AIG MALAYSIA INSURANCE BERHAD

GROUP EMPLOYEE CARE (GEC)

Policy Wording

ABOUT THIS POLICY

This policy wordings, together with the latest Policy Schedule for the applicable Benefits, the proposal form and any Endorsements, forms the basis of the contract between the Policyholder and the Company. The Company agrees to provide the Insured Person the insurance cover for the applicable Benefits as listed in the Schedule of Benefits and described in this Policy provided that the Policyholder pays the premium when due and the Company accepts it subject to the terms and conditions of this Policy.

This policy wordings should be read carefully together with the Policy Schedule and any Endorsements to ensure that the terms and conditions are fully understood, and the coverage meets the requirement of the Policyholder/Insured Person(s). If there are any questions regarding the terms and conditions of this Policy wordings, the Policyholder may contact the Company, or the Policyholder's intermediary, whichever applicable.

A copy of this Policy in Bahasa Malaysia will be made available on request. For all intents and purposes, where there is a conflict or ambiguity as to the meaning in the Bahasa Malaysia provisions of the Policy, it is hereby agreed that the English version shall prevail.

All terms and conditions of this Policy must be continuously satisfied by the Policyholder and Insured Person(s) to be eligible for coverage under this Policy.

SCHEDULE OF BENEFITS

Please refer to the Schedule of Benefits provided along with this Policy for Benefits, corresponding Sum Insured, Aggregate Period and Waiting Period applicable to each Insured Person covered under this Policy.

Individual Benefits under section 'Benefits' should be referred to for full details of coverage.

ONGOING DUTY OF DISCLOSURE

Non-Consumer Insurance Contract

Where the Policyholder and Insured Person(s) have applied for this insurance for purposes related to their trade, business or profession, the Policyholder and Insured Person(s) have a duty to disclose any matter that they know to be relevant to the Company's 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 the cancellation of their contract of insurance, refusal or reduction of claim(s), change of term(s) or termination of the contract of insurance. The Policyholder and Insured Person(s) also have a duty to inform the Company immediately if at any time after the contract of insurance has been entered into, varied or renewed with the Company, any of the information given in the Proposal Form or any other document related to this insurance is inaccurate or has changed.

Failure to do so may:

1. void this Policy from inception (which means treating it as invalid) and the Company may not return the premium or recover any unpaid premium;
2. result in refusal or reduction of claims that has been or will be made under the Policy;
3. change the terms of this Policy;
4. terminate this Policy and return any premium less the Company's cancellation charge or recover any unpaid premium;
5. entitle the Company to recover any shortfall in premium;
6. entitle the Company to recover from Policyholder and Insured Person(s) the total amount of any claim already paid under the Policy or any claim the Company have to pay under any relevant legislation, plus any recovery costs.

ELIGIBILITY

To be eligible for coverage under this Policy, an Insured Person must:

1. be employed by the Policyholder during the Period of Insurance;
2. meet the criteria specified for an Insured Person as described in the Policy Schedule; and
3. continuously satisfy all requirements as specified under sections 'Age' 'Residency' and 'Occupation' of this Policy.

Age

(i) Entry age for an Insured Person under this Policy is 18 to 75 years of age (inclusive).
(ii) The renewable age for each Insured Person is up to the age of 75 years (inclusive).

Important Note:
1. Age means the Insured Person's age as on their last birthday.

Residency

To be eligible for cover under this Policy, the Insured Person must be a:

(i) Malaysian citizen;
(ii) Malaysian permanent resident; or
(iii) Holder of a valid employment pass (of which the place of employment must be in Malaysia during the Period of Insurance).

Occupation

Covered Occupation

This Policy is only offered to the following occupation classes:

1. **Occupational Class 1 & 2** – Persons engaged in professional, managerial, administrative, supervisory or clerical work and not involved in any manual labour or any work which is hazardous in nature.
2. **Occupational Class 3** – Persons engaged in occasional or regular manual work that is not hazardous in nature but involving the use of tools or machinery.

Excluded Occupations

Persons engaged in occupations with high risk or exposure to hazardous conditions are not covered under this Policy. This would include but is not limited to the following occupations:

(a) Military;
(b) Armed forces;
(c) Peacekeeping forces and similar group or exposures;
(d) Security guards/Bodyguards (armed);
(e) Professional or semi-professional sports;
(f) Taxi drivers;
(g) Loggers;
(h) Miner;
(i) Quarry workers;
(j) Underground work;
(k) Air crew;
(l) Sea crew;
(m) Offshore workers for oil & gas;

(n) Secondment programs (working in Overseas exceeding 90 consecutive Days)
(o) Race driver
(p) Stuntman
(q) Fireman
(r) Fisherman
(s) Plantation workers
(t) Window cleaners
(u) Construction workers
(v) Construction of dams, bridges and tunnels

PERIOD OF INSURANCE

This Policy starts on the Policy Start Date as specified on the latest Policy Schedule for this Policy and ends on the earlier of:
(a) the Policy Expiry date as specified on the Policy Schedule for this Policy;
(b) the date this Policy is cancelled; or
(c) the date this Policy is automatically terminated.

GENERAL POLICY DEFINITIONS

Wherever the following words or phrases appear in this Policy and begin in uppercase, the definitions with interpretation as set out below will apply. Where appropriate, words mentioned in the plural shall also have their singular meaning and vice a versa. Please note that this Policy has been designed to offer multiple Modules/Plans and therefore not all the Definitions listed herein will be relevant to the selected Modules/Plan shown in the Schedule of Benefits of this Policy.

1. **Accident or Accidental** means a sudden, fortuitous, visible and specific event caused external to the body which occurs at an identifiable time and place during the Period of Insurance.

2. **Activities of Daily Living** means the following activities which an Insured Person can undertake on their own:
   (a) **Washing** - the ability to wash oneself in the bath, or shower or wash by other means;
   (b) **Dressing** - the ability for one to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances;
   (c) **Feeding** - the ability to eat their food after its preparation and when being made available;
   (d) **Toileting** - the ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate;
   (e) **Mobility** - the ability to move indoors from room to room on level surfaces; and
   (f) **Transferring** - the ability to move from a bed to an upright chair or wheelchair, and vice versa.

3. **AIDS** shall mean Acquired Immune Deficiency Syndrome (AIDS) or any complications associated with infection by any Human Immune Deficiency Virus (HIV) (for the purpose of this policy, the definition of AIDS shall be that used by the World Health Organisation in 1987, or any subsequent revision by the World Health Organisation of that definition; infection shall be deemed to have occurred where blood or other relevant test(s) indicate in the opinion of the Company either the presence of any Human Immune Deficiency Virus or Antibodies to such a Virus).

4. **Aggregate /Conveyance Limit** means the maximum amount that is payable for all Insured Persons under the 'Accidental Death' Benefit arising from the
   a. same Accident or series of Accidents contributed to or caused by the same original cause, event or circumstance; or
   b. Same Conveyance Accident or series of Conveyance Accidents contributed to or caused by the same original cause, event or circumstance.

The Company shall not be liable for any amount in excess of the Aggregate /Conveyance Limit as specified in the Policy Schedule. If the total loss amount is in excess of this Aggregate /Conveyance Limit, payment will be made proportionately to the Sum Insured for each Insured Person.

For the purpose of this definition only, Conveyance means any land vehicle, sea vessel or aircraft which is a licensed registered operator providing regular scheduled transportation services for individuals who travel as fare paying passengers.

5. **Aggregate Period** means the maximum number of consecutive Days for which a Sum Insured is payable as specified against the Benefit in the Schedule of Benefits.

6. **Benefit** means the benefits listed in the Schedule of Benefits and which are subject to the terms and conditions as stated under this Policy.

7. **Big Toe** means the first digit of a Foot.

8. **Category** refers to the designation of Insured Persons who are covered under this Policy as provided by the Policyholder and stated in the Policy Schedule or Endorsement, whichever is issued last.

9. **Chronic Condition** means a condition that is expected to persist for the remainder of the Insured Person's natural life.

10. **Claimant** means the Policyholder, Insured Person or their legal representative, as applicable, making a claim against this Policy.

11. **Company** means AIG Malaysia Insurance Berhad (200701037463).

12. **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 which shall include hernias of all types and epilepsy except when caused by a trauma which occurred after the date the Insured Person is effectively covered under this policy.

13. **Day** means a completed period of 24 hours.

14. **Disablement** means the conditions which are described in Event 1 to 18 in the Table of Events provided under Section 'Benefits' described in Benefit 'Permanent Disablement' of this policy.

15. **Doctor** means a legally registered and qualified medical practitioner with a medical degree in western medicine and authorised by the medical licensing authority of that country to provide medical or surgical service within the scope of their license, specialised accreditation and training. The doctor cannot be the Insured Person, the Insured Person's business partner or agent, Insured Person's employer or employee or a person related to the Insured Person by blood, marriage or adoption.

16. **Educational Institution** means any pre-school, school, vocational institute, polytechnic, college, university or institute of higher learning which is licensed to provide educational services by trained or qualified teachers.

17. **Endorsement** means a written notice stating an amendment, deletion or addition made to this Policy.

18. **Finger** means a digit of a Hand

19. **Foot** means the entire foot below the ankle.

20. **Grace Period** means a maximum of 30 consecutive Days immediately following the Policy Expiry Date.

21. **Hand** means the entire hand below the wrist.

22. **Home** means the Insured Person's usual place of residence at the time of the Accident in Malaysia.

23. **Hospital** means any institution lawfully operated for the care and treatment of sick or injured persons:
    (a) with organised facilities for diagnosis and surgery (including operating theatres) in the same premises;
    (b) with 24 hours daily nursing service by registered graduate nurses; and
    (c) operated under the supervision of Doctor(s); and
    (d) which is not a clinic, a nursing home, rest home, convalescence, palliative care, hospice or rehabilitation centres, a place used for custodial care, a place for the treatment of alcoholics or drug addicts, institution to treat mental or behavioral disorders, sanatorium, any transitional care centre or home for the aged or similar establishment; even if located at the same place.

24. **Hospitalisation/Hospitalised** means the admission of the Insured Person to a Hospital as an In-patient during the Period of Insurance. For the avoidance of doubt, Hospitalisation shall be evidenced by daily boarding charges imposed by a Hospital.

25. **Illness** means a sickness, disease or other physical conditions characterised by a pathological deviation from the normal healthy state suffered by an Insured Person during the Period of Insurance. For the avoidance of doubt, Illness includes but not limited to Infectious Disease, heatstroke, decompression sickness, hypothermia and mountain sickness.

26. **Infectious Diseases** means health disorders or infections caused by pathogenic microorganisms, such as bacteria, viruses, fungi or parasites. Infectious diseases can be passed from person to person, can be transmitted by insects or other animals or by consuming contaminated food or water or while being exposed to organisms in the environment.

