Enhanced Group Hospital and Surgical Policy Contract

WHEREAS the Insured Person (hereinafter called "You") named in the Policy Schedule by a proposal and declaration, has applied to Zurich General Insurance Malaysia Berhad (1249516-V) (hereinafter called "We / Us") for the insurance contained in this Policy.

This Policy is issued in consideration of the payment of premium as specified in the Policy Schedule and pursuant to the answers given in Your Proposal Form (or when You applied for this insurance) and any other disclosures made by You between the time of submission of Your Proposal Form (or when You applied for this insurance) and the time this contract is entered into. The answers and any other disclosures given by You shall form part of this contract of insurance between You and Us. However, in the event of any pre-contractual misrepresentation made in relation to Your answers or in any disclosures given by You, only the remedies in Schedule 9 of the Financial Services Act 2013 will apply.

This Policy reflects the terms and conditions of the contract of insurance as agreed between You and Us.

NOW THIS POLICY WITNESSETH that subject to the term, exclusions, provisions and conditions contained herein or endorsed hereon, We will indemnify You / Your legal personal representative for accidental benefits and medical expenses incurred during the period of insurance, in the manner and to the extent hereinafter provided.

DEFINITIONS

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.

ACCIDENTAL DENTAL TREATMENT shall mean dental procedure necessary as a result of Accident.

ANY ONE DISABILITY shall mean the whole period of Disability arising from the same cause including any and all complications therefrom except that if You completely recover 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.

AS CHARGED refers to actual charges incurred for reasonable, necessary and customary medical care provided in the treatment of a covered Disability.

CONGENITAL CONDITIONS shall mean any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within six (6) months from the time of birth. They will include hernias of all types and epilepsy except when caused by trauma, which occurred after the date You were continuously covered under this Policy.

DAY shall mean the 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).

DENTIST shall mean a registered dental practitioner qualified and licensed to practice dentistry and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area in which a service is provided, but excluding a Dentist who is the Insured Person himself or his immediate family i.e. siblings, spouse, child or parent.

DEPENDANT shall mean any of the following persons:
(a) legally married spouse
(b) unmarried child / children who are unemployed and unmarried, age above thirty (30) days old and below nineteen (19) years of age, or below twenty three (23) years of age who is on full time higher education.

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

DOCTOR or PHYSICIAN or SURGEON shall mean a registered medical practitioner qualified and licensed to practice Western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice, but excluding a Doctor, Physician or Surgeon who is the Insured Person himself or his immediate family i.e. siblings, spouse, child or parent.

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

EMERGENCY shall mean treatment needed in the event whereby immediate medical attention is required within the twelve (12) hours of Injury, Illness or symptoms which are sudden and severe failing where Your life could be threatened or lead to significant deterioration of health.

HOSPITAL shall mean only an establishment duly constituted and registered as a hospital for the care and treatment of sick and injured person as paying bed-patients, and which:
(a) has facilities for diagnosis and major surgery,
(b) provides twenty-four (24) hours a day nursing service by registered and graduate nurse,
(c) is under supervision of a Physician, and
(d) is not a 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.

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

INJURY shall mean bodily injury caused solely by an Accident.

INSURED PERSON / INSURED MEMBER shall mean the person described in the Policy Schedule or an employee of the Policyholder / Insured, including his/her Dependant (if applicable).

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.

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.

MAXIMUM PER ANY ONE DISABILITY shall mean the maximum amount payable for treatment provided to You, as stated in the Schedule of Benefits, irrespective of the several types of Disability treated in a single admission.

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 Your convenience or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient), and
(d) not of an experimental, investigational or research nature, preventive or screening nature,
(e) for which the charges are fair and reasonable and customary for the Disability.

OUTPATIENT shall mean You are receiving medical care or treatment without being hospitalised and includes treatment in a daycare centre.

OVERALL ANNUAL LIMIT shall mean benefits payable in respect of expenses incurred for treatment provided to You during the period of insurance shall be limited to Overall Annual Limit as stated in the Schedule of Benefits irrespective of type / types of Disability. In the event the Overall Annual Limit having been paid in full, all insurance for You hereunder shall immediately cease to be payable for the remaining Policy Year.

POLICY SCHEDULE / CERTIFICATE OF INSURANCE shall refer to the document issued by Us that is issued to verify the existence of Insurance coverage granted to You.

