STAMP DUTY PAID

MI-UW-S008(E)

KURNIA MEDICAL INSURANCE POLICY

AmGeneral Insurance Berhad ("the Company") in return for the payment of such premiums as describes 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 entitle thereto) due to hospitalization as a direct result of an accidental bodily injury, illness or disease or sickness subject to the Definitions, Exclusions, 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 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 AmGeneral Insurance Berhad.

"**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 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.

"**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.

"**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.

"**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 in-patient), and

(d) not of an experimental, investigational or research nature, preventive or screening nature,

(e) or 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 set forth in the Schedule of Benefit irrespective of a type/types of Disability. In the event the Overall Annual Limit having been fully paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining Policy year.

"**Lifetime Limit**" shall mean the maximum amount payable in the lifetime of the Insured Person. Once the lifetime limit is reached, the policy is automatically terminated. Where stated in the Policy, the lifetime limit shall apply.

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 set forth 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.

This Benefit shall not be payable if such expenses incurred has been reimbursed under Out-patient Clinical Benefits, if the Insured Person have been provided with such Supplementary Out-patient Clinical Benefits as set forth in the Policy Schedule and Schedule of Benefit. However, any amount in excess of the maximum payable under Out-patient Clinical Benefits shall be reimbursable under this Benefit, subject to the maximum number of days and amount as set forth in the Schedule of Benefit.

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.

This Benefit shall not be payable if such expenses incurred has been reimbursed under Out-patient Clinical Benefits, if the Insured Person have been provided with such Supplementary Out-patient Clinical Benefits as set forth in the Policy Schedule and Schedule of Benefit. However, any amount in excess of the maximum payable under Out-patient Clinical Benefits shall be reimbursable under this Benefit, subject to the maximum number of days and amount as set forth in the Schedule of Benefit.

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.

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 set forth 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.

EMERGENCY ACCIDENTAL OUT-PATIENT TREATMENT
Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum set forth 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.

This Benefit shall not be payable if such expenses incurred has been reimbursed under Out-patient Clinical Benefits, if the Insured Person have been provided with such Supplementary Out-patient Clinical Benefits as set forth in the Policy Schedule and Schedule of Benefit. However, any amount in excess of the maximum payable under Out-patient Clinical Benefits shall be reimbursable under this Benefit, subject to the maximum number of days and amount as set forth in the Schedule of Benefit.

EMERGENCY DENTAL OUT-PATIENT TREATMENT
Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum set forth in the Schedule of Benefit, as a result of accidental injuries to sound natural teeth for Medical Necessary treatment as an out-patient at any registered dental clinic or hospital within 24 hours of the Accident. Follow-up treatment by the same dentist at the same registered dental clinic or Hospital will be provided up to the maximum amount and the maximum number of days as set forth in the Schedule of Benefit. Subsequent restorative, periodontal, orthodontal and prosthodontal services are not covered.

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 Person 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.

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.

FULL REIMBURSEMENT FOR GOVERNMENT HOSPITAL
All admission to government hospital will not be subject to any limit for expenses incurred but limited to the Overall Annual Limit for plan type selected.

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 set forth 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 set forth 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.

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, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related diseases, 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.

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.

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.

ADDITION OF INSURED PERSONS
Dependants of the Policyholder who are eligible to be Insured Person shall, from time to time this Policy is in force, be included as an Insured Person(s) of this Policy if:–

(a) the Policyholder requests such inclusion;

(b) the Dependants are eligible to be Insured Person in accordance with terms and standards of acceptance by the Company; and

(c) the required additional premium is paid

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

This Policy will be renewable at the option of Policyholder subject to the terms, conditions and termination at each of the anniversary of the Policy date. The renewal premiums payable is not guaranteed and the Company reserves the right to revise the premium rate applicable at the time of renewal. Such changes, if any shall be applicable to all Policyholders irrespective of their claim experience according to the Company's risk assessment.

This Policy is renewable at the option of Policyholder until the occurrence of any of the following:

(a) non payment of premium or premium not made on time

(b) fraud or misrepresentation of material fact during application

(c) the Policy is cancelled at the request of the Policyholder

(d) total claims of the Policy have reached the lifetime limit specified and/or on the death of the Insured Person

(e) the Insured Person ceases to qualify as a dependant based on the definition of the Policy

(f) the Insured Person attains the coverage age limit specified

(g) termination of coverage for all Policies in a certain market and the Company withdraws this Policy completely from the market in accordance with the Portfolio Withdrawal Condition.

