AIG MALAYSIA INSURANCE BERHAD

MyGuardian CI Policy

Policy Wording

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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** for the applicable **Benefits** 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** agent, 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 the **Insured Person** 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 **Compensation**, **Aggregate Period** and **Waiting Period** applicable to the **Insured Person** covered under this **Policy**.

Individual **Benefits** under section '6. Benefits' should be referred to for full details of coverage.

1. ONGOING DUTY OF DISCLOSURE

Pursuant to Schedule 9 of the Financial Services Act 2013, the **Policyholder** and **Insured Person(s)** have a duty to take reasonable care not to make a misrepresentation when purchasing this **Policy**, to answer all questions fully, honestly, accurately and to the best of their knowledge and disclose any matter that they know to be relevant to the **Company** 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. Failure to do so may void this **Policy** or result in refusal or reduction of claims, change of terms or termination of this **Policy**.

This duty of disclosure shall continue until the time this **Policy** is entered into, varied or renewed with the **Company**. The **Policyholder** and **Insured Person(s)** also have a duty to tell the **Company** immediately if at any time after this **Policy** has been entered into, varied or renewed with the **Company**, any information given when the **Policy** was purchased is inaccurate or has changed. In this circumstance, the **Company** reserves the right to review the cover granted including withdrawing or amending cover previously approved.

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2. ELIGIBILITY

All requirement as specified in this section of this **Policy** must be continuously satisfied by the **Policyholder** and **Insured Person** to be eligible for coverage under this **Policy**.

Age

Eligible **Age** for persons covered under the **Policy** are as provided below if the **Insured Person** is:

1. a **Policyholder**:
   (i) Entry **Age** is 18 to 60 years (inclusive).
   (ii) The **Policy** can be renewed up to the **Age** of 75 years (inclusive).

2. an **Employee**:
   (i) Entry **Age** is 18 to 60 years (inclusive).
   (ii) The **Policy** can be renewed up to the **Age** of 65 years (inclusive) or when the **Insured Person** ceases to be an **Employee** of the **Policyholder**, whichever is earlier.

3. a **Child**:
   (i) Entry **Age** is 15 **Days** after birth up to 17 years (inclusive).
   (ii) The **Policy** can be renewed up to the **Age** of 17 years (inclusive).

<u>Important Note</u>:
1. Entry age and maximum age is determined based on **Age** at the **Policy Effective Date**.

Residency

To be eligible for cover under this **Policy**, the **Insured Person** must be residing in Malaysia and:

(i) A Malaysian citizen;
(ii) A Malaysian permanent resident; or
(iii) A Holder of a valid employment pass (of which the place of employment must be in Malaysia during the **Policy Period**) or a dependent pass granted by the relevant Government authority.

Excluded Occupation

Persons engaged in the following occupations are not covered under this **Policy**:

1. Asbestos Workers, miners, tunnellers;

2. Police, armed forces, military personnel and/or similar peace-keeping groups;

3. Semi – professional and professional sports or where a periodic income is received in relation to such sports.

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3. 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.

4. FREE LOOK PERIOD

If the cover does not meet the **Policyholder** or the **Insured Person**’s requirements, the **Policyholder** may cancel this **Policy** within 15 days from the date this **Policy** is received by the **Policyholder**. The **Company** will give the **Policyholder** a full refund of any **Premiums** paid, less any medical expenses incurred by the **Company** to issue the **Policy**, as long as no claim has been made for that period.

5. RENEWAL

Policy Renewal

This **Policy** may be renewed at the option of the **Policyholder** subject to the terms and conditions of the **Policy** and payment of the **Premium** the **Company** requires for the renewal.

Where the **Insured Person** was:

a) a **Child** that has their 18th birthday; or
b) an **Employee** and has ceased to be an **Employee** of the **Policyholder**;

the **Policyholder** can no longer renew the **Policy** for that **Insured Person** under the expiry **Policy Category**. However, the **Insured Person** has an option to renew their **Policy** by switching to an individual **Policy** under the ‘Self’ **Category** where they will become the **Policyholder**.

The **Premium** for the renewal **Policy** must be paid on the **Premium Due Date**. The **Policyholder's** payment of the renewal **Premium** and the **Company's** receipt and acceptance of such payment will constitute consent to renewal of this **Policy**.

The **Policy** is an annual **Policy.** The **Policy** can be renewed at the **Anniversary Date** unless otherwise notified in writing by the **Company**. The **Premium** payable at renewal shall be determined based on the **Age** of the **Insured Person** at the **Anniversary Date**.

Alternatively, the **Company** may elect to no longer renew this **Policy** due to underwriting reasons. In that event, the **Company** shall notify the **Policyholder** in writing at least 30 days before their next **Anniversary Date**.

