GROUP MEDICAL INSURANCE POLICY

KURNIA INSURANS

QUALITY SYSTEM

SIRIM

CERTIFIED TO MS ISO 9001 : 2000

Registration No: AR 0934

SCHEDULE ATTACHED HERETO SHALL BE
TAKEN AND READ AS FORMING PART OF THIS POLICY

STAMP DUTY PAID

KURNIA INSURANS(MALAYSIA)BERHAD
(A member of the Kurnia Group of Companies)
Company Number: 44191-P
HEAD OFFICE: Menara Kurnia, No. 9, Jalan PJS 8/9, 46150 Petaling Jaya,
IBU PEJABAT P.O. Box 8607, 46792 Petaling Jaya, Selangor Darul Ehsan.
Tel: 603-7875 3333 Fax: 603-7875 9933 E-mail: corporate@kurnia.com Website: www.kurnia.com.my

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REV : B

KURNIA GROUP MEDICAL INSURANCE POLICY

(Group Hospitalization And Surgical Insurance Policy)

Kurnia Insurans (Malaysia) Berhad ("the Company") in return for the payment of such premiums as described in the Insurance Schedule hereto ("the Insurance Schedule") agrees to pay or grant benefits in accordance with the Schedule of Benefit to the Policyholder (or to the person otherwise entitled thereto) due to hospitalization as a direct result of an accidental bodily injury, illness or disease or sickness subject to the Definitions, Exclusion, Conditions and Endorsements set out herein and subject to any other Conditions specified in the Insurance Schedule.

PART I - DEFINITIONS

In this Policy where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

DEFINITIONS

"Policy" shall mean the Kurnia Group Medical Insurance plan. Any supplementary contracts, endorsements, attachments and any amendments thereto (signed by the Company), and the application of the Insured Person attached hereto which together constitute the entire contract between the parties.

"Company" shall mean Kurnia Insurans (Malaysia) Berhad.

"Eligible Member" shall mean a full time and permanent employee (or member in the case of association) who is below age 60 years, and who is actively at work for the Policyholder, whose eligibility to participate in this insurance plan has been agreed in writing between the Policyholder and the Company.

"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 Persons" shall mean the person described in the Policy Schedule including his/her Dependant (if applicable).

"Child" shall mean any person who has attained the age of 30 days and is an unmarried person, is financially dependent upon the Insured Person and is under the age of 19, or up to the age of 23 for those registered as full time students at a recognized educational institution.

"Dependant" shall mean any of the following persons:
(a) a legally married spouse
(b) unmarried children over 30 days old but under nineteen (19) years of age or twenty three (23) years of age is still on full-time higher education, and who are not gainfully employed.

"Class" or **"Employees Category"** shall mean the job class under which an Individual is working based upon specific and determinable criteria such as job duties, salary or some other measures.

"Commencement Date" shall mean the date set out in the Insurance Schedule from when the insurance plan under this Policy becomes effective.

"Policy Year" shall mean the one year period including the effective date of commencement of Insurance and immediately following that date, or the one year period following the Renewal or Renewed of the 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.

"Hospital" shall mean only an establishment duly constituted and registered as a hospital for the care and treatment of sick and injured persons as bed-paying patients, and which:-
(a) has facilities for diagnosis and major surgery,
(b) provides 24 hours a day nursing services by registered and graduate nurses,
(c) is under the supervision of a Physician, and
(d) is not primarily a clinic; a place for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.

"Malaysian Government Hospital" shall mean a hospital which charges of services are subject to the Fee Act 1951 Fees (Medical) Order 1982 and/or its subsequent amendments if any.

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

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"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) hours 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.

"Out-Patient" shall mean the Insured Person is receiving medical care or treatment without being hospitalized and includes treatment in a Daycare centre.

"Medical Practitioner" shall mean a physician qualified by a degree in Western Medicine who is legally licensed and qualified to practise medicine and surgery authorized in the geographical area of his practice and authorized by Malaysian Medical Council but excluding a physician who is the Insured Person himself, or the spouse or line relative of the Insured Person.

"Day" shall mean definition of a charging day adopted by the hospital concerned.

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

"Pre-Existing Illness" shall mean disabilities that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:-
(a) the Insured Person had received or is receiving treatment;
(b) medical advice, diagnosis, care or treatment has been recommended;
(c) clear and distinct symptoms are or were evident; or
(d) its existence would have been apparent to a reasonable person in the circumstances.