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

POLICYHOLDER / MASTER HOLDER/ INSURED shall mean a person or a corporate entity or an association/affinity to which the Policy has been issued in respect of cover for persons specifically identified as the Insured Person in this Policy and can exercise all rights, privileges and options available under this Policy.

PRE-EXISTING CONDITION shall be limited to Disabilities which existed before the effective date of cover and for which You should have reasonably been aware of. You may be considered to have reasonable knowledge of a Pre-Existing Condition where the condition is one for which:
(a) You have received or are 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.

PRESCRIBED MEDICINES shall mean medicines that are dispensed by a Physician, registered pharmacist or a Hospital and which have been prescribed by a Physician / Specialist in respect of treatment for a covered 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 gender 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 Your medical condition.

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.

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

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 or Dentist who is the Insured Person himself or his immediate family i.e. siblings, spouse, child or parent.

SPECIFIED ILLNESSES shall mean the following disabilities and its related complications, occurring within the first one hundred and twenty (120) days of continuous cover:
(a) Hypertension, Diabetes Mellitus and Cardiovascular disease
(b) All tumours of any kind, 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 discs) and knee conditions.

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, oesophagus, stomach, intestine, urinary bladder, or urethra.

TAX shall mean any present or future, direct or indirect, tax, levy or duty, including consumption tax or any tax of similar nature, which is imposed on goods and services by government or tax authority.

WAITING PERIOD shall mean the first thirty (30) days between the beginning of Your 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.

WE / OUR / US / THE COMPANY shall mean Zurich General Insurance Malaysia Berhad, who is the insurer / issuer of the Policy.

YOU / YOUR / YOURS shall mean the Insured Person and eligible Dependant(s) as applicable.

SECTION A – HOSPITAL AND SURGICAL INSURANCE

DESCRIPTION OF BENEFITS

1) BASIC BENEFITS

a) HOSPITAL ROOM AND BOARD

We shall reimburse 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 Your 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 Benefits. You will only be entitled to this benefit while confined to a Hospital as an inpatient.

b) INTENSIVE CARE UNIT

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

c) HOSPITAL SUPPLIES & SERVICES

We shall reimburse the Reasonable and Customary Charges actually incurred for general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, laboratory examinations, electrocardiograms, physiotherapy, basal metabolism tests, intravenous injections and solutions, administration of blood and blood plasma, including the cost of blood and plasma whilst You are confined as an inpatient in a Hospital, up to the amount stated in the Schedule of Benefits.

d) PRE-SURGICAL DIAGNOSTIC TESTS

We shall reimburse the Reasonable and Customary Charges for Medically Necessary ECG, X-ray and laboratory tests which are performed for diagnostic purposes on account of an Injury or illness when in connection with a Disability preceding hospitalisation within the maximum number of days and amount as set forth in the Schedule of Benefits in a Hospital and which are recommended by the attending Physician / Specialist. No payment shall be made if upon such diagnostic services, You do not result in surgery of the medical condition diagnosed.

e) SURGICAL FEES

We shall reimburse the Reasonable and Customary Charges for a surgery by the Specialist/Surgeon, including pre-surgical assessment, Specialist's/Surgeon's visits to You and post-surgery care up to the maximum number of days from the date of surgery, subject to the maximum amount of benefits indicated in the Schedule of Benefits. If more than one surgery is performed for Any One Disability, the total payments for all the surgeries performed shall not exceed the maximum amount of benefit stated in the Schedule of Benefits.

f) **ANAESTHETIST'S FEE**

We shall reimburse the Reasonable and Customary Charges by the Anaesthetist for the administration of anaesthesia not exceeding the limits as set forth in the Schedule of Benefits.

g) **OPERATING THEATRE FEE**

We shall reimburse the Reasonable and Customary Operating Room charges incidental to the surgical procedure not exceeding the limits as set forth in the Schedule of Benefits.

h) **PRE-HOSPITAL DIAGNOSTIC TESTS**

We shall reimburse the Reasonable and Customary Charges for ECG, X-ray and laboratory tests which are performed for diagnostic purposes on account of an Injury or illness when in connection with a Disability preceding hospitalisation within the maximum number of days and amount as set forth in the Schedule of Benefits in a Hospital and which are recommended by a Physician / Specialist. No payment shall be made if upon such diagnostic services, You do not result in hospital confinement for the treatment of the medical condition diagnosed.