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Renewal Bonus

A **Renewal Bonus** is applicable to the renewal policy for a maximum of 5 consecutive years subject to the conditions set out below:

1. The **Policy** must be continuously renewed without interruption.
2. The **Policy** must remain **Claims Free** throughout the **Policy Period**.
3. Calculation of the **Renewal Bonus** will be based on the previous year's **Compensation** assigned to the Section A: 'Critical Illness Benefit'.

Policy Period	Year	Renewal	Compensation for Section A: 'Critical Illness Benefit' for the said Policy Period	Calculation of the Renewal Bonus (on cumulative basis)
01.01.2022 - 31.12.2022	*0*	*NA*	RM 200,000	*NA*
01.01.2023 - 31.12.2023	*1*	*1st Renewal*	RM 200,000	*RM 20,000* *(10% of the **Compensation** of Year 0, i.e. RM 200,000)* *Accumulated Renewal Bonus for Year 1 = RM 20,000*
01.01.2024 - 31.12.2024	*2*	*2nd Renewal*	RM 200,000	*Accumulated Renewal Bonus for Year 1 = RM 20,000* + *RM 20,000* *(10% of the **Compensation** of Year 1, i.e. RM 200,000)* *Accumulated Renewal Bonus for Year 2 = RM 40,000*
01.01.2025 - 31.12.2025	*3*	*3rd Renewal*	RM 200,000	*RM 40,000* *(Accumulated Renewal Bonus from Year 2)* + *RM 20,000* *(10% of the **Compensation** of Year 2, i.e. RM 200,000)* *Accumulated Renewal Bonus for Year 3 = RM 60,000*

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01.01.2026 - 31.12.2026	*4*	*4th Renewal*	RM 200,000	*RM 60,000 (Accumulated Renewal Bonus from Year 3) + RM 20,000 (10% of the **Compensation** of Year 3, i.e. RM 200,000)* *Accumulated Renewal Bonus for Year 4 = RM 80,000*
01.01.2027 - 31.12.2027	*5*	*5th Renewal*	RM 200,000	*RM 80,000 (Accumulated Renewal Bonus from Year 4) + RM 20,000 (10% of the **Compensation** of Year 4, i.e. RM 200,000)* *Accumulated Renewal Bonus for Year 5 = RM 100,000*
01.01.2028 - 31.12.2028	*6*	*6th Renewal*	RM 200,000	*RM 100,000 (Accumulated Renewal Bonus from Year 5) + No further accumulation of Renewal Bonus in Year 6* *Accumulated Renewal Bonus for the Policy = **RM 100,000***

Note: the above illustration is based on the **Renewal Bonus** being at 10% of the Compensation assigned to the Section A: 'Critical Illness Benefit'.

4. In the event of any increase or decrease in the **Compensation** assigned to Section A: 'Critical Illness Benefit' under this **Policy**, the **Renewal Bonus** will be calculated on the new **Compensation** for these **Benefits** at the next **Anniversary Date** and shall continue to apply in the following renewals.

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An illustration of the calculation of the **Renewal Bonus** is as follows:

Policy Period	Year	Renewal	Compensation for Section A: 'Critical Illness Benefit' for the said Policy Period	Calculation of the Renewal Bonus (On cumulative basis)
01.01.2022 - 31.12.2022	*0*	*NA*	RM 200,000	*NA*
01.01.2023 - 31.12.2023	*1*	*1st Renewal*	RM 300,000 *(**Policyholder** increases **Compensation** from RM200,000 to RM 300,000 effective 01.01.2023)*	*RM 20,000* *(10% of the **Compensation** of Year 0, i.e. RM 200,000)*
01.01.2024 - 31.12.2024	*2*	*2nd Renewal*	RM 300,000	*RM 20,000* *(10% of the **Compensation** of Year 0, i.e. RM 200,000)* + *RM 30,000* *(10% of the **Compensation** of Year 1, i.e. RM 300,000)* *Accumulated Renewal Bonus = **RM 50,000***

Note: the above illustration is based on the **Renewal Bonus** being at 10% of the **Compensation** for Section A: 'Critical Illness Benefit'.

5. **Renewal Bonus** under this **Policy** will cease to accumulate for subsequent renewals from the year a claim is made under 'Non-Invasive Cancer (Carcinoma-in-Situ or Early-Stage Cancer)' **Benefit**. However, all **Renewal Bonus** accumulated under the **Policy** prior to the year the claim is made will be retained.

