GROUP HOSPITALISATION AND SURGICAL SCHEME

THIS POLICY is issued in consideration of Your payment or agreement to pay premium to Us for benefits as described below subject to the terms, provisions, exclusions, limitations and conditions of and endorsed in this Policy. While this Policy is in force, We agree to pay You upon eligible Insured Member(s) incurring Medically Necessary expenses due to Accident, Sickness, Disease or Illness in accordance with the benefits described in the Schedule of Benefits to the extent and in a manner provided in this Policy.

1. PAYMENT OF PREMIUMS PROVISIONS

1.1. The premium rate is determined at the commencement of the Policy and shall be determined every year on each Policy Anniversary. We reserve the right to establish, at the end of any policy period or whenever the terms of the Policy are changed, new premium rates at which subsequent premiums shall be computed. The premium rate determined shall be applied in calculating premium adjustments in respect of any Insured Member joining or leaving the Scheme during the Policy Year. Extra premiums may be added on account of those Insured Members who do not satisfy Our standard health requirements as stipulated in Participation Provisions of this Policy and those who are engaged in hazardous occupations.

1.2. All premiums on the Policy are to be paid to Our Head Office in Malaysia, or to Our branch offices designated by Us for this purpose.

1.3. The premium including any subsequent renewal premium and the premium accounted due to adjustments must be paid within the premium grace period of sixty (60) days from the Policy Effective Date or the date of invoice issued by Us, whichever is later. We reserve the right to terminate or suspend this Policy if the premium is not paid at the end of the premium grace period. In the event that a covered event occurs during the grace period giving rise to a claim payment and the premium remains unpaid at the time of claim payment, We reserve the right to either set off the outstanding premium from the claim payment or hold the claim payment until the outstanding premium has been paid.

1.4. In the event of termination of Policy pursuant to Clauses 5.1.7 and 5.1.8, You shall be liable for the pro-rated premium for the period the insurance continued to be in force after the due date and up to the date of termination of Policy.

1.5. We will furnish You with a statement of each premium due, which shall include a record of premium adjustments, if any. Premium adjustments involving return of unearned premiums to You shall be limited to the period of twelve (12) months immediately preceding the date of receipt by Us of evidence that such adjustments should be made.

1.6. We will set-off any outstanding premium against premium refundable due to You, if applicable.

2. BENEFITS PROVISIONS

While this Policy is in force, We shall, subject to the provisions contained in it, pay the following benefits:

2.1. HOSPITALISATION AND SURGICAL BENEFIT

If an Insured Member is Hospitalised on the recommendation of a Physician/ Doctor, We will, upon request and receipt of satisfactory supporting documents, provide the following benefits subject to the condition that the following benefits have not been compensated by any other parties or sources and further subject to the limits as specified in the Schedule of Benefits during Any One Period of Disability.

2.1.1. HOSPITAL ROOM & BOARD

Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Member's confinement, but in no event shall the benefit exceed, for any one (1) day, the rate of Room and Board benefit, subject to the limit as specified in the Schedule of Benefits. The Insured Member will only be entitled to this benefit while Hospitalised.

2.1.2. INTENSIVE CARE UNIT

Reimbursement of the Reasonable and Customary Charges for actual Medically Necessary room and board incurred during the Insured Member's Hospitalisation in the Intensive Care Unit of the Hospital. This benefit shall be equal to the actual charges made by the Hospital as specified in the Schedule of Benefits. No Hospital Room and Board benefit shall be paid for the same confinement period where the daily Intensive Care Unit benefit is payable.

2.1.3. HOSPITAL SUPPLIES AND SERVICES

Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary:

2.1.3.1. general nursing;
2.1.3.2. prescribed and consumed drugs and medicines;
2.1.3.3. dressings, splints, plaster casts;
2.1.3.4. x-ray;
2.1.3.5. laboratory examinations;
2.1.3.6. electrocardiograms (ECG);
2.1.3.7. physiotherapy;
2.1.3.8. basal metabolism tests;
2.1.3.9. intravenous injections and solutions; and
2.1.3.10. administration of blood and blood plasma, but excluding the cost of blood and plasma.

whilst the Insured Member is Hospitalised ,subject to the limit as specified in the Schedule of Benefits.

2.1.4. SURGICAL FEES

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary Surgery by a Specialist, including the Specialist's pre-surgical assessment and Medically Necessary visits to the Insured Member while the Insured Member is Hospitalised, subject to the limit as specified 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.

2.1.5. ANAESTHETIST FEES

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia, subject to the limit as specified in the Schedule of Benefits.

2.1.6. OPERATING THEATRE FEES

Reimbursement of the Reasonable and Customary Charges for the operating room incidental to the Medically Necessary surgical procedure, subject to the limit as specified in the Schedule of Benefits.

2.1.7. IN-HOSPITAL PHYSICIAN VISIT

Reimbursement of the Reasonable and Customary Charges by a Physician/ Doctor for the Medically Necessary visits in respect of the Insured Member who is Hospitalised for a non-surgical Disability subject to a maximum of two (2) visits per day within the maximum number of days as specified in the Schedule of Benefits.

2.1.8. PRE-HOSPITALISATION DIAGNOSTIC TESTS

Reimbursement of the Reasonable and Customary Charges for Medically Necessary ECG, X-ray and laboratory tests which are performed in a Hospital for diagnostic purposes on account of an Injury or Sickness, Disease or Illness in connection with a Disability and are incurred within the maximum number of days as specified in the Schedule of Benefits and which are recommended by a Physician/ Doctor. Payment shall be made only if after such diagnostic services, the Insured Member is subsequently Hospitalised for the treatment of the medical condition diagnosed. Medications and consultations charged by the Physician/ Doctor will not be payable.

2.1.9. PRE-HOSPITALISATION SPECIALIST CONSULTATION

Reimbursement of the Reasonable and Customary Charges for the consultation with a Specialist in connection with a Disability which is incurred within the maximum number of days as specified in the Schedule of Benefits, provided that such consultation is Medically Necessary.

Payment for the consultations (including medications and treatments) under this benefit shall only be payable if the Insured Member is subsequently Hospitalised for the treatment of the medical condition diagnosed.

2.1.10. SECOND SURGICAL OPINION

Reimbursement of the Reasonable and Customary Charges incurred for a consultation with or seeking the opinion of a second specialist to determine whether a surgical operation is necessary or required in view of the Insured Member's medical condition. Payment is made only if the Insured Member is subsequently Hospitalised for Surgery and if charges are incurred within the period as specified in the Schedule of Benefits prior to such Hospitalisation.

