STAMP DUTY PAID

PROGRESSIVE INSURANCE BHD (19002-P)

PROGRESSIVE CARE
INDIVIDUAL & FAMILY HOSPITAL & SURGICAL INSURANCE POLICY

IMPORTANT NOTICE

The Insured shall read this Policy carefully, and if any error is found herein, or if the cover is not in accordance with the wishes of the Insured advice should at once be given to the Company and the Policy returned for attention.

DEFINITIONS

POLICY shall mean the agreement together with any endorsements therein, signed by the Company, the Policy Schedule attached hereto and the application form of the Insured Person all of which shall constitute the entire contract between the parties.

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.

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.

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.

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

DEPENDANT shall mean any of the following persons:
(a) a legally married spouse;
(b) unmarried children over 15 days old but under 19 years of age, or 23 years of age, is still on full-time higher education, and who are not gainfully employed.

CHILD shall mean any person who has attained the age of 15 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.

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.

INJURY shall mean bodily injury caused solely by an Accident.

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

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

ANY ONE DISABILITY shall mean all of the periods of disability arising from the same cause including any and all complications therefrom except 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 90 days following the latest date of discharge and subsequent disabilities from the same cause shall be considered as though it were a new disability.

OVERALL ANNUAL LIMIT

Benefits Payable in respect of expenses incurred for treatment provided to the Insured Person during the period of insurance shall be limited to the Overall Annual Limit as stated in the Schedule of Benefits irrespective of a type/types of disability. In the event the Overall Annual Limit has been fully paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining policy year.

ELIGIBLE EXPENSES shall mean Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the Schedule of Benefits.

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 standards 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 in nature, preventive or of screening nature,

(e) for which the charges are fair and reasonable and customary for the Disability.

REASONABLE AND CUSTOMARY CHARGES shall mean charges for medical care which is medically necessary and 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 individuals of the same sex and of comparable age for a similar sickness, disease or injury and in accordance with accepted medical standards and practice and could not have been omitted without adversely affecting the Insured Person's medical condition.

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.

PRE-EXISTING ILLNESSES 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.

WAITING PERIOD shall mean the 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.

SPECIFIC ILLNESSES shall mean the following disabilities and its related complications, occurring within the first 120 days of Insurance of the Insured Person:

(a) Hypertension, diabetes mellitus and cardiovascular disease

(b) All tumours, cancers, cysts, nodules, polyps, stones of the urinary system and biliary system

(c) All ear, nose (including sinuses) and throat conditions

(d) Hernias, haemorrhoids, fistulae, hydrocele, varicocele

(e) Endometriosis including diseases of the Reproductive system

(f) Vertebro-spinal disorders (including disc) and knee conditions.

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

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.

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 hours 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.

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 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.

HOSPITALISATION shall mean admission to a Hospital as a registered inpatient for Medically Necessary treatment 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.

OUTPATIENT shall mean the Insured Person is receiving medical care or treatment without being hospitalised and includes treatment in a Day Care centre.

DAY SURGERY shall mean a patient who needs the use of a recovery facility for a surgical procedure on a planned basis at the hospital/ specialist clinic (but not for an overnight stay).

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.

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 dentist, physician or surgeon who is the Insured himself.

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 dentist, physician or surgeon who is the Insured himself.

SURGERY shall mean any of the following medical procedures:

(a) To incise, excise or electrocauterise 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, oesophagus, stomach, intestine, urinary bladder, or urethra.

DESCRIPTION OF BENEFITS

A. INPATIENT BENEFITS

DAILY 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.

INTENSIVE CARE UNIT

Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an in-patient in the Intensive Care Unit of the Hospital. This benefit shall be payable equal to the actual charges made by the Hospital subject to the maximum benefit for any one day, and maximum number of days, as set forth in the Schedule of Benefits. Where the period of confinement in an Intensive Care Unit exceeds the maximum set forth in the Schedule of Benefits, reimbursement will be restricted to the standard Daily Hospital Room and Board rate.

No Hospital Room and Board Benefit shall be paid for the same confinement period where the Daily Intensive Care Unit Benefit is payable.

HOSPITAL MISCELLANEOUS EXPENSES

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

IN-HOSPITAL PHYSICIAN'S VISIT

Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visits to bed paying patients while confined for a non-surgical disability subject to a maximum of 1 visit per day and not exceeding the maximum number of days as set forth in the Schedule of Benefits.

