PHM MediBooster Policy
(Major Medical Expenses Insurance)

FOR CONSUMER INSURANCE CONTRACTS (INSURANCE WHOLLY FOR PURPOSES UNRELATED TO THE INSURED'S TRADE, BUSINESS OR PROFESSION)

This Policy is issued in consideration of the payment of premium as specified in the Policy Schedule and pursuant to the answers given in your Proposal Form (or when you applied for this insurance) and any other disclosures made by you between the time of submission of your Proposal Form (or when you applied for this insurance) and the time this contract is entered into. The answers and any other disclosures given by you shall form part of this contract of insurance between you and us. However, in the event of any pre-contractual misrepresentation made in relation to your answers or in any disclosures given by you, only the remedies in Schedule 9 of the Financial Services Act 2013 will apply.

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

FOR NON – CONSUMER INSURANCE CONTRACTS (INSURANCE FOR PURPOSES RELATED TO THE INSURED'S TRADE, BUSINESS OR PROFESSION)

This Policy is issued in consideration of the payment of premium as specified in the Policy Schedule and pursuant to the answers given in your Proposal Form (or when you applied for this insurance) and any other disclosures made by you between the time of submission of your Proposal Form (or when you applied for this insurance) and the time this contract is entered into. The answers and any other disclosures given by you shall form part of this contract of insurance between you and us. In the event of any pre-contractual misrepresentation made in relation to your answers 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 terms or termination of your contract of insurance.

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

WHEREAS the Policyholder named in the Policy Schedule has applied to Lonpac Insurance Bhd (hereinafter called 'the Company') for the insurance herein described and has paid or agreed to pay the premium stated in the Policy Schedule as consideration for the insurance hereinafter contained.

NOW THIS POLICY WITNESSES that if the Insured Person is confined to a hospital for treatment or is surgically treated as a day case during the Period of Insurance stated in the Policy Schedule, the Company will pay to the Policyholder or his legal personal representative the sum or sums stated in Policy Schedule. Payment is subject to reasonable and customary charges and will only be made upon receipt and approval of proofs of expenses incurred.

THIS POLICY is a major medical insurance policy designed to provide additional coverage on a "top-up" basis and will only pay after the Insured Person has exhausted all other avenues of compensation from other insurances and is subject to provisions, conditions and limitations as contained herein or as may be endorsed hereon.

24/PRN/TNC/HX16/Jul v-1.4.0

SCHEDULE OF BENEFITS (on launch date: 20/09/2016)

Benefit	Plan 1	Plan 2	Plan 3
Limits of Coverage			
(a) Room and Board, per day limit incurred during the policy period	RM300	RM300	RM300
(b) Deductible Per Disability	RM50,000	RM100,000	RM150,000
(c) Per Disability Limit	RM1,000,000	RM1,000,000	RM1,000,000
(d) Overall Annual Limit	RM3,000,000	RM3,000,000	RM3,000,000
(e) Lifetime Limit	Not Applicable	Not Applicable	Not Applicable
Sub-Limits of Coverage			
Coverage provided by the following shall form part of the Per Disability Limit:			
(a) Outpatient Cancer Treatment, per annum	RM120,000	RM120,000	RM120,000
(b) Outpatient Kidney Dialysis, per annum	RM120,000	RM120,000	RM120,000

Subsequent Changes in Limits

The Room and Board Limit, Per Disability Limit and Overall Annual Limit will increase as stipulated in the Schedule of Limits.

a. The respective new limits will only apply to new policies issued or policies renewed on or after the effective date of the respective increase in limits
b. The limits applicable for the respective claims shall be the limits applicable to the policy during the first intimation of the respective claim and the increased limits will not be applicable to claims already reported.

The Deductible Per Disability shall remain unchanged throughout the whole duration of the policy.

Details of Coverage

Coverage provided by this policy comprises the following:

Before the patient is admitted to hospital or surgically treated in a hospital, the following benefits will be payable subject to reasonable, customary, and necessary expenses incurred for consultation prior to hospital admission or surgery.

a. Pre-Surgical Consultation and Diagnosis, limited to one consultation prior to surgery
b. Pre-Hospital Specialist Consultation, limited to one consultation prior to hospitalisation
c. Pre-Hospital Diagnostic Tests, related to one consultation prior to hospital admission
d. Second Surgical Opinion, limited to one consultation prior to surgery

When the patient is being treated as a bed-paying patient in a hospital or is surgically treated, the following benefits will be payable subject to reasonable, customary, and necessary expenses incurred.

a. Room and Board, incurred during the policy period of insurance
b. Intensive Care Unit, incurred during the policy period of insurance
c. Hospital Supplies and Services, incurred during the policy period of insurance
d. Surgical Fees, with post-surgery care up to 60 days from the date of surgery
e. Anaesthetist Fees
f. Operating Theatre Fees
g. In-Hospital Physician Visit, subject to two visits a day

After the patient is discharged from hospital for a non-surgical treatment, the following benefits will be payable subject to reasonable, customary, and necessary expenses incurred.