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.

SUCCEEDING POLICYHOLDER
In the event of death of the Policyholder while this Policy is in force, the Policyholder's legal spouse if at the time is an Insured Person, shall automatically become the Policyholder and all references in this Policy to the Policyholder shall thereafter mean such spouse.

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.

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.

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

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 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.

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.

MISREPRESENTATION / FRAUD
This policy may be voidable in the event of a misrepresentation, misdescription, error, omission or non-disclosure of fact by the Policyholder and/or the Insured Person, which the Policyholder and/or Insured Person knew or ought to have known to be untrue, misleading or relevant or which may have influenced the judgment of any prudent insurer (including the Company) in determining the premium payable and/or determining if the risk should be accepted, with or without intention to defraud the Company.

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
Subject to the Alterations permitted hereunder, this Policy together with the attached schedules, the Policyholder's / Insured Person's Proposal Form (unless the same is waived) (as the case may be) constitutes the entire Contract between the parties and there are no other undertakings, statements, representations, warranties, promises, express or implied, other than those contained in this 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 occupation, business, duties or pursuits and pay any additional premium that may be required by the Company.

SUBROGATION
If the Company shall become liable for any payment under this Policy, the Company shall be subrogated to the extent of such payment to all the rights and remedies of the Insured Person against any party and shall be entitled at its own expense to sue in the name of the Insured Person. The Insured Person shall give or cause to be given to the Company all such assistance in his 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.

CONTRIBUTON
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 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 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.

TAKE-OVER POLICIES (applicable only if specified in the Policy Schedule)
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.

UPGRADED POLICIES (applicable only if specified in the Policy Schedule)
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 (applicable only if specified in the Policy Schedule)
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 30 days written notice to the Policyholder and the Company will run off all policies to expiry of the period of cover within the portfolio.

CLAUSES AND BENEFITS to be Attached and Read as part of the Policy
(applicable only if specified in the Policy Schedule / 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.

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.

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.

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.

ORGAN TRANSPLANT
Reimbursement of the Reasonable and Customary Charges incurred on transplantation surgery for the Insured Person being the recipient of the transplant of a kidney, heart, lung, liver or bone marrow. Payment for this Benefit is applicable only once per lifetime whilst the Policy is in force and shall be subject to the limit 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.

INSURED 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 Person (age as set forth in the Schedule of Benefit) in the hospital up to the maximum number of days set forth in the Schedule of Benefit.

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

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 as set forth in the Schedule of Benefit.

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.

SECOND SURGICAL OPINIONS
Reimbursement of the Reasonable and Customary Charges for consultation fees with a second Specialist to determine whether a surgical operation is necessary and/or required in view of the Insured Person's medical condition, up to the amount as set forth in the Schedule of Benefit. Payment will not be made for clinical treatment (including medications and subsequent consultation after the illness is diagnosed) or where the Insured Person does not result in hospital confinement for the treatment of the medical condition diagnosed.

TRANSPORTATION OTHER THAN AMBULANCE
Reimbursement of the Reasonable and Customary Charges incurred for Medically Necessary domestic transportation services other than ambulance (inclusive of attendant), including but not limited to taxis and helicopters, to and/or from the Hospital of confinement. Payment will not be made if the Insured Person is not hospitalized and is payable up to the amount as set forth in the Schedule of Benefit.

INTERNATIONAL TRAVEL PLAN
Provides reimbursement for the following travel-related loss incurred when travelling out of Malaysia: Baggage, Personal Money And Documents, Travel Delay, Flight Cancellation, Curtailment. Total benefits payable is up to RM 5,000 in aggregate for the 1-year policy term.

Baggage
Reimburses for loss of or damage to baggage, including personal belongings worn or carried, up to RM 5,000. Any one item shall not be worth more than RM 500.

Personal Money And Documents
Reimburses for accidental loss of cash or travellers' cheques during the journey up to RM 500. Additionally, in the event of lost or accidentally destroyed passports, benefit payable for travel and accommodation expenses including cost of obtaining replacement passports, travel tickets and other relevant travel documents up to RM1,000.

