MEDIGUARD SUPREME POLICY

AmGeneral Insurance 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 MediGuard Supreme 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) hour basis solely for treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.

"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 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, and

(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 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.

"Deductible" Deductible is the amount payable by Insured Person in respect of expenses incurred before any benefits are paid under the Policy for each policy year. The deductible applicable to this Policy is set out in the Schedule of Benefit. Any co-insurance will not apply towards meeting the Deductible.

"General Terms For Critical Illnesses"

I. Irreversible means cannot be reasonably improved upon by medical treatment and/or surgical procedures consistent with the current standard of the medical services available in Malaysia.

II. Permanent means expected to last throughout the lifetime of the Life Assured.

III. Permanent neurological deficit with persisting clinical symptoms means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Life Assured. Symptoms that are covered include numbness, paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

IV. Activities of Daily Living (ADL) are as follows:

(i) **Transfer**
Getting in and out of a chair without requiring physical assistance.

(ii) **Mobility**
The ability to move from room to room without requiring any physical assistance.

(iii) **Continence**
The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.

(iv) **Dressing**
Putting on and taking off all necessary items of clothing without requiring assistance of another person.

(v) **Bathing/Washing**
The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.

(vi) **Eating**
All tasks of getting food into the body once it has been prepared.

V. Assessment Period means the period during which the insurer will assess a condition before deciding whether or not the condition qualifies as being permanent. The assessment period will be for the minimum period time frame stated in the relevant definition and will not be longer than twelve (12) months (provided all required evidence has been submitted).

"Definition of Critical Illnesses"

I. Stroke – resulting in permanent neurological deficit with persisting clinical symptoms

Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolization from an extra cranial source resulting in permanent neurological deficit with persisting clinical symptoms. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist. A minimum Assessment Period of three (3) months applies.

For the above definition, the following are not covered:

(i) Transient ischemic attacks
(ii) Cerebral symptoms due to migraine
(iii) Traumatic injury to brain tissue or blood vessels
(iv) Vascular disease affecting the eye or optic nerve or vestibular functions.

II. Heart Attack – of specified severity

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

(i) A history of typical chest pain;
(ii) New characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block and
(iii) Elevation of the cardiac biomarkers , inclusive of CPK-MB above the generally accepted normal laboratory levels or Troponins recorded at the following levels or higher:
- Cardiac Troponin T or Cardiac Troponin I > / = 0.5 ng/ml

The evidence must show the occurrence of a definite acute myocardial infarction which should be confirmed by a cardiologist or physician.

For the above definition, the following are not covered:

- occurrence of an acute coronary syndrome including but not limited to unstable angina.
- a rise in cardiac biomarkers resulting from a percutaneous procedure for coronary artery disease.

III. Kidney Failure – requiring dialysis or kidney transplant

End-stage kidney failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular dialysis is initiated or kidney transplantation is carried out.

IV. Cancer – of specified severity and does not cover very early cancers

Any malignant tumour positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukemia, lymphoma and sarcoma.

For the above definition, the following are not covered:

(i) All cancers which are histologically classified as any of the following:
- pre-malignant
- non-invasive
- carcinoma in situ
- having borderline malignancy
- having malignant potential
(ii) All tumours of the prostate histologically classified as T1N0M0 (TNM classification)
(iii) All tumours of the thyroid histologically classified as T1N0M0 (TNM classification)
(iv) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM classification)
(v) Chronic Lymphocytic Leukemia less than RAI Stage 3
(vi) All cancers in the presence of HIV
(vii) Any skin cancer other than malignant melanoma.

V. Coronary Artery By-Pass Surgery

Refers to the actual undergoing of open-chest surgery to correct or treat Coronary Artery Disease (CAD) by way of coronary artery by-pass grafting.

For the above definition, the following are not covered:

(i) angioplasty;
(ii) other intra-arterial or catheter based techniques;
(iii) keyhole procedures;
(iv) laser procedures.

