STAMP DUTY PAID

PROGRESSIVE INSURANCE BHD (19002-P)

PROGRESSIVE SMARTMediflex
(Individual & Family Hospital & Surgical Insurance Policy)

IMPORTANT NOTICE - DUTY OF DISCLOSURE

In compliance to Schedule 9 of the Financial Services Act 2013, you are required by law to inform us all the facts that you know or are expected to know about the risk we are accepting from you.

You are required to take reasonable care to provide complete and accurate answers to the questions we ask. You should disclose to us all relevant information which may affect and influence us in accepting this insurance. Your duty shall continue until the time this Policy is renewed.

The duty of disclosure applies to you, and all other persons insured under the Policy. If you are providing information for another insured person, the information you provide will be taken as correct and accurate. You are required to inform us of any changes after the policy is purchased and during the period of your Policy. Please provide us with the details by contacting your Insurance Agent, Broker or our nearest Branch Office.

It is important for you to know that if any information provided by you is incomplete and inaccurate, it may result in:

- Your policy being cancelled; or
- Your policy being declared void from its inception; or
- Your premium and the terms and conditions of your policy being revised; or
- Your claim made on this policy may not be paid.

It is important that you MUST observe and comply with the Terms, Conditions, Endorsement, Clauses and Warranties of this Policy.

THE CONTRACT

This policy is a contract between Progressive Insurance Bhd, (We / Us / Our) and the Policyholder named in the policy (You), insuring the individuals endorsed in the Schedule of Insured Persons. The information provided to us by or on behalf of the Insured Persons in the Proposal Form shall be the basis of this contract.

In consideration of premiums paid, we agree to reimburse you for medical expenses incurred while you are confined as an inpatient in a hospital for a covered condition. The description of the medical expenses covered and payable; and the limit of the coverage shall be endorsed in the Schedule of Benefits, Definitions, Terms & Conditions of the Policy.

DESCRIPTION OF BENEFITS

We shall reimburse you the eligible expenses for the following benefits if you have been hospitalised as a result of a disability.

All hospitalisation referred to in this policy shall mean hospitalisation for a medically necessary condition.

All charges referred to in this policy shall mean reasonable and customary charges.

Singular terms shall imply the plural and the plural terms shall imply the singular where applicable.

1. **OVERALL ANNUAL LIMIT**
   Reimburses benefits payable 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 specified in the Schedule of Benefits irrespective of the type/types of Disability. In the event the Overall Annual Limit has been fully paid, all insurance for the Insured Person named in this policy shall immediately cease to be payable for the remaining policy year.

2. **LIFETIME LIMIT**
   The maximum amount of total benefits we will pay under this policy. The policy shall terminate automatically once the total claims paid reaches or exceeds the lifetime limit.

3. **DEDUCTIBLE AMOUNT**
   The amount of specified eligible claim for each admission you are liable for, as specified in the Schedule of Benefits before any benefits are payable under this policy.

4. **HOSPITAL SERVICES**

   (a) **HOSPITAL ROOM & BOARD**
   Reimburses the actual daily charges by the hospital for the use of the Room and Board during the Insured Person's stay in the hospital, up to the maximum daily benefit and the maximum number of days specified in the Schedule of Benefits.

(b) **INTENSIVE CARE UNIT**
Reimburses the actual daily charges by the hospital for the Insured Person's stay in the Intensive Care Unit up to the maximum daily benefit and the maximum number of days specified in the Schedule of Benefits.

We will not reimburse any Hospital Room and Board charges for the days the Insured Person stays in the Intensive Care Unit.

(c) **GOODS & SERVICES TAX**
Reimburses the 6% Good and Services Tax on the Reasonable and Customary Charges for Medically Necessary supplies and services, consumed by the Insured Person during his stay in the hospital.

(d) **GOVERNMENT HOSPITAL CASH ALLOWANCE**
Pays a daily cash allowance for each complete day of the Insured Person's stay in a Malaysian Government Hospital, provided the Daily Room and Board charge is not more than that stated in the Schedule of Benefits.

(e) **HOSPITAL SERVICES & SUPPLIES**
Reimburses the actual 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 inpatient in the hospital, up to the amount stated in the Schedule of Benefits.

(f) **LODGER BENEFIT**
Reimburses the actual expenses charged for daily food and lodging for a parent or guardian while accompanying the stay of an Insured Person (who is below the age of 15 years) in the hospital.

The maximum number of days and the amount we will reimburse for this Benefit is specified in the Schedule of Benefits.