a. Post-Hospitalisation Treatment, incurred within 60 days following discharge from hospital

If the patient needs to be moved by road ambulance to an appropriate location for treatment or diagnosis, the following benefits will be payable subject to reasonable, customary, and necessary expenses incurred during the policy period of insurance.

a. Ambulance Fees

If out-patient treatment is required for treatment of an injury due to an accident, the following benefits will be payable subject to reasonable, customary, and necessary expenses incurred. Follow-up treatment is payable up to 31 days from the date of accident for each accident.

a. Emergency Accidental Outpatient Treatment
b. Emergency Dental Treatment

The following additional benefits incurred during the policy period of insurance will be payable subject to reasonable, customary, and necessary expenses incurred but shall be payable as part of the Per Disability Limit and Overall Annual Limit.

a. Organ Transplant
b. Sales and Service Tax (where applicable)
c. Medical Report Fee
d. Outpatient Cancer Treatment, subject to sub-limit stipulated in the Schedule of Benefits
e. Outpatient Kidney Dialysis, subject to sub-limit stipulated in the Schedule of Benefits

If the patient needs to be hospitalised or surgically treated, the following service will be provided by the Company's Appointed Service Provider for treatment in the Company's approved panel of hospitals.

a. Hospital Admission Assistance

SCHEDULE OF LIMITS
Plan 1

Schedule of Limits (Ringgit Malaysia)

Year	Effective Revision Date	Room & Board	Deductible Per Disability	Per Disability Limit	Overall Annual Limit	Year	Effective Revision Date	Room & Board	Deductible Per Disability	Per Disability Limit	Overall Annual Limit
1	20/09/2016	300	50,000	1,000,000	3,000,000	51	01/07/2066	810	50,000	2,700,000	8,100,000
2	01/07/2017	300	50,000	1,000,000	3,000,000	52	01/07/2067	810	50,000	2,700,000	8,100,000
3	01/07/2018	330	50,000	1,100,000	3,300,000	53	01/07/2068	810	50,000	2,700,000	8,100,000
4	01/07/2019	330	50,000	1,100,000	3,300,000	54	01/07/2069	840	50,000	2,800,000	8,400,000
5	01/07/2020	330	50,000	1,100,000	3,300,000	55	01/07/2070	840	50,000	2,800,000	8,400,000
6	01/07/2021	360	50,000	1,200,000	3,600,000	56	01/07/2071	840	50,000	2,800,000	8,400,000
7	01/07/2022	360	50,000	1,200,000	3,600,000	57	01/07/2072	870	50,000	2,900,000	8,700,000
8	01/07/2023	360	50,000	1,200,000	3,600,000	58	01/07/2073	870	50,000	2,900,000	8,700,000
9	01/07/2024	390	50,000	1,300,000	3,900,000	59	01/07/2074	870	50,000	2,900,000	8,700,000
10	01/07/2025	390	50,000	1,300,000	3,900,000	60	01/07/2075	900	50,000	3,000,000	9,000,000
11	01/07/2026	390	50,000	1,300,000	3,900,000	61	01/07/2076	900	50,000	3,000,000	9,000,000
12	01/07/2027	420	50,000	1,400,000	4,200,000	62	01/07/2077	900	50,000	3,000,000	9,000,000
13	01/07/2028	420	50,000	1,400,000	4,200,000	63	01/07/2078	930	50,000	3,100,000	9,300,000
14	01/07/2029	420	50,000	1,400,000	4,200,000	64	01/07/2079	930	50,000	3,100,000	9,300,000
15	01/07/2030	450	50,000	1,500,000	4,500,000	65	01/07/2080	930	50,000	3,100,000	9,300,000