VI. Serious Coronary Artery Disease

The narrowing of the lumen of Right Coronary Artery (RCA), Left Anterior Descending Artery (LAD) and Circumflex Artery (not inclusive of their branches) occurring at the same time by a minimum of sixty percent (60%) in each artery as proven by coronary arteriography (non-invasive diagnostic procedures are not covered). A narrowing of sixty percent (60%) or more of the Left Main Stem will be considered as a narrowing of the Left Anterior Descending Artery (LAD) and Circumflex Artery. This covered event is payable regardless of whether or not any form of coronary artery surgery has been performed.

VII. Angioplasty and other invasive treatments for coronary artery disease

The actual undergoing for the first time of Coronary Artery Balloon Angioplasty, artherectomy, laser treatment or the insertion of a stent to correct a narrowing or blockage of one or more coronary arteries as shown by angiographic evidence.

Intra-arterial investigative procedures are not covered. Payment under this clause is limited to ten percent (10%) of the Critical Illness coverage under this policy subject to a maximum of RM25,000. This covered event is payable once only and shall be deducted from the amount of this Contract, thereby reducing the amount of the Lump Sum Payment which may be payable.

VIII. End-Stage Liver Failure

End-stage liver failure as evidenced by all of the following:

- Permanent jaundice;
- Ascites (excessive fluid in peritoneal cavity); and,
- Hepatic encephalopathy.

Liver failure secondary to alcohol or drug abuse is not covered.

IX. Fulminant Viral Hepatitis

A sub-massive to massive necrosis (death of liver tissue) caused by any virus as evidenced by all of the following diagnostic criteria:

(i) A rapidly decreasing liver size as confirmed by abdominal ultrasound;
(ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework;
(iii) Rapidly deteriorating liver functions tests; and
(iv) Deepening jaundice.

Viral hepatitis infection or carrier status alone (inclusive but not limited to Hepatitis B and Hepatitis C) without the above diagnostic criteria is not covered.

X. Coma – resulting in permanent neurological deficit with persisting clinical symptoms

A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously for at least ninety six (96) hours, requiring the use of life support systems and resulting in a permanent neurological deficit with persisting clinical symptoms. A minimum Assessment Period of thirty (30) days applies. Confirmation by a neurologist must be present.

The following is not covered:

(i) Coma resulting directly from alcohol or drug abuse.

XI. Benign Brain Tumor – of specified severity

A benign tumour in the brain or meninges within the skull, where all of the following conditions are met:

(i) It is life threatening.
(ii) It has caused damage to the brain.
(iii) It has undergone surgical removal or has caused permanent neurological deficit with persisting clinical symptoms; and
(iv) Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on MRI, CT or other reliable imaging techniques.

The following are not covered:

(i) Cysts
(ii) Granulomas
(iii) Malformations in or of the arteries or veins of the brain
(iv) Hematomas
(v) Tumours in the pituitary gland
(vi) Tumours in the spine
(vii) Tumours of the acoustic nerve.

XII. Paralysis of limbs

Total, permanent and irreversible loss of use of both arms or both legs, or of one arm and one leg, through paralysis caused by illness or injury. A minimum Assessment Period of six (6) months applies.

XIII. Blindness – Permanent and Irreversible

Permanent and irreversible loss of sight as a result of accident or illness to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in both eyes using a Snellen eye chart or equivalent test and the result must be certified by an ophthalmologist.

XIV. Deafness – Permanent and Irreversible

Permanent and irreversible loss of hearing as a result of accident or illness to the extent that the loss is greater than 80 decibels across all frequencies of hearing in both ears. Medical evidence in the form of an audiometry and sound-threshold tests result must be provided and certified by an Ear, Nose, and Throat (ENT) specialist.

XV. Third Degree Burns – of specified severity

Third degree (i.e. full thickness) skin burns covering at least twenty percent (20%) of the total body surface area.

XVI. End-Stage Lung Disease

End-stage lung disease causing chronic respiratory failure.
All of the following criteria must be met:

(i) The need for regular oxygen treatment on a permanent basis;
(ii) Permanent impairment of lung function with a consistent Forced Expiratory Volume (FEV) of less than 1 liter during the first second;
(iii) Shortness of breath at rest; and
(iv) Baseline Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less.

XVII. Encephalitis – resulting in permanent inability to perform Activities of Daily Living

Severe inflammation of brain substance, resulting in permanent functional impairment. The permanent functional impairment must result in an inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of thirty (30) days applies. The covered event must be certified by a neurologist.

