MediSaversVIP Prime Policy
(Hospitalisation and Surgical 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 the 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 comprises the following Sections:

Section A – Basic Coverage
The benefits provided by Section A is as per the insured Plan specified in the Policy Schedule. Section A is a compulsory section of this Policy.

Section B – Optional Top-Up Insurance
Section B is an optional extension and is only payable if the Policy is extended to cover Section B as specified in the Policy Schedule.

THIS POLICY is subject to provisions, conditions and limitations as contained herein or as may be endorsed hereon.

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SCHEDULE OF BENEFITS
Section A – BASIC COVERAGE

Section	Benefit	Plan 500 (RM)	Plan 300 (RM)	Plan 200 (RM)	Plan 150 (RM)
A	**BASIC COVERAGE**				
	1. Limits of Coverage				
	a. Room and Board, per day limit incurred during the policy period	500	300	200	150
	b. Per Disability Limit	500,000	300,000	200,000	150,000
	c. Overall Annual Limit	1,500,000	900,000	600,000	450,000
	2. Before the patient is admitted to hospital or surgically treated in a hospital a. Pre-Surgical Consultation & Diagnosis b. Pre-Hospital Specialist Consultation c. Pre-Hospital Diagnostic Tests d. Second Surgical Opinion	As Charged, subject to reasonable, customary and necessary expenses which are incurred within 31 days prior to hospital admission or surgery			
	3. When the patient is being treated as a bed-paying patient in a hospital or is surgically treated a. Intensive Care Unit b. Hospital Supplies & Services c. Surgical Fees (including Anaesthetist & Operating Theatre Fees) d. In-hospital Physician Visit not exceeding two visits a day	As Charged, subject to reasonable, customary and necessary expenses which are incurred during the policy period			
	4. After the patient is discharged from hospital for a non-surgical treatment a. Post Hospitalisation Treatment	As Charged, subject to reasonable, customary and necessary expenses which are incurred up to 60 days from the date of discharge from the hospital			
	5. If the patient needs to be moved by road ambulance to an appropriate location for treatment or diagnosis a. Ambulance Fees	As Charged, subject to reasonable, customary and necessary expenses which are incurred during the policy period			
	6. If outpatient treatment is required for injury due to an accident a. Emergency Accidental Outpatient Treatment b. Emergency Accidental Outpatient Dental Treatment	As Charged, subject to reasonable, customary and necessary expenses which are required to treat an injury due to an accident. Follow-up treatment is payable up to 31 days from the date of accident for each accident			
	7. Specific Outpatient Treatments a. Outpatient Cancer Treatment b. Optional Advanced Outpatient Cancer Treatment (applicable only if specified in the Policy Schedule) c. Outpatient Kidney Dialysis Treatment	As Charged, subject to reasonable, customary and necessary expenses which are incurred during the policy period			
	8. Other Benefits a. Insured Child's Daily Guardian Benefit b. Sales and Service Tax (where applicable) c. Medical Report Fee, per disability	As Charged, subject to reasonable, customary and necessary expenses which are incurred during the policy period			
	d. Daily Cash Allowance at Malaysian Government Hospital (up to 60 days)	250	200	150	100
	9. If the Insured Person requires inpatient treatment in any of the Company's approved panel of hospitals a. Hospital Admission Assistance	Provided by the Company's Appointed Service Provider			

Section A – BASIC COVERAGE
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** shall mean a patient who needs the use of a recovery facility for a surgical procedure on a pre-planned basis at the hospital / specialist clinic (but not for overnight stay).

8. **DEDUCTIBLE** refers to the amount of expenses that the Policyholder will bear for each disability. Only the amount exceeding this deductible 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 if still on 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 inpatient for Medically Necessary treatments for a covered Disability upon recommendation of a physician. A patient shall not be considered as an inpatient if the patient does not physically stay in the hospital for the whole period of confinement.

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. **OUTPATIENT** 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** shall mean 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** shall mean 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.

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.

34. **WAITING PERIOD** shall mean the first thirty (30) days between the beginning of an Insured Person's disability and the commencement of this Policy date/reinstatement date and is applied only when the person is first covered. This shall not be applicable after the first year of cover. However, if there is a break in insurance, the Waiting Period will apply again.

Section A – BASIC COVERAGE
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 exceed, for any one day, the rate of Room and Board Benefit, and the maximum number of days as set forth in the Schedule of Benefits. The Insured Person will only be entitled to this benefit while confined to a Hospital as an inpatient.

2. **INTENSIVE CARE UNIT**
Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an inpatient 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 inpatient in a Hospital, up to the amount stated in the Schedule of Benefits.