16	01/07/2031	450	50,000	1,500,000	4,500,000	66	01/07/2081	960	50,000	3,200,000	9,600,000
17	01/07/2032	450	50,000	1,500,000	4,500,000	67	01/07/2082	960	50,000	3,200,000	9,600,000
18	01/07/2033	480	50,000	1,600,000	4,800,000	68	01/07/2083	960	50,000	3,200,000	9,600,000
19	01/07/2034	480	50,000	1,600,000	4,800,000	69	01/07/2084	990	50,000	3,300,000	9,900,000
20	01/07/2035	480	50,000	1,600,000	4,800,000	70	01/07/2085	990	50,000	3,300,000	9,900,000
21	01/07/2036	510	50,000	1,700,000	5,100,000	71	01/07/2086	990	50,000	3,300,000	9,900,000
22	01/07/2037	510	50,000	1,700,000	5,100,000	72	01/07/2087	1,020	50,000	3,400,000	10,200,000
23	01/07/2038	510	50,000	1,700,000	5,100,000	73	01/07/2088	1,020	50,000	3,400,000	10,200,000
24	01/07/2039	540	50,000	1,800,000	5,400,000	74	01/07/2089	1,020	50,000	3,400,000	10,200,000
25	01/07/2040	540	50,000	1,800,000	5,400,000	75	01/07/2090	1,050	50,000	3,500,000	10,500,000
26	01/07/2041	540	50,000	1,800,000	5,400,000	76	01/07/2091	1,050	50,000	3,500,000	10,500,000
27	01/07/2042	570	50,000	1,900,000	5,700,000	77	01/07/2092	1,050	50,000	3,500,000	10,500,000
28	01/07/2043	570	50,000	1,900,000	5,700,000	78	01/07/2093	1,080	50,000	3,600,000	10,800,000
29	01/07/2044	570	50,000	1,900,000	5,700,000	79	01/07/2094	1,080	50,000	3,600,000	10,800,000
30	01/07/2045	600	50,000	2,000,000	6,000,000	80	01/07/2095	1,080	50,000	3,600,000	10,800,000
31	01/07/2046	600	50,000	2,000,000	6,000,000	81	01/07/2096	1,110	50,000	3,700,000	11,100,000
32	01/07/2047	600	50,000	2,000,000	6,000,000	82	01/07/2097	1,110	50,000	3,700,000	11,100,000
33	01/07/2048	630	50,000	2,100,000	6,300,000	83	01/07/2098	1,110	50,000	3,700,000	11,100,000
34	01/07/2049	630	50,000	2,100,000	6,300,000	84	01/07/2099	1,140	50,000	3,800,000	11,400,000
35	01/07/2050	630	50,000	2,100,000	6,300,000	85	01/07/2100	1,140	50,000	3,800,000	11,400,000
36	01/07/2051	660	50,000	2,200,000	6,600,000	86	01/07/2101	1,140	50,000	3,800,000	11,400,000
37	01/07/2052	660	50,000	2,200,000	6,600,000	87	01/07/2102	1,170	50,000	3,900,000	11,700,000
38	01/07/2053	660	50,000	2,200,000	6,600,000	88	01/07/2103	1,170	50,000	3,900,000	11,700,000
39	01/07/2054	690	50,000	2,300,000	6,900,000	89	01/07/2104	1,170	50,000	3,900,000	11,700,000
40	01/07/2055	690	50,000	2,300,000	6,900,000	90	01/07/2105	1,200	50,000	4,000,000	12,000,000
41	01/07/2056	690	50,000	2,300,000	6,900,000	91	01/07/2106	1,200	50,000	4,000,000	12,000,000
42	01/07/2057	720	50,000	2,400,000	7,200,000	92	01/07/2107	1,200	50,000	4,000,000	12,000,000
43	01/07/2058	720	50,000	2,400,000	7,200,000	93	01/07/2108	1,230	50,000	4,100,000	12,300,000
44	01/07/2059	720	50,000	2,400,000	7,200,000	94	01/07/2109	1,230	50,000	4,100,000	12,300,000
45	01/07/2060	750	50,000	2,500,000	7,500,000	95	01/07/2110	1,230	50,000	4,100,000	12,300,000
46	01/07/2061	750	50,000	2,500,000	7,500,000	96	01/07/2111	1,260	50,000	4,200,000	12,600,000
47	01/07/2062	750	50,000	2,500,000	7,500,000	97	01/07/2112	1,260	50,000	4,200,000	12,600,000
48	01/07/2063	780	50,000	2,600,000	7,800,000	98	01/07/2113	1,260	50,000	4,200,000	12,600,000
49	01/07/2064	780	50,000	2,600,000	7,800,000	99	01/07/2114	1,290	50,000	4,300,000	12,900,000
50	01/07/2065	780	50,000	2,600,000	7,800,000						