27. **Injury** means an identifiable physical injury which is sustained by an Insured Person during the Period of Insurance and is caused by an Accident solely and independently of any other causes including any Illness (except illness directly resulting from medical or surgical treatment rendered necessary by such Injury), pre-existing or congenital condition. This includes:
    (a) Accidental drowning;
    (b) Accidental suffocation or inhalation of smoke, poisonous fumes or gases. This does not extend to include air pollution or atmospheric phenomenon including but not limited to haze, smog, and the like. General Exclusion 14 continues to apply.
    (c) Any Injury directly resulting from animal or insect bites. This excludes any claims in connection with any Infectious Diseases.

28. **In-patient** means the Insured Person is confined in a Hospital as a registered patient for Medically Necessary treatments of a covered Injury suffered by the Insured Person for a completed period of at least 6 consecutive hours and such confinement is certified as necessary by the attending Doctor.

29. **Insured Person** means the person(s) as stated in the Policy Schedule:
    (a) who satisfies the criteria under Section – 'Eligibility';
    (b) is declared for cover under this Policy by the Policyholder; and
    (c) falls under the Category provided by the Policyholder.

30. **Limb** means the entire limb between the shoulder and the wrist or between the hip and the ankle.

31. **Loss of Independent Existence** means the Permanent inability to perform at least 3 out of the 6 Activities of Daily Living.

32. **Loss of Use** shall mean permanent limitation in function in relation to the limb or organ following an Injury.

33. **Medically Necessary** shall mean a medical service provided on an attending Doctor's recommendation/advice which is:
    (a) consistent with the diagnosis and customary medical treatment for a covered Injury; 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 Doctor and unable to be reasonably rendered out of Hospital (if admitted as an In-patient); and
    (d) not of an experimental, investigational, research, preventive or screening in nature; and
    (e) for which charges are fair and 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 individuals of the same sex and of comparable age for a similar Injury in accordance with accepted medical standards and practice that could not have been omitted without adversely affecting the Insured Person's Injury.

34. **Mobility Aid(s)** means medical equipment prescribed by the Doctor as necessary for the Insured Person to engage in Activities of Daily Living upon the Insured Person's discharge from the Hospital, including but not limited to Prosthetic Devices, orthopedic braces, crutches, wheelchairs, walking aids and hospital beds.

35. **Module** means:
    (a) Mandatory module;
        i. Core module;
    (b) Optional module:
        i. Accident module;
        ii. Medi-Care module; and
        iii. Employee Assistance module

36. **Ombudsman for Financial Services (OFS)** refers to an independent body that provides a free and efficient avenue to help resolve financial disputes between the Policyholder/ Insured Person and the Company under this Policy as an alternative to the Malaysian courts.

37. **Overseas** means outside any territorial limits of Malaysia.

38. **Paraplegia** means the entire paralysis of both legs and part or whole of the lower half of the body.

39. **Permanent** means lasting for at least 6 consecutive months and at the end of that time is certified by the attending Doctor as being beyond hope of improvement and will in all probability continue for the remainder of the Insured Person's natural life.

40. **Plan** means the Benefits and corresponding Sum Insured limits selected by the Policyholder and approved by the Company for this Policy, as shown in the Policy Schedule.

41. **Policy** refers to this insurance contract which consists of the policy wording, the latest Policy Schedule and any other documents the Company may issue to the Policyholder or Insured Person that will form part of this Policy (e.g. Endorsements).

42. **Policyholder** means the corporate body who is named as the Policyholder in the Policy Schedule and to whom this Policy is issued in respect of cover for the Insured Persons declared to the Company. Also, the Policyholder owns this Policy, is responsible for premium payments and has the right to exercise all privileges under this Policy.

43. **Policy Effective Date** refers to the later of:
    (a) the Policy Start Date as specified on the first Policy Schedule issued to the Policyholder,
    (b) the first date the Insured Person was covered under this Policy, or
    (c) the effective date any additional cover or increased Sum Insured is granted to the Insured Person while they are covered under this Policy, only in respect to the additional cover or increased Sum Insured.

44. **Policy Expiry Date** means the earlier of:
    (a) the expiry date as specified on the Policy Schedule for this Policy;
    (b) the date this Policy is cancelled; or
    (c) the date this Policy is automatically terminated as provided under Section 'Automatic Termination of Policy'.

45. **Period of Insurance** means the period which commences on the Policy Start Date and ends on the Policy Expiry Date as specified in the Policy Schedule, for which premium has been paid.

46. **Policy Schedule** means the document showing details of the Period of Insurance and the particulars of the Policyholder and eligible Insured Persons, including the Schedule of Benefits and the Renewal Policy Schedule, which should be read with this Policy.

47. **Policy Start Date** means the date specified on the Policy Schedule on which the cover under this Policy commences.

48. **Pre-Existing Condition** is any injury, illness or other condition:
    (a) for which the Insured Person has sought or received treatment, medication, advice or diagnosis before the Policy Effective Date;
    (b) which first manifested itself, worsened, became acute or presented signs or symptoms prior to the Policy Effective Date and which would have caused any reasonable person to seek diagnosis, care or treatment; or
    (c) which is a Chronic Condition or cancer diagnosed before the Policy Effective Date.

49. **Prosthetic Devices** means artificial devices replacing body parts, including but not limited to, leg, arm, back, and neck braces, artificial legs, arms and eyes.

50. **Quadriplegia** means the entire paralysis of both legs and both arms.

51. **Renewal Date** means the date after 12 consecutive months following the Policy Start Date and the date after each 12 consecutive months thereafter provided the Policy is renewed.

52. **Schedule of Benefits** means the document containing the applicable Benefits and their corresponding Sum Insured, Aggregate Period and Waiting Period.

53. **Sum Insured** means the maximum amount payable for a Benefit as specified in the Schedule of Benefits.

54. **Thumb** means the first digit of a Hand.

55. **Toe** means a digit of the Foot.

56. **Total Disablement** means a disablement which results in Loss of Independent Existence and entirely prevents the Insured Person from engaging in any business, profession, occupation or employment for which they are reasonably qualified by training, education or experience.

57. **Total Loss** means:
    (a) In the case of a Limb
        (i) Permanent physical severance of the Limb; or
        (ii) Permanent total and irrecoverable loss of use of the Limb.
    (b) In the case of a loss of Thumb, Finger, Big Toe or Toe
        (i) Loss by Permanent physical severance of the entire Thumb, Finger, Big Toe or Toe; or
        (ii) Permanent, total and irrecoverable loss of use of a complete Thumb, Finger, Big Toe or Toe.
    (c) In the case of loss of sight
        (i) Permanent, total and irrecoverable physical loss of one or both eyes; or
        (ii) Permanent, total and irrecoverable loss of the sight of one or both eyes.
    (d) In the case of loss of speech
        Permanent, total and irrecoverable loss of speech resulting in the inability to articulate any three of the four sounds which contribute to the speech such as the labial sounds, the alveololabial sounds, the palatal sounds and the velar sounds or total loss of vocal cord or damage of speech centre in the brain resulting in Aphasia.
    (e) In the case of loss of hearing
        Permanent, total and irrecoverable loss of hearing resulting in inability of the Insured Person to hear sounds quieter than 90 decibels across frequencies between 500 Hz and 3,000 Hz when tested by a qualified audiologist.

58. **Usual Country of Residence** means Malaysia, in which the Insured Person is a resident:
    (a) as a citizen;
    (b) registered as a permanent resident; or
    (c) holding a valid employment or dependent permit granted by the relevant Government authority during the Period of Insurance.

59. **Valid Claim** means any claim under this Policy which, according to the terms of the Policy, the Policyholder or Insured Person is entitled to receive a payment from the Company.

60. **War** shall mean war, whether declared or not, any war like activities including the use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

BENEFITS

Please note that Policyholder or Insured Person must refer to the Schedule of Benefits for applicable Benefits to their Policy as not all the Benefits listed below will apply to their Policy.

CORE MODULE

1. Accidental Death

If an Insured Person sustains an Injury that directly results in Accidental death within 365 days from the date of the Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefits

EXPOSURE

If an Accidental death occurs within 365 days from the date of Accident as a direct result of unexpected exposure to natural elements following an Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefits.

DISAPPEARANCE

If the Insured Person's body has not been found within 365 days after the date of disappearance, sinking or wrecking of the aircraft or other conveyance either on the ground or at sea in which the Insured Person was travelling at the time of the Accident, the Company will presume that the Insured Person died from this Accident. This is subject to a signed undertaking by the Insured Person's legal representative that if this presumption is subsequently found to be wrong, any payment made under this Policy will be refunded to the Company upon demand.

RENEWAL BONUS

A Renewal Bonus is only applicable to Core Module: 1. 'Accidental Death Benefit' and subject to the conditions set out below:

1. The Policy must be continuously renewed without interruption.
2. Renewal Bonus will be calculated as per table below based on the current year's Sum Insured assigned to the Core Module: 1. 'Accidental Death Benefit'.

Renewal Year	Renewal Bonus %
Year 1 - 3	10%
Year 4 onwards	20%

3. Renewal Bonus for previous years under this Policy does not get carried forward for subsequent renewals.
4. In the event of any increase or decrease in the Sum Insured assigned to Core Module: 1. 'Accidental Death Benefit' at the renewal of this Policy, the Renewal Bonus will be calculated based on the new Sum Insured for Core Module: 1. 'Accidental Death'.
5. Renewal Bonus is applied at a Policy level. All employees covered in that Policy year will be eligible for the Renewal Bonus.

DEFINITION - IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS:

1. **Renewal Bonus** means an increase in the Sum Insured assigned to Core Module: 1. 'Accidental Death Benefit' as stated in the Schedule of Benefits on every Anniversary Date subject to the terms and conditions under the section 'Renewal Bonus' in this Benefit.
2. For the purpose of this Benefit, the definition of 'Injury' under the Section 'General Policy Definitions' extends to include Accidental food poisoning.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. All coverages under this Policy will automatically terminate for the Insured Person when Sum Insured is paid under this Benefit.
2. Any Sum Insured payable under this Benefit shall be reduced by any amount paid or payable under 'Permanent Disablement' Benefit during an Insured Person's lifetime.
3. The maximum Sum Insured allowed per person for Class 1&2 is RM 1,000,000 and Class 3 is RM 300,000.

   If the calculation of Sum Insured is based on multiplier of monthly basic salary, the maximum Sum Insured allowed is the monthly basic salary times the multiplier as specified in the Schedule of Benefit, not exceeding RM 1,000,000 for Class 1&2 and RM 300,000 for Class 3.

2. Permanent Disablement

If an Insured Person sustains an Injury that directly results in one of the events listed in the Table of Events below, within 365 days from the date of Accident, the Company will pay the Sum Insured specified in the Schedule of Benefits subject to the applicable percentage as set out in the Table of Events.