Travel Delay
Reimburses the Insured Person if the scheduled sea-going vessel, aircraft or train booked to travel is delayed from the scheduled departure time. For each full eight (8) consecutive hours delay from the time specified in the itinerary due to adverse weather or mechanical breakdown, for reasonable, additional accommodation and travelling expense incurred, benefit payable is RM 200 up to a maximum of RM 2,000.

Flight Cancellation
Reimburses for unrecoverable travel and accommodation expenses prepaid in advance up to RM 5,000 in the event of flight cancellation beyond your control.

Curtailment
Reimburses for unrecoverable travel and accommodation expenses prepaid in advance up to RM 5,000 in the event of curtailment of the trip due to bodily injury, illness or death of Insured Person's immediate family, i.e. spouse, child and parent.

GERIATRIC BENEFIT
A lump sum benefit payable as set forth in the Schedule of Benefit upon diagnosis with hospitalization treatment of deterioration or loss of intellectual capacity illnesses specifically Alzheimers, Parkinson, Senile Dementia or Dementia diagnosed by an appropriate consultant. Such conditions and disorders must be evidenced by clinical state resulting in reduction in mental and social functioning requiring the continuous supervision of the Insured Person by a doctor or caregiver. Benefit shall be paid only once during the Insured Person lifetime and in full sum as set forth in the Schedule of Benefit. However, no benefit shall be payable for presentation of signs and symptoms of ageing solely.

FEMALE CANCER
A lump sum benefit payable once during the Insured Person lifetime as set forth in the Schedule of Benefit upon diagnosis of Female Cancer (Breast Cancer, Cervical Cancer, Uterine Cancer, Ovarian Cancer, Cancer of the Fallopian Tubes and Cancers of the Vulva and Vagina).

Cancer is defined as a malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion & destruction of normal tissue. This diagnosis must be supported by histological evidence of malignancy & confirmed by an oncologist or pathologist. All tumours in the presence of HIV infection are excluded.

"**Breast Cancer**" shall mean malignant lesion arising in epithelial or supporting breast tissue and spreading locally to surrounding tissue or distantly involves lymph nodes and other remote organs. Breast Cancer does not include Ductal Carcinoma in situ of the breast.

"**Cervical Cancer**" shall mean malignant lesion which arises within the cervical epithelium but has extended into and beyond underlying stromia and demonstrates the potential to (or at the time of diagnosis, has) spread to adjacent and/or distant tissues and organs. Cervical Cancer does not include:

(a) Diagnosis of mild, moderate, severe dysplasia (CIN I, CIN II, or CIN III, Carcinoma in situ)
(b) Changes due to Human Papilloma virus not demonstrating malignant transformation.

"**Uterine Cancer**" shall mean malignant lesion arising in the lining or wall of the uterus and demonstrates the potential to, or has spread to local and/or distant tissues and organs.

"**Ovarian Cancer**" shall mean malignant neoplasms arising in the ovary which demonstrates the potential to, or has spread to local and/or distant tissues or organs.

"**Cancer of the Fallopian Tubes**" shall mean malignant neoplasms arising in the Fallopian tubes.

"**Cancers of the Vulva and Vagina**" shall mean malignant neoplasm arising in the epithelium and spreading to involve the underlying supporting tissues, and/or distant tissues or organs.

ACCIDENTAL FACIAL / DENTAL COSMETIC SURGERY
Reimbursement of Reasonable and Customary Charges incurred for a necessary treatment or reconstructive surgery of facial and neck disfigurement or damage to sound natural teeth following injuries sustained as a result of accident, up to the maximum amount as set forth in the Schedule of Benefit. The benefit shall be paid only once during the Insured Person lifetime.

PREGNANCY COMPLICATIONS
Reimbursement of Reasonable and Customary Charges incurred for a Medically Necessary treatment arising from the following pregnancy complications: disseminated intravascular coagulation, ectopic pregnancy, still birth and hydatidiform mole (molar pregnancy), up to the amount as set forth in the Schedule of Benefit. In the event of Pregnancy Complications leading to maternal mortality (death), the maximum amount payable for Pregnancy Complications and maternal mortality in aggregate shall not be more than the Maternity Death benefit.