PRE-HOSPITALISATION TREATMENT

a) Reimbursement of the Reasonable and Customary Charges for the first consultation by a Specialist in connection with a Disability within the maximum number of days as set forth in the Schedule of Benefits preceding confinement in a Hospital and provided that such consultation is Medically Necessary and has been recommended in writing by the attending general practitioner.

   Payment will not be made for clinical treatment (including medications and subsequent consultation after the illness is diagnosed) where the Insured does not result in hospital confinement for the treatment of the medical condition diagnosed.

b) Reimbursement of the Reasonable and Customary Charges for Medically Necessary ECG, X-ray and laboratory tests which are performed for diagnostic purposes on account of an injury or illness when in connection with a Disability preceding hospitalisation, within the maximum number of days and amount as set forth in the Schedule of Benefits and which are recommended by a qualified medical practitioner. No payment shall be made if upon such diagnostic services, the Insured does not result in hospital confinement for the treatment of the medical condition diagnosed.

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.

SURGICAL FEES

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary surgery performed by the Specialist, including;

a) SURGEON'S FEE

Specialist's pre-surgical assessment visits to the Insured Person and post-surgery care up to the maximum number of 31 days from the date of surgery. 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.

b) OPERATING THEATRE

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

c) ANAESTHETIST'S FEES

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia, not exceeding the limits as set forth in the Schedule of Benefits.

B. OUTPATIENT BENEFITS

DAY CARE PROCEDURE

Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary procedures done in an outpatient setting (without hospital admission). Such Day Care Procedure shall include Endoscopy, Intravenous Pyelography (IVP / IVU) and other minimally invasive procedures.

EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily injury arising from an Accident for Medical Necessary treatment as an outpatient at any registered clinic or hospital within 24 hours of the Accident causing the covered bodily Injury. Follow up treatment by the same doctor or same registered clinic or Hospital for the same covered bodily injury will be provided up to the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

AMBULANCE SERVICES

Reimbursement of the Reasonable and Customary Charges incurred for necessary domestic ambulance services (inclusive of an attendant) to and/or from the Hospital of confinement. Payment will not be made if the Insured Person is not hospitalised and is subject to the limits set forth in the Schedule of Benefits.

MEDICAL REPORT FEE

Reimbursement of the Reasonable and Customary Charges incurred for the actual charges by the hospital or doctor for completing a medical report to substantiate a claim. The amount payable shall not exceed the limit as stated in the Schedule of Benefits.

GOVERNMENT SERVICE TAX

Reimbursement of the Reasonable and Customary Charges incurred for the 5% Malaysian government service tax charged on the eligible Hospital Room.

C. RIDER BENEFITS

GOVERNMENT HOSPITAL DAILY ALLOWANCE

Pays a daily allowance for each day of confinement for a covered Disability in a Malaysian Government Hospital, provided that the Insured shall be confined 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/or Malaysian Government Hospital for the covered disability.

D. EXTENDED BENEFITS

ORGAN TRANSPLANT

Reimbursement of Reasonable and Customary Charges, incurred for transplantation surgery for the Insured Person, being the recipient of the transplant of a kidney, heart, lung, liver or bone marrow. Payment for this Benefit is applicable only once per lifetime whilst the policy is in force and shall be subject to the limit as set forth in the Schedule of Benefits. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

OUTPATIENT CANCER TREATMENT

If an Insured is diagnosed with Cancer as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of cancer performed at a legally registered cancer treatment centre, subject to the limit of this disability as set forth in the Schedule of Benefits.

Such treatment (radiotherapy or chemotherapy excluding consultation, examination tests and 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 who had been diagnosed as a cancer patient and/or is receiving cancer treatment prior to the effective date of Insurance.

OUTPATIENT KIDNEY DIALYSIS TREATMENT

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

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

Kidney Failure means end stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis is initiated.

It is a specific condition of this Benefit that notwithstanding the exclusion of pre-existing conditions, this Benefit will not be payable for any Insured who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the effective date of Insurance.

ACCIDENTAL DEATH BENEFIT

This benefit is paid in the event of an Insured Person's death as a result of an accident occurring within six (6) calendar months from the date of the accident and which is the sole cause of the death.