Table of Events		
Event	**Injury resulting in:**	**Percentage of Sum Insured payable per Insured Person as specified in the Schedule of Benefits**
1	Permanent Total Disablement	150%
2	Permanent and incurable paralysis of all Limbs	150%
3	Permanent Total Loss of Sight of both eyes	150%
4	Permanent Total Loss of Sight of one eye	150%
5	Total Loss of two Limbs or Permanent Total Loss of Use of two Limbs	150%
6	Total Loss of one Limb or Permanent Total Loss of Use of one Limb	150%
7	Permanent Total Loss of speech and hearing	150%
8	Permanent Total Loss of hearing in:	
	a) Both ears	75%
	b) One ear	25%
9	Permanent Total Loss of speech	50%
10	Permanent and incurable insanity	100%
11	Permanent Total Loss of the natural lens of one eye	50%
12	Total Loss of all Fingers or Permanent Total Loss of Use of all Fingers of either Hand	70%
13	Total Loss of one Thumb or Permanent Total Loss of Use of one Thumb:	
	a) Both phalanges of either Hand	30%
	b) One phalanx of either Hand	15%
14	Total Loss of four Fingers or Permanent Total Loss of Use of four Fingers of either Hand	40%
15	Total Loss of Fingers or Permanent Total Loss of Use of Fingers:	
	a) Three phalanges of either Hand	10%

	b) Two phalanges of either Hand	7.5%
	c) One phalanx of either Hand	5%
16	Total Loss of Toes or Permanent Total Loss of Use of Toes:	
	a) All of one Foot	15%
	b) Big Toe, both phalanges	5%
	c) Big Toe, one phalanx	3%
	d) Other than Big Toe, each Toe (one phalanx or more)	1%
17	Fractured leg and/or patella with established non-union	10%
18	Shortening of Leg by at least 5 cm	7.5%

In the event of any Permanent Disablement not otherwise provided for under the Table of Events, the Company will assess the percentage of the amount payable and shall have absolute discretion in determining such percentage, consistent with the percentage provided under Events 8 to 18 inclusive subject to a maximum of 75% of the applicable amount as specified in the Schedule of Benefits.

Conditions - In addition to the General Policy Conditions applying to all sections:

1. The Benefit is payable only once for the same part of the body. For an example, if an Insured Person sustains an Injury under Event 12, the Company will not pay out under Events 13 to 15 for the same Hand.

2. Limitation on multiple Events: If an Insured Person sustains one or more Injury(ies) from the same Accident for which amounts are payable under more than one of the Events as listed in the above Table of Events, the maximum Sum Insured payable under all of the Events combined will not exceed 100% of the Sum Insured as specified on the Schedule of Benefits, unless a Valid Claim is payable under Events 1 to 7 of the Table of Events. In the event of a Valid Claim under Events 1 to 7 of the Table of Events, the maximum Sum Insured payable under all of the Events combined will not exceed 150% of the Sum Insured as specified on the Schedule of Benefit respectively.

   Should the maximum limit as mentioned above be reached before the expiry of the Period of Insurance, then coverage under this Benefit for the Insured Person lapses when the last Event giving rise to the maximum payment of Sum Insured for this Benefit or that difference making up the balance of the maximum Sum Insured for this Benefit occurs.

   The Policy will continue as if that Benefit had been cancelled for that Insured Person.

3. The maximum Sum Insured allowed per person for Class 1&2 is RM 1,000,000 and Class 3 is RM 300,000.

   If the calculation of Sum Insured is based on multiplier of monthly basic salary, the maximum Sum Insured allowed is the monthly basic salary times the multiplier as specified in the Schedule of Benefit, not exceeding RM 1,000,000 for Class 1&2 and RM 300,000 for Class 3.

3. Accidental Death In Common Carrier

If an Insured Person sustains an Injury when boarding, travelling in or exiting a Common Carrier as a fare paying passenger that directly results in Accidental death within 365 days from the date of Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefits.

Exposure

If an Accidental death occurs within 365 days from the date of Accident as a direct result of unexpected exposure to natural elements following an Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefits.

Disappearance

If the Insured Person's body has not been found within 365 days after the date of disappearance, sinking or wrecking of the aircraft or other conveyance either on the ground or at sea in which the Insured Person was travelling at the time of the Accident, the Company will

presume that the Insured Person died from this Accident. This is subject to a signed undertaking by the Insured Person's legal representative that if this presumption is subsequently found to be wrong, any payment made under this Policy will be refunded to the Company upon demand.

Definitions - In addition to the General Policy Definitions applying to all Sections

1. **Common Carrier** means any licensed registered operator which provides regular scheduled transportation services for individuals who travel as fare paying passengers in vehicles as listed below:
   (a) Airport limousine, bus, coach, taxi or e-hailing ride, ferry, hovercraft, hydrofoil, ship, train, tram or underground train; and
   (b) Any fixed-wing aircraft operated by a licensed airline or an air charter company; and helicopters operating only between established and recognised commercial airports or licensed commercial heliports, of which both the said aircrafts and helicopters must have current and valid air worthiness certificates issued by the appropriate authority.

Conditions - In addition to the General Policy Conditions applying to all Sections

1. The Policy will automatically terminate for the Insured Person when this Benefit becomes payable.
2. The maximum Sum Insured allowed per person for Class 1&2 is RM 1,000,000 and Class 3 is RM 300,000.

   If the calculation of Sum Insured is based on multiplier of monthly basic salary, the maximum Sum Insured allowed is the monthly basic salary times the multiplier as specified in the Schedule of Benefit, not exceeding RM 1,000,000 for Class 1&2 and RM 300,000 for Class 3.

Exclusions - In addition to the General Exclusions applying to all Sections

The Company will not pay under this Policy any claim in connection with:

1. Any loss directly or indirectly related to the Insured Person threatening safety or disrupting other passengers and crew, or in the event of any violation of the Passenger Code of Conduct.

4. Accidental Death due to Natural Catastrophe

If an Insured Person sustains an Injury due to a Natural Catastrophe that directly results in their Accidental death within 365 days from the date of Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefits.

Definition - In addition to the General Policy Definitions applying to all sections:

Natural Catastrophe means cyclone, flood, hurricane, earthquake, landslide, tornado, tsunami, typhoon, volcanic eruption, windstorm, hailstorm, and wildfire, which are major adverse events resulting from natural processes of the earth.

Conditions - In Addition To The General Policy Conditions Applying To All Sections

1. The Policy will automatically terminate for the Insured Person when this Benefit becomes payable.
2. The maximum Sum Insured per person for Class 1&2 is RM 500,000 and Class 3 is RM 150,000.

   If the calculation of Sum Insured is based on multiplier of monthly basic salary, the maximum Sum Insured allowed is the monthly basic salary times the multiplier as specified in the Schedule of Benefit, not exceeding RM 500,000 for Class 1&2 and RM 150,000 for Class 3.

5. Medical Expenses due to An Injury

If an Insured Person sustains an Injury, the Company will reimburse the actual Medically Necessary Medical Expenses incurred to treat an Injury sustained by the Insured Person within 365 days from the date of Accident up to the maximum Sum Insured specified in the Schedule of Benefits.

DEFINITIONS - IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS:

1. **Medical Expenses,** for the purpose of this Benefit, means any actual, reasonable and necessary expenses incurred for Hospitalisation, medical treatment or supplies, medical services to treat an Insured Person as prescribed by a Doctor and which do not exceed the usual level of charges for similar treatment for the same Injury, supplies or medical services in the locality where the expenses are incurred and does not include charges that would not have been made if no insurance existed. It does not include treatment by a physiotherapist or treatments by alternative and traditional medical practitioners, traditional Chinese medicine practitioner or chiropractor.

2. For the purpose of this Benefit, the definition of 'Injury' under the Section 'General Policy Definitions' extends to include Accidental food poisoning.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS:

1. This Benefit is only payable after supporting documents for Medical Expenses, including attending Doctor's reports and referral letters (where applicable), are provided to the Company along with original Medical Expenses bills and receipts.
2. If the Insured Person is entitled to a refund of all or part of the Medical Expenses stated in this Benefit from any other source, the Company will only pay the amount incurred over and above the refunded amount up to the maximum Sum Insured as shown on the Schedule of Benefits.
3. Any Hospitalisation accommodation for the Insured Person is restricted up to the cost of a single standard private room.

EXCLUSIONS - IN ADDITION TO THE GENERAL EXCLUSIONS APPLYING TO ALL SECTIONS

The Company will not pay under this Policy any claim in connection with:

1. any medical transportation services;
2. any dental treatment unless necessitated by Injury to sound and natural teeth

6. Alternative Medical Treatments

If an Insured Person sustains an Injury, the Company will reimburse for any Medically Necessary Alternative Medical Treatment expenses incurred by the Insured Person for up to 365 days from the date of the Accident up to the maximum Sum Insured payable as specified in the Schedule of Benefits, for any one Accident provided the first Alternative Medical Treatment for the Injury is sought within 30 days from the date of the Accident.

DEFINITION - IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS:

1. **Alternative Medical Treatments** means either Traditional Chinese Medicine or Chiropractor Treatment.

2. **Traditional Chinese Medicine** means treatment or medicine prescribed by a Chinese Physician.

3. **Chinese Physician** means a registered herbalist, acupuncturist or bonesetter licensed under any applicable laws and acting within the scope of his/her license and training. The attending Chinese Physician shall not be the Insured Person, the Insured Person's business partner or agent, Insured Person's employer or employee or a person related to the Insured Person by blood, marriage or

adoption.

4. **Chiropractor Treatment** means treatment provided by a legally licensed practitioner in chiropractic medicine who is registered and can practice within the scope of their license under the laws of the country. The attending Chiropractor shall not be the Insured Person, the Insured Person's business partner or agent, Insured Person's employer or employee or a person related to the Insured Person by blood, marriage or adoption.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This Benefit is only payable if the first Alternative Medical Treatment for the Injury is sought within 30 days from the date of the Accident.

2. The Benefit is payable only after supporting documents for such Alternative Medical Treatments, including attending Chinese Physician or chiropractor's reports and referral letters (where applicable), are provided to the Company along with original treatment bills or receipts.

3. If the Insured Person is entitled to a refund of all or part of the Alternative Medical Treatments stated in this Benefit from any other source, the Company will only pay the amount incurred over and above the refunded amount up to the maximum Sum Insured as specified on the Schedule of Benefits.

EXCLUSIONS– IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

The Company will not pay any claim in connection with:

1. Any medical transportation services.
2. Any dental treatment whilst Overseas.
3. Any treatment which is purchased as a part of a treatment package.

MODULE 1: ACCIDENT

1. Funeral Expenses

If an Insured Person dies within 365 days from the date of Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefit.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

For this Benefit to be payable, there must be a Valid Claim payable under Core Module: 1. 'Accidental Death Benefit'.

2. Mobility Assistance Due to Temporary Total Disablement

If an Insured Person sustains an Injury that results in Temporary Total Disablement exceeding a minimum period of 7 consecutive Days and requires the use of specific Mobility Aid(s) for their disability, the Company will reimburse, for any one Accident, the actual reasonable expenses incurred for purchasing or renting of Mobility Aid(s) up to the maximum Sum Insured as specified in the Schedule of Benefits.