5. PRE & POST-HOSPITALISATION SERVICES

(a) **PRE-SURGICAL AND PRE-HOSPITALISATION SPECIALIST CONSULTATION**
Reimburses the actual Reasonable and Customary Charges for the first time consultation by a Specialist for a Disability within the maximum number of days as specified 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 consultations after the illness is diagnosed) or where the Insured Person does not result in hospital confinement for the treatment and/or surgery of the medical condition diagnosed.

(b) **PRE-HOSPITALISATION DIAGNOSTIC X-RAY AND LABORATORY**
Reimburses the actual 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 specified in the Schedule of Benefit.

No payment shall be made if upon such diagnostic services, the Insured Person does not result in hospital confinement for the treatment of the medical condition diagnosed.

(c) **POST-HOSPITALISATION FOLLOW-UP CONSULTATION**
Reimburses the actual Reasonable and Customary Charges incurred for Medically Necessary follow-up consultation by the same attending physician, within the maximum number of days and amount as specified in the Schedule of Benefits, immediately following discharge from hospital, for a non-surgical Disability. This shall include medicines prescribed during the follow-up consultation but shall not exceed the supply needed for the maximum number of days as specified in the Schedule of Benefits.

(d) **POST-HOSPITALISATION OUTPATIENT PHYSIOTHERAPY**
Reimburses the actual Reasonable and Customary Charges for Medically Necessary physiotherapy; prescribed by the attending surgeon, and facilitated in a hospital Physiotherapy Department. The physiotherapy should be administered immediately following discharge from the hospital and within the maximum number of days specified in the Schedule of Benefits; for the mobilisation of the limb/s for which surgery was performed on.

This benefit will not be paid when physiotherapy services are facilitated outside of a hospital Physiotherapy Department.

(e) **AMBULANCE SERVICES**
Reimburses the actual Reasonable and Customary Charges (inclusive of attendant's fee) for the use of a ground ambulance service by the Insured Person to and/or from the hospital.

This fee will not be reimbursed if the Insured Person is not admitted to a hospital. The maximum amount for this Benefit is stated in the Schedule of Benefits.

(f) **EMERGENCY ACCIDENTAL INJURY OUTPATIENT TREATMENT**
Reimburses the actual Reasonable and Customary Charges for treatment of Injury to the Insured Person as an outpatient in any registered clinic or hospital. Such treatment must be done within 24 hours from the time of an Accident.

This benefit will also reimburse the actual Reasonable and Customary Charges incurred for subsequent follow-up treatments for the same Injury by the same Specialist, clinic or hospital. The maximum amount and the maximum number of days for this Benefit is specified in the Schedule of Benefits.

(g) **EMERGENCY SICKNESS TREATMENT**
Reimburses the actual Reasonable and Customary Charges for treatment to an Insured Person within the hours specified in the Schedule of Benefits, as an outpatient, in a registered 24 hour service clinic or hospital emergency department, for a life threatening and emergency condition, which requires immediate treatment.

The maximum amount for this Benefit is stated in the Schedule of Benefits.

(h) **EMERGENCY ACCIDENTAL OUTPATIENT DENTAL TREATMENT**
Reimburses the actual charges incurred for the treatment of wholly sound natural teeth as a result of an accidental injury and received as an outpatient, within twenty four (24) hours of the occurrence of the accident in a registered dental clinic or hospital. Follow-up treatment by the same dentist will be provided up to the maximum number days specified in the Schedule of Benefits.

6. PROFESSIONAL SERVICES AND FEES

(a) **IN-HOSPITAL PHYSICIAN'S WARD VISIT**
Reimburses the actual Reasonable and Customary Charges for ward visits by the attending Physician, while the Insured Person is admitted as a non-surgical patient in the hospital. We will reimburse the Reasonable and Customary Charges up to a maximum of two (2) visits per day, irrespective of the number of visiting doctors.

The maximum number of days for such visits is specified in the Schedule of Benefits.

(b) **SURGEON'S FEES**
Reimburses the actual Reasonable and Customary Charges for Surgery performed on the Insured Person in the hospital and shall include charges for pre-surgical assessment, in-hospital visits by the Surgeon or Specialist and post-surgical care.

The maximum number of days and the maximum amount for this Benefit is specified in the Schedule of Benefits and subject to regulated fees.

(c) **DAYCARE SURGERY**
Reimburses the actual Reasonable and Customary Charges for a surgical procedure performed at a hospital or Daycare Centre which requires the use of a recovery facility, but without an overnight stay at the hospital or Daycare Centre.

The maximum number of days and the maximum amount for this Benefit is specified in the Schedule of Benefits.