2.1.11. POST-HOSPITALISATION TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary follow-up treatment for a surgical or non-surgical Disability by the same attending Physician/ Doctor, subject to the

limit as specified in the Schedule of Benefits. This shall include Medically Necessary physiotherapy as recommended by the attending Physician/ Doctor, where applicable.

Notwithstanding with the above, medicines prescribed shall be limited to one (1) month supply of medication for every follow up visit and the follow up visit must be within the number of days for Post-Hopitalisation Treatment specified in the Schedule of Benefits.

2.1.12. HOME NURSING CARE

Reimbursement of the Reasonable and Customary Charges incurred for full-time or part-time services of a State-registered or Government-licensed nurse in the Insured Member's home when prescribed by the original attending Physician/ Doctor for the continued treatment of the specific medical condition for which the Insured Member was Hospitalised and only when such services are considered Medically Necessary by the original attending Physician/ Doctor subject to a maximum number of days set forth in the Schedule of Benefits. The care must be provided within seven (7) days following discharge from the Hospital subject to a minimum of three (3) days of Hospitalisation. The number of days of Hospitalisation shall refer to the number of days charged under Hospital Room and Board Benefit.

2.1.13. AMBULANCE FEES

Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary domestic land ambulance services within Malaysia (inclusive of attendant) to and/ or from the Hospital of confinement. Payment is made only if the Insured Member is subsequently Hospitalised.

2.1.14. ACCIDENTAL DENTAL TREATMENT

Reimbursement of the Reasonable and Customary Charges for Emergency Medically Necessary Outpatient dental treatment to sound natural teeth rendered in a Hospital or registered dental clinic within twenty-four (24) hours after an Accident. This shall include Eligible Expenses for follow-up treatment by the same Dentist for the same covered Bodily Injury up to the maximum number of days as specified in the Schedule of Benefits.

2.1.15. ACCIDENTAL OUTPATIENT TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary Outpatient treatment at any registered clinic or Hospital for a covered Bodily Injury arising from an Accident within twenty-four (24) hours of such Accident. This shall include the follow-up treatment by the same Physician/ Doctor or same registered clinic or Hospital for the same covered Bodily Injury up to the maximum number of days as specified in the Schedule of Benefits.

2.1.16. OUTPATIENT CANCER TREATMENT

If the Insured Member is diagnosed with Cancer, We will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary Outpatient treatment of Cancer performed at a Hospital or a legally registered Cancer treatment centre.

Such treatment (i.e. conventional radiotherapy or chemotherapy including consultation, examination tests and prescribed 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.

The reimbursement of the Reasonable and Customary Charges for Medically Necessary consultation, examination tests or prescribed take-home drugs are only payable if the said consultation, examination tests or prescribed take-home drugs are prescribed on the day the Insured Member undergoes chemotherapy and/ or radiotherapy.

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:
- Carcinorma in situ of the cervix;
- Ductal Carcinorma in situ of the breast;
- Papillary Carcinorma of the bladder & Stage 1 Prostate Cancer;
- All skin cancers except malignant melanoma;
- Stage 1 Hodgkin's disease;
- Tumours manifesting as complications of AIDS.

It is a specific condition of this benefit that notwithstanding the exclusion of Pre-Existing Conditions (if any), this benefit will not be payable to any Insured Member who had been diagnosed as a Cancer patient and/ or was receiving Cancer treatment prior to the effective date of insurance.

2.1.17. OUTPATIENT KIDNEY DIALYSIS TREATMENT

If the Insured Member is diagnosed with Kidney Failure, We will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary outpatient treatment of kidney dialysis performed at a Hospital or legally registered dialysis centre.

Such treatment (dialysis including 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 (if any), this benefit will not be payable to any Insured Member who has chronic renal diseases and/ or was receiving dialysis treatment prior to the effective date of insurance.

2.1.18. OUTPATIENT STROKE TREATMENT

If the Insured Member is diagnosed with Stroke, We will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary Outpatient treatment of Stroke performed at a Hospital or a legally registered clinic or Hospital.

Such treatment (including consultation, examination tests, take-home drugs) must be received at the Outpatient department of a Hospital or a registered treatment centre immediately following discharge from Hospital confinement or Surgery

Stroke is defined as resulting in Permanent Neurological Deficit with Persisting Clinical Symptoms

Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolisation from an extra cranial source resulting in Permanent Neurological Deficit with Persisting Clinical Symptoms.

The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist. A minimum Assessment Period of three (3) months applies.

For the above definition, the following are not covered:
i) transient ischemic attacks;
ii) cerebral symptoms due to migraine;
iii) traumatic injury to brain tissue or blood vessels; and
iv) vascular disease affecting the eye or optic nerve or vestibular functions.

It is a specific condition of this benefit that notwithstanding the exclusion of Pre-Existing Conditions (if any), this benefit will not be payable to any Insured Member who has and/or was receiving stroke treatment prior to the effective date of insurance.

2.1.19. ORGAN TRANSPLANT TREATMENT

Reimbursement of Reasonable and Customary Charges incurred for transplantation surgery where the Insured Member is the recipient of the transplant of a kidney, heart, lung, liver or bone marrow. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

2.1.20. OUTPATIENT TREATMENT FOR DENGUE TREATMENT OR ENTERIC (TYPHOID) FEVER

If the Insured Member is diagnosed with Dengue or Enteric Fever, We will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of Dengue or Enteric Fever received as an Outpatient at any registered clinic or Hospital.

Dengue shall mean an acute infectious disease caused by an arthropod-borne virus and transmitted to humans by the Aedes Mosquito.

Enteric Fever shall mean symptomatic bacterial infection due to Salmonella Typhi.

Both the diseases must be diagnosed by a Physician/Doctor and be supported by acceptable clinical, serology, histology and laboratory evidence. Diagnosis based solely on clinical observation is not sufficient.

Such treatment (including consultation, examination tests, take-home drugs) must be received at the Outpatient department of a registered clinic or Hospital.

2.1.21. ALTERNATIVE TREATMENT

Reimbursement of the Reasonable and Customary Charges for Alternative Treatment due to Accident, subject to a maximum of ten (10) visits per policy period up to the limit as specified in the Schedule of Benefits.