24/PRN/TNC/HX16/Jul v-1.4.0

SCHEDULE OF LIMITS
Plan 2

Schedule of Limits (Ringgit Malaysia)

Year	Effective Revision Date	Room & Board	Deductible Per Disability	Per Disability Limit	Overall Annual Limit
1	20/09/2016	300	100,000	1,000,000	3,000,000
2	01/07/2017	300	100,000	1,000,000	3,000,000
3	01/07/2018	330	100,000	1,100,000	3,300,000
4	01/07/2019	330	100,000	1,100,000	3,300,000
5	01/07/2020	330	100,000	1,100,000	3,300,000
6	01/07/2021	360	100,000	1,200,000	3,600,000
8	01/07/2023	360	100,000	1,200,000	3,600,000
7	01/07/2022	360	100,000	1,200,000	3,600,000
9	01/07/2024	390	100,000	1,300,000	3,900,000
10	01/07/2025	390	100,000	1,300,000	3,900,000
11	01/07/2026	390	100,000	1,300,000	3,900,000
12	01/07/2027	420	100,000	1,400,000	4,200,000
13	01/07/2028	420	100,000	1,400,000	4,200,000
14	01/07/2029	420	100,000	1,400,000	4,200,000
15	01/07/2030	450	100,000	1,500,000	4,500,000
16	01/07/2031	450	100,000	1,500,000	4,500,000
17	01/07/2032	450	100,000	1,500,000	4,500,000
18	01/07/2033	480	100,000	1,600,000	4,800,000
19	01/07/2034	480	100,000	1,600,000	4,800,000
20	01/07/2035	480	100,000	1,600,000	4,800,000
21	01/07/2036	510	100,000	1,700,000	5,100,000
22	01/07/2037	510	100,000	1,700,000	5,100,000
23	01/07/2038	510	100,000	1,700,000	5,100,000
24	01/07/2039	540	100,000	1,800,000	5,400,000
25	01/07/2040	540	100,000	1,800,000	5,400,000
26	01/07/2041	540	100,000	1,800,000	5,400,000
27	01/07/2042	570	100,000	1,900,000	5,700,000
28	01/07/2043	570	100,000	1,900,000	5,700,000
29	01/07/2044	570	100,000	1,900,000	5,700,000
30	01/07/2045	600	100,000	2,000,000	6,000,000
31	01/07/2046	600	100,000	2,000,000	6,000,000
32	01/07/2047	600	100,000	2,000,000	6,000,000
33	01/07/2048	630	100,000	2,100,000	6,300,000
34	01/07/2049	630	100,000	2,100,000	6,300,000
35	01/07/2050	630	100,000	2,100,000	6,300,000
36	01/07/2051	660	100,000	2,200,000	6,600,000
37	01/07/2052	660	100,000	2,200,000	6,600,000
38	01/07/2053	660	100,000	2,200,000	6,600,000
39	01/07/2054	690	100,000	2,300,000	6,900,000
40	01/07/2055	690	100,000	2,300,000	6,900,000
41	01/07/2056	690	100,000	2,300,000	6,900,000
42	01/07/2057	720	100,000	2,400,000	7,200,000
43	01/07/2058	720	100,000	2,400,000	7,200,000
44	01/07/2059	720	100,000	2,400,000	7,200,000
45	01/07/2060	750	100,000	2,500,000	7,500,000
46	01/07/2061	750	100,000	2,500,000	7,500,000
47	01/07/2062	750	100,000	2,500,000	7,500,000
48	01/07/2063	780	100,000	2,600,000	7,800,000
49	01/07/2064	780	100,000	2,600,000	7,800,000
50	01/07/2065	780	100,000	2,600,000	7,800,000

Year	Effective Revision Date	Room & Board	Deductible Per Disability	Per Disability Limit	Overall Annual Limit
51	01/07/2066	810	100,000	2,700,000	8,100,000
52	01/07/2067	810	100,000	2,700,000	8,100,000
53	01/07/2068	810	100,000	2,700,000	8,100,000
54	01/07/2069	840	100,000	2,800,000	8,400,000
55	01/07/2070	840	100,000	2,800,000	8,400,000
56	01/07/2071	840	100,000	2,800,000	8,400,000
58	01/07/2073	870	100,000	2,900,000	8,700,000
57	01/07/2072	870	100,000	2,900,000	8,700,000
59	01/07/2074	870	100,000	2,900,000	8,700,000
60	01/07/2075	900	100,000	3,000,000	9,000,000
61	01/07/2076	900	100,000	3,000,000	9,000,000
62	01/07/2077	900	100,000	3,000,000	9,000,000
63	01/07/2078	930	100,000	3,100,000	9,300,000
64	01/07/2079	930	100,000	3,100,000	9,300,000
65	01/07/2080	930	100,000	3,100,000	9,300,000
66	01/07/2081	960	100,000	3,200,000	9,600,000
67	01/07/2082	960	100,000	3,200,000	9,600,000
68	01/07/2083	960	100,000	3,200,000	9,600,000
69	01/07/2084	990	100,000	3,300,000	9,900,000
70	01/07/2085	990	100,000	3,300,000	9,900,000
71	01/07/2086	990	100,000	3,300,000	9,900,000
72	01/07/2087	1,020	100,000	3,400,000	10,200,000
73	01/07/2088	1,020	100,000	3,400,000	10,200,000
74	01/07/2089	1,020	100,000	3,400,000	10,200,000
75	01/07/2090	1,050	100,000	3,500,000	10,500,000
76	01/07/2091	1,050	100,000	3,500,000	10,500,000
77	01/07/2092	1,050	100,000	3,500,000	10,500,000
78	01/07/2093	1,080	100,000	3,600,000	10,800,000
79	01/07/2094	1,080	100,000	3,600,000	10,800,000
80	01/07/2095	1,080	100,000	3,600,000	10,800,000
81	01/07/2096	1,110	100,000	3,700,000	11,100,000
82	01/07/2097	1,110	100,000	3,700,000	11,100,000
83	01/07/2098	1,110	100,000	3,700,000	11,100,000
84	01/07/2099	1,140	100,000	3,800,000	11,400,000
85	01/07/2100	1,140	100,000	3,800,000	11,400,000
86	01/07/2101	1,140	100,000	3,800,000	11,400,000
87	01/07/2102	1,170	100,000	3,900,000	11,700,000
88	01/07/2103	1,170	100,000	3,900,000	11,700,000
89	01/07/2104	1,170	100,000	3,900,000	11,700,000
90	01/07/2105	1,200	100,000	4,000,000	12,000,000
91	01/07/2106	1,200	100,000	4,000,000	12,000,000
92	01/07/2107	1,200	100,000	4,000,000	12,000,000
93	01/07/2108	1,230	100,000	4,100,000	12,300,000
94	01/07/2109	1,230	100,000	4,100,000	12,300,000
95	01/07/2110	1,230	100,000	4,100,000	12,300,000
96	01/07/2111	1,260	100,000	4,200,000	12,600,000
97	01/07/2112	1,260	100,000	4,200,000	12,600,000
98	01/07/2113	1,260	100,000	4,200,000	12,600,000
99	01/07/2114	1,290	100,000	4,300,000	12,900,000