(d) **SECOND SURGICAL OPINION CONSULTATION**
Reimburses the actual Reasonable and Customary Charges incurred for a Medically Necessary second surgical opinion consultation with a surgeon, after the Insured Person has been diagnosed with a disability which requires surgery.

The consultation with a surgeon for a second surgical opinion must take place within the number of days preceding confinement specified in the Schedule of Benefits, in a hospital, and for the same condition for which a second opinion is sought.

Payment will not be made for clinical treatment (including medications and subsequent consultations after the illness is diagnosed), or where the Insured Person does not result in hospital confinement for surgery of the conditions for which the second opinion is sought.

(e) **ANAESTHETIST'S FEES**
Reimburses the Reasonable and Customary Charges for the administration of anaesthesia on the Insured Person by an anaesthetist up to the maximum amount for this Benefit as specified in the Schedule of Benefits.

(f) **OPERATING THEATRE FEES**
Reimburses the Reasonable and Customary Charges for the use of the Operating Theatre or Operating Room up to the maximum amount for this Benefit as specified in the Schedule of Benefits.

(g) **MEDICAL REPORT FEES**
Reimburses the actual fees charged for the completion of a medical report by the attending physician or surgeon in respect of an admission; and the amount payable shall not exceed the amount as stated in the Schedule of Benefits.

(h) **TRADITIONAL MEDICAL TREATMENT**
Reimburses the Reasonable and Customary Charges for Medically Necessary treatment as an outpatient due to an accident, by a registered traditional medical practitioner up to the maximum specified in the Schedule of Benefits. This benefit is only payable if the Insured Person receives treatment within twenty four (24) hours of the accident.

7. MAJOR SICKNESS BENEFITS

(a) **ORGAN TRANSPLANTATION (PER LIFE TIME)**
Reimburses the actual Reasonable and Customary Charges for the transplant of kidney, heart, lungs, liver or bone marrow on the Insured Person as a recipient of the organ.

We will not pay for any costs incurred by the donors, or any costs to transport or store the organs, or the cost to purchase the organs.

Payment for this Benefit is applicable only once per lifetime whilst the Policy is in-force and shall be subject to the limit specified in the Schedule of Benefits.

(b) **ANNUAL OUTPATIENT CANCER TREATMENT**
Reimburses the Reasonable and Customary Charges for radiotherapy or chemotherapy for the treatment of cancer on the Insured Person, as an outpatient, in a legally registered cancer treatment centre or hospital.

This Benefit will pay the Reasonable and Customary Charges for the doctor's consultation and related examinations, laboratory or diagnostic tests or any drugs prescribed under this Benefit.

The maximum amount this Benefit shall pay is specified in the Schedule of Benefits.

Cancer shall mean any malignant tumour characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

This Benefit will not be payable where you have already been diagnosed as a cancer patient and/or are receiving cancer treatment prior to the effective date of this Policy.

(c) **ANNUAL OUTPATIENT KIDNEY DIALYSIS**
Reimburses the Reasonable and Customary Charges for kidney dialysis on the Insured Person, as an outpatient, performed in a registered dialysis centre or hospital.

This Benefit will pay the Reasonable and Customary Charges for the doctor's consultation and related examinations, laboratory or diagnostic tests or any drugs prescribed under this Benefit.

The maximum amount this Benefit will reimburse is specified in the Schedule of Benefits.

This Benefit will not be payable if you have already developed chronic renal disease and/or are receiving dialysis treatment prior to the effective date of this Policy.

8. PERSONAL ACCIDENT BENEFIT

(a) **ACCIDENTAL DEATH BENEFITS**
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.

DEFINITIONS

1. **ACCIDENT** shall mean a sudden, unforeseen and unplanned event that result in bodily injury.

2. **ANY ONE DISABILITY** shall refer to all of the periods of Disability arising from the same cause including any and all complications except if the Insured Person completely recovers and remains free from further treatment (including drugs, medicines, special diets, injections or advice for the condition) of the Disability for at least thirty (30) days following the latest date of discharge and any subsequent Disability from the same cause shall be considered as though it were a new Disability.

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

4. **CHILD** shall mean a person who is aged fifteen (15) days and under the age of nineteen (19) years, or up to the age of twenty three (23) for those registered as full time students at a locally registered and recognised educational institution of higher learning.

   A child shall be a person who is unmarried, and financially dependent upon the Insured.

5. **CONGENITAL CONDITION** 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. It 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.

6. **DENTIST** shall mean a healthcare practitioner that specialises in the diagnosis, prevention and treatment of diseases or conditions of the oral cavity. He must be registered in the geographical area of practice and holds a valid practicing certificate.