Alternative Treatment refers to chiropractic, chiropody, homeopathy, osteopathy, acupuncture or practice of traditional and complementary medicine, provided by a practitioner who is practicing within the scope of practice of his/ her profession and is duly registered with the Traditional and Complementary Division of Ministry of Health or the Drug Control Authority or as mandated under any prevailing or future laws or regulations.

Proof of prior Hospitalisation and satisfactory proof that the practitioners of chiropractic, chiropody, homeopathy, osteopathy or acupuncture are duly registered are required upon claim on this benefit.

2.1.22. DAY CARE PROCEDURE / SURGERY

Reimbursement of the Reasonable and Customary Charges for Outpatient Day Care Procedure/ Surgery (surgical and medical) performed at a Hospital or Day Care Specialist Center including incidental costs for pre-day care and post-day care visits relating to the Day Care Procedure levied by the Hospital or Day Care Specialist Center within the maximum number of days as specified in the Schedule of Benefits. Medical procedures shall include Endoscopy (all types), Intravenous pyelography (IVP/ IVU), Magnetic Resonance Imaging (MRI), Computerised Tomography Scan (CT Scan) and Angiographic studies and such other diagnostic procedures deemed Medically Necessary and duly referred by a qualified Physician/ Doctor.

Injection into joint(s) is not covered.

We reserve the right to treat any In-Patient surgical procedure as Day Care Procedure / Surgery when such In-Patient treatment could have been done as an Outpatient Treatment.

2.1.23. DAILY CASH ALLOWANCE AT GOVERNMENT HOSPITAL

Payment of a daily allowance for each day of confinement for a covered Disability in a Malaysian Government Hospital, provided that the Insured Member is confined to a room with a Room and Board rate that does not exceed the amount shown in the Schedule of Benefits and subject to the limit as specified in the Schedule of Benefits. This benefit shall not apply to any confinement in any Private Hospital.

2.1.24. MEDICAL REPORT FEE

Reimbursement of Reasonable and Customary Charges for any medical report required by Us subject to the limit as specified in the Schedule of Benefits.

2.1.25. FUNERAL EXPENSE

The Funeral Expenses as specified in the Schedule of Benefits will be payable upon the death of the Insured Member. An official death certificate shall be required to establish the death of the Insured Member.

The amount payable under this benefit is not subjected to the Overall Annual Limit.

2.2. BENEFITS LIMITATIONS

2.2.1. OVERALL ANNUAL LIMIT

The maximum aggregate amount payable for all benefits for an Insured Member under this Policy, unless otherwise stated, shall subject to the Overall Annual Limit stated under the selected plan as specified in the Schedule of Benefits. In the event the Overall Annual Limit having been paid, all insurance for the Insured Member in this Policy shall immediately cease to be payable for the remaining Policy Year.

2.2.2. UPGRADED ROOM AND BOARD
DIFFERENCE IN HOSPITAL ROOM AND BOARD RATE

If the Insured Member is Hospitalised and is charged a Room and Board rate higher than his/ her eligible benefit as specified in the Schedule of Benefits, the Insured Member shall bear the difference in the Hospital Room and Board charges.

2.3. MANAGED CARE - MEDICAL CARD

2.3.1. Subject to the payment of premium to Us for this benefit, We shall issue a Managed Care membership card (subsequently called the Medical Card) to the Insured Members upon Policy issuance, provided all premiums due have been settled and upon receipt of a completed enrolment notice from You. Subject to the terms and conditions of this Policy, the Medical Card will facilitate cashless access, admission and discharge to and from participating Hospitals and medical centers / clinics (if applicable) where payments are guaranteed by Us prior to Us assessing such claims (subsequently called the Facility).

2.3.2. You shall reimburse Us for expenses advanced by Us pursuant to the Facility provided to the extent that the Facility was advanced as a result of Your negligence and willful misconduct. In this respect, You shall reimburse Us for all expenses incurred (including taxes which are not based upon Our income or receipts) within thirty (30) days from the date of receipt of Our written advice by You or Your appointed intermediary (if any).

2.3.3. Where it is subsequently discovered by Us upon assessment of a claim that an Insured Member is ineligible for such coverage, including any non-covered medical related items after We had provided the Facility, then notwithstanding the aforementioned, You shall reimburse Us for all reasonable and actual expenses, claims and costs incurred by Us as a result thereof, and which are not as a result of Our negligence or willful misconduct within thirty (30) days from the date of receipt of Our written advice by You or Your appointed intermediary (if any).

2.3.4. In the event You wish to, in good faith, dispute an invoice, You or Your appointed intermediary (if any) shall notify Us within thirty (30) days of receipt of the invoice. In such circumstances, You shall not be required to pay any disputed amounts pending resolution of the dispute.

2.3.5. Except where there is a dispute on any outstanding sum, You are liable to pay to Us interest at the rate of one per centum (1%) per month on all outstanding sum (subsequently called the Agreed Sum) not paid by You to Us by the last day of the time period stipulated in Clauses 2.3.2 and 2.3.3 above (subsequently called the Due Date). The interest shall be incurred from the Due Date until the date of receipt of Agreed Sum by Us and all such interest shall be paid to Us together with your payment of the Agreed Sum, failing which, We reserve the right to suspend or terminate the Facility by giving seven (7) days' prior notice to You. No interest shall be imposed pending resolution of a dispute on any outstanding sum.

2.3.6. The Medical Card of respective Insured Member is not transferable and You shall assume full responsibility for any improper use of the Medical Card.

2.3.7. The Medical Card ceases to be valid upon termination of the Insured Member in accordance to Termination Provisions. You shall withdraw the Medical Card of the terminated Insured Member on or before such termination of the Insured Member and return the Medical Card to Us immediately.

2.3.8. In the event of loss, damage or theft of the Medical Card, You must report this to Us immediately. Any expenses involving any unauthorised use of the stolen or lost Medical Card shall be Your responsibility.

2.3.9. In the event that an Insured Member obtains medical services during the period the Medical Card is pending issuance or replacement, payment of benefit under this Policy shall be by way of reimbursement.

2.3.10. We further reserve the right to review the Facility upon each renewal. We will inform You in the event of any proposed changes to the Facility.

3. OWNERSHIP PROVISIONS

3.1. OWNERSHIP OF POLICY

Unless otherwise expressly provided for by Endorsement in the Policy, We shall be entitled to treat You as the absolute owner of the Policy. We 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 You (or by Your legal or authorised representative) alone shall be an effective discharge of all Our obligations and liabilities. You shall be deemed to be responsible principal or agent of the Insured Members covered under this Policy.

