



PROGRESSIVE INSURANCE BHD

Registration no. 197401001891 (19002-P)

STAMP DUTY
PAID

GROUP HOSPITAL & SURGICAL INSURANCE POLICY

The benefit(s) payable under eligible product is(are) protected by PIDM up to limits. Please refer to PIDM's TIPS Brochure or contact Progressive Insurance Bhd or PIDM (visit www.pidm.gov.my)

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 correction.

WHEREAS THE INSURED by an application and declaration which shall be the basis of this contract and is deemed to be incorporated herein has applied to PROGRESSIVE INSURANCE BHD (hereinafter called "the Company") for the insurance hereinafter contained and has paid or agreed to pay the premium stated in the Policy Schedule as consideration for such insurance for the period stated therein.

NOW THIS POLICY OF INSURANCE WITNESSES that if during the Period of Insurance, any sickness, disease, illness or injury necessitates the Insured Person to be confined to a hospital for treatment, the Company will subject to the terms, provisions, exclusions and conditions as contained herein or as may be endorsed hereon, pay to the Insured or his legal personal representative the sum or sums stated in the Schedule of Benefits.

PROVIDED ALWAYS THAT

- a) The liability of the Company shall not exceed the benefits as set out in the Schedule of Benefits for any one period of insurance.
- b) This Policy shall become effective as of the date stated in the Policy Schedule. This Policy shall be issued for one year and at the end of each period of insurance may be renewed for another year subject to the consent of the Company.

1. PERSONS ELIGIBLE

1.1. Employees

All present, full-time employees shall be eligible for cover under this Policy on the commencement date of this Policy. If the cover is effected on 100% premium payment by the Insured, all eligible employees must be included in the Scheme. If the cover is effected on a contributory premium between the Insured and the eligible employees, the employees who agree to contribute may be included in the Scheme:-

- i. upon the date of eligibility if the request to be included in the scheme is made prior to that date; or
- ii. upon the date of such request if made within the first thirty (30) days of eligibility; or
- iii. upon the date the Company determines evidence of insurability to be satisfactory; such evidence is to be furnished at the expense of those employees who request to be included more than thirty (30) days after the date of their eligibility, or who request reinstatement of their cover after it has been discontinued because of their failure to make any agreed contribution when due.

The effective date of cover for each person and future employees shall be determined in accordance with the requirements stated in the Schedule. If an employee is not at work on the date when he would otherwise be eligible to join the scheme, the effective date of such employee's insurance shall be the date of the return to work.

1.2. Dependents

The dependents are eligible to be included in the Scheme only when the employee is covered. The dependents' coverage shall become effective on any of the following eligibility dates provided they are included within thirty (30) days, otherwise the dependents may join the Scheme upon the date the Company determines the evidence of insurability to be satisfactory; such evidence is to be furnished at the expense of the employee:-

- i. the dependents may only be included in the Scheme upon the date the employee becomes eligible;
- ii. the spouse of a newly married employee becomes eligible on the date of his/her marriage to the employee who is already covered;
- iii. the new-born child becomes eligible on the fifteenth (15th) day following the date of birth.

If the dependent is confined in a hospital on the date when his/her cover would otherwise become effective, such cover would not become effective until the dependent is no longer confined.

2. CHANGE OF CATEGORY OF ELIGIBILITY

Any increase in the cover to be provided to an employee who is already included in the Group which is due to the promotion of an employee, shall become effective from the date of the employee's promotion; unless the employee is absent from work on that date due to Illness or Injury, in which case the increase in cover will take effect from the date on which the employee returns to work full-time.

3. POLICY PERIOD

3.1. 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 may be renewed, provided:

- i) The number of employees covered is not less than the total number of those eligible, except if premiums are partly paid by the employees on a contributory basis, in which case is not less than 75% of those eligible; and
- ii) The number of employees is not less than the minimum requirement of six (6) employees.

3.2. On each Annual Renewal Date, provided this policy is renewed, the premiums effective at that time as notified by the Company, shall be payable and due.

3.3. This policy is renewable at the option of the Company.

3.4. 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.

4. QUALIFYING PERIOD

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

DEFINITIONS

1. RELATING TO THE CONTRACTUAL DETAILS

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.

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).

POLICY YEAR shall mean the one (1) year period including the effective date of commencement of Insurance and immediately following that date, or the one (1) 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.

2. RELATING TO INSURANCE COVER

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

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 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 ninety (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 pays benefits in respect of expenses incurred for treatment provided to the Insured Person during the period of insurance and 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.

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 was continuously covered under this Policy.

CHILD shall mean any person who attained the age of fifteen (15) days and is an unmarried person, is financially dependent upon the Insured and is under the age of nineteen (19), or up to the age of twenty-three (23) for those registered as full-time students at a recognised educational institution.

DEPENDANT shall mean any of the following persons:

- a) a legally married spouse
- b) unmarried children over fifteen (15) days old but under nineteen (19) years of age or twenty-three (23) years of age, still on full-time higher education, and who are not gainfully employed.