   A Dentist who is himself the Policyholder or the Insured Person shall not be considered a Dentist in this Policy when making a claim.

7. **DEPENDANT** shall mean any of the following persons:
   (1) One legally married spouse;
   (2) Children who are over 15 days old but under the age of 19 years;
   (3) Children who are above the age of 19 years but below the age of 23 years if they are still studying full time in a locally registered and recognised educational institution of higher learning.

8. **DAY SURGERY** shall mean a surgical procedure performed at a hospital or Daycare Centre which requires the use of a recovery facility, but without an overnight stay at the hospital or Daycare Centre.

9. **DISABILITY** shall mean a Sickness, Disease, Illness or Injury arising out of a single or continuous series of causes.

10. **DOCTOR** or **PHYSICIAN** or **SURGEON** shall mean a medical practitioner qualified and licensed to practice western medicine. He must be registered in the locality of practice and must practice within the scope of his licensing and training. A Medical Practitioner who is himself the Policyholder or the Insured Person shall not be considered a Medical Practitioner in this Policy when making a claim.

11. **ELIGIBLE EXPENSES** shall mean Medically Necessary expenses incurred for the treatment of the Disability during the period of Insurance but not exceeding the limits specified in the Schedule of Benefits.

12. **HOSPITAL** shall mean a registered institution established for the purpose of providing treatment and care of bed-paying sick or injured patients, and has facilities for:
    - 24-hour nursing services by registered and graduate nurses;
    - Diagnostic and major surgery; and
    - Under the supervision of a physician.

    A hospital is expressly NOT:
    - Primarily a clinic;
    - A convalescent, nursing or rest home;
    - A rehabilitation centre for alcoholics or drug addicts; or
    - A home for the elderly or infirmed.

13. **HOSPITALISATION** shall mean admission to a hospital as a registered inpatient for Medically Necessary treatment for a covered Disability and upon written 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.

14. **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 the treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the hospital.

15. **INJURY** shall mean damage to the body as a result of an Accident.

16. **INSURED PERSON** shall mean the person who is named in the Policy as the life being insured. The Insured Person is entitled to the benefits under this Policy.

17. **MALAYSIAN GOVERNMENT HOSPITAL** shall mean a hospital established, maintained, operated or provided by the Malaysian Government, but excludes privatised or corporatised Malaysian Government Hospitals.

18. **MEDICALLY NECESSARY** shall mean a medical service which is consistent with the diagnosis and customary medical treatment for a covered Disability;
    - in accordance with standards of good medical practice, consistent with current standards of professional medical care, and of proven medical benefits;
    - not for the convenience of the Insured Person or the medical practitioner, and unable to be reasonably rendered out of hospital;
    - is based on established medical practices, and not of an experimental, investigational or research nature, preventive or screening nature, medical technology/procedure which have not been proven to be effective, or which has not been approved by a recognised body in Malaysia;
    - for which the charges are fair, reasonable and customary for the covered Disability; and
    - provides treatment directly related to the covered Disability.

19. **OUTPATIENT** shall mean a person who visits the hospital, clinic or other healthcare facility for diagnosis or treatment but is not hospitalised.

20. **POLICYHOLDER** shall mean the person named in the Policy as the owner. It can be an individual or a corporate body. The Policyholder controls the Policy, unless the Policy has been assigned.

21. **POLICY YEAR** shall mean the one year period including the effective or commencement date of Insurance, or the one year period following the Renewal or Renewed Policy.

22. **PRE-EXISTING ILLNESSES** shall mean a disability that the Insured Person has reasonable knowledge of before the effective date of insurance. 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 has 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.

23. **PRESCRIBED MEDICINES** shall mean medicines dispensed by a Physician or Registered Pharmacist for the treatment of a covered Disability.

24. **REASONABLE AND CUSTOMARY CHARGES** shall refer to 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 within Malaysia according to the13th Schedule of the Private Healthcare Facilities and Services Act (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013, and its subsequent amendments, if any.

25. **RENEWAL OR RENEWAL POLICY** shall mean a Policy that has been renewed without any lapse of time from the expiry of the earlier Policy.

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

27. **SPECIALIST** shall mean a medical practitioner who specialises in a specific field of medicine and who is recognised by the appropriate health authority as an expert in that field. A Specialist shall include a Physician or a Surgeon.

    A Specialist who is himself the Policyholder or the Insured Person shall not be considered a Specialist in this Policy when making a claim.