Policy Period	Year	*Renewal*	Compensation for Section A: 'Critical Illness Benefit' for the said Policy Period	Calculation of the Renewal Bonus (on cumulative basis)	Claim
01.01.2022 - 31.12.2022	*0*	*NA*	RM 200,000	*NA*	*Nil*
01.01.2023 - 31.12.2023	*1*	*1st Renewal*	RM 200,000	*RM 20,000* *(10% of the **Compensation** of Year 0, i.e. RM 200,000)*	*Nil*

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01.01.2024 - 31.12.2024	*2*	*2nd Renewal*	RM 200,000	*RM 20,000 (10% of the **Compensation** of Year 0, i.e. RM 200,000) + RM 20,000 (10% of the **Compensation** of Year 1, i.e. RM 200,000)* *Accumulated Renewal Bonus =* ***RM 40,000***	*Claim amounting to RM 30,000 under the* 'Non-Invasive Cancer (Carcinoma-in-Situ or Early-Stage Cancer)' ***Benefit*** *is paid*
01.01.2025 - 31.12.2025	*3*	*3rd Renewal*	RM 170,000[5.b.]	***RM 40,000*** *The Year 2 Renewal Bonus is retained as stated in this table and no further Renewal Bonus is accumulated for subsequent renewals from Year 2 onwards.*	*Nil*

Note:

5.a. The above illustration is based on the **Renewal Bonus** being at 10% of the **Compensation** assigned Section A: 'Critical Illness Benefit'.

5.b. The **Compensation** for **Cancer** under the Section A: 'Critical Illness Benefit' shall be reduced by any amount paid or payable under 'Non-Invasive Cancer (Carcinoma-In-Situ or Early-Stage Cancer)' **Benefit** whether during the current or preceding **Policy Period**.

6. The **Renewal Bonus** accumulated under the **Policy** after 5 consecutive years will be retained on the **Policy** for subsequent renewal policy periods for the **Insured Person** as long as the **Policy** is continuously renewed without interruption.

7. In the event of any change in **Category** at time of renewal, all **Renewal Bonus** accumulated under the **Policy** prior to the year of such change will be retained and shall continue to apply in the following renewals subject to the terms and conditions mentioned under points 1 to 7 in this section 'Renewal Bonus'.

Specific Definitions Applicable To Renewal Bonus

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

1. **Claims Free** means that no claims were payable under this **Policy** for the **Insured Person** during the **Policy Period**.

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6. BENEFITS

Please note that this **Policy** has been designed to offer multiple core **Plans** and optional **Benefits**. The **Policyholder** or **Insured Person** must refer to the **Schedule of Benefits** for applicable **Benefits** as not all the **Benefits** listed below will apply to the **Policy**.

SECTION A: CRITICAL ILLNESS

CRITICAL ILLNESS BENEFIT

If the **Insured Person** is **Diagnosed** to be suffering from a **Critical Illness** during the **Policy Period,** the **Company** will pay the **Insured Person** a **Compensation** as specified in the **Schedule of Benefits.**

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This benefit is payable if:
   a) the **Diagnosis** of the **Critical Illness** occurs or manifests itself as a first incidence after the applicable **Waiting Period**;
   b) the signs or symptoms of such **Critical Illness** first manifests itself after the applicable **Waiting Period**; and
   c) the **Insured Person** survives for at least 30 days after the **Critical Illness Diagnosis**.

2. The **Company** will only pay the **Insured Person** for one **Critical Illness Diagnosed** on them during a **Policy Period** and this **Policy** will terminate immediately upon such **Compensation** payment.

3. If the **Insured Person** has been **Diagnosed** with a **Cancer** under this **Benefit**, the **Company** will pay the **Compensation** less any amount which has already been paid or is payable on account of any claims made for the 'Non-Invasive Cancer (Carcinoma-In-Situ or Early-Stage Cancer)' **Benefit**, whether during the current or preceding **Policy Period** as stated in the **Schedule of Benefits**.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. The **Insured Person** having more than one policy in force with the **Company** which is the same product and provides the same cover.
2. Any critical illness or medical condition diagnosed prior to the **Policy Effective Date** in the same body or organ site as the **Critical Illness** or which subsequently metastasised into the **Critical Illness**.

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SECTION B: ADDITIONAL BENEFITS

GENDER-SPECIFIC CANCER

If the **Insured Person** is **Diagnosed** to be suffering from a **Gender-Specific Cancer** during the **Policy Period,** the **Company** will pay the **Insured Person** a **Compensation** as specified in the **Schedule of Benefits**.