SCHEDULE OF LIMITS
Plan 3

Schedule of Limits (Ringgit Malaysia)

Year	Effective Revision Date	Room & Board	Deductible Per Disability	Per Disability Limit	Overall Annual Limit
1	20/09/2016	300	150,000	1,000,000	3,000,000
2	01/07/2017	300	150,000	1,000,000	3,000,000
3	01/07/2018	330	150,000	1,100,000	3,300,000
4	01/07/2019	330	150,000	1,100,000	3,300,000
5	01/07/2020	330	150,000	1,100,000	3,300,000
6	01/07/2021	360	150,000	1,200,000	3,600,000
7	01/07/2022	360	150,000	1,200,000	3,600,000
8	01/07/2023	360	150,000	1,200,000	3,600,000
9	01/07/2024	390	150,000	1,300,000	3,900,000
10	01/07/2025	390	150,000	1,300,000	3,900,000
11	01/07/2026	390	150,000	1,300,000	3,900,000
12	01/07/2027	420	150,000	1,400,000	4,200,000
13	01/07/2028	420	150,000	1,400,000	4,200,000
14	01/07/2029	420	150,000	1,400,000	4,200,000
15	01/07/2030	450	150,000	1,500,000	4,500,000
16	01/07/2031	450	150,000	1,500,000	4,500,000
17	01/07/2032	450	150,000	1,500,000	4,500,000
18	01/07/2033	480	150,000	1,600,000	4,800,000
19	01/07/2034	480	150,000	1,600,000	4,800,000
20	01/07/2035	480	150,000	1,600,000	4,800,000
21	01/07/2036	510	150,000	1,700,000	5,100,000
22	01/07/2037	510	150,000	1,700,000	5,100,000
23	01/07/2038	510	150,000	1,700,000	5,100,000
24	01/07/2039	540	150,000	1,800,000	5,400,000
25	01/07/2040	540	150,000	1,800,000	5,400,000
26	01/07/2041	540	150,000	1,800,000	5,400,000
27	01/07/2042	570	150,000	1,900,000	5,700,000
28	01/07/2043	570	150,000	1,900,000	5,700,000
29	01/07/2044	570	150,000	1,900,000	5,700,000
30	01/07/2045	600	150,000	2,000,000	6,000,000
31	01/07/2046	600	150,000	2,000,000	6,000,000
32	01/07/2047	600	150,000	2,000,000	6,000,000
33	01/07/2048	630	150,000	2,100,000	6,300,000
34	01/07/2049	630	150,000	2,100,000	6,300,000
35	01/07/2050	630	150,000	2,100,000	6,300,000
36	01/07/2051	660	150,000	2,200,000	6,600,000
37	01/07/2052	660	150,000	2,200,000	6,600,000
38	01/07/2053	660	150,000	2,200,000	6,600,000
39	01/07/2054	690	150,000	2,300,000	6,900,000
40	01/07/2055	690	150,000	2,300,000	6,900,000
41	01/07/2056	690	150,000	2,300,000	6,900,000
42	01/07/2057	720	150,000	2,400,000	7,200,000
43	01/07/2058	720	150,000	2,400,000	7,200,000
44	01/07/2059	720	150,000	2,400,000	7,200,000
45	01/07/2060	750	150,000	2,500,000	7,500,000
46	01/07/2061	750	150,000	2,500,000	7,500,000
47	01/07/2062	750	150,000	2,500,000	7,500,000
48	01/07/2063	780	150,000	2,600,000	7,800,000
49	01/07/2064	780	150,000	2,600,000	7,800,000
50	01/07/2065	780	150,000	2,600,000	7,800,000
51	01/07/2066	810	150,000	2,700,000	8,100,000
52	01/07/2067	810	150,000	2,700,000	8,100,000
53	01/07/2068	810	150,000	2,700,000	8,100,000
54	01/07/2069	840	150,000	2,800,000	8,400,000
55	01/07/2070	840	150,000	2,800,000	8,400,000
56	01/07/2071	840	150,000	2,800,000	8,400,000
57	01/07/2072	870	150,000	2,900,000	8,700,000
58	01/07/2073	870	150,000	2,900,000	8,700,000
59	01/07/2074	870	150,000	2,900,000	8,700,000
60	01/07/2075	900	150,000	3,000,000	9,000,000
61	01/07/2076	900	150,000	3,000,000	9,000,000
62	01/07/2077	900	150,000	3,000,000	9,000,000
63	01/07/2078	930	150,000	3,100,000	9,300,000
64	01/07/2079	930	150,000	3,100,000	9,300,000
65	01/07/2080	930	150,000	3,100,000	9,300,000
66	01/07/2081	960	150,000	3,200,000	9,600,000
67	01/07/2082	960	150,000	3,200,000	9,600,000
68	01/07/2083	960	150,000	3,200,000	9,600,000
69	01/07/2084	990	150,000	3,300,000	9,900,000
70	01/07/2085	990	150,000	3,300,000	9,900,000
71	01/07/2086	990	150,000	3,300,000	9,900,000
72	01/07/2087	1,020	150,000	3,400,000	10,200,000
73	01/07/2088	1,020	150,000	3,400,000	10,200,000
74	01/07/2089	1,020	150,000	3,400,000	10,200,000
75	01/07/2090	1,050	150,000	3,500,000	10,500,000
76	01/07/2091	1,050	150,000	3,500,000	10,500,000
77	01/07/2092	1,050	150,000	3,500,000	10,500,000
78	01/07/2093	1,080	150,000	3,600,000	10,800,000
79	01/07/2094	1,080	150,000	3,600,000	10,800,000
80	01/07/2095	1,080	150,000	3,600,000	10,800,000
81	01/07/2096	1,110	150,000	3,700,000	11,100,000
82	01/07/2097	1,110	150,000	3,700,000	11,100,000
83	01/07/2098	1,110	150,000	3,700,000	11,100,000
84	01/07/2099	1,140	150,000	3,800,000	11,400,000
85	01/07/2100	1,140	150,000	3,800,000	11,400,000
86	01/07/2101	1,140	150,000	3,800,000	11,400,000
87	01/07/2102	1,170	150,000	3,900,000	11,700,000
88	01/07/2103	1,170	150,000	3,900,000	11,700,000
89	01/07/2104	1,170	150,000	3,900,000	11,700,000
90	01/07/2105	1,200	150,000	4,000,000	12,000,000
91	01/07/2106	1,200	150,000	4,000,000	12,000,000
92	01/07/2107	1,200	150,000	4,000,000	12,000,000
93	01/07/2108	1,230	150,000	4,100,000	12,300,000
94	01/07/2109	1,230	150,000	4,100,000	12,300,000
95	01/07/2110	1,230	150,000	4,100,000	12,300,000
96	01/07/2111	1,260	150,000	4,200,000	12,600,000
97	01/07/2112	1,260	150,000	4,200,000	12,600,000
98	01/07/2113	1,260	150,000	4,200,000	12,600,000
99	01/07/2114	1,290	150,000	4,300,000	12,900,000