"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 disease of the reproduction system
(f) Vertebro-spinal disorders (including disc) and knee conditions.

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

"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.

"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 there from except that if the Insured Person completely recovers and remain free from further treatment (including drugs, medicines, special diet or injection or advice for the condition) of the Disability for at least ninety (90) days following the latest date of discharge and subsequent Disability from the same cause shall be considered as though it were a new Disability.

"Accidental Dental Treatment" shall mean dental procedures necessary to restore or replace sound natural teeth lost or damaged in an accident.

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

"Dentist" shall mean a person who is duly licensed or registered to practise 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.

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

"Surgery" 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, esophagus, stomach, intestine, urinary bladder, or urethra.

"Eligible Expenses" shall mean Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the schedule.

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

(a) consistent with the diagnosis and customary medical treatment for a covered Disability, and
(b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits, and
(c) not for the convenience of the Insured Person or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient), and
(d) not of an experimental, investigational or research nature, preventive or screening nature,
(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 shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individual of the same sex and of comparable age for a similar sickness, disease or injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured Person's medical condition.

"Waiting Period" shall mean first 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.

"Overall Annual Limit" shall mean benefits payable in respect of expenses incurred for treatment provided to the Insured Person during the period of insurance shall be limited to Overall Annual Limits as stated in the Schedule of Benefit irrespective of a type/types of Disability. In the event the Overall Annual Limit having been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining Policy year.

"Lifetime Limit" shall mean the twice of the Overall Annual Limit for the Insured Person Plan Type as stated in the Insurance Schedule attached hereto and is the maximum limit of liability to the Insured Person.

PART II- BENEFIT EXTENT AND CONDITIONS OF PAYMENT

HOSPITAL ROOM AND BOARD

Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Person's confinement, but in no event shall the benefit exceed, for any one day, the rate of Room and Board Benefit, and the maximum number of days as set forth in the Schedule of Benefit. The Insured Person will only be entitled to this benefit while confined to a Hospital as an in-patient.

INTENSIVE CARE UNIT

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

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

SURGICAL FEES

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary surgery by the Specialists, including pre-surgical assessment Specialist's visits to the Insured Person and post-surgery care up to the maximum number of days from the date of surgery, but within the maximum indicated in the Schedule of Benefit. 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 Benefit.

OPERATING THEATRE

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

ANAESTHETIST FEE

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

PRE-HOSPITAL DIAGNOSTIC TESTS

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

PRE-HOSPITAL SPECIALIST CONSULTATION

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

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

IN-HOSPITAL PHYSICIAN VISIT

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

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POST-HOSPITALIZATION TREATMENT
Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up treatment by the same attending Physician, within the maximum number of days and amount as set forth in the Schedule of Benefit immediately following discharge from Hospital for a non-surgical Disability.

HOSPITAL SUPPLIES & SERVICES
Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary general nursing, 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 Benefit.

PRESCRIBED MEDICINES
Reimbursement of the Reasonable and Customary Charges for 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 during in-patient stay. This shall include medicines prescribed during the follow-up treatment but shall not exceed the supply needed for the maximum number of days as set forth in the Schedule of Benefit.

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

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

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

MEDICAL REPORT
Reimburses the expenses incurred for pursuing the medical report up to the maximum amount as set forth in the Schedule of Benefit.

GOVERNMENT SERVICE TAX
Reimburses the Government tax on reimbursable charges actually incurred. In any case tax reimbursable shall be limited to the amount of tax based on the maximum Hospital Room and Board benefit of designated plan.

FUNERAL EXPENSES
Upon receipt of proof of death and adequate documentary proof that the Insured Person died in the hospital while insured under this Policy, an amount as stated in the Schedule of Benefit shall be paid to defray death expenses.

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PART III – LIMITATIONS AND EXCLUSIONS

BENEFITS LIMIT
Benefits payable in respect of expenses incurred for treatment provided to an Insured Person during the Period of Insurance shall be limited to the

i. **REASONABLE AND CUSTOMARY CHARGES** for the treatment provided and no benefit shall be payable if the hospital confinement upon which the claim is based is not related to the diagnosis and treatment of the condition for which hospital confinement is required by the attending medical practitioner;
ii. Benefit limit stated in the Schedule of Benefit of this Policy in accordance with the Insured Person's Plan Type as specified in the Insurance Schedule of attached hereto; and
iii. Overall Annual Limits stated in the Schedule of Benefit of this Policy in accordance with the Insured Person's Plan Type as specified in the Insurance Schedule attached hereto.