MATERNITY DEATH
A lump sum benefit payable as set forth in the Schedule of Benefit upon death directly caused by a pregnancy disorder or complications arising within 30 days from child birth or miscarriage. In the event of maternal mortality (death) following Pregnancy Complications, the amount payable for maternal mortality shall be the remaining amount of Maternity Death benefit after deduction of the accelerated amount paid for Pregnancy Complications.

DOUBLE OVERALL ANNUAL LIMIT FOR ACCIDENTAL INJURY WHILST TRAVELLING OVERSEAS
In the event of an Accidental Injury while travelling outside of Malaysia, the monetary value of the Overall Annual Limit under the Schedule of Benefits will be doubled, and will be subject only to the Lifetime Limit whichever is lower.

MAJOR MEDICAL
If the Insured Person suffers from one of the major disability, as defined, he is eligible to be covered under the Major Medical with benefits as defined herein subject to policy terms and conditions. The Policy provides increased annual benefit limits on top of the Overall Annual Limit up to the amount as set forth in the Schedule of Benefit for the following conditions: Stroke or Cerebrovascular Accident, Heart Attack, Kidney Failure, Cancer, Coronary Artery Disease Requiring By-Pass, Chronic Liver Disease, Fulminant Viral Hepatitis, Coma, Paralysis/Paraplegia, Major Burns, Chronic Lung Disease, Encephalitis, Major Organ Transplant, Brain Surgery, Heart Valve Replacement, Multiple Sclerosis, Open Heart Surgery, Total Blindness, Total Loss of Hearing/Deafness, Bacterial Meningitis. Amount payable shall be in excess of the amount reimbursement under the basic plan and benefits up to a lifetime maximum amount per Insured Person as set forth in the Schedule of Benefit for Major Medical. The benefit limit, time frame and co-payment (if any) specified for treatments rendered under each benefit set forth under the Schedule of Benefit must still be observed to qualify for benefit payment.

ACCIDENTAL DEATH
A lump sum payment as set forth in the Schedule of Benefit shall be payable to the legal representative or next of kin, when injury is sustained by an Insured Person during the period of insurance, caused by accidental, violent, external and visible means which shall solely and independently of any other cause results in loss of life of the Insured Person, provided death occurring within twelve (12) months from the date of accident. This benefit ceases to be payable once the Permanent Total Disablement benefit, which is an acceleration of the Accidental Death benefit, has been paid under the same period of insurance coverage. The Accidental Death benefit payable is not subject to the Overall Annual Limit.

PERMANENT TOTAL DISABLEMENT
A lump sum payment as set forth in the Schedule of Benefit shall be payable, when injury is sustained by an Insured Person during the period of insurance, caused by accidental, violent, external and visible means which shall solely and independently of any other cause results in his permanent total disablement or total paralysis or being permanently bedridden within twelve (12) months from the date of accident. This benefit is an acceleration of the Accidental Death benefit; Under the same period of insurance coverage, once the Permanent Total Disablement benefit has been paid, the Accidental Death benefit ceases to be payable. The Permanent Total Disablement payable is not subject to the Overall Annual Limit.

"**Permanent Total Disablement**" shall mean absolute disablement from engaging in or giving attention to profession or occupation of any kind.

BEREAVEMENT BENEFIT
A lump sum payment as set forth 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. The Bereavement Benefit payable is not subject to the Overall Annual Limit.

EVACUATION AND REPATRIATION FEES
In the event of an Accidental Injury occurring while traveling outside Malaysia resulting in death or disablement of the Insured Person to the extent that requires Medically Necessary evacuation and repatriation assistance back to Malaysia, actual expenses incurred by the Insured Person shall be reimbursed up to the maximum amount set forth in the Schedule of Benefit, whichever is lower. The Evacuation And Repatriation Fees payable is not subject to the Overall Annual Limit.

TUITION FEES REIMBURSEMENT
In the event of an Accidental Injury resulting in temporary disablement of the Insured Person for at least thirty (30) days which prevents the Insured Person from completing a term/semester of his tertiary course of study, the prepaid tuition fees for the incomplete term/semester which are not refunded to the Insured Person shall be reimbursed up to the maximum amount set forth in the Schedule of Benefit, whichever is lower. The Insured Person is required to provide an official letter from the educational institution stating that the Insured Person is permitted to repeat the course specifically due to the temporary disablement of the Insured Person. The Tuition Fees Reimbursement payable is not subject to the Overall Annual Limit.