DEFINITIONS

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

2. **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 remains 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.

3. **AS CHARGED** refers to actual charges incurred for reasonable, necessary and customary medical care provided in the treatment of an insured disability.

4. **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 recognised educational institution.

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

6. **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.

7. **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).

8. **DEDUCTIBLE PER DISABILITY** refers to the amount of expenses that the Policyholder will bear for each disability. Only the amount exceeding this deductible (and all other avenues of compensation from other insurance policies) will be payable by this policy.

9. **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.

10. **DEPENDANT** shall mean any of the following persons:
    a. a legally married spouse
    b. unmarried children over 30 days old but under nineteen (19) years of age or twenty-three (23) years of age and is still pursuing full-time higher education, and who are not gainfully employed.

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

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

13. **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.

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

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

16. **INJURY** shall mean bodily injury caused solely by Accident.

17. **INSURED** shall mean the Policyholder described in the Policy Schedule.

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

19. **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.

20. **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, and
    e. for which the charges are fair and reasonable and customary for the Disability.

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

22. **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 has been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining policy year.

23. **PARENT** refers to the Policyholder's mother or father whose age does not exceed 70 years at next birthday at the time of purchasing the insurance policy.

24. **PER DISABILITY LIMIT**
Benefits payable in respect of expenses incurred for treatment provided to the Insured Person during the period of insurance shall be limited to Per Disability Limit as stated in the Schedule of Benefits. A disability shall be deemed to be the same disability unless 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. The Per Disability Limit stipulated in the Schedule of Benefits refers to the maximum amount payable over and above the Deductible Per Disability.

25. **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. The Policyholder shall also be referred to as the Insured.

26. **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.

27. **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.

28. **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.

29. **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.

30. **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.

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

32. **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.

33. **SURGERY** shall mean any of the following medical procedures:
a. to incise, excise or electro-cauterize 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.

DESCRIPTION OF BENEFITS

1. **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 exceeds, 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.

2. **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.

3. **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.

4. **PRE-SURGICAL CONSULTATION & DIAGNOSIS**
Specialists' fees for consultation, pathology and radiography following referral from a general practitioner, for each illness or injury requiring confinement in a hospital. Benefit is not payable for outpatient treatment (including medications and any subsequent consultations after the illness is diagnosed), nor if the patient is not subsequently surgically treated after such diagnostic services have been performed.