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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 Insured Person 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 the first-time consultation by a Specialist in connection with a Disability within the maximum number of days as set forth in the Schedule of Benefit preceding confinement in a Hospital and provided that such consultation is Medically Necessary and has been recommended in writing by the attending general practitioner. Payment will not be made for clinical treatment (including medications and subsequent consultation after the illness is diagnosed) or where the Insured Person 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 Benefit in a Hospital and which are recommended by a qualified medical practitioner. No payment shall be made if upon such diagnostic services, the Insured Person 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 within the number of days as set forth in the Schedule of Benefits. Payment is limited to one 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 visit to an in-paying patient while confined for a non-surgical disability subject to a maximum of 2 visits per day not exceeding the maximum number of days as set forth in the Schedule of Benefit.

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 of 60 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 Benefit.

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 as 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 of days as set forth in the Schedule of Benefits.

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

17. 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.

18. 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.

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

20. 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.

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

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

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

a. Carcinoma in situ including of the Cervix;
b. Ductal Carcinoma in situ of the Breast;
c. Papillary Carcinoma of the Bladder & Stage 1 Prostate Cancer;
d. All Skin Cancers except Malignant Melanoma;
e. Stage 1 Hodgkin's Disease;
f. Tumours manifesting as complications of AIDS.

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

22. OPTIONAL ADVANCED OUTPATIENT CANCER TREATMENT (applicable only if specified in the Policy Schedule)
If an Insured Person 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 an outpatient department of a Hospital or a legally registered Cancer treatment centre subject to the limit of this disability as specified in the Schedule of Benefit.

Such treatment shall:

1. include but not be limited to Chemotherapy, Radiotherapy, Targeted Therapy, Immunotherapy, and Hormonal Therapy.
2. has been proven effective according to established local, regional, and international medical standards and duly approved by the National Pharmaceutical Regulatory Agency of Malaysia and/or the Ministry of Health, Malaysia at the time such treatment is rendered. Experimental, investigational, research, preventive, and/or screening treatments are excluded.
3. include specialist consultations, related examinations, laboratory and/or diagnostic tests, and Cancer medications, provided that such consultations, examinations, tests, and medications are performed/prescribed on the day the Outpatient Cancer Treatment is rendered and by the same specialist who prescribed the Outpatient Cancer Treatment.
4. cover Cancer-related Molecular Profiling which aims at assisting Specialist in selecting optimal Cancer treatments for diagnosed Cancer patients, including the cost of laboratory preparation of tissue sample, up to a Lifetime Limit of RM15,000. Genetic Testing which primarily screens for gene mutations in individuals without a Cancer diagnosis is excluded.

This benefit also reimburses expenses incurred for specialist consultations, related examinations, and laboratory and/or diagnostic tests within 31 days prior to the first Outpatient Cancer Treatment session. Payment will not be made for any subsequent consultations, examinations, and laboratory and/or diagnostic tests after diagnosis of Cancer has been confirmed.

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 Person who had been diagnosed as a Cancer patient and/or is receiving Cancer treatment prior to the date this benefit is first covered.

This benefit shall not cover any claim whereby the signs and/or symptoms first occur within the first one hundred and twenty (120) days, from the date this benefit is first covered.

Surveillance or prevention of Cancer shall not be covered.

This Optional Advanced Outpatient Cancer Treatment Benefit is only applicable to policyholders who have opted for both Section A (Basic Coverage) and Section B (Optional Top-Up Insurance) of MediSaversVIP Prime.

23. OUTPATIENT KIDNEY DIALYSIS TREATMENT

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

Such treatment (dialysis excluding consultation, examination tests, take-home drugs) must be received at the outpatient 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 Person who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the effective date of Insurance.

Section A – BASIC COVERAGE
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.

Section A – BASIC COVERAGE
SPECIFIC CONDITIONS

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

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

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SCHEDULE OF BENEFITS (on launch date: 01/07/2021)
Section B – OPTIONAL TOP-UP INSURANCE

This is a major medical insurance extension and the benefits provided by Section B will only be paid after the Insured Person has exhausted all the limits under Section A of this policy and all other avenues of compensation from other insurance policies. Extension of this Benefit is optional, and the Benefit is only valid if the extension is specified in the Policy Schedule.