3.2. CHANGE OF OWNERSHIP/ ASSIGNMENT

The insurance provided in this Policy and the benefits payable under such insurance are not assignable.

4. PARTICIPATION PROVISIONS

4.1. ELIGIBILITY

4.1.1. The Eligible Persons are Your Employees who are sixty-nine (69) years of age nearest birthday or below, subject to underwriting where necessary and who are Actively at Work on the Eligibility Date under this Scheme.

4.1.2. Subject to the above requirements, present Employees' Eligibility Date shall be on the Policy Effective Date and future Employees' Eligibility Date shall be according to the cover effective date mentioned in the Member Schedule provided that a written notice on the enrolment of the future Employee is provided to Us within sixty (60) days from the date of his/her becoming an Eligible Person.

4.1.3. If an Employee is not Actively at Work on the Eligibility Date in accordance with the above mentioned requirements, his/ her Eligibility Date will be deferred to the first (1st) day immediately following his/ her return to be Actively at Work.

4.1.4. Eligibility Date of Employees' Dependants shall be on the respective Employees' Effective Date for the same quantum of benefit as the Employees, subject to requirements stated in the Application.

4.2. PARTICIPATION REQUIREMENT

In order to establish and continue the Policy, all Eligible Persons as stipulated in the Eligibility Clause and/or Take Over Provisions are required to participate in this Scheme.

4.3. LATE NOTIFICATION OF ELIGIBILITY

In circumstances where We are not informed of an Eligible Person's insurance coverage and/ or any changes to his/ her insurance coverage within the period stipulated in the Eligibility Clause or other periods as endorsed, this shall be deemed late notification of eligibility. In the event of late notification and where a claim has arisen in respect of such affected Eligible Person, We reserve the right not to admit claims which arise prior to the date of Our receipt of such notification.

5. TERMINATION PROVISIONS

5.1. TERMINATION OF EMPLOYEE'S INSURANCE

The insurance of an Insured Employee under this Scheme shall automatically terminate if any one (1) of the following occurs:

5.1.1. on the date of termination of employment of the Insured Member with You; or

5.1.2. on the date the Insured Employee commences full-time military service; or

5.1.3. when this Policy is cancelled pursuant to the Cancellation of Policy Clause; or

5.1.4. on the date when premium payments for the Insured Member's insurance are discontinued for any reason; or

5.1.5. on the Policy Anniversary when the Insured Employee attains age seventy (70) nearest birthday; or

5.1.6. upon the expiry date of this Policy unless written notice that the Policy will be renewed is given to Us by You on or before the said expiry date; or

5.1.7. upon Our receipt of written notice that the Policy will not be renewed given by You during the grace period as stipulated in the Payment of Premiums Provisions above; or

5.1.8. at the end of the grace period as stipulated in the Payment of Premiums Provisions above if the premium is not paid; or

5.1.9. upon the death of the Insured Employee.

5.2. TERMINATION OF DEPENDANT'S INSURANCE

The insurance of an Insured Employee's Dependant shall terminate if any one (1) of the following occurs:

5.2.1. on the date of termination of the Insured Employee's insurance according to Termination of Employee's Insurance Clause; or

5.2.2. on the date such Dependant ceases to be a Dependant as defined in this Policy; or

5.2.3. on the date the Dependant commences full-time military service; or

5.2.4. on the Policy Anniversary when the Dependant (Insured Employee's legal spouse) attains age seventy (70) nearest birthday; or

5.2.5. upon the death of the Dependant.

6. EXCLUSIONS PROVISIONS

We shall not pay any benefit except for Funeral Expenses benefit, arising from or accelerated directly or indirectly, wholly or partly, for any one (1) of the following:

6.1. Pre-existing Conditions for the first one hundred twenty (120) days of the Insured Member's continuous cover, whether disclosed to Us or not. This shall include any cross over waiting period admission where the admission date falls within the waiting period and the admission continues until after the waiting period, in which case the entire Disability is not payable; or

6.2. Specified Illnesses occurring during the first one hundred and twenty (120) days of the Insured Member's continuous cover. This shall include any cross over waiting period admission where the admission date falls within the waiting period and the admission continues until after the waiting period, in which case the entire Disability is not payable; or

6.3. Any Disability (except for Bodily Injury) arising within the first thirty (30) days of the Insured Member's continuous cover. This shall include any cross over waiting period admission where the admission date falls within the waiting period and the admission continues until after the waiting period, in which case the entire Disability is not payable; or

6.4. Plastic/ Cosmetic surgery or treatment including but not limited to double eyelids, acne, keloids, scars, skin tags, gynaecomastia, diffused alopecia/ hair loss, or treatment of their complications; or

6.5. Circumcision unless Medically Necessary for the treatment of a Disease; or

6.6. Any corrective treatment for refractive errors including but not limited to Orthoptics, Visual Stimulation, Radial Keratotomy, Lasik, Intralase, Zyoptics, Phakic IOL implant or intra-ocular lenses replacement surgery; or

6.7. All corrective glasses or contact lenses, except monofocal intraocular lenses in cataract surgery. Expenses incurred for contact lens, use of cosmetic topically/ orally/ surgical procedures and any complications arising therefrom; or

6.8. Use or acquisition of all appliances (including but not limited to artificial limbs, hearing aids, aero chambers and equipment for nebulising, Continuous Positive Airway Pressure (CPAP), Continuous Ambulatory Peritonieal Dialysis (CAPD), orthopedic pads) and the rental charges for the use of such devices except during Hospitalisation under the Policy subject to the limits for such coverage; or

6.9. Pacemakers, implantable cardiac defibrillator (ICD) and cochlear implants; or

6.10. Dental conditions including dental treatment or oral surgery (except as necessitated by Accidental Injuries as specified in the Accidental Dental Treatment Clause to sound natural teeth occurring wholly during the period of cover); or

6.11. Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilisation, venereal disease and its sequelae, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and Human Immunodeficiency Virus (HIV) related diseases or its sequelae, and any communicable diseases requiring quarantine by law; or

6.12. Any treatment or assessment for Congenital Conditions, hereditary or developmental conditions, deformities and any Disability or complications arising therefrom including but not limited to childhood hernias/ hydrocele (all hernia up to age of six (6) is not covered), clubfoot, Ventricular Septal Defect (VSD), Atrial Septal Defect (ASD), Thalassemia, Squint, Haemangioma, etc; or