5. **PRE-HOSPITAL SPECIALIST CONSULTATION**
Reimbursement of the Reasonable and Customary Charges for a first-time consultation by a Specialist in connection with a Disability within the maximum number of days as set forth in the Schedule of Benefits 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.

6. **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 Benefits 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.

7. **SECOND SURGICAL OPINION**
Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary consultation or opinion with the second specialist to determine whether a surgical operation is necessary or required in view of the Insured Person's medical condition up to maximum amount and number of days as set forth in the Schedule of Benefits. Payment is limited to one (1) consultation prior to surgery. Payment will not be made if the Insured Person does not undergo surgery for the medical condition diagnosed.

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

9. **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.

10. **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.

11. **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 Benefits.

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

13. **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.

14. **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 Medically 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 days as set forth in the Schedule of Benefits.

15. **EMERGENCY DENTAL TREATMENT**
Reimburses expenses incurred as a result of an injury to wholly sound natural teeth arising from an Accident for treatment as an outpatient at any registered dental clinic or hospital within 24 hours of the Accident causing the Injury. Follow-up treatment by the same dentist at the same registered dental clinic or Hospital will be provided up to the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

16. **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 Benefits. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

17. **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 Benefits.

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.

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Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered necessary. The cancer must be confirmed by histological evidence of malignancy. The following conditions are excluded:

a. Carcinoma in situ including of the cervix;
b. Ductal Carcinoma in situ of the breast;
c. Papillary Carcinoma of the bladder & Stage 1 Prostate Cancer;
d. All skin cancers except malignant melanoma;
e. Stage 1 Hodgkin's disease;
f. Tumours manifesting as complications of AIDS.

It is a specific condition of this Benefit that notwithstanding the exclusion of pre-existing conditions, this Benefit will not be payable for any Insured who had been diagnosed as a cancer patient and/or is receiving cancer treatment prior to the effective date of Insurance.

18. 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 Benefits.

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.

19. MEDICAL REPORT FEE

It is hereby declared and agreed that notwithstanding anything contained herein to the contrary, the policy is extended to reimburse Medical Report Fee not exceeding the amount stated in the Schedule of Benefits in respect of each disability.

20. SALES AND SERVICE TAX (where applicable)

Reimburses the actual amount of sales and service tax payable in respect of treatment received for illnesses or conditions covered under the policy.

21. HOSPITAL ADMISSION ASSISTANCE

If an Insured Person requires inpatient treatment or surgery in a hospital listed in the Company's Approved Panel of Hospitals, the Company's Appointed Service Provider shall provide assistance in the hospital admission and settlement of the payment to the hospital. Where the insured plan is subject to a Deductible, the Policyholder shall pay to the hospital the Deductible amount and all uninsured expenses. The Company's Appointed Service Provider shall only be responsible for arranging the settlement of amounts exceeding the Deductible and other uninsured expenses. In the event of overpayment by the Appointed Service Provider, the Company's Appointed Service Provider reserves the right to recover the excess payment from the Policyholder.

GENERAL PROVISIONS

1. PERSONS ELIGIBLE

Persons eligible to be covered under this Policy are:-

a. Policyholder age up to 70 on the first inception date of insurance, or
b. Policyholder's legal spouse age up to 70 on the first inception date of insurance, unless legally separated from the Policyholder, or
c. Policyholder's child 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 recognised educational institution, or
d. Policyholder's parent age up to 70 on the first inception date of insurance.

2. PERIOD OF INSURANCE 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 will be renewable at the option of policyholder subject to the terms, conditions and termination at each of the anniversary of the Policy date. During renewal, the terms and conditions of coverage shall not be amended.

The renewal premiums payable is not guaranteed and the Company shall revise the premium rate every three years and the respective revised premium shall be applicable at the time of renewal. Such changes, if any, shall be applicable to all policyholders irrespective of their claim experience according to the Company's risk assessment.

This policy is renewable at the option of policyholder until the occurrence of any of the following:

a. non-payment of premium or premium not made on time
b. fraud or misrepresentation of material fact during application
c. the policy is cancelled at the request of the policyholder
d. on the death of the Insured Person
e. the Insured Person ceases to qualify as a dependant based on the definition of the policy

The Company will give thirty (30) days written notice prior to Policy renewal in the event of premium revision.

3. GEOGRAPHICAL TERRITORY

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

4. SUCCEEDING POLICYHOLDER

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

b. When an Insured Person ceases to be a dependent child, the Insured Person may continue to renew the policy in the Insured Person's own name as a policyholder and all references in this Policy to the Policyholder shall thereafter mean such Insured Person.

5. VALIDITY PERIOD

This product shall only be valid from the launch date. The launch date is 20 September 2016 and the product will no longer be valid after 30 June 2115.