28. **SPECIFIC ILLNESSES** shall refer to the following Disabilities or any complications caused by such Disabilities occurring within the first 120 days from the commencement date or reinstatement date of the policy, whichever is later:
    (a) Hypertension, diabetes mellitus or cardiovascular disease;
    (b) Growths of any kind including tumours, cancers, cysts, nodules, polyps;
    (c) Stones of the urinary system and billiary system;
    (d) Any disease of the ear, nose (including sinuses) or throat;
    (e) Hernias, haemorrhoids, fistulae, hydrocele or varicocele;
    (f) Any disease of the reproductive system including endometriosis; or
    (g) Any disorders of the spine (including a slipped disc) or any knee conditions.

29. **SURGERY** shall mean a procedure that involves the cutting of a patient's tissues or closure of a previously sustained wound. Other procedures may be considered surgery if they involve surgical procedures or settings, such as the use of an operating theatre, anaesthesia, antiseptic conditions, typical surgical instruments, suturing or stapling.

30. **WAITING PERIOD** shall refer to the first 30 days from the commencement date or the reinstatement date of the Policy, whichever is later.

31. **DEDUCTIBLE** shall mean the specified amount in the Schedule of Benefits that you are liable for, before any benefits are payable under this Policy.

32. ***flex*-BENEFITS** shall mean the increase in the quantum of benefits at the time of policy renewal.

EXCLUSIONS

This policy shall not reimburse charges incurred for hospitalisation, directly or indirectly resulting from any of the following medical conditions or situations:

1. Pre-existing illnesses.
2. Specified Illnesses within 120 days from the commencement date or reinstatement date, whichever is later.
3. Any medical or physical conditions arising within the first thirty (30) days of the Insured Person's cover or date of reinstatement whichever is later, except for accidental injuries.
4. Self-inflicted injuries or suicide or attempted suicide, while sane or insane.
5. Injuries or hospitalisation as a result of drug abuse, addictive disorders from substance misuse or while under the influence of alcohol.
6. War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes and civil commotions or insurrection, and illegal activities.
7. Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste.
8. Sickness or injuries arising from racing of any kind (except foot racing), hazardous sports such as but not limited to skydiving, winter sports, and professional sports.
9. Participation of any form in aviation including private flying (except as a fare-paying passenger or crew member on a commercial airline licensed to carry passengers over established routes), or aerial sports such as skydiving, parachuting, bungee jumping, hand gliding or ballooning.
10. Plastic/Cosmetic surgery, circumcision or any surgery of the foreskin, eye examinations, surgical corrections for visual impairments due to near-sightedness, far-sightedness or astigmatism, or radial keratotomy or Lasik Glasses, multifocal lens, or contact lens.
11. The use or acquisition of external prosthetic appliances or devices including but not limited to crutches, artificial limbs, external fixators, hearing aids, cochlear apparatus, implanted pacemakers, implantable cardiac defibrillators (ICD) and cochlear implants.
12. Impotence, infertility, sterilisation, erectile dysfunctions and its complications.
13. Dental conditions including dental treatment by a Dentist, or oral surgery except as necessitated by accidental injuries to sound natural teeth occurring wholly during the period of Insurance.
14. Private nursing care, non-hospital nursing care, rest cures, sanitaria care, hospice care and care or treatment that do not lead to a recovery, conservation of your condition or restoration to your previous state of health.
15. Venereal diseases 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.
16. Congenital disorders/diseases or deformities including hereditary and developmental conditions.
17. Pregnancy or pregnancy related conditions including childbirth (whether surgical or otherwise), complications arising from pregnancy such as miscarriage, abortion, pre or postnatal care, contraceptive methods for birth control, infertility treatments and its complications.
18. Mental or nervous disorders (including psychosis, neurosis and their physiological or psychosomatic manifestations).
19. Admission primarily for investigative purposes, screening, diagnosis, X-rays, scans, general physical or medical examinations that are done routinely or are not incidental to treatment or diagnosis of a Disability, treatment or investigations of a Disability that are not Medically Necessary to be hospitalised, and preventive treatments and medicines.
20. Treatment specifically for weight reduction or gain, or bariatric surgery.
21. Donations of body parts or organs by the Insured Person and sex changes.
22. Investigation and treatment of sleep apnoea and snoring disorders, hyperhidrosis, hormone replacement therapies, stem cell therapies (except hematopoietic blood disorders), and alternative therapies, or treatment of an experimental, investigational or research nature.
23. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured Person for Disabilities arising out of duties of employment or profession that is already covered under a Workman's Compensation Insurance Contract.
24. Items that are not directly related to the medical treatment of the Disability or Costs/expenses for services of a non-medical nature including rental of television, radios or similar facilities, telephones, broadband services, electricity charges, admission/registration/medical record fees, admission kits/packs and other ineligible non-medical items.
25. Alternative treatments such as chiropractic services, acupuncture, acupressure, reflexology, bone-setting, herbalist treatment, hyperbaric oxygen therapy, massage or aroma therapy or other alternative medicines.