DEFINITION - IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS:

In addition to the definitions set out in the General Policy Definitions, the following specific definitions apply:

1. **Mobility Aid(s)** means medical equipment prescribed by the Doctor as necessary for the Insured Person to engage in Activities of

Daily Living, including but not limited to Prosthetic Devices, orthopedic braces, crutches, wheelchairs, walking aids and hospital beds.

2. **Prosthetic Devices** means artificial devices replacing body parts, including but not limited to, leg, arm, back, and neck braces, artificial legs, arms and eyes.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS:

1. The Temporary Total Disablement must exceed a minimum period of 7 consecutive Days.
2. For this Benefit to be payable, the Company should be provided with the supporting documents for:
    a. Temporary Total Disablement being duly certified by the attending Doctor; and
    b. the expenses incurred to rent or purchase Mobility Aid(s).
3. The Company retains the right to determine if the purchase or rental of any Mobility Aid(s) is Medically Necessary and appropriate.
4. An Insured Person can make a claim either under this Benefit or under the Benefit 'Mobility Assistance Due to Permanent Total Disablement', but not both.

EXCLUSIONS - IN ADDITION TO THE GENERAL EXCLUSIONS APPLYING TO ALL SECTIONS

In addition to the exclusions set out in the General Policy Exclusions, this Policy will not pay any claim in connection with:

1. Mobility Aid(s) not prescribed by a Doctor as being Medically Necessary.
2. Any repair or replacement for any Mobility Aid(s) that was purchased or rented.
3. Any external prosthetics appliances or devices such as hearing aids, implanted pacemakers, contact lenses and glasses for eye refraction, corrective aids and treatment of refractive errors unless necessitated by Injury caused by an Accident.
4. Any motorised wheelchairs and beds unless Insured Person unable to do at least 3 out of 6 Activities of Daily Living for at least 12 consecutive months and confirmed in writing by the attending Doctor.
5. Any ancillary items such as telephone arms and over bed tables, items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners), disposable supplies, exercise bikes, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment and other similar items.
6. Any rental deposits or bonds, delivery or assembling charges and shipping or import fees.

3. Fractures

If an Insured Person sustains an Injury which results in a Complete Fracture as per the events listed in the Table of Events below and is certified by the attending Doctor, the Company will pay up to the Sum Insured as specified in the Table of Events below.

Table of Events

Event	Injury resulting in a Complete Fracture of:	Percentage of the Sum Insured as specified in the Schedule of Benefits payable per Insured Person
A	Vertebral column (other than coccyx)	100%
B	Pelvis or Hip	80%
C	Skull (other than nose and teeth	30%
D	Breast bone, ankle, or one or more bones of the leg (femur, patella, tibia, and fibula)	30%
E	Collar bone, elbow, wrist or one or more bones of the arm (humerus, radius, ulna)	15%
F	Rib or coccyx	10%
G	One or more bones of the Hand, Fingers, Foot, Thumb, Toes, the nose, or any bone not specifically covered in A to F above	3%
The percentage of the amount reflected in the Table of Events above is payable for each Event under Events A to G regardless of the number of Fractures suffered on each Bone Site.		

Maximum Percentage of Sum Insured payable in any one Accident or any one Period of Insurance	100%

Definition - In addition to the General Policy Definition applying to all sections:

1. **Bone Site** means the bone(s) or body part as listed in Events A to G in the Table of Events.

2. **Complete Fracture** means a Fracture in which the bone is broken completely across with no connection left between the bone pieces.

3. **Fracture** means a complete or incomplete break in the continuity of a bone and is diagnosed by the attending Doctor through radiological evidence and diagnostic techniques.

4. **Pathological Fracture** means a complete or incomplete break in the continuity of a bone, in an area where disease has caused weakening of the affected bone.

Conditions - In addition to the General Policy Conditions applying to all sections:

This Benefit is payable only once per Insured Person within the Period of Insurance.

Exclusions - In addition to the General Exclusions applying to all Sections

The Company will not pay under this Policy any claim in connection with:
1. Any Fracture caused by osteoporosis or any Pathological Fracture. If osteoporosis or Pathological Fracture is first diagnosed by a Doctor during the Period of Insurance, the Company will pay the claim as provided under this Benefit for the initial Fracture after diagnosis; however, all subsequent Fractures will not be covered by this Policy.
2. Any Fractures classed as hairline, stress or fatigue Fractures.
3. Any Fractures involving body parts or bone sites not listed in the Table of Events above.

4. Coma

If an Insured Person sustains an Injury and is Hospitalised in a Comatose State within 180 days from the date of Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefits.

This Definitions - In addition to the General Policy Definitions applying to all sections

1. **Comatose State (i.e., Coma)** means a state of profound unconsciousness, characterised by the absence of spontaneous eye openings, response to painful stimuli, and vocalisation. This diagnosis must be supported by the attending Doctor with evidence of all of the following:
    a) No more than Glasgow Coma Score of 6 for at least 72 consecutive hours;
    b) Life support measures are necessary to sustain life; and
    c) Brain damage resulting in Permanent Neurological Deficit.

2. **Permanent Neurological Deficit** means any neurological impairment which is certified by the attending Doctor as being beyond hope of improvement and will in all probability continue for the remainder of the Insured Person's natural life resulting in a disablement that consequentially leads to a total inability to perform, by oneself, at least 2 or more Activities of Daily Living.

3. **Glasgow Coma Scale** (GCS) means an internationally recognised neurological scale which aims to give a reliable and objective way of recording the state of a person's consciousness for initial as well as subsequent assessment.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. The Insured Person must be diagnosed to be in a Comatose State whilst Hospitalised and continue to be Hospitalised for the whole duration of the Comatose State for this Benefit to be payable.
2. The Comatose State must be supported by the attending Doctor's report outlining the cause and period of the Insured Person's Comatose State.
3. An assessment for brain damage resulting in Permanent Neurological Deficit for the Insured Person must be conducted 90 days after the Accident, unless an alternative later date is recommended by the Company's medical advisers. This assessment is to be conducted by the attending neurosurgeon and certified in writing.
4. This Benefit is only payable once in a Period of Insurance.

EXCLUSIONS - IN ADDITION TO THE GENERAL EXCLUSIONS APPLYING TO ALL SECTIONS

This Benefit will not pay any claim in connection with any Illness or a medically induced Comatose State.

5. Serious Burns

If an Insured Person sustains an Injury resulting in Serious Burns as per the events listed in the Table of Events below, the Company will pay the Sum Insured as specified in the Table of Events below.

Table of Events:

Events - Serious Burns resulting in damage as a % of total surface area:		**Percentage of the Sum Insured payable per Insured Person as specified in the Schedule of Benefits**
Area		
Head	Equals to or greater than 2% but less than 5%	50%
	Equals to or greater than 5% but less than 8%	75%
	Equals to or greater than 8%	100%
Body	Equals to or greater than 10% but less than 15%	50%
	Equals to or greater than 15% but less than 20%	75%
	Equals to or greater than 20%	100%

DEFINITIONS - IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS

1. **Serious Burns** means either Second Degree Burns or Third Degree Burns as diagnosed by the attending Doctor.

2. **Second Degree Burns** means partial thickness burns which affect both the epidermis (the outer layers of the skin) and dermis (the layers of the skin that contain hair follicles, nerve endings, sweat and sebaceous glands) as diagnosed by the attending Doctor.

3. **Third Degree Burns** means full thickness burns which result in the destruction of both the epidermis (the outer layers of the skin) and dermis (the layers of the skin that contain hair follicles, nerve endings, sweat and sebaceous glands), that can also affect deeper tissues, as diagnosed by the attending Doctor. These burns usually require surgery or skin grafting.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This Benefit is payable provided an assessment of the percentage of body affected by burns is determined and certified by the attending Doctor.
2. The maximum claim amount payable under this Benefit during the Period of Insurance regardless of the number of Events suffered, is 100% of the Sum Insured specified in the Schedule of Benefits.

Exclusions - In addition to the General Exclusions applying to all sections

This Benefit will not pay any claim in connection with:

1. any first-degree burns, sunburn, in-door tanning, cosmetic tanning or burns resulting from any aesthetic or surgical procedure.

6. Accidental Death at Workplace

If an Insured Person sustains an Injury at the Insured Person's Workplace arising in and out of the course of employment during the Period of Insurance, that directly results in their Accidental Death within 365 days from the date of Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefits.

Definition - In addition to the General Policy Definitions applying to all sections:

1. **Workplace** means the Insured Person's primary place of employment located within Malaysia. This definition shall include:
   a) business sites and offices visited to carry out occupational duties in the course of employment for the Policyholder's business.
   b) work related engagements or undertakings which is directly related to the Insured Person's occupational duties.

Conditions - In Addition To The General Policy Conditions Applying To All Sections

The Policy will automatically terminate for the Insured Person when this Benefit becomes payable.

Exclusions - In addition to the General Exclusions applying to all sections

The Company will not pay under this Benefit any claim in connection with:

1. An Injury while working from home or outside of the Workplace.
2. Any daily commute to and from the Insured Person's Home and Workplace;
3. Any Accident which occurs in the course of the Insured Person's non-work related engagements/undertakings which is not directly related to the Insured Person's occupational duties;
4. Any Accident which occurs outside of Malaysia even if the Insured Person is there to carry out occupational duties for the Policyholder's business.

7. Mobility Assistance Due to Permanent Total Disablement

If an Insured Person sustains an Injury that results in Permanent Total Disablement and requires the use of specific Mobility Aid(s) for their disability, the Company will reimburse, for any one Accident, the actual reasonable expenses incurred for purchasing or renting of Mobility Aid(s) up to the maximum Sum Insured as specified in the Schedule of Benefits.

Definition - In addition to the General Policy Definitions applying to all sections:

In addition to the definitions set out in the General Policy Definitions, the following specific definitions apply:

1. **Mobility Aid(s)** means medical equipment prescribed by the Doctor as necessary for the Insured Person to engage in Activities of Daily Living, including but not limited to Prosthetic Devices, orthopedic braces, crutches, wheelchairs, walking aids and hospital beds.

2. **Prosthetic Devices** means artificial devices replacing body parts, including but not limited to, leg, arm, back, and neck braces, artificial legs, arms and eyes.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS:

1. For this Benefit to be payable, the Company should be provided with the supporting documents for:
    a. Permanent Total Disablement being duly certified by the attending Doctor; and
    b. the expenses incurred to rent or purchase Mobility Aid(s).
2. The Company retains the right to determine if the purchase or rental of any Mobility Aid(s) is Medically Necessary and appropriate.
3. An Insured Person can make a claim either under this Benefit or under the Benefit 'Mobility Assistance Due to Temporary Total Disablement', but not both.