Section	Benefit	
B	**OPTIONAL TOP-UP INSURANCE**	
	1. Limits of Coverage	
	a. Room and Board, per day limit incurred during the policy period	As per Basic Plan
	b. Per Disability Limit	1,000,000
	The Per Disability Limit will be increased by RM100,000 every three (3) years from the Product Launch Date, subject to the following: a. The new Per Disability Limit will only apply to new policies issued or policies renewed on or after the effective date of the increase in limit; b. The Per Disability Limit applicable for the respective claims shall be the limit applicable to the policy during the first loss date of the respective claim and the new Per Disability Limit will not be applicable to claims already incurred prior to the effective date of the increase in limit.	
	2. Before the patient is admitted to hospital or surgically treated in a hospital a. Pre-Surgical Consultation & Diagnosis b. Pre-Hospital Specialist Consultation c. Pre-Hospital Diagnostic Tests	As Charged, subject to reasonable, customary and necessary expenses which are incurred within 31 days prior to hospital admission or surgery
	3. When the patient is being treated as a bed-paying patient in a hospital or is surgically treated a. Intensive Care Unit b. Hospital Supplies & Services c. Surgical Fees (including Anaesthetist & Operating Theatre Fees) d. In-hospital Physician Visit not exceeding two visits a day	As Charged, subject to reasonable, customary and necessary expenses which are incurred during the policy period
	4. After the patient is discharged from hospital for a non-surgical treatment a. Post Hospitalisation Treatment	As Charged, subject to reasonable, customary and necessary expenses which are incurred up to 60 days from the date of discharge from the hospital
	5. If the patient needs to be moved by road ambulance to an appropriate location for treatment or diagnosis a. Ambulance Fees	As Charged, subject to reasonable, customary and necessary expenses which are incurred during the policy period
	6. If outpatient treatment is required for injury due to an accident a. Emergency Accidental Outpatient Treatment b. Emergency Accidental Outpatient Dental Treatment	As Charged, subject to reasonable, customary and necessary expenses which are required to treat an injury due to an accident. Follow-up treatment is payable up to 31 days from the date of accident for each accident
	7. Specific Outpatient Treatments a. Outpatient Cancer Treatment b. Optional Advanced Outpatient Cancer Treatment (applicable only if specified in the Policy Schedule) c. Outpatient Kidney Dialysis Treatment	As Charged, subject to reasonable, customary and necessary expenses which are incurred during the policy period
	8. Other Benefits a. Insured Child's Daily Guardian Benefit b. Sales and Service Tax (where applicable) c. Medical Report Fee, per disability d. Daily Cash Allowance at Malaysian Government Hospital (up to 60 days)	As Charged, subject to reasonable, customary and necessary expenses which are incurred during the policy period As per Basic Plan

Section B – OPTIONAL TOP-UP INSURANCE
DEFINITIONS

Definitions stipulated in Section A of this Policy shall apply to Section B.

Section B – OPTIONAL TOP-UP INSURANCE
DESCRIPTION OF BENEFITS

Description of Benefits stipulated in Section A of this Policy shall apply to Section B.

Section B – OPTIONAL TOP-UP INSURANCE
EXCLUSIONS

Exclusions stipulated in Section A of this Policy shall apply to Section B.

Section B – OPTIONAL TOP-UP INSURANCE
SPECIFIC CONDITIONS

Specific Conditions stipulated in Section A of this Policy shall apply to Section B.

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; renewable up to age of 100 years, or
b. Policyholder's legal spouse age up to 70 on the first inception date of insurance; renewable up to age of 100 years, unless legally separated from the Policyholder, or
c. Policyholder's child who has attained the age of 30 days on the first inception date of insurance 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; renewable up to age of 100 years, or
e. Policyholder's employee age up to 70 on the first inception date of insurance; renewable up to age of 100 years.

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 (1) 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.

At the renewal stage, the Company shall not make any changes or amendments to the terms and conditions applicable to the renewed policy. The terms and conditions shall remain unchanged unless there is/are material change(s) to the Insured Person's occupation, business, duties or pursuits or there had been a misstatement or omission of material fact by the Insured/Insured Person before or at the time the insurance contract was first entered into.

The renewal premium 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 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 payment 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
f) the Insured Person attains the coverage age limit specified
g) termination of coverage for all policies in a certain market and the company withdraws this policy completely from the market in accordance with the Portfolio Withdrawal Condition

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

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.
c. In the event of an Employee leaving the employment with the Policyholder while this Policy is in force, the Employee shall automatically become the Policyholder and all references in this Policy to the Policyholder shall thereafter mean the said Employee.

5. PRODUCT LAUNCH DATE

The product launch date was 01 July 2021.

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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.

GENERAL CONDITIONS

1. AMENDMENTS

Subject to the foregoing, the Company reserves the right to amend the terms and provisions of this Policy. Such amendment will be applicable at the next renewal of this Policy. No amendment to this Policy shall be valid unless it is authorised by the Company and such approval is endorsed thereon. The Company should give thirty (30) days prior written notice to the Policyholder according to the last recorded address for any amendments made.

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 follow:

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 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 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.

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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 issue of the Policy.

11. 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.

12. DEDUCTIBLE

The Insured has the option to choose a Deductible under the Basic Coverage. The Deductible shall be deducted from the eligible medical expenses, on a per Disability basis.

The Insured can choose to increase, decrease or remove the Deductible upon Policy Anniversary. Any decrease or removal in Deductible limit would require re-underwriting and the Company retains the absolute right to decide whether to approve such request.

No midterm amendment to the Deductible is allowed.

13. GOVERNING LAW

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

14. 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.

15. 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.

16. 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.

17. 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 our 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.

18. 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.

19. 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 initialed by an authorised representative of the Company.

20. 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.

21. PORTFOLIO WITHDRAWAL CONDITION

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

22. 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.

23. TERMINATION OF INSURED PERSON AND COMPANY LIABILITY

An Insured Person shall cease to be an Insured Person on:

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. 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.

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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