SUPPLEMENTARY OUT-PATIENT CLINICAL BENEFITS to be Attached and Read as part of the Policy

(applicable only if specified in the Policy Schedule/Schedule of Benefit)

PART I – BENEFIT EXTENT AND CONDITIONS OF PAYMENT

The following out-patient clinical services are available to the Insured Person when he visits the general practitioner (GP) or specialist (SP) for any treatment subject to the provisions of this Policy and up to the maximum amount and maximum number of visits as set forth in the Schedule of Benefit:

OUT-PATIENT GENERAL PRACTITIONER (GP) CARE
Reimbursement of Reasonable and Customary Charges for general practitioner consultation during normal clinical hours, medications, injections, dressing and diagnostic testing (for Accidental Injury only) as prescribed by the general practitioner for an illness or injury as an out-patient (in the Physician's office or clinic) subject to the maximum limit, number of visits, Out-patient Co-Payment amount and/or Out-patient Annual Limit as set forth in the Schedule of Benefit. Out-patient Co-Payment shall be waived for Accidental Injury only.

OUT-PATIENT SPECIALIST (SP) CARE
Reimbursement of Reasonable and Customary Charges for specialist consultation during normal clinical hours, medications, injections, dressing and diagnostic testing (for Accidental Injury only) as prescribed by the specialist for an illness or injury as an out-patient (in the Physician's office or clinic) with a Panel Doctor's

referral (excluding subsequent consultation/treatment with the same specialist), subject to the maximum limit, number of visits, Out-patient Co-Payment amount and/or Out-patient Annual Limit as set forth in the Schedule of Benefit. Out-patient Co-Payment and maximum limit per visit shall be waived for Accidental Injury only.

If the Insured Person with a Panel Doctor's referral seeks a second specialist consultation for the referenced provisional diagnosis (involving surgical operation) any amount in excess of the maximum payable under this Benefit shall be reimbursable under Second Surgical Opinions benefit up to the maximum amount as set forth in the Schedule of Benefit.

PREVENTIVE SCREENING (PAP SMEAR / PROSTATE SPECIFIC ANTIGEN)

Reimbursement of Reasonable and Customary Charges for pap smear examination or prostate specific antigen (PSA) test performed by a Panel Doctor subject to the limits set forth in the Schedule of Benefit. This benefit is limited to one screening per Insured Person per Policy year.

OVERALL ANNUAL LIMIT (for Out-patient Clinical)

"Overall Annual Limit" shall mean benefits payable in respect of expenses incurred for out-patient clinical services provided to the Insured Person during the period of insurance shall be limited to the Out-patient Annual Limit as set forth in the Schedule of Benefit irrespective of the type/types of Disability. In the event the Out-patient Annual Limit having been fully paid, the out-patient clinical benefits for the Insured Person herein shall immediately cease to be payable for the remaining Policy year.

LIFETIME LIMIT (for Out-patient Clinical)

"Lifetime Limit" shall mean the maximum amount payable in the lifetime of the Insured Person as set forth in the Schedule of Benefit attached hereto and is the maximum limit of out-patient clinical benefits liability to the Insured Person.

PART II - LIMITATIONS AND EXCLUSIONS

BENEFITS LIMITS

As a result of sickness or injury, an Insured Person shall necessarily incur expenses for consultation during normal clinical hours, medications and treatment by a general practitioner or specialist (in the Physician's office or clinic), the Company shall make reimbursement for the actual Reasonable and Customary charges up to the maximum benefit as set forth in the Schedule of Benefit and in accordance with the Procedure Guides, provided that:–

1. Such reimbursement shall be limited to no more than one general practitioner (GP) and one specialist (SP) visit per day, and to a maximum of either a maximum number of visits or a maximum amount in one policy year, as set forth in the Schedule of Benefit, if any; and
2. Requirement for referral and/or authorization as set forth in the Policy, Procedure Guides, and/or Schedule of Benefit, if any, is fulfilled.
3. If no amount is specified per any specific type of services under this benefit in the Schedule of Benefit, such specific type of services shall not be payable.
4. Preventive care such as childhood immunizations, annual pap smear examination and annual prostate specific antigen examination, if specified in the Schedule of Benefit must be rendered by panel GP and subject to the maximums and limitations as set forth in the Schedule of Benefit.
5. Any utilization of health services outside the Company's network panel of clinics would be on reimbursement basis up to a maximum of 80% of the actual charges or RM 20 whichever is lower and is limited to "emergency" situations only except for Accidental Injury.