Encephalitis in the presence of HIV infection is not covered.

XVIII. Major Organ / Bone Marrow Transplant

The receipt of a transplant of:

- Human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation; or
- One of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ.

Other stem cell transplants are not covered.

XIX. Loss of Speech

Total, permanent and irreversible loss of the ability to speak as a result of injury or illness. A minimum Assessment Period of six (6) months applies. Medical evidence to confirm injury or illness to the vocal cords to support this disability must be supplied by an Ear, Nose, and Throat specialist.

All psychiatric related causes are not covered.

XX. Brain Surgery

The actual undergoing of surgery to the brain under general anesthesia during which a craniotomy (surgical opening of skull) is performed.

For the above definition, the following are not covered:

(i) Burr hole procedures
(ii) Transphenoidal procedures
(iii) Endoscopic assisted procedures or any other minimally invasive procedures
(iv) Brain surgery as a result of an accident.

XXI. Heart Valve Surgery

The actual undergoing of open-heart surgery to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities.

For the above definition, the following are not covered:
(i) Repair via intra-arterial procedure
(ii) Repair via key-hole surgery or any other similar techniques.

XXII. Terminal Illness

The conclusive diagnosis of a condition that is expected to result in death of the Life Assured within twelve (12) months. The Life Assured must no longer be receiving active treatment other than that for pain relief. The diagnosis must be supported by written confirmation from an appropriate specialist and confirmed by the Company's appointed doctor.

XXIII. Loss of Independent Existence

Confirmation by an appropriate specialist of the loss of independent existence and resulting in a permanent inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of six (6) months applies.

XXIV. Bacterial Meningitis - resulting in permanent inability to perform Activities of Daily Living

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent functional impairment. The permanent functional impairment must result in an inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of thirty (30) days applies.

The diagnosis must be confirmed by:

(i) an appropriate specialist; and
(ii) the presence of bacterial infection in the cerebrospinal fluid by lumbar puncture.

For the above definition, other forms of meningitis, including viral meningitis are not covered.

XXV. Major Head Trauma - resulting in permanent inability to perform Activities of Daily Living

Physical head injury resulting in permanent functional impairment verified by a neurologist. The permanent functional impairment must result in an inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of three (3) months applies.

XXVI. Chronic Aplastic Anemia - resulting in permanent Bone Marrow Failure

Irreversible permanent bone marrow failure which results in anemia, neutropenia and thrombocytopenia requiring at least two (2) of the following treatments:

(i) Regular blood product transfusion;
(ii) Marrow stimulating agents;
(iii) Immunosuppressive agents; or
(iv) Bone marrow transplantation.

The diagnosis must be confirmed by a bone marrow biopsy.

XXVII. Motor Neuron Disease – permanent neurological deficit with persisting clinical symptoms

A definite diagnosis of motor neuron disease by a neurologist with reference to either spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be permanent neurological deficit with persisting clinical symptoms.

XXVIII. Parkinson's Disease – resulting in permanent inability to perform Activities of Daily Living

A definite diagnosis of Parkinson's Disease by a neurologist where all the following conditions are met:

(i) Cannot be controlled with medication;
(ii) Shows signs of progressive impairment; and
(iii) Confirmation of the permanent inability of the Life Assured to perform without assistance three (3) or more of the Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinsonism are not covered.

XXIX. Alzheimer's Disease/Severe Dementia

Deterioration or loss of intellectual capacity confirmed by clinical evaluation and imaging tests arising from Alzheimer's Disease or Severe Dementia as a result of irreversible organic brain disorders. The covered event must result in significant reduction in mental and social functioning requiring continuous supervision of the Life Assured. The diagnosis must be clinically confirmed by a neurologist.

From the above definition, the following are not covered:

(i) Non organic brain disorders such as neurosis
(ii) Psychiatric illnesses
(iii) Drug or alcohol related brain damage

XXX. Muscular Dystrophy

The definite diagnosis of a Muscular Dystrophy by a Neurologist which must be supported by all of the following:
(i) Clinical presentation of progressive muscle weakness
(ii) No central/peripheral nerve involvement as evidenced by absence of sensory disturbance
(iii) Characteristic electromyogram and muscle biopsy findings

No benefit will be payable under this Covered Event before the Life Assured has reached the age of 12 years next birthday.