i) **PRE-HOSPITAL SPECIALIST CONSULTATION**

We shall reimburse the Reasonable and Customary Charges for the consultation by a Specialist in connection with a Disability within the maximum number of days and amount as set forth in the Schedule of Benefits preceding confinement in a Hospital and provided that such consultation is Medically Necessary and has been recommended in writing by the attending Physician / Specialist, which includes prescription for medication and any subsequent consultation which subject to the Schedule of Benefit limit. Payment will not be made where You do not result in hospital confinement for the treatment of the medical condition diagnosed.

j) **IN-HOSPITAL PHYSICIAN VISIT**

We shall reimburse the Reasonable and Customary Charges by a Physician for Medically Necessary visiting an in-paying patient while confined for a non-surgical Disability not exceeding the maximum number of Days and amount as set forth in the Schedule of Benefits.

k) **POST-HOSPITALISATION TREATMENT**

We shall reimburse the Reasonable and Customary Charges incurred in follow-up treatment for the same Disability as during hospitalisation immediately following discharge from Hospital for a non-surgical Disability within the maximum number of days and amount as stated in the Schedule of Benefits.

l) **AMBULANCE FEES**

We shall reimburse the Reasonable and Customary Charges incurred for necessary domestic road ambulance services (inclusive of attendant) to and/or from the Hospital of confinement. Payment will not be made if You are not hospitalised and subject to the limits set forth in the Schedule of Benefits.

m) **DAYCARE PROCEDURES**

We shall reimburse the Reasonable and Customary Charges for medical and professional charges incurred in respect of a day Surgery (Surgical and Medical) performed in an outpatient setting (without hospital admission) up to maximum limit per Disability stated in the Schedule of Benefits. This shall include follow-up treatment by the same Attending Physician / Specialist / Surgeon within the maximum number of days and amount as stated in the Schedule of Benefits. Any Daycare Procedure done for investigative and diagnostic purposes not related to Treatment for any specific Disabilities is not covered.

2) OPTIONAL BENEFITS (not applicable unless specified in Schedule of Benefits)

a) **OUTPATIENT ACCIDENT TREATMENT**

We shall reimburse the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily injury arising from an Accident for Medically Necessary treatment as an outpatient at any registered clinic or Hospital within twenty-four (24) hours of the Accident causing the covered bodily injury. Follow up treatment by the same doctor or same registered clinic or Hospital for the same covered bodily injury will be provided up to the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

***b)* ACCIDENTAL DENTAL TREATMENT**

We shall reimburse the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of an Accidental Injury and received as an outpatient Accidental Dental Treatment within twenty-four (24) hours of the occurrence of the Accident in a registered dental clinic or hospital and the subsequent follow-up treatment by the same Dentist will be provided up to the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

***c)* DAILY-CASH ALLOWANCE AT GOVERNMENT HOSPITAL**

We shall pay daily cash allowance for each Day of confinement for a covered Disability in a Malaysian Government Hospital, provided that You shall be confined in a Room and Board at a rate that does not exceed the amount and number of Days shown in the Schedule of Benefits.

***d)* HOME NURSING CARE**

We shall reimburse the Reasonable and Customary Charges, up to the amount stated in the Schedule of Benefits, for Medically Necessary continued nursing care by a registered nurse to You in a home. Such nursing care must be recommended by the attending Physician / Surgeon and be for a minimum duration of four (4) hours each day. This benefit is only payable if there has been an earlier claim paid for In-Hospital Benefits in respect of the medical condition for which hospitalisation was required by You.

Home Nursing Care cover under this Policy includes:

(i) Physical, occupational or speech therapies;

(ii) Therapy, treatments for wound, respiratory, diabetes care, colostomy care, tube feeding, injection and other medication administration to You at home.

Custodial care, meals, general house-keeping services, companions and personal comfort item, or any services for activities of daily living that are not Medically Necessary will not be payable. The benefit payable shall not exceed the Disability limit for the plan as stated in the Schedule of Benefit.

***e)* REPATRIATION OF MORTAL REMAINS**

We shall reimburse the amount specified in the Schedule of Benefits for the transportation of Your body or mortal remains back to Malaysia. Affirmative proof of death must be submitted to Us at the expense of the claimant.

***f)* DEPENDANT CHILD'S DAILY GUARDIAN BENEFIT**

We shall reimburse the expenses for meals and lodging incurred to accompany Your Dependant child (aged below fifteen (15) years) in the hospital but shall not exceed the limits set forth in the Schedule of Benefits.