6.13. Pregnancy, child birth (including surgical delivery), miscarriage (except any miscarriage of below twenty eight (28) weeks due to accidental causes under this Policy coverage), voluntary abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility and erectile dysfunction and tests or treatment related to impotence or sterilisation; or

6.14. Any care or diagnostic tests or treatment which is not Medically Necessary, has not been established as being effective or which is experimental or treatment which have not been recognized and approved by Ministry of Health of Malaysia. This exclusion includes but is not limited to stem cell treatment, related workout and any complications arising thereafter and blood surety; or

6.15. Hospitalisation primarily for investigatory purposes, routine physical examinations, health check-ups, preventive treatments and diagnostic tests not incidental to treatment or diagnosis of a covered Disability; or

6.16. Treatment for injuries sustained while committing a crime or felony, or while under the influence of alcohol, narcotics, or mind altering substance, or suicide, attempted suicide or intentionally self-inflicted injury while sane or insane; or

6.17. War, riot, rebellion, insurrection, civil commotion, explosion of war weapons, terrorism related activity, active duty in any armed forces, direct participation in strikes, nuclear war, biological and chemical warfare/ activities; or

6.18. Effects from radiation or contamination by radioactivity from any source; or

6.19. Expenses incurred for donation of any body organ by the Insured Member and costs of acquisition of the organ including all costs incurred by the donor during organ transplant and its complications; or

6.20. Investigation and treatment of sleep and snoring disorders, hormone therapy and hormone replacement therapy (except for surgically induced menopause), surgical treatment specifically for weight reduction or gain, hyperhidrosis, etc.; or

6.21. Alternative therapy comprising alternative treatment, medical services or supplies, including but not limited to Acupuncture, Acupressure, Chiropractic, Osteopathy, Reflexology, Bone Setting, Massage, Aroma Therapy, Herbal, Podiatric, Dietetic consultation and treatment, education services/therapies and Traditional Complimentary Medicine; or

6.22. Care or treatment for which payment is not required or which is payable to an extent by any other insurance or indemnity covering the Insured Member and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract; or

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

6.24. Costs/ expenses of services of a non-medical nature, such as television, telephones, telex services, radios or similar facilities and other ineligible non-medical items, except for the following items:

- **6.24.1.** medical record fees
- **6.24.2.** insurance billing fees/billing service/billing insurance;
- **6.24.3.** insurance processing fees;
- **6.24.4.** administration fees;
- **6.24.5.** admission fee; and

6.24.6. admission kit/pack

incurred during Hospitalisation only; or

6.25. 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, winter sports, professional sports and illegal activities; or

6.26. Private flying other than in any commercial scheduled airlines licensed to carry passengers over established routes; or

6.27. Expenses incurred for sex changes; or

6.28. Speech and Occupational therapy when not part of a rehabilitation program following Hospitalisation due to trauma, unless it is a follow-up to an inpatient Disability which shall then be subject to its relevant limit; or

6.29. Any preventive supplements/ supplies including but not limited to the following:

6.29.1. vitamins/ supplements, herbal cures, anti-obesity/ weight reducing agents, eye lubricants and any over the counter purchases except prescribed medicines; and

6.29.2. soaps, shampoos, cleansers, vitamin creams, vitamin ointment, moisturisers, lubricants, anti-aging, fairness treatment and any other product having similar effects.

7. CLAIM PROVISIONS

7.1. CLAIM PROCEDURES

The Insured Member shall within thirty (30) days of a Disability incurring claimable expenses, give written notice to Us stating full particulars of such event, including all original bills and receipts, and a full Physician's/ Doctor's report stipulating the diagnosis of the condition treated and the date the Disability commenced according to the Physician's/ Doctor's opinion and the Physician's/ Doctor's summary of the cost of treatment including medicines and services rendered.

Failure to furnish such notice within the time stipulated 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. We reserve the right on whether to accept the reason(s) given for the failure to give notice within the time stipulated.

The Insured Member shall immediately procure and act on proper medical advice and We shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured Member to do so.

7.2. INCOMPLETE CLAIMS

All claims must be submitted to Us 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 original final tax invoices, original itemised/ detailed medical bills, original receipts and any supporting documents required by Us for such claims have been submitted to and agreed upon by Us. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing is subject to Our approval.

7.3. PAYMENT OF CLAIM

In case of death of an Insured Member while in the course of treatment, We may, subject to the terms and conditions of the Policy, pay fees or charges of the treatment provided You submit to Us receipted bills or invoices showing payment of such fees or charges. Such payments to You shall fully discharge all Our liabilities under this Policy with respect to the deceased person.

8. TAKE OVER PROVISIONS (If applicable)

8.1. This Take Over Provisions shall only apply to individuals insured under the preceding policy at the date of the take over under this Policy and who are eligible for this Policy in accordance with the Participation Provisions of this Policy.

8.2. Eligibility Date of Employees' Dependants shall be on the respective Employees' Effective Date for the same quantum of benefit as the Employees, subject to requirements stated in the Application.

8.3. If this Policy shall have commenced immediately upon termination of a preceding policy and if an Insured Member shall have been afflicted with a Disability prior to or at the time this Policy commences (and the Disability would have been covered under the preceding policy), such Insured Member shall continue to be covered for the existing Disability, but not to exceed the limits of this Policy.

9. GENERAL PROVISIONS

9.1. ALTERATIONS

We reserve the right to amend the terms and provisions of this Policy by giving thirty (30) days' prior notice in writing and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless authorised by Us and such approval is endorsed thereon.

9.2. ANTI-MONEY LAUNDERING, ANTI-TERRORISM FINANCING AND PROCEEDS OF UNLAWFUL ACTIVITIES ACT 2001

If We receive an order from the relevant authorities to freeze or seize the monies received as premium or monies payable in respect of this Policy as provided under the Anti-Money Laundering, Anti-Terrorism Financing and Proceeds of Unlawful Activities Act 2001 or such similar legislation or if We discover or have reasonable suspicion that this Policy is exploited for money laundering activities and/ or to finance terrorism, We reserve the right to terminate this Policy immediately. We shall deal with all premiums paid and all benefits/ sums payable in respect of this Policy in any manner which We deem appropriate, including but not limited to handing it over to the relevant authorities.