XXXI. Surgery to Aorta

The actual undergoing of surgery via a thoracotomy or laparotomy (surgical opening of thorax or abdomen) to repair or correct an aortic aneurysm, an obstruction of the aorta or a dissection of the aorta. For this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

For the above definition, the following are not covered:

(i) angioplasty;
(ii) other intra-arterial or catheter based techniques;
(iii) other keyhole procedures;
(iv) laser procedures

XXXII. Multiple Sclerosis

A definite diagnosis of multiple sclerosis by a neurologist. The diagnosis must be supported by all of the following:

- Investigations which confirm the diagnosis to be Multiple Sclerosis;
- Multiple neurological deficits resulting in impairment of motor and sensory functions occurring over a continuous period of at least 6 months; and
- Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

XXXIII. Primary Pulmonary Arterial Hypertension – of specified severity

A definite diagnosis of primary pulmonary arterial hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterization, resulting in permanent physical impairment to the degree of at least Class III of the New York Heart Association (NYHA) classification of cardiac impairment.

Pulmonary arterial hypertension resulting from other causes shall be excluded from this benefit.

The NYHA Classification of Cardiac Impairment for Class III and Class IV means the following:

Class III: Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes symptoms.
Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

XXXIV. Medullary Cystic Disease

A progressive hereditary disease of the kidney characterized by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anemia, polyuria and renal loss of sodium, progressing to chronic kidney failure. Diagnosis must be supported by a renal biopsy.

XXXV. Cardiomyopathy – of specified severity

A definite diagnosis of cardiomyopathy by a cardiologist which results in permanently impaired ventricular function and resulting in permanent physical impairment of at least Class III of the New York Heart Association's classification of cardiac impairment. The diagnosis has to be supported by echocardiographic findings of compromised ventricular performance.

The NYHA Classification of Cardiac Impairment for Class III and Class IV means the following:

Class III: Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes symptoms.
Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Cardiomyopathy directly related to alcohol or drug abuse is not covered.

XXXVI. Systemic Lupus Erythematosus With Severe Kidney Complications

A definite diagnosis of Systemic Lupus Erythematosus confirmed by a rheumatologist.

For this definition , the covered event is payable only if it has resulted in Type III to Type V Lupus Nephritis as established by renal biopsy. Other forms such as discoid lupus or those forms with only hematological or joint involvement are not covered.

WHO Lupus Classification:

Type III - Focal Segmental glomerulonephritis
Type IV - Diffuse glomerulonephritis
Type V - Membranous glomerulonephritis

EXCLUSION OF CRITICAL ILLNESSES

This provision does not cover the following occurrences:

i. An episode of coronary artery or ischaemic heart disease that occurred before the Issue Date or any reinstatement date of Policy, whichever is later.
ii. Diagnosis of the disease within sixty (60) days from the Issue Date or any reinstatement date of this Policy, whichever is later
iii. Other than the first incidence of the critical illnesses.
iv. Diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) regardless of how this syndrome was acquired or may be named.

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
Reimburtsement 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 2 visits 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 Benefits.

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 Benefits.

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.

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.

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 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.

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 per Definition Of Critical Illnesses, 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.

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.

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.

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.

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

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.

DOUBLE OVERALL ANNUAL LIMIT (DUE TO CRITICAL ILLNESSES)
Upon diagnosis of Critical Illnesses as defined in this Policy, this benefit doubles the current Overall Annual Limit for the plan type selected.

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.

HEALTH SCREENING
This Benefit allows the Insured Person to seek a pre-determined health screening, consisting blood and urine tests, from the service provider appointed by Company once every Policy year for as long as this Policy remains in force.

This Health Screening benefit is not guaranteed and the Company reserves the right to revise, suspend, remove or cancel this benefit at anytime by delivering a written notice of the same by ordinary post to the last known address of Policyholder as informed to the Company. In such circumstances, the premiums shall be adjusted accordingly, if deemed necessary by the Company.