EXCLUSIONS - IN ADDITION TO THE GENERAL EXCLUSIONS APPLYING TO ALL SECTIONS

In addition to the exclusions set out in the General Policy Exclusions, this Policy will not pay any claim in connection with:

1. Mobility Aid(s) not prescribed by a Doctor as being an essential requirement for an Insured Person's Activities of Daily Living.
2. Any repair or replacement for any Mobility Aid(s) that was purchased or rented.
3. Any external prosthetics appliances or devices such as hearing aids, implanted pacemakers, contact lenses and glasses for eye refraction, corrective aids and treatment of refractive errors unless necessitated by Injury caused by an Accident.
4. Any motorised wheelchairs and beds unless Insured Person suffers a Permanent Total Disablement or unable to do at least 3 out of 6 Activities of Daily Living for at least 12 consecutive months and confirmed in writing by the attending Doctor.
5. Any ancillary items such as telephone arms and over bed tables, items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners), disposable supplies, exercise bikes, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment and other similar items.
6. Any rental deposits or bonds, delivery or assembling charges and shipping or import fees.

8. Repatriation Of Mortal Remains

If an Insured Person sustains an Injury whilst Overseas during the Period of Insurance that directly results in Accidental death within 30 Days from date of Accident, the Company will reimburse up to the maximum Sum Insured specified in the Schedule of Benefits either for:

(a) the reasonable cost of returning the Insured Person's mortal remains to their Usual Country of Residence; or

(b) the reasonable funeral and related costs if the Insured Person is buried or cremated at the place of death, provided this location is outside their Usual Country of Residence.

EXCLUSIONS - IN ADDITION TO THE GENERAL EXCLUSIONS APPLYING TO ALL SECTIONS

In addition to the exclusions set out in the General Policy Exclusions, this Policy will not pay any claim in connection with:

1. Any expenses incurred for religious rights or ceremonies; and
2. Any expenses incurred for body retrieval or recovery.

9. Emergency Medical Evacuation

If an Insured Person sustains an Injury whilst Overseas resulting in Hospitalisation and it is judged Medically Necessary and appropriate by the attending Doctor to move the Insured Person to another Hospital or to return the Insured Person back to Malaysia for medical treatment, the Company will reimburse the Covered Expenses for emergency medical evacuation of the Insured Person up to the maximum Sum Insured specified in the Schedule of Benefits.

DEFINITION - IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS:

Covered Expenses, for the purpose of this Benefit, means reasonable cost of arranging the transportation services, medical services and medical supplies necessarily incurred as a result of an emergency medical evacuation of an Insured Person utilizing the means best suited to do so, based on the medical severity of the Insured Person's condition.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. The Benefit is payable only if:

   a. the emergency medical evacuation is recommended by the attending Doctor as being Medically Necessary.

   b. supporting documents including written confirmation from attending Doctor and other relevant supporting documents on the reason for such medical evacuation, are provided to the Company along with original bills and receipts.

EXCLUSIONS - IN ADDITION TO THE GENERAL EXCLUSIONS APPLYING TO ALL SECTIONS

The Company will not pay under this Benefit any claim in connection with:

1. Any Injury sustained whilst the Insured Person is in the Usual Country of Residence.

10. Physiotherapy Expenses

If an Insured Person sustains an Injury, the Company will reimburse the cost of physiotherapy incurred within 365 days from the date of the Accident up to the maximum Sum Insured specified in the Schedule of Benefits if the physiotherapy treatment is deemed Medically Necessary by the attending Doctor and the Insured Person has a written medical referral from the attending Doctor to the physiotherapist.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This Benefit is payable only after the supporting documents, including attending Doctor's reports and referral letters, are provided to the Company along with original Medical Expenses bills or receipts for the physiotherapy treatment.

2. If the Insured Person is entitled to receive a reimbursement of all or part of the expenses for physiotherapy treatment stated in this Benefit from any other source, the Company will only pay the amount incurred over and above the reimbursed amount, up to the maximum Sum Insured as specified in the Schedule of Benefits.

EXCLUSIONS - IN ADDITION TO THE GENERAL EXCLUSIONS APPLYING TO ALL SECTIONS

The Company will not pay under this Benefit any claim in connection with:

1. Any physiotherapy treatment received but is not part of treatment for the Injury.
2. Any treatment or services provided by the Insured Person, the Insured Person's business partner or agent, Insured Person's employer or employee or employee or a person related to the Insured Person by blood, marriage or adoption.

11. Snatch Theft

If an Insured Person becomes a victim of Snatch Theft during the Period of Insurance, the Company will pay the Sum Insured as specified in the Schedule of Benefits, provided that the Snatch Theft incident is reported to the police within 24 hours. This Benefit is only payable once for each Insured Person per Period of Insurance.

DEFINITION - IN ADDITION TO THE GENERAL POLICY DEFINITION APPLYING TO ALL SECTIONS:

1. **Snatch Theft** means Theft or attempted Theft accompanied with the elements of stealth, surprise and force.

2. **Theft** means the act of dishonestly taking movable property out of the possession of another, without that other person's consent, and with the intention of permanently depriving that other person of it. The definition of Theft is synonymous with that described in Section 378 of the Malaysian Penal Code.

Conditions - In addition to the General Policy Conditions applying to all sections

1. The Snatch Theft must be inflicted upon the Insured Person by individuals other than their relative or any individual who resides with the Insured Person on a permanent basis.
2. The Claim must be supported with police report made within 24 hours of the Snatch Theft.

12. Ambulance Fees

If an Insured Person sustains an Injury and requires ambulance transportation as deemed Medically Necessary, either:

a) To the Hospital from the accident site;
b) From the Hospital to their Home upon discharge; or
c) Between Hospitals as recommended by the attending Doctor

the Company will reimburse the actual ambulance fees up to the maximum Sum Insured payable as specified in the Schedule of Benefits for any one Accident.

13. Staff Replacement

If an Insured Person sustains an Injury and is certified by the attending Doctor to be continuously disabled and entirely prevented from performing their usual occupational duties with the Policyholder for a minimum period of 60 consecutive days from the Date of Accident, the Company will reimburse the Policyholder reasonable and necessary expenses incurred to hire a temporary replacement for the Insured Person up to the Sum Insured as specified in the Schedule of Benefits.

Reasonable and necessary expenses to hire temporary employees includes but is not limited to expenses related to salaries, administrative costs of recruitment and training costs.

Conditions - In addition to the General Policy Conditions applying to all Sections

1. All expenses must incur within 90 days from the Date of Accident.
2. This Benefit is payable only once for any one Accident per Insured Person.
3. The attending Doctor must certify and confirm that the Insured Person is continuously disabled and entirely prevented from attending their usual occupational duties for at least 60 consecutive days from the Date of Accident, along with supporting medical reports.

Exclusions - In addition to the General Exclusions applying to all Sections

The Company will not pay under this Policy any claim in connection with:

1. Any individual who is not employed on a temporary basis or on a short contract term by the Policyholder as a temporary replacement as specified above.

14. Retraining For Alternative Employment

If an Insured Person sustains an Injury that directly results in one of the Events listed in the Table of Events below within 365 days from the date of the Accident, the Company will reimburse the reasonable and necessary expenses incurred by the Insured Person to receive Training for an alternative employment with the Policyholder up to the maximum Sum Insured as specified in the Schedule of Benefits.

Table of Events

Events – Injury resulting in	
1	Permanent Total Disablement
2	Permanent Total Loss of Sight of both eyes
3	Permanent Total Loss of Sight of one eye
4	Total Loss of two Limbs or Permanent Total Loss of Use of two Limbs
5	Total Loss of one Limb or Permanent Total Loss of one Limb

6	Permanent Total Loss of Speech and Hearing

Definitions - In addition to the General Policy Definitions applying to all Sections

1. **Training** means any full-time or part-time further education or training courses provided by any licensed educational or occupational rehabilitation institutions that will qualify or certify an Insured Person with new skills that will assist an Insured Person in obtaining an alternative employment with the Policyholder.

Conditions - In addition to the General Policy Conditions applying to all Sections

1. This Benefit must be claimed within 12 consecutive months from the date of the Accident.

Exclusions - In addition to the General Exclusions applying to all Sections

The Company will not pay under this Policy any claim in connection with:

1. Any recruitment costs for an alternative employment.

MODULE 2: MEDI-CARE

1. Bereavement Benefit Due to Death From Dengue Fever or Malaria

If an Insured Person is diagnosed with dengue fever or malaria during the Period of Insurance that directly results in death within 30 days from the date of diagnosis of dengue fever or malaria, the Company will pay Sum Insured as specified in the Schedule of Benefits upon submission of relevant documents required by the Company.

Definitions - In addition to the General Policy Definitions applying to all Sections

1. **Waiting Period** means a time period that needs to elapse from the Policy Effective Date before the Insured Person becomes entitled to claim a Benefit and during which no claim is payable. The Waiting Period for this Benefit is 30 consecutive days from the Policy Effective Date.

Conditions - In addition to the General Policy Conditions applying to all sections

This Benefit is payable only:

1) if the Insured Person is diagnosed with dengue fever or malaria after the applicable Waiting Period
2) when supporting documents, including attending Doctor's reports are provided to the Company

Exclusions - In addition To The General Exclusions Applying To All Sections

The Company will not pay under this Benefit any claim in connection with:

1. Death as a result of any Illness other than dengue fever or malaria.
2. An Insured Person having been covered under this Policy for less than 30 consecutive days from the Policy Effective Date.
3. Death which occurs after 30 days from the date of diagnosis of dengue fever or malaria.

2. Daily Hospitalisation Income – Accident Only

If the Insured Person sustains an Injury and is Hospitalised, the Company will pay the Sum Insured as stated in the Schedule of Benefits for each Day the Insured Person spends as an In-patient.

This Benefit shall continue up to the maximum number of days as specified in the Schedule of Benefits for any one Accident or until the Insured Person is discharged from the Hospital as an In-patient, whichever occurs first.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This Benefit is payable:
   a) Only if the Hospitalisation commences during a valid Period of Insurance.

   b) For only one Injury per Accident, regardless of the number of Injuries sustained in any one Accident during the same Hospitalisation period.

   c) After evidence of Insured Person's Hospital discharge summary or Hospital billing statement and medical report(s) are provided to the Company.

   d) For subsequent periods of Hospitalisation for the same Injury which are considered to be part of the same claim and subject to the same Aggregate Period, provided that:
      (i) each subsequent Hospitalisation occurs while this Policy is in force and the person who is the subject of the claim is an Insured Person.
      (ii) the time between the different Hospitalisation periods does not exceed 90 consecutive Days.

3. Surgical Cash – Accident Only

If an Insured Person sustains an Injury which directly results in a Medically Necessary Surgery recommended by the attending Doctor requiring a minimum Hospitalisation period of 3 consecutive Days within 365 Days from the date of the Accident, the Company will pay the Sum Insured as specified in the Schedule of Benefits.

DEFINITION - IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS:

1. **Surgery** means any of the following medical procedures:

   (a) To incise, excise or electro cauterise any organ or body part
   (b) To repair, revise, or reconstruct any organ or body part
   (c) To reduce by manipulation a fracture or dislocation

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS:

1. The surgical procedure undergone by an Insured Person shall be supported with a Doctor's written recommendation and evidenced by a medical report, Insured Person's Hospital discharge summary or Hospital billing statement.
2. For this Benefit to be payable, there must be a minimum Hospitalisation period of 3 consecutive Days.