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

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 experimental, investigational or research in nature, or preventive or screening in 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 Malaysia, 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.

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.

SPECIFIED 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.

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

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.

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

3. RELATING TO MEDICAL SUPPLIERS

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

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 twenty-four (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.

MALAYSIAN GOVERNMENT HOSPITAL shall mean a hospital where charges of services are subject to the Fee Act 1951 fees (Medical) Order 1982 and/or its subsequent amendments if any.

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.

DOCTOR, 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 license 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 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 physician or surgeon who is the Insured himself.

SURGERY or SURGICAL OPERATION shall mean any of the following medical procedures:

- a) To incise, excise or electrocauterize 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

OVERALL ANNUAL LIMIT

Benefits payable with respect to 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, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining policy year.

HOSPITAL ROOM AND BOARD

Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Person's confinement, but in no event shall the benefit exceed, for any one day, the rate of Room and Board benefit and the maximum number of days as set 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 (ICU)

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

GOVERNMENT TAX

Reimbursement of statutory tax imposed by the Government of Malaysia on eligible claims, where applicable.

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 set 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,

HOSPITAL MISCELLANEOUS EXPENSES

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

PRE-HOSPITAL SPECIALIST CONSULTATION

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

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

PRE-HOSPITAL DIAGNOSTIC, X-RAY/LABORATORY

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 in the Schedule of Benefits, in a Hospital, and which are recommended by a qualified medical practitioner. No payment shall be made if upon such diagnostic services, the Insured does not result in hospital confinement for the treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.

POST-HOSPITALISATION TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary follow-up treatment by the same attending Physician, within the maximum number of days and amount as set 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 in the Schedule of Benefits.

POST HOSPITAL PHYSIOTHERAPY

Reimbursement of the Reasonable and Customary Charges incurred for post-hospitalisation physiotherapy as a continuing therapy prescribed by the attending physician for the same disability admitted for treatment and such continuing therapy should follow immediately after the patient is discharged and within the maximum number of days and amount as set in the Schedule of Benefits from the date of discharge.

AMBULANCE FEE

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 in the Schedule of Benefits.

EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred, up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily injury arising from an Accident for Medically Necessary treatment as an outpatient at any registered clinic or hospital within twenty-four (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 shall be provided up to the maximum amount and the maximum number of days as set in the Schedule of Benefits.

Emergency Outpatient Treatment shall extend to cover Emergency Accidental Dental Treatment for damage to sound, natural teeth as a result of an accident. The Emergency Accidental Dental Treatment must be within twenty-four (24) hours of the accident and follow-up visits shall be payable if sought within the maximum number of days and amount as set in the Schedule of Benefits from the date of the first treatment.

SURGEON'S FEE

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary surgery by Specialists, including the Specialist's pre-surgical assessment visits to the Insured Person and post-surgery care up to a maximum number of days and amount as set in the Schedule of Benefits 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.

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 the maximum number of days and amount as set in the Schedule of Benefits 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.

ANAESTHETISTS FEE

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

OPERATION THEATRE FEES

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

IN-HOSPITAL PHYSICIAN'S VISIT

Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visits to a bed paying inpatient while confined for a non-surgical disability, subject to a maximum of one (1) visit per day and not exceeding the maximum number of days stated in the Schedule of Benefits.

MEDICAL REPORT

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 stated in the Schedule of Benefits.

ORGAN TRANSPLANT

Reimburses the Reasonable and Customary Charges incurred on transplantation surgery for the Insured Person being the recipient of the transplant of a kidney, heart, lung, liver or bone marrow. Payment for this Benefit is applicable only once per lifetime whilst the policy is in force and shall be subject to the limit set 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 specified in the Schedule of Benefits and the Overall Annual Limit.

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 the pre-existing conditions clause, this Benefit will not be payable for any Insured who has 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 specified in the Schedule of Benefits and the Overall Annual Limit.

Such treatment (dialysis excluding consultation, examination tests, and 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 specific condition of this Benefit that notwithstanding the exclusion of the pre-existing conditions clause, this Benefit will not be payable for any Insured who has developed chronic renal disease 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's death as a result of accidental injuries happening within the term of the policy.

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.

COOLING-OFF PERIOD

If this Policy has been issued and for any reason whatsoever the Insured Person decides 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 fifteen (15) days of the date of delivery of the Policy. The Insured Person is entitled to the return of the full premium paid less deduction of expenses incurred by the Company in the issuance of the Policy.

AGE LIMIT

This Policy shall insure all eligible adult persons up to the age of sixty (60) years. In respect of the renewal of Policies purchased before the age of sixty (60) years, cover can be considered for extension until age seventy (70) years. Unmarried children are covered from fifteen (15) days old and under nineteen (19) or twenty-three (23) years of age if the child is registered as a full-time student with a local institution for higher education and is 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 a 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 fulfilment of the terms, provisions and conditions of this Policy by the Insured Person and in so far as they relate to anything to be done or complied with by the Insured Person shall be conditions precedent to any liability of the Company.