E. ENHANCED BENEFITS

SECOND SURGICAL OPINION

Upon diagnosis of a disability which requires surgery, this benefit shall reimburse the Reasonable and Customary Charges for the consultation fees incurred by the Insured Person for a second medical opinion on his / her diagnosed medical condition from a second Specialist. The second surgical opinion must take place within 30 days preceding confinement in a Hospital for the same condition for which a second opinion is sought. Payment will not be made for clinical treatment (including medication and subsequent consultation after the illness is diagnosed), or where the Insured Person does not result in hospital confinement for surgery of the condition for which the second opinion is sought.

EMERGENCY SICKNESS TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred by the Insured Person for services and supplies furnished by the hospital or clinic in connection with an emergency treatment of an illness or sickness between the hours of 12:00 midnight to 6:00 am and received as an outpatient subject to the maximum amount stated in the Schedule of Benefits.

ACCIDENTAL DENTAL TREATMENT

Reimbursement of the Reasonable and Customary Charges by a dentist or orthodontist for treatment to sound natural teeth injured as a result of accidental injuries to an Insured Person and such treatment should take place within 6 calendar months from the date of the accident.

PRIVATE HOME NURSING

Reimbursement of the Reasonable and Customary Charges incurred for private home nursing care rendered by a registered and graduate nurse. This benefit is paid when home nursing is required by an Insured Person, who is certified by the attending physician as non-ambulatory and for a continuous period of 24 hours a day. The maximum benefits payable shall not exceed the benefits as in the Schedule of Benefits.

OVERALL ANNUAL LIMIT

The Overall Annual Limit shall be the aggregate benefits that may be claimed in any one insurance period by an Insured Person as set forth in the Schedule of Benefits.

Benefits reimbursed with respect of expenses incurred for treatment provided to the Insured Person during the period of insurance shall be limited to the Overall Annual Limit as stated in the Schedule of Benefits irrespective of the type/types of disability. In the event that the Overall Annual Limit has been fully paid, the insurance for the Insured Person shall immediately cease to be payable for the remaining of the policy year.

LIFETIME LIMIT

The Lifetime Limit shall be the aggregate benefits that may be claimed in any one lifetime of the Insured Person during the period of insurance, as set forth in the Schedule of Benefits.

GENERAL CONDITIONS

OWNERSHIP OF POLICY

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

EFFECTIVE DATE OF INDIVIDUAL INSURANCE

The effective date of the individual's insurance shall be the date his/her application for cover is accepted in writing by the Company.

COOLING-OFF PERIOD

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

CANCELLATION

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

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

* Applicable to renewal only

TERMINATION OF INDIVIDUAL INSURANCE

The insurance of an Insured Person shall terminate on the earliest happening of the following events:

a) on the death of the Policyholder; or

b) on the Policy Anniversary following the 70th birthday of an Insured Person; or

c) on the date on which the Insured Person enters full-time military, naval or air services; or

d) on the date when premium payments for the Insured Person's insurance are discontinued for any cause; or

e) on the date of termination of the Policy by either the Policyholder or the Company; or

f) at midnight standard Malaysian time on the last day of the Period of Insurance unless the Insured Person is confined to a Hospital at such time. If this being the case, the time of termination shall be extended to:

   I. the time the Insured Person is discharged from Hospital, or

   II. the time the Overall Annual Limit shall have been exhausted; whichever is the first to occur.

The insurance of the Policyholder's Dependent shall terminate on the earliest happening of the following events: -

a) on the date of termination of the Insurance afforded by the Policyholder; or

b) on the date such Dependent ceases to be a Dependent as defined herein; or

c) at midnight standard Malaysia time on the last day of the Period of Insurance unless an Insured Person is confined to a Hospital at such time. If this being the case, the time of termination shall be extended to: -

   I. the time the Insured Person is discharged from Hospital; or

   II. the time the Overall Annual Limit shall have been exhausted; whichever is the first to occur.

AGE LIMIT

This Policy shall insure all eligible adult persons up to the age of 60 years. In respect of the renewal of Policies purchased before the age of 60 years, cover can be considered for extension until age 70 years. Unmarried children are covered from 15 days old and under 19 or 23 years of age if the child is registered as a full-time student with a local institution for higher education and are not gainfully employed.

MISSTATEMENT OF AGE

If the age of the Insured Person is 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.