EXCLUSIONS - IN ADDITION TO THE GENERAL EXCLUSIONS APPLYING TO ALL SECTIONS

In addition to the exclusions set out in the General Policy Exclusions, this Policy will not pay any claim in connection with:

1. Any dental or oral surgeries.

MODULE 3: EMPLOYEE ASSISTANCE

1. Household Bills Protection

If an Insured Person suffers an Injury that results in Hospitalisation for a minimum period of 7 consecutive Days, the Company will pay the Insured Person the Sum Insured as specified in the Schedule of Benefits for any one covered Accident as set out below to assist the Insured Person financially for household expenses:

Table of Events:

Event	Hospitalisation Period	Sum Insured Payable as specified in the Schedule of Benefits
1	At least 7 to 31 consecutive Days	1 payment of the monthly Sum Insured
2	At least 32 to 62 consecutive Days	2 payments of the monthly Sum Insured
3	At least 63 consecutive Days or more	3 payments of the monthly Sum Insured

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. For this Benefit to be payable, there must be a Hospitalisation for a minimum period of 7 consecutive Days.
2. Hospitalisation of an Insured Person shall be evidenced by Insured Person's Hospital discharge summary or Hospital billing statement and medical report.
3. This Benefit is payable only once for any one Accident

2. Weekly Indemnity Due To Temporary Total Disablement

If an Insured Person sustains an Injury resulting in Temporary Total Disablement, the Company will pay a weekly allowance as specified in the Schedule of Benefits up to a maximum of 52 weeks for any one Accident, provided:

1. The Insured Person is employed by the Policyholder at the time of the Accident; and
2. The Insured Person is under the continuous care of and acting in accordance with the instructions or professional advice of the attending Doctor during the period of the claim.

CONDITIONS - IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. The Insured Person must provide the Company with proof of being employed by the Policyholder with the Policyholder at the time of the Accident and throughout the period of the claim.
2. The claim must be supported by ongoing medical reports as required by the Company.
3. This Benefit is payable only once for any one Accident and will not be paid for subsequent Injury(ies) sustained during the same Temporary Total Disablement period.
4. Recurrent periods of Temporary Total Disablement due to the same or related Injury will be considered as one period of Temporary Total Disablement provided the time between such recurrent periods does not exceed 90 consecutive Days of return to their profession or occupation.

3. Home Nursing Care

If an Insured Person sustains an Injury during the Period of Insurance and is Hospitalised for a minimum period of 3 consecutive Days and upon discharge, the attending Doctor certifies in writing that the Insured Person is unable to perform at least 2 out of 6 Activities of Daily Living and requires to engage the services of a Nurse to care for them at their home post-hospitalisation, the Company will pay the Sum Insured for each Day the Nurse visits, up to a maximum number of Days, for any one Accident as specified in the Schedule of Benefits, provided that the first visit by the Nurse occurs within 7 Days following the date of the Insured Person's discharge from the Hospital.

Compensation under this Benefit shall continue up to the maximum number of visits under this Benefit or until such nursing care is no longer Medically Necessary for the Insured Person, whichever occurs first. All visits must occur within 30 days from date of discharge from the Hospital.

Definitions - In addition to the General Policy Definitions applying to all sections

1. **Nurse** means a person who is legally certified with a nursing qualification and registered with the relevant statutory nursing council to provide nursing services within the scope of their licensing and training in the geographical area of practice. The attending Nurse cannot be the Insured Person, the Insured Person's business partner or agent, Insured Person's employer or employee or a person related to the Insured Person by blood, marriage or adoption.

Conditions - In addition to the General Policy Conditions applying to all sections

1. For this Benefit to be payable, there must be a Hospitalisation for a minimum period of 3 consecutive Days.
2. Hospitalisation of an Insured Person shall be evidenced by Insured Person's Hospital discharge summary or Hospital billing statement and medical report.
3. This Benefit is payable either until the Doctor certifies that the Insured Person is fit and does not require nursing care or when the maximum amount as specified in the Schedule of Benefits has been paid, whichever occurs first.
4. For this Benefit to be payable, the Company should be provided with a Doctor's report stating that the Insured Person is unable to perform at least 2 out of 6 Activities of Daily Living and the receipts from the nursing care service provider for the expenses incurred.
5. The first visit by the Nurse must occur within 7 Days following the date of the Insured Person's discharge from the Hospital.

Exclusions - In addition to the General Exclusions applying to all sections

The Company will not pay under this Benefit any claim in connection with:

1. Any nursing care provided whilst Insured Person is Overseas.
2. Any expenses occurred for visits after 30 days from date of discharge from the Hospital.

4. Education Fund Benefit

If an Insured Person sustains an Injury that directly results in Accidental death within 365 days from the date of the Accident, the Company will pay up to the maximum Sum Insured as specified in the Schedule of Benefits for the Insured Person's surviving Child(ren) enrolled as a full-time student in a recognised Educational Institution at the time of Insured Person's death..

Definitions - In addition to the General Policy Definitions applying to all sections

1. **Child(ren)** for the purpose of this benefit means:
   (a) dependent children including legally adopted and stepchildren of the Insured Person;
   (b) from the age of 30 Days after birth up to 19 years or up to 25 years of age if attending as a full-time student in an accredited institution of higher learning; and
   (c) who are unmarried, primarily reside with the Insured Person and receive financial maintenance and support from the Insured Person.

Conditions - In addition to the General Policy Conditions applying to all sections

1. This Benefit is only payable if supporting documents showing the surviving Child or Children's enrollment in an Educational Institution at the time of Insured Person's death are provided to the Company.

GENERAL POLICY EXCLUSIONS

The following exclusions apply to all sections of this Policy. Where there is conflict between specific exclusions under the Benefit sections and General Policy Exclusions, the specific exclusion will prevail.

The Company shall not pay under this Policy any claim in connection with:

1. An Insured Person's:
   (a) Pre-Existing Condition or any complication arising from it;
   (b) failure to follow medical advice given by a Doctor;
   (c) pregnancy, miscarriage, abortion, childbirth, sterilisation, contraception as well as treatment for infertility or birth control treatments or any complications;
   (d) congenital anomalies and conditions arising out of or resulting therefrom or physical impairment;
   (e) mental, psychiatric or nervous disorder (including any neuroses and their physiological or psychosomatic manifestations), sleep disturbance disorder, anxiety, stress or depression. For avoidance of doubt, this exclusion does not refer to Event 10 "Permanent and Incurable insanity" under "Permanent Disablement" Benefit.

2. Any sexually transmitted diseases, 'Acquired Immunodeficiency Syndrome' (AIDS), AIDS-related complex or, any infection by 'Human Immunodeficiency Virus' (HIV) or any type of venereal disease.

3. Any Illness except for dengue fever or malaria covered under the 'Bereavement Benefit Due To Death From Dengue Fever Or Malaria' Benefit if available in this Policy.

4. Any Injury arising directly or indirectly due to osteoporosis except as specified under benefit 'Fractures' covered under the 'Accident Module' if opted for in this Policy.

5. Erectile dysfunction and tests or treatment related to impotence or sterilisation, or circumcision or expenses incurred for sex change.

6. Any eye examination, refractive surgery (such as Radial Keratotomy or Lasik) unless they are a direct consequence of an Accident.

7. Cosmetic, plastic surgery or elective surgery or treatment, unless necessitated by an Injury caused by an Accident.

8. Any form of dental care or dental surgery unless necessitated by Injury caused by an Accident to sound and natural teeth.

9. Any expenses incurred for:
   (a) any routine health checks;
   (b) any routine dental treatment or consultation, or any dental treatment due to normal wear and tear or the normal maintenance of dental health or lack thereof;
   (c) any diagnosis, tests, examinations or x-rays where there is no objective indication of impairment of normal health;
   (d) any treatment or investigation of a preventive nature, vaccinations or acupuncture;
   (e) any treatment or investigation which is not Medically Necessary, convalescence, custodial or rest cure;
   (f) receiving treatment not incidental to the treatment or diagnosis of an Injury;
   (g) treating an Injury for which such treatments are provided free or for which payment is not required;
   (h) weight reduction or gain.

10. An Insured Person's suicide or attempted suicide or intentional self-inflicted injury whether sane or insane or from deliberate or reckless exposure to danger.

11. An Insured Person committing or attempting to commit any criminal or illegal act.

12. Any violation of a law.

13. Any war, invasion, act of foreign enemy, hostilities or warlike operation (whether war be declared or not) mutiny, civil war, rebellion, revolution, insurrection, conspiracy, military or usurped power, martial law, or state of siege, any of the events or causes which determine the proclamation or maintenance of martial law, or state of siege, seizure, quarantine, or customs regulations or nationalisation by or under the order of any government or public or local authority, or any engagement or participation by the Insured Person or Policyholder in a strike, riot or civil commotion.

14. Any Insured Person engaging, practicing, training or participating in:
    (a) any professional sports or any sports in which an Insured Person would or could earn or receive remuneration, donation, sponsorship or financial reward of any kind from engaging in such sport;

    (b) underwater activities which ordinarily require the use of artificial breathing apparatus. This exclusion does not apply to recreational scuba diving whereby an:
        (i) Insured Person dives no deeper than 30 meters under the supervision of a qualified diving instructor; or
        (ii) Insured Person holds a PADI certification (or equivalent qualification) and dives with a buddy who holds a PADI certification (or equivalent qualification).

    (c) racing other than on foot, stunts, reliability trials and speed or duration testing. Training or practicing in relation to these activities is also not covered;

    (d) any aerial activity including but not limited to parachuting, BASE jumping, sky diving or travel in any other air supported device, except as a fare paying passenger in any properly licensed private and/or commercial aircraft having a current and valid air worthiness certificate issued by the appropriate authority of the country of its registry;

    (e) any extreme sports or activity that presents a high level of inherent danger (i.e. involving exceptional speed and height, high level of expertise, exceptional physical exertion or highly specialised gear) or of personal risk. This shall include but not be limited to:
        (i) any mountaineering; involving climbing harnesses, belay or rappel devices ropes and guides; or
        (ii) any activity or trekking above 3,000 meters;
        (iii) big wave surfing;
        (iv) winter activities like luging, bobsleighing, ski or snow board jumping or stunts;
        (v) bicycle, motor, air or sea craft speed trials or stunts;
        (vi) canoeing/kayaking and white and black water rafting in grade 4 or higher rapids;
        (vii) cliff jumping, or any aerobatics;
        (viii) hunting trips, caving or pot holing.

        It does not mean usual tourist activities that are accessible to the general public without restriction (other than height or general health or fitness warnings) and conducted under the supervision of qualified licensed personnel of a registered tour operator.