9.3. CANCELLATION OF POLICY

Other than those provided under the Termination Provisions of this Policy, the Policy may be cancelled by You by serving at least fourteen (14) days' prior written notice to Us, such notice to state when the cancellation shall become effective. In such an event, provided no claim has been made during the current Policy Year, You shall be entitled to refund a pro-rated premium less any medical examination fee incurred.

We may cancel the Policy by giving a written notice of cancellation to You, stating when, not less than thirty (30) days after that, such cancellation shall become effective. A pro-rated premium less any medical examination fee incurred will be refunded to You if We cancel the Policy.

9.4. CERTIFICATION, INFORMATION AND EVIDENCE

All certificates, information, medical reports and evidence as required by Us shall be furnished at the expense of the Insured Member and in such a form that We may require. In any event all notices which We shall require You to give must be in writing and addressed to Us. The Insured Member shall, at Our request and expense, submit to Us a medical examination whenever such is deemed necessary.

9.5. CHANGE IN RISK

You shall give immediate notice in writing to Us of any material change in Insured Member's occupation, business, duties or pursuits and pay any additional premium that may be required by Us.

9.6. CONDITION PRECEDENT TO LIABILITY

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

9.7. CONTRACT

The Application contains material information that shall form part of this Policy. If any of the answers or statements or information is not fully and accurately given, this Policy may be avoided, a claim may be denied or reduced or the terms of this Policy may be changed or varied, or this Policy may be terminated.

No agent is authorised to make or modify this Policy, or extend the time of payment of premium, to waive any lapse or forfeiture or waive any of Our right or requirements or to bind Us by making any promise or by accepting any representation or information not contained in the Application to this Policy.

Only Our authorised personnel have the power on Our behalf to issue permits or to extend the time for making any premium payment under the Policy. We shall not be bound by any promise or representation in this Policy or subsequently given by any person other than Our authorised personnel, and only in writing.

9.8. CONTRIBUTION

If an Insured Member carries other insurance covering any Disability or Injury insured by this Policy, We shall not be liable for such Disability or Injury in a proportion greater than the amount applicable to it under this Policy bears to the total amount of all valid insurance covering such Disability or Injury.

An Insured Member shall not be insured for more than one such benefit provided under any Policy issued by Us unless otherwise declared and accepted by Us. If the Insured Member is insured for more than one such Policy, We will consider the Insured Member to be insured under the Policy, which provides the largest amount of benefits.

9.9. CURRENCY OF PAYMENT

All payments under this Policy shall be made in the legal currency of Malaysia.

9.10. FREE-LOOK PERIOD

This Policy may be cancelled by written request and by returning this Policy to Us within fifteen (15) days from the date of receipt of this Policy by You. The amount refunded to You shall be the premium paid less any expenses incurred for medical examination in issuance of the Policy.

9.11. GEOGRAPHICAL SCOPE

All benefits provided in the Policy are applicable without geographical limitation for twenty-four (24) hours a day subject to Overseas Treatment Clause.

9.12. GOVERNING LAW

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

9.13. 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 You and/ or the Insured Member shall fail to furnish the requisite proof of loss as stipulated by the terms, provisions and conditions of this Policy at the material time, You and/ or the Insured Member may, within a grace period of one (1) calendar year from the time that the written proof of loss was required to be furnished, submit the relevant proof of loss to Us accompanied by cogent reason(s) for the failure to comply with the time required to furnish the requisite proof of loss as stipulated under the terms, provisions, and conditions of this Policy. We reserve the right whether to accept such proof of loss. After such grace period has expired, We will not accept, for any reason whatsoever, such written proof of loss.

9.14. MISREPRESENTATION/ FRAUD

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

9.15. MISSTATEMENT OF AGE

If the age of the Insured Member has been misstated and the premium paid as a result is insufficient, any claim payable under this Policy shall be pro-rated based on the ratio of the actual premium paid to the correct premium, which should have been charged for the year.

If at the correct age the Insured Member would not have been eligible for cover under this Policy, no benefit shall be payable.

Any excess premium, which may have been paid as a result of such misstatement of age, shall be refunded without interest.

9.16. NON-PARTICIPATION

This Policy shall be Non-Participating and shall not share in Our Divisible Surplus.

9.17. NOTICE

Every notice or communication to Us shall be in writing and sent to Us. No alterations in the terms of this Policy or any Endorsement on it, will be held valid unless the same is signed or initialled by Our authorised representative.

9.18. OVERSEAS TREATMENT

If the Insured Member elects or is referred by the attending Physician/ Doctor to receive treatment outside Malaysia, the benefits payable in respect of such treatment shall be limited to the Reasonable and Customary Charges that are Medically Necessary for such equivalent local treatment in Malaysia and shall exclude the cost of transport to the place of treatment.

For the avoidance of doubt, if there is no equivalent local treatment in Malaysia, then the benefits in respect of any treatment outside Malaysia shall be limited to the cost of the current available treatment in Malaysia for the Insured Member’s condition as recommended by the attending Physician/ Doctor.

9.19. PERIOD OF COVER 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 Policy Effective Date and annually from then on. On each Policy Anniversary, this Policy is renewable at the premium rates in effect at that time as notified by Us.

The Policy is issued on a yearly renewable basis subject to Our consent and the provisions as contained in this Policy.

9.20. PERSONAL DATA PROTECTION, OBLIGATIONS AND RIGHTS

9.20.1. Any personal information including financial information and sensitive personal data ("Personal Data") disclosed to Us by the Policy Owner or the Insured Member will be collected, used, retained, disclosed and otherwise processed by Us or Our employees, representatives, reinsurers, agents and affiliates in accordance with the Personal Data Protection Act 2010 or such other related legislation.

9.20.2. Personal Data will be collected, used, retained, disclosed and otherwise processed for the following purposes:

9.20.2.1. to better understand Your insurance situation, provide quotes, enter into and execute Your insurance contract, and to set up and administer Your Policy;

9.20.2.2. for underwriting, risk assessment, handling and settling of claims and audit purposes;

9.20.2.3. for detection and prevention of criminal activity or fraud in connection with an insurance transaction;

9.20.2.4. to manage and service Our relationship with You and provide You with better customer service including marketing and promoting of other products and services by Us or Our affiliates;

9.20.2.5. to maintain and develop Our business systems and infrastructure; and

9.20.2.6. for data transfer, and sharing with, Us and Our affiliates and/or third parties acting on Our behalf, including those located outside Malaysia.