***g)* MEDICAL REPORT FEES**

We shall reimburse the actual fee charged for completion of a medical report by the attending Physician / Surgeon in respect of each Disability but not to exceed the amount as stated in the Schedule of Benefits.

***h)* TAX ON ELIGIBLE EXPENSES**

We shall reimburse the amount of the Tax On Eligible Expenses levied by the Clinics or Hospitals on taxable supplies and services provided to You that are payable under this policy subject to the limits set forth in the Schedule of Benefits.

***i)* OUTPATIENT SICKNESS TREATMENT**

We shall reimburse the Reasonable and Customary charges up to the maximum set forth in the Schedule of Benefits, for emergency treatment of sickness rendered by a Hospital or a registered twenty-four (24) hour clinic and received as an outpatient between the hours of 10.00pm and 8.00am of the following morning. The time of treatment as certified by the attending Physician shall be a condition precedent to liability.

***j)* FUNERAL EXPENSES**

We shall pay a lump sum as specified in the Schedule of Benefits, if You die during surgery or hospitalisation or within fourteen (14) days from the date of discharge from a Hospital.

k) **DEATH BENEFIT**
We shall pay a lump sum as specified in the Schedule of Benefits, if You die during the period of insurance as a result of Sickness or Accident.

l) **ACCIDENTAL DEATH BENEFIT**
We shall pay a lump sum as specified in the Schedule of Benefits, if You die during the period of insurance as a result of an Accident.

m) **HOSPITALISATION CASH BENEFIT**
We shall pay in addition to any other items reimbursable under any Policy a daily cash allowance for each Day the patient is confined to a Hospital as specified in the Schedule of Benefits.

n) **SECOND SURGICAL OPINION**
We shall reimburse the Reasonable and Customary Charges for consultation with a specialist to obtain a second opinion prior to surgery in respect of an illness or Injury requiring surgery up to the maximum as set forth in the Schedule of Benefits.

o) **ORGAN TRANSPLANT**
We shall reimburse the Reasonable and Customary Charges incurred on transplantation surgery for You being the recipient of the transplant of a kidney, heart, lung, liver or bone marrow. Payment for this benefit 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.

p) **OUTPATIENT CANCER TREATMENT**
If You are diagnosed with Cancer as defined below, We will reimburse the Reasonable and Customary Charges incurred for the treatment of cancer performed at a legally registered cancer treatment centre subject to the limit of this Disability as specified in the Schedule of Benefits. The treatment types covered as cancer treatment are only limited to radiotherapy and chemotherapy (injectable or oral), including consultation, examination tests and take home drugs.

Such treatment must be received or advised at the outpatient department of a Hospital or a registered cancer treatment centre or immediately following discharge from the Hospital Confinement or after the 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.

It is a specific condition of this Benefit that notwithstanding the exclusion of Pre-Existing Conditions, this Benefit will not be payable for You who had been diagnosed as a Cancer patient and/or is receiving Cancer treatment prior to the effective date of Insurance.

q) **OUTPATIENT KIDNEY DIALYSIS TREATMENT**
If You are diagnosed with Kidney Failure as defined below, We will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of kidney dialysis performed at a legally registered dialysis centre subject to the limit of this Disability as specified in the Schedule of Benefits.

Such treatment (dialysis including consultation, examination tests and take home drugs) must be received at the outpatient department of a Hospital or a registered dialysis treatment centre or 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 You, if You have developed chronic renal diseases and/or are receiving dialysis treatment prior to the effective date of Insurance.

r) OUTPATIENT PHYSIOTHERAPY TREATMENT

We shall reimburse the Reasonable and Customary Charges incurred for outpatient physiotherapy treatment referred in writing by a licensed Specialist / Physician after Surgery or in-hospital treatment, within ninety (90) days from the date of Hospital discharge up to the maximum as set forth in the Schedule of Benefits.

s) MAXIMUM LIMIT PER ADMISSION

We shall reimburse the Reasonable and Customary Charges incurred for services and/or treatments provided to You which shall be capped to the maximum limit per admission as stated in the Schedule of Benefits irrespective of the type of disability. The benefit payable is further subject to the Overall Annual Limit.