    (f) any naval, military or air force services, training exercise or participating in operations of an offensive nature planned or conducted by the civil or military authorities against bandits, terrorists or other elements.

15. Any deliberate provocation of the Insured Person against another person that results in an Injury.

16. An Insured Person being under the influence of alcohol or drugs, unless the drug was prescribed or administered by a Doctor and taken in accordance with the directions of a Doctor.

17. Any 'infectious or contagious disease' leading to an outbreak of which has been declared a Public Health Emergency of International Concern (PHEIC) by the World Health Organisation (WHO).

    This exclusion shall apply to claims made after the date of any such declaration(s), other than where a relevant diagnosis has been made by a Doctor before the date of any such declaration(s). This exclusion will continue to apply until the WHO cancels or withdraws any relevant PHEIC.

In this exclusion, 'an infectious or contagious disease' means any disease capable of being transmitted from an infected person, animal or species to another person, animal or species by any means.

GENERAL POLICY CONDITIONS

1. Condition precedent to liability

The Policyholder and Insured Person must follow the terms, provisions and conditions of this Policy in order to qualify for any payment under this Policy. The Policyholder and Insured Person's failure to do so will invalidate all claims made under this Policy.

2. Cover Selection

This Policy provides the Insured Person with cover for Benefits under the Modules/Plan as set out in the Policy Schedule which is selected by the Policyholder during the application process and approved by the Company.

3. Reasonable Care

The Policyholder and Insured Persons must take all reasonable steps to prevent and mitigate any accident or loss.

4. Governing Law

This Policy and all rights, obligations and liabilities arising under this Policy shall be construed, determined and enforced in accordance with the laws of Malaysia.

5. Conformity of law

Any provision of this policy which, on its Effective Date is in conflict with the Law of the country in which the policy was delivered or issued for delivery is hereby amended to conform to the minimum requirement of such laws.

6. Dispute resolution

Any dispute or difference which may arise between the Policyholder/Insured Person and the Company on any matters relating to this Policy involving amounts exceeding RM250,000 shall be referred to the Malaysian courts**.** Any dispute or difference where the disputed amount is less than or equal to RM250,000, the Policyholder/Insured Person may refer the matter to the Ombudsman for Financial Services to resolve the dispute. All disputes or differences which may arise between the Policyholder/Insured Person and the Company must be referred to the Malaysian courts and / or the Ombudsman for Financial Services within a reasonable time from the date the decision of the claim is communicated to the Policyholder/Insured Person.

7. Geographical Limits & Territorial Limits

(a) This Policy covers an Insured Person in their Usual Country of Residence for 24 hours and 7 days a week, unless otherwise stated or endorsed under this Policy.

(b) This Policy covers an Insured Person outside their Usual Country of Residence, on a worldwide basis subject to the section 'General Policy Conditions – Sanctions' provided that the maximum period an Insured Person is outside their Usual Country of Residence is not more than 12 consecutive months at any one time. There may be Benefits that are restricted to Usual Country of Residence only and where this applies these restrictions will be noted under the 'Benefits' section.

8. Overseas Hospitalisation and Treatment

The Company will only cover an Insured Person's Overseas treatment if:

(a) the travel Overseas is not for the purpose of seeking medical treatment; or

(b) the Insured Person is advised by the attending Doctor to be transferred to a hospital Overseas to obtain medical treatment because the nature of treatment is not available in Malaysia.

The following are excluded:

i. Non-emergency Hospitalisation or treatments i.e., where the treatment can reasonably be postponed until return to Malaysia;

ii. Overseas Hospitalisation or treatments of an Injury which is sustained or diagnosed in Malaysia where treatment can reasonably be postponed until return to Malaysia; or

9. Service Tax

The amount of premium payable by the Policyholder for this Policy includes an amount on account of the service tax payable by the Policyholder. Service tax refers to any service tax, value added tax, goods and services tax, consumption tax, or tax, duty, charge or imposition of a similar nature whatsoever by whatever name known, which may from time to time be imposed or charged (including any increases or decreases to the rate) by any competent tax authority.

10. Duplication of Cover

No person shall be insured under more than one Policy issued by the Company under this product. In the event the person is insured under more than one such Policy, the Company shall consider that person to be insured under the Policy with the highest Sum Insured or, where the Sum Insured under each Policy is identical, under the Policy that was first issued. The Company shall refund any duplicated Premium payment which may have been made by or on behalf of that Insured Person.

11. Offset Clause

If Insured Person is entitled to receive a reimbursement of all or part of claimed expenses from any other source for any of the Benefits in this Policy, the Company will only be liable for the excess of the amount recoverable from such other source or insurance, up to the maximum Sum Insured specified in the Schedule of Benefits. This condition is only applicable to Benefits whereby payment is on a reimbursement basis.

12. Limitation of Time for Bringing Suit

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 90 days from the date the Company receives complete documents on the claim filed in accordance with the requirements of this Policy.

13. Premium

A. Premium Payment Warranty

It is a fundamental and absolute condition of this Policy that the premium due must be paid and received by the Company within sixty (60) days from the Policy Start Date of this Policy/Endorsement/renewal. If this condition is not complied with then this Policy is automatically cancelled and the Company shall be entitled to the pro-rata premium for the period the Company have been on risk. Where the premium payable pursuant to this warranty is received by an authorised intermediary of the Company, the payment shall be deemed to be received by the Company for the purposes of this warranty and the onus of proving that the premium payable was received by a person, including an insurance agent, who was not authorised to receive such premium shall lie on the Company.

14. Changes to Premium Payable

1. The Company may vary premium payments for the Policy due to underwriting reasons. In such instance the Company will notify the Policyholder of such premium variation in writing at least 30 days before the change is to take place. The new premium amount payable will take effect from the next Premium Due Date.

2. If the changes to the premium made by the Company are acceptable, the Policyholder may choose to continue with the existing Modules/Plan and renew their Policy at the new premium amount applicable or the Policyholder may also opt to transfer to a new Module/Plan offered under this product.

3. A shorter notice period and effective date may apply if a premium variation is required due to tax or other imposts levied by any Government, regulatory or any other sanctioned authority in connection with this Policy.

4. The Policy is automatically cancelled if premium is not paid by the Policyholder within the period stated in the "Premium Payment Warranty" clause or within the Grace Period.

15. Misstatement of Age

If at the correct age an Insured Person would not have been eligible for cover under this Policy, no Benefit shall be payable, and the Company's liability shall be limited to the refund of the premium paid without interest.

If at the time of claim, it is noted that the Policyholder and/or Insured Person has misstated their age and due to which a lower Sum Insured is applicable, the Company will determine at its sole discretion to either continue to cover the Insured Person on the applicable terms and conditions or terminate this Policy.

16. Misrepresentation or Fraud

Any fraud, deliberate dishonesty or deliberate hiding of any information connected with the application for this Policy, for ongoing/subsequent disclosures or in connection with a claim made, will make this Policy invalid. In this event, the Company will not refund any premiums paid and the Company will not consider making payments for any claims submitted to the Company. The Company will report the matter to the police if deemed necessary. The Company also reserves the right to recover any amount paid to the Policyholder/Insured Person in respect to any fraudulent claims submitted.

17. Policy Changes

A. Changes of the Terms or Conditions by the Company

(a) The Company reserves the right to change the terms or conditions of this Policy by giving the Policyholder: 30 days' written notice of such change if it is due to underwriting reasons,
(b) 7 days' written notice of such change if due to an infectious disease outbreak, or
(c) Immediate written notice of such change if it is due to any government or statutory declaration which impacts this Policy.

Important note:

1. If the changes in terms or conditions by the Company are acceptable to the Policyholder, then this Policy will continue with the changed terms or conditions. If the changes are not acceptable, the Policyholder may cancel this Policy under 'Cancellation and Refund'.
2. Any changes made to this Policy shall be binding on all Insured Persons whether covered under this Policy prior to, during, or after the effective date of the changes.

3. No alteration to this Policy shall be valid unless approved in writing by the Company's authorised representative and reflected in an Endorsement.
4. No agent or advisor has the authority to amend or waive any of the terms and conditions of this Policy.

B. Change of Insured Person's occupation

The Policyholder must give immediate written notice to the Company of any change in the occupation of an Insured Person and agree to pay an additional premium if applicable.

No claim will be payable in respect of:
(a) Any injury or illness arising out of or in the course of an occupation of greater risk than the occupation disclosed in the Policyholder's application, unless the Company had agreed to the change in occupation; or
(b) Any injury or illness where the Company has been prejudiced by the non-disclosure of change in occupation.

C. Change of Usual Country of Residence

The Policyholder must inform the Company in writing of any change to an Insured Person's Usual Country of Residence. A change in the Usual Country of Residence will be deemed to mean the Insured Person is living or intending to live in another country for more than 12 consecutive months. Upon receipt of this information, the Company will determine at its sole discretion to either cover the Insured Person on the same terms and conditions or terminate coverage for the Insured Person under this Policy.

D. Changes in Plan and/or Module

The Policyholder can change the Module, Plan or increase the Sum Insured at the time of renewal only. Any change in Module, Plan or increase in Sum Insured is subject to the Company's prior written approval. If the Insured Person suffers an event which could give rise to a claim prior to this change being approved in writing, the Company will adjudicate the claim for the Insured Person based on the Policy terms and conditions applicable prior to the change.

18. Personal Data Use

The Policyholder is deemed to have read, understood, and consented to the collection and subsequent processing of their personal information by the Company (whether obtained during the application process or administration of this Policy) in accordance with, the Company's Privacy Notice as from time to time published on the website at https://www.aig.my/privacy-notice. If the Policyholder submits information relating to other individuals, the Policyholder further represents and warrants that they have the authority to provide information relating to the other individuals to the Company, that the Policyholder has informed the other individuals about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by the Company, and that the other individuals agree and consent that the Company may collect, use and process his/her personal information in accordance with the Privacy Notice. The Policyholder reserves the right to obtain access, request correction or withdraw their consent to the use of any of their personal information held by the Company. Such request can be made by writing to the Company at:

AIG Malaysia Insurance Berhad
Attn: Customer Care Department
PO Box 11768,
50756 Kuala Lumpur

Email: AIGMYCare@aig.com
Phone: 1800-88-8811
Fax: 603-21180288

19. Currency

(i) Premium: All premiums must be paid in Malaysian Ringgit.

(ii) Claims: All payments will be made in Malaysian Ringgit. Settlement in foreign currencies will only be made if the Policyholder or Insured Person is not in Malaysia at the time of payment. The rate of exchange will be based on the prevailing exchange rate on the date of claim settlement as determined by Bank Negara Malaysia. The Policyholder or Insured Person will bear all the administration and costs of conversion**.**

20. Discharge of Liability:

The Company shall not be committed by any notice or any trust charge, a lien, assignment or other dealing with the Policy and the receipt of the Policyholder or Insured Person for any Sum Insured payable herein shall in all cases be effectual discharge of liability of the Company.