CONDITION PRECEDENT TO LIABILITY

The due observance and the fulfillment 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.

WAITING PERIOD

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

TAKE-OVER POLICIES

If this policy shall have commenced immediately upon termination of a preceding policy and if an Insured 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 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.

CONVERSION POLICIES

If the Eligible Benefits provided under this Policy shall have been converted from an existing coverage of an 'Inner Limits' to an 'As Charged/Full Reimbursement' coverage, and if such Insured shall have been afflicted with a Disability prior to, 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.

UPGRADED POLICIES

If the Eligible Benefits to any Insured under the terms of this Policy be increased while it is in force or at the time of Renewal or replacement and if such Insured shall have been afflicted with a Disability prior to or at the time the Benefits were increased, the Limits of Benefits payable immediately following this upgrade of benefit, in respect of such Disability within 12 months shall not exceed the Limit of Benefits prior to the date the Benefits were upgraded.

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 an additional premium that may be required by the Company.

RENEWAL

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company. This policy is renewable at the option of the Company. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.

CONDITIONAL RENEWABLE

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.

The renewal premium payable is not guaranteed and the Company reserves the right to determine the premium applicable specifically to each Insured Person at the time of renewal.

During renewal, the terms and conditions of coverage shall not be amended, except where a particular disability has reached the maximum limit per disability. In such situation, the Company reserves the right to specifically exclude such disability from the policy.

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

(a) non-payment of premium or premium not made on time
(b) fraud or misrepresentation of material fact during application
(c) the policy is cancelled at the request of the policyholder
(d) total claims of the policy have reached the lifetime limit specified and/or 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 covered 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.

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.

PREMIUM WARRANTY

It is a fundamental and absolute Condition of this contract of insurance that the premium due must be paid before inception date of this Policy / Endorsement / Renewal Certificate.

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

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

GEOGRAPHICAL TERRITORY

All benefits provided in this policy are applicable worldwide for 24 hours a day.

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.

RESIDENCE OVERSEAS

No benefit whatsoever shall be payable for any medical treatment received by the Insured outside Malaysia, if the Insured resides or travels outside Malaysia for more than 90 consecutive days.

GOVERNING LAW

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

MISREPRESENTATION / FRAUD

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

ALTERATIONS

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

NOTICE

Every notice or communication to the Company shall be in writing and sent to the Company. No alterations in the terms of this Policy or any endorsement thereon, will be held valid unless the same is signed or initialled by an authorised representative of the Company.

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 bring to suit in the name of the Insured Person.

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 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 12 calendar months from the date of such disclaimer.

LEGAL PROCEEDINGS

No action at law or in equity shall be brought to recover on this Policy prior to expiration of 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.

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.

CLAIM PROCEDURES

REPORTING AND LODGING OF CLAIM

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

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

INCOMPLETE CLAIMS

All claims must be submitted to the Company within 30 days of completion of the events for which the claim is being made. Claims are not deemed complete and Eligible Benefits are not payable unless all bills for such claims have been submitted and agreed upon by the Company. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing shall be at the Company's sole discretion.

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.

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.

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 for the first 12 months of continuous cover.
2. Specified Illnesses occurring during the first 120 days of continuous cover.
3. Any medical or physical conditions arising within the first 30 days of the Insured Person's cover or date of reinstatement whichever is latest except for accidental injuries.
4. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.
5. Dental conditions including dental treatment or oral surgery except as necessitated by Accidental Injuries to sound, natural teeth, occurring wholly during the Period of Insurance.
6. Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilisation, 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.

7. Any treatment or surgical operations for congenital abnormalities or deformities including hereditary conditions.

8. Pregnancy, child birth (including surgical delivery), miscarriage, abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility, erectile dysfunction and tests or treatments related to impotence or sterilisation.

9. Hospitalisation primarily for investigatory purposes, diagnosis, X-ray examination, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary, and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for weight reduction or gain.

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

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

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

13. Expenses incurred for donation of any body organ by an Insured Person and costs of acquisition of the organ including all costs incurred by the donor during organ transplant and its complications.

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

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

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

17. Costs/expenses of services of a non-medical nature, such as television, telephone, telex services, radio or similar facilities, admission kits/packs and other ineligible non-medical items.

18. 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.

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

20. Expenses incurred for sex change.