ELIGIBILITY
Maximum age for enrolment and renewal is sixty (60) next birthday. The spouse of the employee who is not legally separated is eligible for insurance. Any unmarried child of the employee who is at least thirty (30) days old to nineteen (19) years old next birthday, or twenty three years old (23) if completing tertiary studies, is eligible for insurance, subject to a declaration of health.

MINIMUM PERIOD OF CONFINEMENT
Upon the recommendation of a physician, each hospital confinement must be for a minimum period of twelve (12) consecutive hours before any benefits are payable. However, no minimum period of hospital confinement is required if such confinement is in connection with a surgical operation or accidental emergency treatment.

EXCLUSIONS
This Policy does not cover any hospitalization, 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 date reinstatement whichever is latest except for accidental injuries.

4. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.

5. Dental conditions including dental treatment or oral surgery except as necessitated by Accidental Injuries to sound natural teeth occurring wholly during the Period of Insurance.

6. Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilization, venereal disease and its sequelae, and any communicable diseases required quarantine by law.

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

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

9. Hospitalization 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. Ionizing 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 Person 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.

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PART IV – CLAIMS PROCEDURES

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

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

3. **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 Person 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.

4. **PAYMENT OF CLAIM**

Payment of claim will be made by cheque to the Policyholder, or to another party at the request of the Policyholder but subject to approval of the Company. Benefits shall be payable only after Hospitalization has ceased, except where Hospitalization exceeds thirty (30) days, the Company may make periodic payments while Hospitalization continues, on receipt of appropriate hospital bills from the Insured Person.

PART V – OTHER POLICY PROVISIONS

This Policy and the Schedules shall be read together as one contract and any words or expressions to which a specific meaning has been attached in any part of this Policy or of the Schedules shall bear such specific meaning wherever it may appear.

EMPLOYEE

Each present full-time and future employee shall be eligible for insurance;

i) upon the effective date of the policy or

ii) upon the date of employment for future employees.

Where coverage is implemented, each applicant will be required to satisfy the underwriting requirements of the Company in force at that time, and be actively at work and below 60 of age.

DEPENDANTS

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

i. the Dependant may only include for coverage upon the date employee becomes eligible;

ii. the spouse of a newly-married employee becomes eligible for coverage on his/her marriage to the employee already covered;

iii. the new-born child becomes eligible on the 31st day following the date of birth.

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

LATE ENROLMENT

Every member who fulfils the conditions necessary to participate must elect to do so within 30 days from the date he becomes eligible. Otherwise, he shall be able to participate only after he has furnished, at his own expense, evidence of his insurability satisfactory to the Company.

CHANGE OF CATEGORY OF ELIGIBILITY

Upgrading of Plan due to promotion or any other reasons can only be done on the anniversary year/renewal unless otherwise approved or agreed by the Company.

INCLUSION AND DELETIONS

The insurance afforded by this Policy is automatically extended to include additions of further employees (and/or their dependants) depending on the group size, who by virtue of the employees' employment and in accordance with the Schedule of Benefit are entitled to the benefits of this Policy.

The Policyholder shall declare to the Company details of additions and/or deletions in respect of the members insured during the Period of Insurance for the purpose of premium adjustment by the end of the first week of every month or as specified in the Insurance Schedule.

Employee Group Size 20 and below

The cover shall commence upon the written confirmation of acceptance from the Company following the submission of the Personal Health Declaration form.

Employee Group Size 21 to 50

The cover shall commence from the date of employment or otherwise approved or agreed upon provided that advice of inclusion is given within 30 days. Thereafter, the commencement date would be on the Anniversary Date or otherwise approved or agreed upon by the Company.

For employees age 40 years old and above, the cover shall commence upon the written confirmation of acceptance from the Company following the submission of the Personal Health Declaration form.

Employee Group Size 50 and above

The cover shall commence from the date of employment or otherwise approved or agreed upon provided that advice of inclusion is given within 30 days. Thereafter, the commencement date would be on the Anniversary Date or otherwise approved or agreed upon by the Company.

Deletion/Termination of Employment

The following applies to all the employee group size.

The date of termination shall be the date of termination of employee provided that advice of termination is given within 30 days. Thereafter, the date of termination shall be the date upon receipt of such advice or otherwise approved and agreed by the Company.

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 initiated by an authorized representative of the Company.

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.