9.20.3. For the avoidance of doubt, We may disclose or share the Personal Data provided to Us to :

9.20.3.1. Allianz General Insurance Company (Malaysia) Berhad;

9.20.3.2. other entities within the Allianz group;

9.20.3.3. Our authorised agents and service providers with whom We have contractual agreements for some of Our functions, services and activities;

9.20.3.4. other insurance companies and distribution partners (such as, banks, Islamic banks, insurance brokers, reinsurance companies);

9.20.3.5. industry trade associations such as Life Insurance Association of Malaysia (LIAM), Persatuan Insurans Am Malaysia (PIAM) and Malaysian Takaful Association (MTA);

9.20.3.6. Our merchants and strategic partners;

9.20.3.7. any parties authorised by the Policy Owner or an Insured Member (from time to time); and/ or

9.20.3.8. enforcement regulatory and governmental agencies as permitted or required by law, authorised by any order of court or to meet obligations to regulatory authorities.

9.20.4. The Policy Owner or Insured Member shall keep Us updated in respect of any changes in the Personal Data provided to Us as soon as it is practicable. We shall not be liable for any direct or indirect loss or damage which You or the Insured Member may suffer due to any inaccuracy or incompleteness of the Personal Data provided to Us.

9.20.5. In providing Personal Data of the Insured Member to Us, You hereby confirm that the Insured Member has consented to You processing the Insured Member's Personal Data including disclosing such Personal Data to Us.

9.20.6. For the detailed privacy notice on how We collect, use, process, protect and disclose Personal Data, please refer to Our website at www.allianz.com.my.

9.21. RECORD

Upon inception and any subsequent renewal, You shall provide Us with the information relating to Insured Members in the form and manner prescribed by Us. During the Policy Year, You shall periodically furnish to Us, information relating to any new Insured Member to be insured and termination of insurance of any Insured Member required by Us to administer the insurance coverage. Upon Our request, not more than once a year, You shall furnish a statement to Us in relation to the ages, occupations and such other relevant data as may be requested by Us concerning the Employees for the purpose of administration of the insurance coverage and the determination of the future premium rates. Such information and records shall be open to inspection by Us at any reasonable time.

9.22. SEVERABILITY

If any provision or part of a provision in this Policy shall be held or found to be void, invalid or otherwise unenforceable, it shall be deemed to be severed from this Policy. However, the remainder of the provisions contained in this Policy shall remain in full force and effect.

9.23. SUBROGATION

If We shall become liable for any payment under this Policy, We shall be subrogated to the extent of such payment to all the rights and remedies of the Insured Member against any party and shall be entitled at Our own expense to sue in the name of the Insured Member. The Insured Member shall give or cause to be given to Us all such assistance in his/ her power as We shall require to secure the rights and remedies and at Our request shall execute

or cause to be executed all documents necessary to enable Us to effectively to bring suit in the name of the Insured Member.

9.24. APPLICABLE TAX
In the event that any sales and services tax, value added tax or any similar tax and any other duties, taxes, levies or imposts (collectively "Applicable Tax") whatsoever are introduced by any authority and are payable under the laws of Malaysia in connection with any supply of goods and/or services made or deemed to be made under this Policy, We will be entitled to charge any Applicable Tax as allowed by the laws of Malaysia. Such Applicable Tax payable shall be paid in addition to the applicable premiums and other charges. All provisions in this Policy on payment of premiums and default hereof shall apply equally to the Applicable Tax.

9.25. UPGRADED BENEFITS CLAUSE
Any upgrade in the insurance coverage for an Insured Member shall become effective provided that such upgrade is reported to Us. We may, if necessary, require further evidence of health from such person.

9.26. WAIVER
Failure or neglect by either party to enforce at anytime the provisions of this Policy shall not be construed or be deemed to be a waiver of either party's right in this Policy nor in anyway affect the validity of the whole or any part of this Policy nor prejudice either party's right to take subsequent action.

10. DEFINITIONS

10.1. **"Accident"** shall mean a sudden, unintentional, unexpected, 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.

10.2. **"Actively at Work"** shall mean that the Employee is currently engaged in full-time employment performing any duty related to his/her occupation or employment for a regular salary or pay and is not absent from work due to sick leave, or any reasons other than annual leave, emergency leave, compassionate leave, normal holiday (public holiday, company declared holiday), study leave, examination leave, paternity leave, maternity leave or work related training.

10.3. **"Any One Period of Disability"** shall mean all of the periods of Disability arising from the same cause including any and all of its complications except that after an Insured Employee has returned to Active full-time work for a separation period of not less than fourteen (14) days from the latest date of discharge, subsequent Disability from the same cause shall be considered as though it were a new Disability. In the case of a Dependant, the separation period shall be fourteen (14) days following the latest discharge from Hospital. However, this separation period is not applicable for, including but not limited to the following therapies where the limits stated in the Schedule of benefits is available on a per annum basis under the Overall Annual Limit (whichever is applicable):
10.3.1. Outpatient Rehabilitation therapy
10.3.2. Chemotherapy
10.3.3. Radiation therapy
10.3.4. Kidney Dialysis

10.4. **"Application"** shall mean the answers and disclosures in the application form, medical reports, questionnaires and all relevant documentary declaration and/ or statements made by the Insured Member between the time of submission of the application form and the time this Policy contract is entered into.

10.5. **"Bodily Injury"** means bodily Injury caused directly and independently of all other causes, by an Accident of which, except in the case of drowning or of internal injury revealed by autopsy, there is evidence of visible contusion or wound on the exterior of the body. For the avoidance of doubt, internal injury is also compensated provided that it is substantiated with an X-ray or other relevant medical report(s) to prove that such internal injury is accidental and not due to sickness.

10.6. **"Congenital Conditions"** shall mean any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within six (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 Member was continuously covered under this Policy.

10.7. **"Day Care Procedure/Surgery"** shall mean a patient who needs the use of a recovery facility for a surgical and medical procedure as stipulated in Day Care Procedure/ Surgery Clause on a pre-plan basis at the Hospital/ Specialist clinic (but not for overnight stay).

10.8. "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 Doctor who is the Insured Member himself.

10.9. "Dependant" shall mean any of the following persons:

10.9.1. An Insured Employee's legal spouse and who is not Your Employee.

10.9.2. An Insured Employee's unmarried children who are not gainfully employed and are from the following age groups:

10.9.2.1. from fifteen (15) days old to eighteen (18) years old nearest birthday, and

10.9.2.2. from nineteen (19) years old nearest birthday to twenty-three (23) years old nearest birthday if still on Full-time Higher Education.