   "Emergency" shall mean in the event whereby immediate medical attention is required within 12 hours for illness or symptom which is sudden and severe failing which the Insured Person's life could be threatened (e.g. heart attack), or lead to significant deterioration of health.
6. The Out-patient Co-payment and any other fees for services excluded under this policy, if any, shall be made to the panel doctor directly at the time the service is rendered to the Insured Person or deducted upon reimbursement of eligible expenses.

   "Out-patient Co-Payment" shall mean a fixed fee or percentage portion of cost (as set forth in the Schedule of Benefit and may be varied by the Company from time to time) borne by the Insured Person in order to obtain the out-patient clinical services.

AUTOMATIC BENEFIT TERMINATION

The Out-patient Clinical Benefit shall automatically cease upon the occurrence of any of the following:

1. Total out-patient clinical claims has reached the out-patient lifetime limit specified in the Schedule Of Benefit (Section B).
2. Total claims of the Policy have reached the lifetime limit specified in the Schedule Of Benefit (Section A) and subject to the terms and conditions set forth under Part V - Other Policy Provisions.

EXCLUSIONS

This policy does not cover any out-patient clinical treatment or charges caused directly or indirectly, wholly or partly, by any one (1) of the following occurrences:

1. 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, aero chambers, equipment from nebulising, implanted pacemakers and prescriptions thereof.
2. 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.

3. Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilization, venereal disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related diseases, and any communicable diseases required quarantine by law.
4. Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.
5. 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.
6. Consultation 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.
7. Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.
8. 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.
9. Ionizing radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.
10. 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.
11. 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.
12. Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestations).
13. 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.
14. Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes.
15. Long term medications for the following conditions are excluded: Arthritis, Asthma, High Blood Pressure, Coronary Artery Disease, Cerebrovascular Disease, Cerebrovascular Accident, Diabetes Mellitus, Epilepsy, Gout, Hyperlipidemia, Parkinson, Peptic Ulcer, Psoriasis and Thyroid.
16. Personal comfort and convenience items (e.g. soaps, shampoos, vitamin creams and vitamin ointment) or services and similar incidental services and supplies, durable medical equipment including supplement medication even though prescribed by a physician.
17. Upper and lower jaw bone surgery (including that related to the temporomandibular joint) except for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
18. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.
19. Services rendered by a provider with the same legal residence as an Insured Person or who is a member of a Insured Person's family, including spouse, brother, sister, parent or child.
20. Education services such as speech improvement, diabetic classes and nutritional services, or group support services, unless authorized by the Company.
21. Out-patient prescribed or non-prescribed medical supplies including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; over the counter drugs and treatments.
22. Any preventive vaccination or childhood immunization (unless specifically included in the Schedule of Benefit).
23. Topical skin testing at a GP clinic.
24. General screening profiles at a GP clinic (unless specifically included in the Schedule of Benefit).
25. Growth hormone therapy.
26. Out-patient physical therapy, physiotherapy and/or rehabilitation therapy is not covered and cannot be referred at general practitioner level. This service would only be covered when referred by a specialist and treatment must be provided by a registered physiotherapist.

PART III - CLAIMS PROCEDURES

1. Enrolling for coverage under the policy does not guaranteed medical services by a particular panel clinic on the list of Company's network of panel clinics. The list of panel clinics is subject to change.
2. Insured Persons are responsible for verifying the participation status of any panel clinic prior to receiving health services. The Insured Person must show his medical card and a picture identity card. The medical card and a picture identity card must be shown every time health services are requested.
3. If the panel GP is not able to provide a Medically Necessary treatment to the Insured Person, a written referral letter by a panel GP must be obtained and a copy given to the specialist prior to receiving specialist care. Failure to provide referral letter to the specialist may result in denial of service or payment. A referral letter allows Insured Person up to two specialist consultations for the referenced provisional diagnosis.
4. In the event of utilization of health services outside the Company's network panel of clinics, 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, receipts and referral letter (for out-patient specialist care) and a full Physician's report stipulating the diagnosis of the condition treated and date the Disability commenced in the Physician's opinion and the Physician's summary of the cost of treatment including medicines and services rendered.