t) CO-INSURANCE

You are require to pay the co-insurance % of the cost of an eligible benefit, subject to a minimum co-insurance amount of Ringgit Malaysia three hundred (RM300.00) and a maximum co-insurance amount of Ringgit Malaysia three thousand (RM3,000.00) for Hospital & Surgical Benefit. The remaining balance is paid by Zurich General Insurance Malaysia Berhad. However, if You are admitted to any Government Hospital, the eligible expenses incurred will not be subject to any co-insurance.

u) DEDUCTIBLE

The Policy is subject to a deductible amount which is stated in the Schedule of Benefit. Deductible means a monetary sum that shall be deducted from the Eligible Expenses incurred by You, and on per admission / per claim basis when You are admitted to any Private Hospital. However, if You are admitted to any Government Hospital, the eligible expenses incurred will not be subject to the deductible amount.

SECTION B – Special Provisions

1) ALTERATIONS

We reserve the right to amend the terms and provisions of this Policy by giving a thirty (30) days prior notice in writing by ordinary post to Your last known address in Our 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 Us and such approval is endorsed thereon. We would also give thirty (30) days prior written notice to the Policyholder according to the last recorded address for any alterations made.

2) 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 Us for any claim hereunder must be referred to an Arbitrator within twelve (12) calendar months from date of such disclaimer.

3) AUTOMATIC TERMINATION

Your insurance shall automatically terminate on the earliest happening of the following events:

(a) on the date this Policy is terminated; or

(b) on the date of termination of employment (cessation of active work of the member shall be deemed termination of employment) provided that:

   i. while a member is temporarily on part time employment or is absent on account of sickness or Injury, employment shall be deemed to continue until premium payments for such member's insurance are discounted;

   ii. a member who is laid off may be continued, but not beyond the end of the Policy month following the Policy in which the layoff starts;

   iii. a member who is granted a leave of absence not in connection with Your business may be continued, but not beyond the end of the Policy month following the Policy month in which the leave starts;

(c) on the date of termination of membership (for association, affinity / scheme); or

(d) on Your death; or

(e) on Your Policy anniversary or the maximum age next birthday (as stated in the Policy); or
(f) on the premium due date if the Policyholder fail to pay the required premium for You; or
(g) any other date on which You cease to be eligible for assurance; or
(h) if the total benefits paid under the member's Policy since the last Policy anniversary exceeds the Overall Annual Limit for the respective Policy Year.

Termination of this Policy shall be without prejudice to any claim arising prior to such termination. The payment or acceptance of any premium hereunder subsequent to termination of this Policy shall not create any liability but We shall refund any such premium.

4) AUTOMATIC TERMINATION OF DEPENDANT COVER
(a) on the date member's cover terminates; or
(b) on the Your death; or
(c) on the date such Dependant ceases to be a Dependant as defined in this Policy.

5) CANCELLATION
This Policy may be cancelled by the Policyholder at any time by giving written notice to Us; 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%
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

There shall be no refund of premium for non-annual payment mode.

6) CASH BEFORE COVER
It is fundamental and an absolute special condition of this contract of insurance that the premium due must be paid and received by Us before insurance cover is effective.

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

8) CHANGE IN RISK
You shall give immediate notice in writing to Us of any material change in Your occupation, business, duties or pursuits and pay any additional premium that may be required by Us.

9) CLAIM PROCEDURES
(a) You shall within thirty (30) days of a Disability that incurs claimable expenses, give written notice to Us 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 invalidate any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.
(b) You shall immediately procure and act on proper medical advice and We shall not be held liable in the event a treatment or service becomes necessary due to Your failure to do so.

10) CONDITION PRECEDENT TO LIABILITY
The due observance and the fulfilment of the terms, provisions and conditions of this Policy by You and in so far as they relate to anything to be done or complied with by You shall be conditions precedent to any liability of Us.

11) CONTRIBUTION
If You carry other insurance covering any illness or Injury insured by this Policy, We 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.

12) CONVERSION POLICIES
If the Eligible Benefits provided under this Policy shall have been converted from an existing coverage of an 'Inner Limits' to an 'As Charged / Full Reimbursement' coverage, and if You 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 Benefits prior to the date the Eligible Benefits were converted.

13) COOLING-OFF PERIOD
If this Policy shall has been issued and for any reason whatsoever You shall decide not to take up the Policy, You may return the Policy to Us for cancellation provided such request for cancellation is delivered by You to Us within fifteen (15) days from the date of delivery of the Policy. You are entitled to the return of the full premium paid less deduction of medical expenses incurred by Us in the issue of the Policy.