WAITING PERIOD

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

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 to 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 in respect of such Disability shall not exceed the Limit of Benefits prior to the date the Benefits were upgraded.

UPGRADED ROOM AND BOARD CO-PAYMENT

If the Insured Person is hospitalised at a published Room & Board rate which is higher than his / her eligible benefit, the Insured Person shall bear the difference in the Hospital Room & Board charges as well as 20% of the other eligible benefits described in the Schedule of Benefits.

CHANGE IN RISK

The Insured Person shall give immediate notice in writing to the Company of any material change in his or her occupation, business, duties or pursuits and pay any additional premium that may be required by the Company.

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 and the Company shall notify the policyholder in writing at least thirty (30) days before the change is effected.

PREMIUM WARRANTY

It is a fundamental and absolute Condition of this contract of insurance that the premium due must be paid and received by the Company within sixty (60) days from the 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-rata premium for the period they have been on risk.

Where the premium payable pursuant to this warranty is received by an authorized 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 twenty-four (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 Malaysian equivalent charges and 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 traveling abroad for a reason other than for medical treatment, needs to be confined to a Hospital outside of Malaysia as a consequence of a Medical Emergency.
- (b) an Insured Person upon recommendation of a Physician has to be transferred to a Hospital outside of 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 ninety (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 slated 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 thirty (30) days prior notice in writing by ordinary post to the Policy Owner's last known address in the Company's records, and such amendments 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.

NOTICE

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

CANCELLATION

This Policy may be cancelled by the Policyholder at any time by giving 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 premiums as follows:*

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

* Applicable to renewal only

SANCTION LIMITATION AND EXCLUSION CLAUSE

No insurer shall be deemed to provide cover and no insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, Japan, United Kingdom or United States of America.

INFECTIOUS OR CONTAGIOUS DISEASE EXCLUSION DURING A PHEIC (LMA5500 13 MAY 2020)

1. This Insurance does not cover claims in any way caused by or resulting from an infectious or contagious disease, an outbreak of which has been declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organization (WHO).
2. This exclusion shall apply to claims made after the date of any such declaration(s), other than where a relevant diagnosis has been made by a qualified medical practitioner before the date of any such declaration(s).
3. This exclusion will continue to apply until the WHO cancels or withdraws any relevant PHEIC.
4. Infectious or contagious disease means any disease capable of being transmitted from an infected person, animal or species to another person, animal or species by any means.

REPORTING AND LODGING OF CLAIM

- (a) The Insured shall, within thirty (30) days of a Disability that incurs claimable expenses, give written notice to the Company stating full particulars of such event, including all original bills and receipts, 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 invalidate 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 thirty (30) days of completion of the events for which the claim is being made. Claims are not deemed complete and eligible benefits are not payable unless all bills for such claims have been submitted and agreed upon by the Company. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing shall be at the Company's sole discretion.

CERTIFICATION, INFORMATION AND EVIDENCE

All certificates, information, medical reports and evidence required by the Company shall be furnished at the expense of the Insured, and in such a form that the Company may require. In any event, all notices which the Company shall require the Insured to give must be in writing and addressed to the Company. An Insured 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.

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 one (1) month of being required in writing to do so then both parties shall be entitled to appoint an Arbitrator, each who shall proceed to hear the differences together with an Umpire to be appointed by both Arbitrators. However, this is provided that any disclaimer of liability by the Company for any claim hereunder must be referred to an Arbitrator within twelve (12) calendar months from the date of such disclaimer.

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.

LEGAL PROCEEDINGS

No action at law or in equity shall be brought to recover on this Policy prior to expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. If the Insured Person shall fail to supply the requisite proof of loss as stipulated by the terms, provisions and conditions of the Policy, the Insured Person may, within a grace period of one calendar year from the time that the written proof of loss to be furnished, submit the relevant proof of loss to the Company with cogent reason(s) for the failure to comply with the Policy terms, provisions and conditions. The acceptance of such proof of loss shall be at the sole and entire discretion of the Company. After such grace period has expired, the Company will not accept, for any reason whatsoever, such written proof of loss.

EXCLUSIONS

This contract does not cover any hospitalisation, surgery or charges caused directly or indirectly, wholly or partly, by any one (1) of the following occurrences:

1. Pre-existing illness.
2. 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 reinstatement date, 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 hereof.
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 sanatoria 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 operation for congenital abnormalities or deformities including hereditary conditions.
8. Pregnancy, childbirth (including surgical delivery), miscarriage, abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility. Erectile dysfunction and tests or treatment related to impotence or 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 treatment.
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, telephones, telex services, radios or similar facilities, admission kit/pack 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 airlines licensed to carry passengers over established routes.
20. Expenses incurred for sex changes