GENERAL CONDITIONS & PROVISIONS

1. **ALTERATIONS**
We reserve the right to change the terms and conditions of this Policy. Such changes shall take effect from the next renewal date. We will write to you to inform of any change of terms and conditions 30 days before the next renewal date.

2. **ARBITRATION**
In the event of a claims dispute arising from this Policy that you might feel has not been fairly nor satisfactorily resolved, you can refer to the:

Chief Executive Officer
Ombudsman for Financial Services
(Formerly known as Financial Mediation Bureau)
14th Floor, Main Block
Menara Takaful Malaysia
No. 4, Jalan Sultan Sulaiman
50000 Kuala Lumpur.
Fax: 603-2272 1577
Online: http://www.ofs.org.my/en/feedback.html

If the Ombudsman for Financial Services is not eligible to handle the claim dispute, we can write to appoint an Arbitrator. If you do not agree with the appointment of our Arbitrator, you can appoint your own Arbitrator within one month from the date our Arbitrator was appointed.

Both Arbitrators shall then appoint an Umpire who will hear the claim dispute. The referral of any claim dispute to an Arbitrator must be done within twelve (12) calendar months from the date we declined or varied the claim.

3. **CANCELLATION OF POLICY**
You may write to us to cancel this Policy at any time. We will refund a percentage of the premium provided no claims were made on this Policy during the current policy year. The amount of premium refund shall be based on the duration that the Policy has been in force:

Duration not exceeding	Percentage of Annual Premium/Annual Certificate Refund
15 days	90% (for renewal only)
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%
>11 months	No refund

4. **CASH BEFORE COVER**
This contract of insurance will not be effective unless the full premium has been paid and received by us.

5. **CERTIFICATION, INFORMATION AND EVIDENCE**
We may ask you to provide us with information and evidence such as certificates and medical reports. This will be provided at your expense and shall be in the form required by us.

6. **CHANGE IN RISK**
You have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in the Proposal Form is inaccurate or has changed. This includes any change in occupation, hobby or sporting activities of the Insured Person that may increase the risk.

We reserve the right to alter the terms and conditions, including the premium, of this Policy if warranted by the change in occupation, hobby or sporting activities.

7. **CLAIM PROCEDURES**
You are to submit the following documents within 30 days from the date of discharge from the hospital to speed up the processing of your claim:

- All original bills and receipts;
- A Physician's report with information of diagnosis, scans and tests done, the date of Disability, date of Discharge, conclusion and summary of treatment provided and follow-ups.

If you were not able to notify us within 30 days from the date of discharge from the hospital, it does not invalidate the claim if you can show that it was not reasonable to do so.

8. **COOLING-OFF PERIOD**
You have the right to return this Policy within 15 days after we deliver it to you, if, for any reason, you are not satisfied with this Policy.

If returned, the Policy will be considered void from the beginning and any Premium paid will be refunded to you, less any medical examination fees and administrative expenses incurred while issuing this policy.

9. **CONDITION PRECEDENT TO LIABILITY**
You must observe and comply with the terms, provisions and conditions of this Policy in order for us to be liable under this Policy.

10. CONTRIBUTION

We reserve the right to reduce the amount of Benefits reimbursed to you or the Insured Person, if you or the Insured Person has been reimbursed for the medical expenses incurred for the same hospitalisation from other sources.

The total amount of claim reimbursed shall not exceed the expenses actually incurred for the same hospitalisation.

11. CONVERSION POLICIES

If you have converted the Policy from an 'Inner Limits' Policy to an 'As Charged' Policy or from a policy with lesser benefit coverage; and the Insured Person has suffered a Disability before such conversion, we will reimburse the Reasonable and Customary Charges for the treatment of such Disability according to the Schedule of Benefits before the conversion

12. CURRENCY OF PAYMENT

All payments under this Policy shall be made in the legal currency of Malaysia. Should any payment be requested by the Insured to be payable in any other currency, then such amount shall be payable in the demand currency as may be purchased in Malaysia at the prevailing currency market rates on the date of the claim settlement.

13. GEOGRAPHICAL TERRITORY

This Policy provides you with 24-hour worldwide cover.