14) CURRENCY OF PAYMENT
All payments under this Policy shall be made in the legal currency of Malaysia. Should any payment be requested by You 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.

15) DUTY OF DISCLOSURE
Consumer Insurance Contract – Where you have applied for this Insurance wholly for yourself, family or dependants, you had a duty to take reasonable care not to make a misrepresentation in answering the questions in the Proposal Form (or when you applied for this insurance) i.e. you should have answered the questions fully and accurately. Failure to have taken reasonable care in answering the questions may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance in accordance with the remedies in Schedule 9 of the Financial Services Act 2013. You were also required to disclose any other matter that you knew to be relevant to our decision in accepting the risks and determining the rates and terms to be applied. You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in the Proposal Form (or when you applied for this insurance) is inaccurate or has changed.

Non-Consumer Insurance Contract – Where you have applied for this Insurance for the purpose of providing medical insurance benefits to your employees and their dependants, you had a duty to disclose any matter that you knew to be relevant to our decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant otherwise it may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance. You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in the Proposal Form (or when you applied for this insurance) is inaccurate or has changed.

16) ELIGIBILITY
(a) You:
Your eligibility to be covered under this Policy must be:
- (i) Within the eligible age as specified in the Policy issued to You (as stated in the Schedule of Benefits).
- (ii) Persons who legally reside in Malaysia i.e. Malaysian, Malaysia permanent resident, expatriate with valid employment pass, foreign worker with valid working permit. Persons become ineligible when they have resided continuously for ninety (90) days outside Malaysia.

(b) Dependants:
The Dependants are eligible for insurance only when You are applying to enrol the Dependants and shall take effect when We determine evidence of insurability to be satisfactory, such evidence to be furnished at Your expense.

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

1. Pre-Existing Condition.
2. Specified Illnesses occurring during the first one hundred and twenty (120) days of continuous cover.
3. Waiting Period of thirty (30) days for all except Accident Injuries.
4. Elective cosmetic or plastic surgery except re-constructive surgery necessary to restore function after an Accident that has occurred during the period of cover.
5. Eye Examinations, glasses, contact lenses and surgical procedures for the correction of eye refractive errors and the use or acquisition of external prosthetic appliances or corrective devices such as artificial limbs, hearing aids, implanted pacemakers, prescription thereof.
6. 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.
7. Private nursing, rest cures or sanitaria care, any treatment received purely as an outpatient hospitalisation primarily for investigatory purposes, diagnosis, X-ray examination, general physical or medical examinations, not incidental to the treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary and any preventive treatment, preventive medicines or examination carried out by a Physician and treatments specifically for weight reduction or gain.
8. Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.
9. Pregnancy, child birth (including surgical delivery), miscarriage, abortion and prenatal or postnatal care and any surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility, gender change, sexual dysfunction including impotency, tests or treatment related to sterilization and circumcision performed due to any reason other than illness or infection.
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. Sanction - We shall not be deemed to provide coverage or will make any payments or provide any service or benefit to You or Your Dependants or any other party to the extent that such cover, payment, service, benefit would violate any applicable trade or economic sanctions law or regulation.
13. Treatment for any medical conditions arising directly or indirectly from radioactivity contamination or any nuclear material whatsoever, including the combustion of nuclear fuel.
14. Expenses incurred for donation of any body organ by You and costs of acquisition of the organ including all costs incurred by the donor during organ transplant and its complications.
15. Investigation into and treatment of sleep and snoring disorders, psychiatric, psychotic, mental or nervous disorders, including neuroses and their physiological or psychosomatic manifestations, psychiatric disorders such as neuro-psychosis, schizophrenia and others.
16. Hormone replacement therapy and alternative therapy such as treatment, medical services or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bone setting, herbalist treatment, massage or aromatherapy.
17. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering You and Disabilities arising out of duties of employment or profession that is covered under a Workmen's Compensation Insurance Contract.
18. Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestations).
19. 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.
20. 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, mountaineering with use of ropes or mountain guides and illegal activities.
21. Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes.

18) FULL REIMBURSEMENT IN A GOVERNMENT HOSPITAL

Charges for eligible medical expenses are covered in full for treatment in a Malaysian Government Hospital for each illness or Injury.

19) GENERAL CONDITIONS

(a) This Policy and the Schedule of Benefits shall be read together as one (1) contract and any words or expression 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.