"Full-time Higher Education" shall mean enrolment in and attending full-time education at a recognised college or university or vocational school.

10.10. "Disability" shall mean a Sickness, Disease or Illness or the entire Injuries arising out of a single or continuous series of causes.

10.11. "Divisible Surplus" shall mean any surplus from the life insurance fund to be distributed from time to time as bonus and/ or dividends.

10.12. "Eligibility Date" shall mean the date the Eligible Person is eligible for insurance under this Scheme.

10.13. "Eligible Expenses" shall mean Medically Necessary expenses incurred due to a covered Disability subject to the limits as specified in the Schedule of Benefits.

10.14. "Eligible Person" shall mean a person who is eligible for the insurance under this Scheme.

10.15. "Emergency" shall mean treatment needed in the event whereby immediate medical attention is required within twenty-four (24) hours for injury, illness or symptoms which are sudden and severe failing which will be life-threatening (e.g. Accident and heart attack), or lead to significant deterioration of health.

10.16. "Employee" shall mean all present and/ or future employee(s) of the Policy Owner.

10.17. "Endorsement" shall mean a variation to this Policy.

10.18. "Head Office" refers to Our principal place of business.

10.19. "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:

10.19.1. Has facilities for diagnosis and major Surgery,

10.19.2. Provides twenty four (24) hours a day nursing services by registered and graduate nurses,

10.19.3. Is under the supervision of a Physician/ Doctor, and

10.19.4. Is not primarily a clinic; an ambulatory care centre; a place for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.

10.20. "Hospitalisation/ Hospitalised" shall mean admission to a Hospital as a registered In-Patient for Medically Necessary treatments for a covered Disability upon recommendation of a Physician/ Doctor and continuously stay in Hospital prior to discharge. 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.

10.21. "In-Patient" shall mean the Insured Member who undergoes confinement for a Disability, as a registered resident bed patient using and being charged for the Hospital Room and Board facilities.

10.22. "Insured Employee(s)" shall mean eligible Employees as listed or described in the Member Schedule or by Endorsement.

10.23. "Insured Member" shall mean Eligible Persons and their eligible Dependants as listed or described in the Member Schedule or by Endorsement accepted by Us under the Scheme whose insurance coverage under this Policy is in force.

10.24. "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.

10.25. "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.

10.26. "Medically Necessary" shall mean a medical service, which is: -

10.26.1. consistent with the diagnosis and customary medical treatment for a covered Disability,
10.26.2. in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits,
10.26.3. not for the convenience of the Insured Member or the Physician/ Doctor, and unable to be reasonably rendered out of Hospital (if admitted as an In-Patient),
10.26.4. not of an experimental, investigational or research nature, preventive or screening nature and
10.26.5. for which the charges are fair and reasonable and customary for the Disability.

10.27. "Member Schedule" refers to the list of all the Insured Member insurance coverage details under this Policy.

10.28. "Non-Participating" shall mean the Policy does not participate in the Divisible Surplus of Our life insurance business.

10.29. "Outpatient" shall mean the Insured Member who is receiving medical care or treatment without being Hospitalised and includes treatment in a Day Care Procedure/Surgery.

10.30. "Physician/Doctor" shall mean a registered medical practitioner qualified and licensed to practise western medicine and who, in rendering such treatment, is practising within the scope of his licensing and training in the geographical area of practice, but excluding a Physician or Doctor who is the Insured Member himself.

10.31. "Policy" shall mean this agreement, any Endorsement, annexure or schedule, any amendment to them signed by Our authorised representative and Your Application. Policy shall form an integral part of the entire legal contract between You and Us.

10.32. "Policy Anniversary" shall mean the anniversary of the Policy Effective Date.

10.33. "Policy Effective Date" shall mean the date from which the insurance coverage under this Policy becomes effective and shall be the date as specified in The Schedule.

10.34. "Policy Owner" shall mean the entity whose name and address is as specified in The Schedule and shall include its successors in title and assigns.

10.35. "Policy Year" shall mean the one (1) year period from the Policy Effective Date or in the event this Policy is renewed, the one (1) year period following the Renewal of the Policy.

10.36. "Pre-existing Conditions" shall mean any Disability (physical or mental) of the Insured Member where the Disability is one (1) for which:

10.36.1. the Insured Member had received or is receiving the treatment;
10.36.2. medical advice, diagnosis, care or treatment has been recommended; or
10.36.3. clear and distinct symptoms are or were evident.

10.37. "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 in Malaysia, 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 Illness or Injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured Member's medical condition.

We reserve the right to determine whether any particular Hospital/ medical charge is a Reasonable and Customary Charge with reference but not limited to the Private HealthCare Facilities and Services (Private Hospitals and Other Private HealthCare Facilities) Regulations 2006 of Malaysia including any subsequent amendment(s) or enactment of it.

10.38. "Scheme" shall mean the Group Hospitalisation and Surgical Scheme.

10.39. "Sickness, Disease or Illness" shall mean a physical condition marked by a pathological deviation from the normal healthy state.

10.40. "Specialist" shall mean a Physician/Doctor 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 Specialist who is the Insured Member himself.

10.41. **"Specified Illnesses"** shall mean any one (1) of the following Disabilities and its related complications, occurring within the first one hundred twenty (120) days of insurance coverage of the Insured Member:

10.41.1. hypertension, diabetes mellitus and cardiovascular disease;
10.41.2. all tumours of any kind, cancers, cysts, nodules, polyps, stones of the urinary and biliary system;
10.41.3. all ear, nose (including sinuses) and throat conditions;
10.41.4. hernias, haemorrhoids, fistulae, hydrocele, varicocele;
10.41.5. endometriosis including disease of the reproduction system; or
10.41.6. vertebro-spinal disorders (including disc) and knee conditions.

10.42. **"Surgery"** shall mean any one (1) of the following medical procedures:

10.42.1. to incise, excise or electrocauterise any organ or body part;
10.42.2. to repair, revise, or reconstruct any organ or body part;
10.42.3. to reduce by manipulation a fracture or dislocation; or
10.42.4. use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or urethra;

and shall exclude all dental treatment.

10.43. **"We/ Us/ Our"** shall mean Allianz Life Insurance Malaysia Berhad.

10.44. **"You/ Your"** shall mean the Policy Owner.

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