14. GOVERNING LAW

This Policy shall be interpreted and governed by the laws of Malaysia. Any action or suit against us shall only be instituted in a Malaysian court.

15. GRACE PERIOD FOR RENEWAL

You have a grace period of 30 days from the date your policy is due for renewal to renew your policy. Any policy not renewed after the 30 days grace period will be lapsed.

16. INCOMPLETE CLAIMS

All claims must be submitted to us 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 us. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing shall be at our sole discretion.

17. LEGAL PROCEEDINGS

You shall not take any legal action within 60 days from the date we receive your letter informing us of a claim under this Policy.

You shall give us all the necessary documents for the claim within one calendar year from the date we receive your letter. We shall not process the claim if any of the necessary documents are received after one calendar year.

18. MISREPRESENTATION / FRAUD

Failure to give full and accurate answers may result in avoidance of Your Policy, refusal or reduction of your claim(s), or change in terms or termination of Your Policy.

This Policy shall be void if fraudulent or exaggerated claims are made, or if any false declarations or statements are made in support of such claims.

19. MISSTATEMENT OF AGE

If the age of the Insured Person has been misstated, any benefits payable will be prorated on the ratio of the actual premium paid to the correct premium which should have been paid, based on the correct age. We will refund any excess premium paid without interest.

If we do not have the rates for the corrected age and we are therefore unable to issue the Policy, the policy will be voided. We will refund the premiums paid without interest.

20. NOTICE

All notices to us must be in writing and sent to us at the following address:

Progressive Insurance Bhd
6th, 9th, and 10th Floor, Menara Cosway
Plaza Berjaya,
No. 12 Jalan Imbi
55100 Kuala Lumpur

21. OVERSEAS TREATMENT

We will reimburse the Reasonable and Customary Charges incurred for overseas treatment if:

- the Insured Person was hospitalised for a medical emergency while travelling out of Malaysia. Such overseas travel must not be for treatment of any medical condition.
- the Insured Person was recommended by a Physician to seek treatment outside of Malaysia because there is no other treatment available in Malaysia for that Disability.

We reserve the right to determine whether such treatment outside of Malaysia is necessary, in consultation with our appointed medical doctor.

We will reimburse the actual charges according to the terms and conditions and the limits of this Policy and the amount shall be calculated at the exchange rate published by a local bank in Malaysia on the day of discharge from the hospital.

We will not reimburse the costs of transportation of the Insured Person (or any other person) to or from the place of treatment.

22. OWNERSHIP OF POLICY

Unless otherwise expressly provided for by endorsement in the Policy, we will be entitled to treat you as the absolute owner of the Policy. We will 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 are deemed to be the responsible Principal or Agent of the Insured Person covered under this Policy.

23. PORTFOLIO WITHDRAWAL CONDITION

We reserve the right not to continue with the underwriting of this insurance product. In doing so, we will stop accepting any new Policies and will not offer renewal of your Policy once it has expired. We will write to inform you of our intention by giving you at least 30 days notice.

24. PERSONS ELIGIBLE

Persons eligible to be covered under this Policy are:-

(a) the Policyholder aged below eighty (80) years;
(b) the Policyholder's legal spouse aged below eighty (80) years; and
(c) the Policyholder's child who has attained the age of fifteen (15) days and is an unmarried person, is financially dependent upon the Insured Person 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 locally recognised educational institution.

25. PERIOD OF COVER AND RENEWAL GUARANTEE

The Policy is issued for the term of one year starting from the Commencement Date and terminated on the Expiry Date as specified in the Schedule. You can renew the Policy on each Policy Anniversary at the prevailing premium rate calculated based on the Insured Person's age next birthday on the Renewal Date.

The policy will be renewable at the option of the Policyholder subject to the terms, conditions and termination at each of the policy's Anniversary Date. The premium rates are not guaranteed. We reserve the right to change the premium rates. Any change in premium rates shall apply to all policyholders purchasing the same plan and shall commence from the next Renewal Date. We shall write to inform you of the change in the premium rates by giving you 30 days notice.

This policy is renewable at the option of the policyholder unless one of the following occurs:

(a) If any premium remains unpaid at the expiry of the Grace Period;
(b) If the Policy expires, lapses or is cancelled;
(c) On the Expiry Date of the Policy as stated in the Schedule;
(d) Upon the written request of the Policyholder to terminate this Policy;
(e) When an Insured Person ceases to qualify as a dependent, based on the Policy's definition;
(f) When the Insured Person reaches the maximum age limit as defined in the Policy;
(g) On the death of the Insured Person; or
(h) The total claim of the Policy has reached or exceeded the Lifetime Limit.