(b) Where the context so permits, words importing the singular number only shall include the plural number and vice versa and words importing the masculine gender only shall include the feminine gender and neuter gender and words importing persons shall include corporations.

20) GEOGRAPHICAL TERRITORY

All benefits provided in this Policy are applicable worldwide for twenty-four (24) hours a day. If You are non-Malaysian, Your coverage will be limited to Hospitals within Malaysia only.

21) GRACE PERIOD

Notwithstanding the Cash before Cover condition, a Grace period of number of Days, as set forth in the Policy Schedule, from the premium due date will be allowed for payment of each premium. During such number of Days as set forth in the Policy Schedule, We shall remain liable thereunder if by the last of such days, the premium is actually paid.

If any premium is not paid in respect of this Policy Contract before the end of the Grace period, this Policy Contract shall be deemed as terminated at the expiry date of the Policy.

22) GOVERNING LAW

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

23) IMPORTANT NOTICE

We wish to draw Your attention to the following important information:

(c) Proof of Age will be required at times of maturity / claims, if Age has not been admitted

(d) You can contact Our Agents, Branch Officers, and Customer Service Department at our Head Office for any enquiry or service relating to Your Policy.

(e) The change of address of the Policyholder should be notified to Us so that all correspondence can be directed promptly.

24) INCOMPLETE CLAIMS

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

25) 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 You fail to supply the requisite proof of loss as stipulated by the terms, provisions and conditions of the Policy, You may, within a Grace Period of one (1) calendar year from the time that the written proof of loss to be furnished, submit the relevant proof of loss to Us 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 Our sole and entire discretion. After such Grace Period has expired, We will not accept, for any reason whatsoever, such written proof of loss.

26) MEDICAL EXAMINATION

We shall have the right to examine Your body whenever it may reasonably require and to conduct an autopsy in case of death where it is not forbidden by law.

27) MISSTATEMENT OF AGE

If Your age had 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 Your correct age would not have been eligible for cover under this Policy, no benefit shall be payable.

28) MISTATEMENT OR OMMISSION OF MATERIAL FACT

If:

(a) any answer, disclosure or representation by You, before this contract of insurance is entered into, varied or renewed, in or to any proposal or declaration or query, has been deliberately or recklessly incorrectly stated in any respect; or

(b) before this contract of insurance is entered into, varied or renewed, You have failed to disclose any fact You knew to be relevant to Our decision on whether to accept the risk or not and the rates and the terms to be applied; or

(c) any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support of such claim.

then in any of the above cases, this Policy shall be void.

29) NOTICE

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

30) OVERSEAS TREATMENT

If You seek 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) You are travelling abroad for a reason other than for medical treatment, need to be confined to a Hospital outside Malaysia as a consequence of an Emergency.

(b) Upon recommendation of a Physician and You have to be transferred to a Hospital outside Malaysia because the specialized 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.

31) OWNERSHIP OF POLICY

Unless otherwise expressly provided for by Endorsement in the Policy, We shall be entitled to treat the Policyholder as the absolute owner of the Policy. We shall not be bound to recognise any equitable or other claim to or interest in the Policy, and the receipt of the Policy or a Benefit by the Policyholder (or by his legal or authorized representative) alone shall be an effective discharge of all Our obligations and liabilities. The Policyholder shall be deemed to be responsible Principal or Agent of Your covered under this Policy.

32) PERIOD OF COVER AND RENEWAL

This Policy shall become effective as of the date stated in the Policy 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 Us. This Policy is renewable at Our option. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by Us upon renewal.

33) PORTFOLIO WITHDRAWAL

We reserve the right to cancel the portfolio as a whole if We decide to discontinue underwriting this insurance product. Cancellation of the portfolio as a whole shall be given by written notice to the Policyholder and We will run off all policies to expiry of the period of cover within the portfolio.

34) PREMIUM

The premiums for insurance under this Policy are not guaranteed and shall be based on the premium rates in force at the time of renewal. We shall have the right to change the rate at which premiums shall be calculated, at the start of any Policy Year.

35) PROOF OF LOSS

Upon receipt of such notice We will furnish to the Claimant forms for filing proof of loss. If the forms are not furnished within fifteen (15) days, the Claimant by submitting written proof covering the occurrence, the character and the extent of the loss for which claim is made shall be deemed to have complied with the requirement of this provision.