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PERIOD OF COVER AND RENEWAL (applicable to yearly renewable policy)
This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company provided;

i. At least 90% of eligible and existing membership renew, if the insurance plan is contributory, unless otherwise agreed or allowed by the Company; or
ii. 100% of eligible and existing membership renew, if the insurance is non-contributory.

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 the official exchange rate ruling on the last day of the Period of Confinement and shall exclude the cost of transport to the place of treatment provided;

(a) an Insured Person travelling abroad for a reason other than for medical treatment, needs to be confined to a Hospital outside Malaysia as a consequence of a Medical Emergency
(b) an Insured Person upon recommendation of a Physician and has to be transferred to a Hospital outside Malaysia because the specialised nature of the treatment, aid, information or decision required can neither be rendered nor furnished nor taken in Malaysia.

Overseas treatment of a disease, sickness or injury which is diagnosed in Malaysia and non-emergency or chronic conditions where treatment can reasonably be postponed until return to Malaysia are excluded.

ASSIGNMENT OF SUCCESSION
If the business of the Policyholder shall be assigned to or succeeded by any person, persons, or corporation, then subject to the consent of the Company, the payment of premiums under this Policy may at the option of such person, persons or corporation shall as from the date of such Assignment or succession take the place of and be treated for all purposes of this policy (including this present condition) as being the Policyholder hereof.

PREMIUM
During the Period of Insurance, the premium for insurance under this Policy shall be based upon the Premium Rates shown in the Insurance Schedule.

Premiums are payable annually in advance by the Policyholder unless otherwise approved or stated by the Company. The first premium shall be payable at the Commencement Date or otherwise stated by the company and subsequent premiums shall be due and payable at the start of each subsequent Policy Year.

The Company shall have the right to change the rate at which premiums shall be calculated, on any Policy Renewal Date, provided the rate that is then being charged has been in effect for at least twelve (12) months and provided further that the Company notifies the Policyholder at least thirty (30) days in advance of the date such premium is due.

RENEWAL
It shall not be incumbent on the company to give notice that any premium for renewal is due and such premium shall be deemed to be due on the date on which the policy expires and must be paid within 14 days thereafter. However, during such 14 days the company shall remain liable thereunder if by the last of such days the premium is actually paid unless the company or the Insured Person shall have given notice that the Insurance would not be renewed.

This Policy is renewable at the option of the Company. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.

REINSTATEMENT
After termination of the Policy or any of the supplementary contracts, the Policyholder may apply for reinstatement which shall be subjected to the consent of the Company and to the terms and conditions which the Company may impose.

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

RECORDS
The Policyholder shall keep a record of the employees included in the Scheme containing for each employee the essential particulars of the insurance. Such information relating to a new employee becoming insured, adjustments because of changes in category and termination of insurance as may be required by the Company to administer this insurance shall be furnished to the Company at the end of each policy month unless as stated by the Company.

CERTIFICATION, INFORMATION AND EVIDENCE
All certificates, information, medical reports and evidence as required by the Company shall be furnished at the expense of the Insured Person, and in such a form that the Company may require. In any event all notices which the Company shall require the Policyholder to give must be in writing and addressed to the Company. An Insured Person shall, at the Company's request and expense, submit to a medical examination whenever such is deemed necessary.

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

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

Period Not Exceeding:	Refund of Annual Premium
15 days	90% (applicable to 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%
Period exceeding 11 months	No refund

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.

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

AUTOMATIC TERMINATION
The insurance of an Insured Person shall automatically terminate on the earliest happening of the following events:
(a) on the death of an Insured Person; or
(b) on the date of termination of employment with the Policyholder (or cessation of membership in good standing in the case of association), except that while an Insured Person is temporarily on part-time employment or is absent on account of sickness or injury, coverage shall be deemed to continue until premium payments for such Insured Person's insurance premium are discontinued; or
(c) on the date in which an employee is retired or pensioned; or
(d) on the date which he enters full-time military, naval, or air or police service; or
(e) on the premium due date if Policyholder fails to pay the required premium for the Insured Person; or
(f) on the Policy Anniversary immediately following the 60th birthday of an Insured Person; or
(g) for a dependent child, on his/her 19th birthday or his/her 23rd birthday if in full-time tertiary institution in Malaysia; or
(h) if the total benefits paid under the Policy since the last Policy Anniversary exceeds the Overall Annual Limit for the respective Policy Year; or
(i) if the total benefits paid to the Insured Person since the first and original Commencement Date exceeds the Lifetime Limit for the Plan Type Insured Person as stated in the Insurance Schedule attached hereto; or
(j) at mid-night standard Malaysian time on the last day of the Period of Insurance.