26. SUCCEEDING POLICYHOLDER

(a) In the event of the death of the Policyholder while this Policy is in-force, the Policyholder's legal spouse shall automatically become the Policyholder and all reference in this Policy to the Policyholder shall thereafter refer to the legal spouse.
(b) When an Insured Person ceases to be a dependent child, the Insured Person may continue to renew the policy in the Insured Person's own name as a policyholder and all references in this Policy to the Policyholder shall thereafter mean such Insured Person.

27. *flex*-BENEFITS

(a) OVERALL ANNUAL LIMIT *flex*

This policy provides *flex*-benefits at the renewal of your policy. Your Overall Annual Limit will be increased, provided there has been no claim incurred or paid for the preceding 12 months of cover from your last renewal date.

Plan	Initial Overall Annual Limit RM	After 12 Consecutive Months with No Claims RM	After 24 Consecutive Months with No Claims RM	After 36 Consecutive Months with No Claims RM
M200	80,000	85,000	90,000	95,000
M250	100,000	105,000	110,000	115,000
M350	150,000	155,000	160,000	165,000
M450	250,000	255,000	260,000	265,000
M650	350,000	355,000	360,000	365,000

After attaining the maximum Overall Annual Limit *flex*-benefits at 36 consecutive months with no claims, the latest *flex*ed Overall Annual Limit quantum shall continue to apply on subsequent renewals, unless you claim against the policy.

If you make a claim after this benefit has been increased, the Overall Annual Limit will be reset to its initial quantum before the *flex*-Benefits were applied, and you will start accumulating the benefits again.

We reserve the right to revoke any *flex*-benefits offered in the event of late or backdated claim notifications or submissions.

(b) ACCIDENTAL DEATH *flex*-BENEFITS

This policy provides Accidental Death *flex*-benefits starting from the 4th renewal of your policy. Your Accidental Death Benefits will be increased irrespective of claims.

Plan	Accidental Death Benefit RM	On the 4th Renewal RM	On the 5th Renewal RM	On the 6th Renewal RM
M200	10,000	15,000	20,000	25,000
M250	15,000	20,000	25,000	30,000
M350	15,000	20,000	25,000	30,000
M450	15,000	20,000	25,000	30,000
M650	15,000	20,000	25,000	30,000

28. UPGRADING OF POLICIES

If you want to upgrade your Policy to a higher plan, you can do that on the Renewal Date. Please write to inform us of your intention to upgrade your plan a month before the Renewal Date. We shall re-underwrite your new plan and shall write to confirm our acceptance.

If you increase the Benefit of this Policy and the Insured Person has suffered a Disability before the Benefit has been increased, we will only reimburse the Reasonable and Customary Charges for the treatment of such Disability up to the limits of the earlier Benefit.

Any upgrading or downgrading of plan shall cause the *flex*-benefits for the Overall Annual Limit to be reset to its original quantum before the *flex*-benefits were applied.

29. RESIDENCE OVERSEAS

We will not reimburse the charges incurred for overseas treatment if the Insured Person has travelled or resides out of Malaysia for a continuous period of more than 90 days.

30. TAKE-OVER POLICIES

We will continue to provide cover to the Insured Person for an existing Disability that he has suffered before the commencement of this Policy provided:

- the earlier Policy terminates immediately before the Commencement of this Policy,
- the Benefits of the earlier Policy covers the Insured Person for this Disability, and
- a copy of the earlier Policy was given to us.

We will reimburse the Reasonable and Customary Charges for the treatment of the Disability up to the limit of the earlier Policy or the limit of this Policy whichever is lower.

31. TERMINATION OF INSURED PERSON AND COMPANY LIABILITY

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

(a) the policy anniversary following the attainment of the eightieth (80th) birthday and for children, on the policy anniversary following the attainment of the nineteenth (19th) birthday or the twenty third (23rd) birthday for those registered as full time students at a locally recognised educational institute of higher learning.
(b) the date of termination of the Policy or any person's coverage.

In any case our liability shall cease with the date of termination of the policy or any Insured Person's coverage.

32. UPGRADED ROOM AND BOARD CO-PAYMENT

If you are hospitalised at a published Room & Board rate which is higher than your eligible benefit, you shall bear the difference in the Hospital Room & Board charges as well as 20% of the other eligible benefits where benefits are listed "As Charged" in the Schedule of Benefits.

If you have opted for a plan with deductible, the upgraded Room & Board Co-Payment clause shall not apply.

IMPORTANT - The Insured is requested to read this Policy. If any error or misdescription is found, the Policy should be returned to the issuing office for correction.