Proof of loss must be furnished to Us in case of claim for Disability within ninety (90) days after termination of the period of Disability for which We are liable, and in case of claim of any other loss, within ninety (90) days after the date of such loss.

36) REINSTATEMENT
If You do not pay a premium within the Grace Period and the Policy terminates, You will not have any Insurance cover or benefit.

If the Policy terminates, You may apply to reinstate the Policy within one (1) year after the premium's due date which was not paid. However, You must:

(a) fill in and sign a reinstatement form;
(b) truthfully declare all facts in the reinstatement form;
(c) produce all the information (if any) We have asked for; and
(d) pay all overdue premiums.

37) RESIDENCE OVERSEAS
No benefit whatsoever shall be payable for any medical treatment received by You outside Malaysia, if You reside or travel outside Malaysia for more than ninety (90) consecutive days.

38) SUBROGATION
If We shall become liable for any payment under this Policy, We shall be subrogated to the extent of such payment to all the rights and remedies of You against any party and shall be entitled at its own expense to sue in Your name. You shall give or cause to be given to Us all such assistance in his/her power as We shall require to secure the rights and remedies and at Our request shall execute or cause to be executed all documents necessary to enable Us to effectively to bring suit in Your name.

39) TAKE-OVER POLICIES
If this Policy shall have commenced immediately upon termination of a preceding Policy and if You 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 You), You shall continue to be covered for the existing Disability, but not to exceed the limits of the previous Policy on condition We have secured a copy of the preceding Policy.

40) UPGRADED POLICIES
If the Eligible Benefits to You under the terms of this Policy be increased while it is in force or at the time of Renewal or replacement and if You 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.

41) UPGRADED ROOM AND BOARD CO-PAYMENT
If You are hospitalised at a published Room & Board rate which is higher than Your eligible benefit, You shall bear twenty percent (20%) of the other eligible benefits described in the Schedule of Benefits.

42) TAX PROVISION
All premium and fees payable under this Policy may be subject to Tax. If Tax is imposed, it will be stated in the invoice and We reserve the right to claim or collect the Tax from You in addition to the premium and/or fees payable under this Policy.

PROCEDURES FOR MAKING INSURANCE COMPLAINTS

Please examine the insurance Policy to ensure that it meets Your requirement.

To avoid misunderstanding, it is very important that this Policy, the Policy Schedule and any Endorsements attached therein be read thoroughly. If You have any complaints or grievances pertaining to Your Policy, please contact Your agent, if any or get in touch with Our issuing office.

We assure You that Your complaints will be attended to promptly. As a responsible insurer, We wish to bring to Your attention that You could also address Your dissatisfaction to the Ombudsman For Financial Services (OFS) or to Bank Negara Malaysia's Customer Service Bureau (CSB) as listed below.

PROCEDURES FOR COMPLAINT TO OFS
If You are not satisfied with Our decision, You may write to the Mediator with details of the dispute and particulars of Your Policy.

If the Mediator makes an award against Us, You are required to inform the Mediator of Your decision to accept or deny the award within fourteen (14) days.

If You do not accept the award, You may reject the decision of the Mediator. You are free to institute a court proceeding against Us or refer it to Arbitration.

You may lodge a complaint with Us at:
Zurich General Insurance Malaysia Berhad
Level 23A, Mercu 3, No. 3, Jalan Bangsar, KL Eco City, 59200 Kuala Lumpur, Malaysia.
Call Centre: 1-300-888-622 Tel: 03 – 2109 6000 Fax: 03 – 2109 6888
Email: CallCentre@zurich.com.my

Ombudsman for Financial Services (Formerly known as Financial Mediation Bureau)
Level 14, Main Block, Menara Takaful Malaysia,
No. 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur, Malaysia
Tel: 03-2272 2811 Fax: 03-2272 1577
Email: enquiry@ofs.org.my Website: www.ofs.org.my

Procedures for complaint to CSB
Alternatively You may put forward You dissatisfaction over Our conduct by writing to CSB giving details of Your complaint and particulars of Your Policy to:

Contact Centre (BNMTELELINK)
Bank Negara Malaysia
P.O. Box 10922, 50929 Kuala Lumpur
Tel: 1-300-88-5465 (1-300-88-LINK) (Overseas: +603-2174-1717) Fax: +603-2174-1515
E-mail: bnmtelelink@bnm.gov.my