5. All claims must be submitted to the Company within 30 days of completion of the events for which claim is being made. 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 of the foregoing shall be at the Company's sole discretion.

CLAUSES AND ENDORSEMENT to be Attached and Read as part of the Policy
(applicable only if specified in the Policy Schedule)

SPECIAL CONDITIONS FOR INSTALMENT PAYMENT

PART I – DEFINITIONS

"Nominated Account" shall mean the account nominated by the Policyholder in the Monthly Instalment Payment Instruction, or as subsequently instructed by the Policyholder in writing, to which premiums for this Policy to be debited or charged.

PART V – OTHER POLICY PROVISIONS

Automatic Termination
This Policy shall terminate immediately on the termination of the Policyholder's Nominated Account to which premium payable for this policy is charged.

This shall similarly affect the insurance of the Insured's dependant.

Termination for the Non-Payment of Premium

(a) In the event initial premium charged to the Policyholder's Nominated Account is not paid within 15 days, this policy shall be deemed to have been void from the intended Effective Date of Insurance, if policy has been issued.

(b) Provided one or more premiums charged to the Policyholder's Nominated Account have been paid, non-payment of subsequent premium shall terminate insurance under this policy as of the due date of such unpaid premium and no cancellation notice will be served.

Position of Claims Upon Termination
Such termination shall be without prejudice to any claim with a date of event prior to the effective date of termination.

Premium Position Upon Termination
No refund of premium is allowed for payment made until the date of termination. In the event premium has been paid for any period beyond the date of termination of this Policy, the relevant proportion thereof shall be credited to the Policyholder's Nominated Account or refunded to the Policyholder by the Company. If the premium has not been paid for any period up to the date of termination as aforesaid, the Policyholder shall be liable to the Company for the payment of such premium, which the Company may, at its option, charge to the Policyholder's Nominated Account.

Premium

(a) Premium as stated in the Policy schedule shall be due on the Effective Date of Policy and if payable monthly, on the same date of each month thereafter. If the month for which premium is due, does not have a corresponding date, then premium shall be paid on the last day of that month.

(b) Premium will be charged to the Policyholder's Nominated Account when due.

Additions Of Insured Persons
The relevant addition premium for such eligible dependant will be charged to the Policyholder's Nominated Account and the insurance for such eligible dependant will commence on the date such request is approved or otherwise agreed by the Company and premium is paid.

Consideration
This Policy is issued in consideration of the statements contained in the Proposal Form, Monthly Instalment Payment Instruction and the Policyholder's agreement to pay premiums charged to his Nominated Account.

Renewal Certificate / Schedule
Subject to the terms and conditions of this Policy, payment of premium when due automatically renews the Policy. A renewal certificate/schedule shall be issued to the Policyholder upon expiry of each Policy year.

KURNIA MEDICAL INSURANCE 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 immediately 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 recourse through our Complaint Handling Unit and alternatively, may also seek redress or assistance with the Financial Mediation Bureau or to approach Bank Negara Malaysia's Laman Informasi Nasihat dan Khidmat (LINK) addressed below:-

a. Complaint Handling Unit
Risk and Compliance Department
AmGeneral Insurance Berhad
Menara Shell
No. 211, Jalan Tun Sambanthan
50470 Kuala Lumpur
PO Box 11228, GPO Kuala Lumpur
50740 W.P. Kuala Lumpur, Malaysia
Tel : 03-2268 3333
Fax: 03-2268 2222

b. Financial Mediation Bureau (FMB)
Tingkat 25, Blok Utama
Dataran Kewangan Darul Takaful
No. 4, Jalan Sultan Sulaiman
50000 Kuala Lumpur
Tel : 03-2272 2811
Fax: 03-2274 5752

c. Laman Informasi Nasihat dan Khidmat (LINK)
Tingkat Bawah, Blok C
Bank Negara Malaysia
Peti Surat 10922
50929 Kuala Lumpur
Tel : 1300 88 5465
Fax: 03-2174 1515