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

MISSTATEMENT OF AGE
If the age of the Insured Person has been misstated and the premium paid as a result thereof is insufficient, any claim payable under this Policy shall be prorated based on the ratio of the actual premium paid to the correct premium which should have been charged for the year. Any excess premium, which may have been paid as a result of such misstatement of age, shall be refunded without interest.

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

THE CONTRACT
The rights of the Policyholder or of any Insured Person Member shall not be affected by any provision other than those contained in this Policy, the Policyholder's Proposal Form, and any other document which constitutes any part of the entire contract.

No agent or broker is authorized to modify this Policy, to accept premiums in arrears, to extend the due date of any premium, to waive any of the Company's rights or requirements, to bind the Company by making any promise or by accepting any representation or information in respect of this Policy. No change in this Policy shall be valid unless approved by the Company and evidenced by endorsement hereto, or by amendment hereto assigned by the Company.

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.

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SUBROGATION

If the Company shall become liable for any payment under this Policy, the Company shall be subrogated to the extent of such payment to all the rights and remedies of the Insured Person against any party and shall be entitled at its own expense to sue in the name of the Insured Person. The Insured Person shall give or cause to be given to the Company all such assistance in his/her power as the Company shall require to secure the rights and remedies and at the Company's request shall execute or cause to be executed all documents necessary to enable the Company to effectively to bring suit in the name of the Insured Person.

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.

UPGRADED ROOM AND BOARD CO-PAYMENT

If the Insured Person is hospitalized at a published Room & Board rate which is higher than his/her eligible benefit, the Insured Person shall bear 20% of the other eligible benefits described in the Schedule of Benefit but subject to a maximum limit of RM 3,000 per Disability for plans described in the Schedule of Benefit with Overall Annual Limit not exceeding RM 100,000 or subject to a a maximum limit of RM 5,000 per Disability for plans described in the Schedule of Benefit with Overall Annual Limit exceeding RM 100,000.

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 recognize any equitable or other claim to or interest in the Policy, and the receipt of the Policy or a Benefit by the Policyholder (or by his legal or authorized representative) alone shall be an effective discharge of all obligations and liabilities of the Company. The Policyholder shall be deemed to be responsible Principal or Agent of the Insured Persons covered under this Policy.

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.

RESIDENCE OVERSEAS

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

UPGRADED POLICIES

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

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 Person shall have been afflicted with a Disability prior or at the time the Benefits were converted, the benefits payable in respect of the Disability shall be in accordance with the Schedule of Benefit prior to the date the Eligible Benefits were converted.

COOLING-OFF PERIOD

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

PORTFOLIO WITHDRAWAL CONDITION

The Company reserves the right to cancel the portfolio as a whole if it decides to discontinue underwriting this insurance product.

Cancellation of the portfolio as a whole shall be given by written notice to the Policyholder and the Company will run off all policies to expiry of the period of cover within the portfolio.

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CLAUSES, ENDORSEMENTS AND WARRANTIES
to be Attached and Read as part of the Group Policy
(not applicable unless specified in the Schedule)

BENEFIT EXTENT AND CONDITIONS OF PAYMENT

INTERNATIONAL BUSINESS RIDER BENEFITS
When traveling outside Malaysia, the monetary limit for hospital related benefit shall be doubled. For the purpose of this benefit, the following benefits shall be included:

- Hospital Room & Board
- Intensive Care Unit
- Surgical Fees
- Operating Theatre
- Anaesthetist Fee
- Pre-Hospital Diagnostic Tests & Specialist Consultation
- In-Hospital Physician Visit
- Post-Hospitalization Treatment
- Hospital Supplies & Services
- Prescribed Medicines
- Ambulance Fees
- Emergency Accidental Out-Patient Treatment
- Overall Annual Limit (subject to a maximum local claim not exceeding the Overall Annual Limits specified under the basic coverage).

Cover excludes elective overseas treatment of medical conditions which can be treated adequately in Malaysia, and further excludes overseas treatment of non-emergency or chronic conditions where treatment can reasonably be postponed until return to the Country of Issue.