21. Contract Rights of 3rd Parties

A person or any entity who is not a party to this Policy shall have no right to enforce any terms or conditions of this Policy.

22. To Whom Indemnity is Payable

All indemnities of this Policy are payable to the Policyholder or at Policyholder's written request to the Insured Person. The process of claim including settlement will be handled directly between the Company and the Policyholder whose sole discharge will constitute full and final discharge of the claim lodged.

23. Rights of Assignment

The Policyholder cannot assign or transfer the rights under this Policy to another person or entity.

24. Rights of Ownership

The Policyholder shall have the right to exercise every option, benefit or privilege conferred by the provisions of the Policy. Every transaction relating to the Policy shall be between the Company and the Policyholder and shall be valid without notice to or with the consent of the Insured Person.

25. Sanction

The Company shall not be deemed to provide cover and shall not be liable to pay any claim or provide any Benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Company, the Company's parent company or its ultimate controlling entity to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union or the United States of America.

26. Portfolio withdrawal condition:

The Company reserves the right to cancel the portfolio as a whole if the Company decides to discontinue underwriting this 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 the policies to expiry of the Period of Insurance within the portfolio.

27. Policy Renewal

This Policy may be renewed with the consent of the Company from term to term provided payment of the agreed premium is made to the Company prior to the expiry of this Policy, as provided in the "Premium Payment Warranty" clause or within the Grace Period.

The Company reserves the right to decline the renewal, or amend premium rates, benefits and terms and conditions of this Policy at the end of any Period of Insurance.

Important Note for section 'Policy Renewal':
The Policy is automatically cancelled if premium is not paid by the Policyholder within the period stated in the "Premium Payment Warranty" clause or within the Grace Period.

28. Grace Period

A grace period of thirty (30) days from the Policy Expiry Date shall be allowed for renewal. In the event of premium being paid during the Grace Period, the Policy will continue as on the Renewal Date with no gap.

If any Injury is sustained or Illness is diagnosed during the Grace Period, adjudication of any claim in relation to such Injury or Illness will follow the terms and conditions of the renewal Policy subject to receipt of applicable premium.

Any premium received by the Company after the Grace Period will be a commencement of a new Policy.

29. Addition and Deletion

Additional Insured Person(s) will be automatically covered by this Policy from the first day of qualification for coverage.

Automatic addition will not be applicable for:
1. Categories where the occupation has changed from occupations declared at the inception of the Policy; or
2. any Category or inclusions from any new acquisition or subsidiary where the nature of business differs from the declared nature of business of the Policyholder; or
3. any increase in the total number of employees by more than 20% or 5 persons (whichever higher) of the current headcount

No refund will be accorded for the deletion of any Insured Person who ceases to qualify for coverage under this Policy.

CANCELLATION & REFUND

CANCELLATION RIGHT OF COMPANY

The Company can cancel this Policy:

1. by giving 30 days' prior written notice to the Policyholder's last known address or via email.

2. immediately if the Policyholder fails to make the premium payment within the period stated in the "Premium Payment Warranty" clause or within the Grace Period. No Benefits will be payable for any claim that occurs during a period for which premium was not received.

3. by giving 7 days' prior written notice to the Policyholder in the event of War in Usual Country of Residence.

On cancellation of the Policy:
(a) If no claim has been made, the Company will refund the pro-rated premium for the remaining Period of Insurance to the Policyholder.

(b) If a claim has been paid by the Company in the current Period of Insurance, no return premium will be paid.
(c) If an incident has occurred that could give rise to a claim under this Policy, then no return premium will be considered until the Company and the Policyholder finalises the claim and subsequently, if the claim is paid, no return premium will be paid to the Policyholder.

CANCELLATION RIGHT OF THE POLICYHOLDER

Provided there is no claim made on the Policy, the Policyholder can cancel this Policy by giving 30 days' prior written notice to the Company. Such cancellation shall become effective on the date the notice is received or on the date specified in such notice, whichever is the earlier.

On cancellation of the Policy by the Policyholder, the Company will refund the pro-rated premium for the remaining during the Period of Insurance to the Policyholder.

AUTOMATIC TERMINATION OF POLICY

This Policy will automatically terminate for an Insured Person on the date:

(i) this Policy is cancelled for reasons stated under section 'Cancellation & Refund';

(ii) the Policyholder requests that an Insured Person be removed from this Policy;

(iii) where the Insured Person, ceases to be an employee as declared by the Policyholder;

(iv) of an Insured Person's death, from any cause;

(v) the Insured Person ceases to satisfy any of the requirements as specified under section 'Eligibility';

(vi) the Insured Person is paid the maximum Sum Insured for certain Benefits where such termination of the Policy is specified under the Specific Conditions of that Benefit; or

(vii) any fraud or misrepresentation to the Company discovered as mentioned under section 'General Policy Conditions - Misrepresentation or Fraud'.

CLAIMS PROCEDURE

STEPS TO MAKE A CLAIM

1. **Step 1**: The Policyholder must notify the Company immediately after the event which could give rise to a claim under 'Claim Notification'.
   (i) Call the Company at 1800 88 8811; or
   (ii) Complete the Personal Accident & Health Claims Form and email it to MYPAClaims@aig.com.

2. **Step 2**: The Policyholder must prepare the relevant basic supporting documents according to the nature of claim as specified in the link below:
   https://www.aig.my/claims/personal-claims/personal-accident-claims

3. **Step 3**: The Policyholder must submit the claims evidence to the Company within 90 days after the event which could give rise to a claim under 'Claims Evidence/ Information' to:

   AIG Malaysia Insurance Berhad (200701037463)
   Claims Department
   PO Box 11768,
   50756 Kuala Lumpur
   Email: MYPAClaims@aig.com

   The Company may request for additional documents depending on nature and circumstances of the claim in which case the Company will contact the Claimant.

COMPLIANCE

The Company shall not be liable for any consequences arising by reason of the Insured Person's failure to obtain or follow a Doctor's advice and use such appliances or remedies as may be prescribed in the event of an Injury or Illness when making a claim.

CLAIM NOTIFICATION

(a) The Company must be notified as soon as it is reasonably practical and in any event within 30 days after the date of Accident or from the date of diagnosis of an Illness which leads to a claim.

(b) Failure to comply with (a) above may result in the Company's rejection of all or part of the claim. Reasons include, but are not limited to, if it is made so long after the event that the Company is unable to investigate it fully, or may result in the Insured Person not receiving the full amount claimed if the amount payable changes as a result of the delay.

BURDEN OF PROOF

If the Company alleges that by reason of any of the exclusions listed, an event is not covered by this Policy, the Company shall communicate to the Claimant the exclusion based on which the claim is repudiated. The burden of proving the contrary shall be on the Claimant.

CLAIMS EVIDENCE / INFORMATION

(a) The Company must be provided with all reasonable and necessary evidence required by the Company to support a claim within 90 days after the date of Accident or Illness which leads to a claim. Information provided to the Company to support a claim includes but is not limited to original reports, invoices and receipts, medical certificates and other documents (such as translation of a foreign-language document into the English language), confirmed by oath if necessary. If the information supplied is insufficient, the Company will confirm the additional information required.

(b) If the Company does not receive the information it requires within the time period advised, the Company may reject the claim or withhold payment in the likelihood of a Valid Claim until the information it requires has been received.

(c) Where medical certificates or reports are required, the Company will only accept original medical certificates or reports issued by the attending Doctor. For avoidance of doubt, medical certificates or reports issued by other practitioners, including traditional medical practitioners, traditional Chinese medicine practitioner or chiropractors will not be accepted except as provided under '6. Alternative Medical Treatments' Benefit.

(d) The Company may refuse to refund any expense for which the Claimant cannot provide original receipts and invoices.

(e) The Company may require the Insured Person undergo a medical examination by a Doctor appointed by the Company before the initial or additional Sum Insured can be paid at the Claimant's own expense.

(f) The Company may at their expense arrange an autopsy unless this is illegal in the country in which the autopsy is to be performed.

SETTLEMENT OF CLAIM

(a) A claim will be paid in accordance to the Policy terms and conditions. It can only be made once the Company has received the information it requires to investigate and verify the claim (including information supplied) and it is satisfied that the claim falls within the Policy. A claim will generally be paid immediately unless the claim is for events like Permanent Total Disablement or for any periodic payment which will be paid according to the terms set out in the Policy.

(b) The Sum Insured for each Benefit is payable as specified on the Schedule of Benefits. Any claim payment that the Company makes under this Policy will not exceed the limit shown in the Schedule of Benefits for the claim event. The Sum Insured under each Benefit is included only for the events specified in the Policy Schedule.

(c) Unless otherwise specified in this Policy, all payments or reimbursements are payable to the Policyholder or at Policyholder's written request to the Insured Person.

(d) In the course of the Company's claims process, the Claimant is to render full cooperation to the Company and to its appointed service providers, vendors and experts, including providing face to face interviews, if and when required.

SUBROGATION

In the event that a third party is held liable for all or part of any claim paid under this Policy, the Company may exercise its legal right to pursue the third party to recover its outlay. The Claimant, upon the Company's request, will agree to and permit the Company to do such acts and things as may be necessary or reasonably required for the purpose of exercising this right. The Company will pay the costs and expenses involved in exercising its right against the third party.

RIGHTS TO RECOVERY

If the Company makes a payment and subsequently is made aware that the claim is not payable, the Company has the right to recover the amount paid from the Policyholder and/or Insured Person.

COMPLAINTS PROCEDURE

(a) If there is any occasion when the Company's service does not meet the Policyholder's expectations, the Policyholder may contact the Company using the appropriate contact details below, providing the Policy/claim number and the name of the Policyholder to help the Company deal with Policyholder's comments quickly.

AIG Malaysia Insurance Berhad
Complaints Handling Unit,
P O Box 11768,
50756 Kuala Lumpur

Phone: 1 800 88 8811 / 603 2118 0188
Fax: 603 2118 0288
Email: AIGMYComplain@aig.com

(b) Any Policyholder who is not satisfied with the decision of the Company may refer to the Ombudsman for Financial Services (OFS) giving details of the dispute, the name of the insurance company and the policy number. The contact details of the OFS are as follows:

Ombudsman for Financial Services
Level 14, Main Block
Menara Takaful Malaysia,
No 4, Jalan Sultan Sulaiman,
50000 Kuala Lumpur

Phone: 603 2272 2811
Fax: 603 2272 1577
Email: enquiry@ofs.org.my

(c) Any Policyholder who is not satisfied with the conduct of the Company may write to BNMLINK giving details of the complaint, the name of the insurance company and the policy number or the claim number. The contact details of BNMLINK are as follows:

Bank Negara Malaysia
Laman Informasi Nasihat dan Khidmat (BNMLINK)
P.O Box 10922,
50929 Kuala Lumpur

Phone: 1-300-88-5465 (1300-88-LINK) or 603 2174 1717 (Overseas)
Fax: 603 2174 1515

Physical Visits: BNMLINK will receive visitors by appointment only. You may request for an appointment through their website or telephone.