMENT ARE TO BE READ AS ONE CONTRACT**. If a special meaning is attached to any word or expression in this Policy, the Schedule or Endorsement, it will continue to bear such meaning throughout this contract.

23. **UPGRADED BENEFITS**: If the Eligible Benefits to any Insured Person 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 Person 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.

CLAIMS PROCEDURES

1. **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 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 calendar months from date of such disclaimer.

2. **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 Insured to give must be in writing and addressed to the Company. An Insured Person shall, at the Company's request and expense, submit a medical examination report whenever such is deemed necessary.

3. **EVENT LEADING TO CLAIMS**: The Insured shall within thirty (30) days of a Disability that incurs claimable expenses, give written notice to the Company stating full particulars of such event, including all ORIGINAL bills and ORIGINAL receipts, and a full Physician's report stipulating the diagnosis of the condition treated and the date the Disability commenced in the Physician's opinion and the Physician's summary of the cost of treatment including medicines and services rendered. Failure to furnish such notice within the time allowed shall not invalid any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

4. **INCOMPLETE CLAIMS:** All claims must be submitted to the Company within thirty (30) days of completion of the events for which the claim is being made. Claims are not deemed complete and Eligible Benefits are not payable unless all bills for such claims have been submitted and agreed upon by the Company.

5. **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 reasons(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.

EXCLUSIONS

This Policy does not cover any costs, expenses or consequences caused directly or indirectly, wholly or partly, by any one of the followings:

1. Any Pre-existing Condition, except Disabilities that are declared to the Company in the Proposal form and which the Company may decide not to exclude or impose conditions on will be covered after the Insured Person has been covered under this Policy for more than twelve (12) consecutive months.

2. Specified Illnesses occurring during the first one hundred and twenty (120) days of continuous cover of an Insured Person.

3. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity.

4. Cosmetic / plastic surgery / treatment except as necessitated by Accidental Injuries occurring wholly during the Period of Insurance, eye examination, eye refraction and its correction by any means, 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, venereal disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex), and HIV (Human Immune-deficiency Virus) related diseases, treatment of alcohol dependence syndrome, illegal drugs and any communicable diseases required quarantine by law.

7. 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, sexual dysfunction, sterilization or sex changes.

9. Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestations), self-inflicted injury or attempted suicide.

10. Hospitalisation primarily for investigatory purposes, diagnosis, X-ray examination, general physical or medical examinations, or any diagnostic test 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, and treatments pertaining to weight control.

11. Costs / expenses of services of a non-medical nature, such as a television, telephones, telex services, radios or similar facilities, admission kit / pack and other ineligible non-medical items.

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

13. Racing of any kind (except foot racing), professional sports and criminal activities.

14. War or any act of war, declared or undeclared, terrorist activities, active duty in any armed force, direct participation in strikes, riots and civil commotion or insurrection.

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