When this rider benefit is in force, the Overall Annual Limit under this Policy shall be doubled in accordance with the Insured Person's Plan Type as specified in the Schedule of Enrolment attached hereto, but claims arising in Malaysia shall be subject to a maximum not exceeding the Overall Annual Limit specified under the basic coverage.

ANNUAL OUT-PATIENT 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 Benefit.

Such treatment (radiotherapy or chemotherapy excluding consultation, examination tests, take home drugs) must be received at the out-patient 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) Carcinorma in situ including of the cervix;
(b) Ductal Carcinorma in situ of the breast;
(c) Papillary Carcinorma of the bladder & Stage 1 Prostate Cancer;
(d) All skin cancers except malignant melanoma;
(e) Stage 1 Hodgkin's disease;
(f) Tumours manifesting as complications of AIDS.

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

ANNUAL OUT-PATIENT 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 Benefit.

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

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

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

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
If an Insured Person has been hospitalized and diagnosed of AIDS with all illnesses or diseases in the presence of the Human Immune-Deficiency Virus (HIV) or AIDS Related Complex (ARC) and certified by the hospital practitioner, the benefit shall be paid only once during the Insured Person lifetime and in full sum and shall not exceed the maximum lifetime limit shown in the Schedule of Benefit.

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

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EMERGENCY OUT-PATIENT ILLNESSES
Reimbursement of the actual charges incurred for services and supplies furnished by the hospital or clinic in connection with an emergency treatment of an illness or sickness between the hours of midnight, 12:00 midnight to 6:00 am and received as an out-patient subject to the maximum amount stated in the Schedule of Benefit. Benefit is limited to one visit per year.

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

OUT-PATIENT PHYSIOTHERAPY TREATMENT
Reimbursement of the Reasonable and Customary Charges for out-patient physiotherapy treatment rendered after surgery or in-hospital treatment, within the maximum number of days and amount as set forth in the Schedule of Benefit from the date of hospital discharge or surgery for any one Disability, provided that the said out-patient physiotherapy treatment is referred in writing by a licensed specialist physician.

ACCIDENTAL DEATH
A lump sum payment as stated in the Schedule of Benefit shall be payable to the legal representative or next of kin, when injury results in loss of life of the Insured Person, provided death occurring within twelve (12) months from the date of accident.

HOME NURSING
A home nursing benefit shall be payable if care is provided under a plan established and periodically reviewed by a Registered Medical Practitioner and is only payable after a minimum of three (3) days' hospitalization beginning within seven (7) days of hospital discharge. The benefit payable shall equal the actual charges made but in no event shall the benefit exceed a maximum of twenty (20) weeks and the maximum amount set forth in the Schedule of Benefit for Any One Disability.

Home Nursing Care covered under this Policy includes:
- Physical, occupational, or speech therapies;
- Part-time or intermittent nursing care provided under the supervision of a registered nurse;
- Part-time or intermittent services of a home health aide;
- Medical social services provided under the direct supervision of a physician.

Custodial care, meals, general housekeeping services, companions, and personal comfort items are excluded.

DOUBLE PLAN BENEFITS FOR ACCIDENTAL INJURY WHILST TRAVELLING OVERSEAS
When traveling outside Malaysia, the monetary limit for hospital related benefit under the Schedule of Benefit shall be doubled if it is as a result of **Accidental Injury** only.

TAKE-OVER POLICIES
If this policy shall have commenced immediately upon termination of a preceding Policy and if an Insured Person shall have been afflicted with a medical Disability prior or at the time this Policy started (and benefits under the preceding Policy would have been available to him), such Insured Person shall continue to be covered for the existing Disability, but not to exceed the limits of the previous Policy on condition the Company has secured a copy of the preceding Policy.

IMPORTANT NOTICE

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

2. Any Policyholder / Insured Person who is not satisfied with the course of the action or decision of the Company, may seek redress or assistance with the Financial Mediation Bureau or alternatively to approach Bank Negara Malaysia's Customer Services Bureau, addressed below:

   a. Financial Mediation Bureau (FMB)
   Level 25, Dataran Kewangan Darul Takaful,
   No. 4, Jalan Sultan Sulaiman,
   50000 Kuala Lumpur.

   Tel : 03 2272 2811
   Fax : 03 2274 5752

   b. Customer Services Bureau (CSB)
   Jabatan Pengawalan Insurans,
   Bank Negara Malaysia
   P.O. Box 10922, Jalan Dato' Onn,
   50480 Kuala Lumpur.
   Tel : 03 2698 8044
   Fax : 03 2694 5986

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