6. PREMIUM PRICING

The pricing of the premium and all subsequent revisions shall be done on a portfolio basis. New applications will be subjected to individual underwriting and premium loadings applicable at the first inception date will be applicable to the standard premium rates as well as all subsequent revisions.

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. Pre-existing illness.

2. 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.

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

4. 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.

5. 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 requiring quarantine by law.

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

7. Pregnancy, childbirth (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.

8. 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.

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

10. 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.

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

12. 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.

13. 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.

14. 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 Person and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.

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

16. 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.

17. 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.

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

19. Expenses incurred for sex change.

GENERAL CONDITIONS

1. AMENDMENTS

No amendment to this policy shall be valid unless mutually agreed upon by the Company and the Policyholder, and such amendment is endorsed thereon.

2. 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.

3. 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.

4. CANCELLATION OF POLICY

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 follows:-

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

5. CASH BEFORE COVER

It is fundamental and absolute special condition of this contract of insurance that the premium due must be paid and received by the Company before insurance cover is effective.

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. CLAIMS PROCEDURES

a. The Insured shall within 30 days of a Disability that incurs claimable expenses, give written notice to the Company stating full particulars of such event, including all original bills and receipts, and a full Physician’s report stipulating the diagnosis of the condition treated and the date the Disability commenced in the Physician's opinion and the Physician's summary of the cost of treatment including medicines and services rendered. Failure to furnish such notice within the time allowed shall not invalid any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.
b. The Insured shall immediately procure and act on proper medical advice and the Company shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured to do so.

8. 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.

9. 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.

10. 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 issuance of the Policy.

11. CONVERSION POLICIES (applicable only if specified in the Policy Schedule)

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 Person 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.

12. 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.

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13. FULL REIMBURSEMENT IN A GOVERNMENT HOSPITAL

Charges for eligible medical expenses are covered in full for treatment in a Malaysian Government Hospital for each Illness or Injury, provided the claimant does not transfer from or to a private hospital for treatment and the room and board charge is not greater than that provided under the chosen Plan applicable to the claimant. These charges are only payable for amounts exceeding the Deductible Per Disability.

14. GOVERNING LAW

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

15. GRACE PERIOD

Notwithstanding the Cash Before Cover Condition, a Grace Period of fourteen (14) days following the expiry date shall be allowed to the Policyholder for the payment of any premiums after the first policy year. If any premium is not paid in respect of this Policy or any supplementary contracts before the end of the Grace Period, this Policy and the relevant supplementary contracts shall be deemed as terminated at the expiry date of the policy. Even if payment is made during the grace period any disability occurring during the period from the expiry date to the payment date shall not be payable.

16. 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. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing shall be at the Company's sole discretion.

17. 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.

18. LOCAL TREATMENT CLAUSE

Notwithstanding anything contained herein to the contrary, if the Insured Person is not a Malaysian, the coverage and benefits provided by this Policy shall be limited to treatment in Malaysia only.

19. MISSTATEMENT OR OMISSION OF MATERIAL FACT

If:

a. any answer, disclosure or representation by the Policyholder, before this contract of insurance is entered into, varied or renewed, in or to any proposal or declaration or query, has been deliberately or recklessly stated in any respect; or
b. before this contract of insurance is entered into, varied or renewed, the Policyholder failed to disclose any fact he/she knew to be relevant to the Company decision on whether to accept this risk or not and the rates and the terms to be applied; or
c. any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support of such claim.

then in any of the above cases, this Policy shall be void.

20. 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.

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. OVERSEAS TREATMENT

If the 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:

a. 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.
b. 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.

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23. 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 authorized 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.

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

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

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

27. TERMINATION OF INSURED PERSON AND COMPANY LIABILITY
An Insured Person shall cease to be an Insured Person:-

a. for children, on the anniversary following attainment of the 19th birthday or 23rd birthday for those registered as full time students at a recognised educational institution.
b. on the date of termination of the Policy or any person's coverage.

In any case the Company's liability shall cease with the date of termination of the policy or any person's coverage.

28. UPGRADED POLICIES (applicable only if specified in the Policy Schedule)
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.

29. 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.

30. WAITING 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 the effective date of coverage.

DUTY OF DISCLOSURE

Consumer Insurance Contracts
Where you have applied for this Insurance wholly for yourself/family/dependants, you have a duty to take reasonable care not to make a misrepresentation in answering the questions in the Proposal Form (or when you applied for this insurance) i.e. you should have answered the questions fully and accurately. Failure to have taken 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 accordance with the remedies in Schedule 9 of the Financial Services Act 2013. You are also required to disclose any other matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied.

You also 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.

Non-Consumer Insurance Contracts
Where you have applied for this Insurance for the purpose of providing insurance benefits to your employees and their family/dependants, you have a duty to disclose any matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant otherwise it 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.

You also 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.

IMPORTANT NOTICE

This Policy with its conditions should be carefully examined and in the event of any correction being found necessary, should be communicated to the Company at once.

Notice of every accident whether a claim is anticipated or not under this Policy should be given immediately to the nearest office of the Company.

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