MEDICAL SECOND OPINION BENEFIT (DUE TO CRITICAL ILLNESSES)
Upon diagnosis of Critical Illnesses as defined in this Policy, this Benefit allows the Insured Person to seek a second medical opinion on his/her diagnosed medical condition from the service provider's appointed medical specialists once every Policy year for as long as this Policy remains in force. Through this Benefit, the Insured Person can access an exclusively assembled panel of appointed medical specialists in defined specialists and medical facilities subject to the following terms and conditions:

(a) the Insured Person will be provided a comprehensive treatment recommendation plan for their health conditions;

(b) any costs incurred in order to obtain the medical visual material (such as x-rays, CT and MRI scans, ultrasound images and so forth) are not covered by the Company;

(c) use of Medical Second Opinion Benefit shall not be taken as admission by the Company of Critical Illnesses claim or Surgical Benefit

(d) In the case the service provider ceases to provide the second opinion service, the Company shall find a suitable service provider to continue to provide the service.

(e) This Medical Second Opinion Benefit is not guaranteed and the Company reserves the right to revise, suspend, remove or cancel this benefit at anytime by delivering a written notice of the same by ordinary post to the last known address of Policyholder as informed to the Company. In such circumstances, the premiums shall be adjusted accordingly, if deemed necessary by the Company.

(f) Each Insured Person is only entitled to one Medical Second Opinion per policy year irrespective of the number of policies/plans he/she owns with the Company.

Exclusions Of Medical Second Opinion Benefit
The Company does not cover Second Opinion Benefit on any Critical Illnesses related to or caused directly or indirectly, wholly or partly, by any of the following occurrences:

(i) Any illness other than the occurrence of Critical Illnesses as defined in this policy;

(ii) Any Critical Illnesses the signs or symptoms of which first occurred prior to, or within sixty (60) days following, the Effective Date;

(iii) Any Critical Illnesses which was diagnosed due, directly or indirectly, to Congenital Conditions or disease which has manifested or was diagnosed before the Policy Effective Date;

(iv) Any of the Critical Illnesses or covered surgeries defined herein which is caused by a self-inflicted injury; and

(v) The diagnosis of Critical Illnesses of the Insured Person, where in the opinion of the Company was directly or indirectly due to an Acquired Immune Deficiency Syndrome (AIDS) or infection by any Human Immunodeficiency Virus (HIV).

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.

NO CLAIM BONUS (NCB)
Increases Overall Annual Limit by 5% annually, up to maximum 50% of first policy year's Overall Annual Limit, provided no claim is submitted on previous policy

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, except the lump sum benefit upon its diagnosis as stated in Schedule Of Benefit, 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 initialed by an authorized representative of the Company.

CONDITION PRECEDENT TO LIABILITY

The due observance and the fulfillment of the terms, provisions and conditions of this Policy by the Insured Person and in so far as they relate to anything to be done or complied with by the Insured Person shall be conditions precedent to any liability of the Company.

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 by giving a 30 days written notice. 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 (where 30 days cancellation notice in writing shall be given to the Policyholder).

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 there under 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.

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 eligible benefit, the Insured Person shall bear 20% of the other eligible benefits described in the Schedule of Benefits 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 (FREE-LOOK 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.

COVERAGE AGE LIMIT
Person eligible to be covered under this Policy must be Age between 30 days up to 60 years old. Renewal is up to age 85 at the option of the Policyholder, provided that the Insured Person is enrolled before 61 years old. Age is defined as age next birthday.

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 Installment 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.

MEDIGUARD SUPREME POLICY

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.

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 Complaints Management Unit and alternatively, may also seek redress or assistance with the Ombudsman for Financial Services or to approach Bank Negara Malaysia's Laman Informasi Nasihat dan Khidmat (LINK) addressed below:-

   (a) Complaints Management Unit
   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 :+603-2268 3333
   Fax :+603-2268 2222

   (b) Ombudsman for Financial Services (OFS)
   Level 14, Main Block
   Menara Takaful Malaysia
   No. 4, Jalan Sultan Sulaiman
   50000 Kuala Lumpur.
   Tel :+603-2272 2811
   Fax :+603-2272 1577

   (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 :+603-2174 1515

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