SPECIFIC DEFINITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS

Gender-Specific Cancer means any of the following **Cancers** listed below:

1	Breast Cancer
2	Cervical Cancer
3	Ovarian Cancer
4	Fallopian Tube Cancer
5	Uterine Cancer
6	Vaginal Cancer
7	Vulvar Cancer
8	Prostate Cancer
9	Testicular Cancer
10	Penile Cancer

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This **Benefit** is payable if:
    a) the **Diagnosis** of the **Gender-Specific Cancer** occurs or manifests itself as a first incidence after the applicable **Waiting Period**;
    b) the signs or symptoms of such **Gender-Specific Cancer** first manifests itself after the applicable **Waiting Period**; and
    c) the **Insured Person** survives for at least 30 days after the **Gender-Specific Cancer Diagnosis**.
2. The **Company** will only pay the **Insured Person** for one **Gender-Specific Cancer Diagnosed** on them during a **Policy Period** and this **Policy** will terminate immediately upon such **Compensation** payment.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. The **Insured Person** having more than one policy in force with the **Company** which is the same product and provides the same cover.
2. Any critical illness or medical condition diagnosed prior to the **Policy Effective Date** in the same body or organ site as the **Gender-Specific Cancer** or which subsequently metastasised into the **Gender-Specific Cancer**.
3. Any gender specific cancers which are not listed in the definition of **Gender-Specific Cancer**.

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NON-INVASIVE CANCER (CARCINOMA-IN-SITU OR EARLY-STAGE CANCER)

If the **Insured Person** is **Diagnosed** to be suffering from a **Non-Invasive Cancer** during the **Policy Period**, the **Company** will pay the **Insured Person** a **Compensation** as specified in the **Schedule of Benefits**.

Non-Invasive Cancer includes the following:

i) **Carcinoma-In-Situ;** and

ii) **Early-Stage Cancer:**

a) **Early Bladder Cancer**

b) **Early Chronic Lymphocytic Leukemia (CLL)**

c) **Early Melanoma**

d) **Early Prostate Cancer**

e) **Early Thyroid Cancer**

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This benefit is payable if:
   a) the **Diagnosis** of the **Non-Invasive Cancers** occurs or manifests itself as a first incidence after the applicable **Waiting Period**;
   b) the signs or symptoms of such **Non-Invasive Cancers** first manifests itself after the applicable **Waiting Period**; and
   c) the **Insured Person** survives for at least 30 days after the **Non-Invasive Cancer Diagnosis**.

2. The **Company** will only pay the **Insured Person** once for a **Non-Invasive Cancer Diagnosed** in their lifetime. This **Benefit** will terminate immediately upon such **Compensation** payment and will not be available on subsequent renewals of this **Policy**.

3. The **Policy** may be renewed subject to the **Company** imposing additional conditions that the **Company** may deem as necessary.

4. In the event the **Insured Person** is subsequently **Diagnosed** with any **Cancer** under the Section A: 'Critical Illness Benefit', any **Compensation** paid under this **Benefit** shall be reduced from any amount payable for **Cancer** under the Section A: 'Critical Illness Benefit'.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. The **Insured Person** having more than one policy in force with the **Company** which is the same product and provides the same cover.
2. Any critical illness or medical condition diagnosed prior to the **Policy Effective Date** in the same body or organ site as the **Non-Invasive Cancer** or which subsequently metastasised into the **Non-Invasive Cancer**.
3. Any type of cancer which is not listed in the definition of **Non-Invasive Cancer.**

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SPECIFIED OUTPATIENT TREATMENT

If the **Insured Person** is **Diagnosed** with a **Critical Illness**, the **Company** will pay the **Insured Person** a **Compensation** as per the table below up to the maximum **Compensation** as specified in the **Schedule of Benefits** for the expenses incurred for related **Medical Treatment(s)**, provided the **Medical Treatments** have occurred within 180 days from the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

Critical Illness Benefit	**Applicable Medical Treatment(s)**	**Compensation paid per**:
CANCER *Of Specified Severity And Does Not Cover Very Early Cancers*	Radiotherapy	day
	Chemotherapy	cycle
KIDNEY FAILURE Requiring Dialysis Or Kidney Transplant	Kidney dialysis	Calendar month

In the event the **Insured Person** is prescribed by a **Doctor** with both radiotherapy and chemotherapy treatments as a result of a **Diagnosis** of **Cancer**, the maximum **Compensation** payable for these **Medical Treatments** combined will not exceed the **Compensation** specified in the **Schedule of Benefits**.

SPECIFIC DEFINITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS

Medical Treatment means the following listed out-patient medical treatment which are **Medically Necessary** to treat an **Insured Person Diagnosed** with a **Critical Illness** as prescribed by a **Doctor**:

a) radiotherapy for **Cancer**
b) chemotherapy for **Cancer**
c) kidney dialysis for **Kidney Failure**

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

This **Benefit** is payable:

1. if a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**.

2. only after the **Insured Person's Medical Treatment's** supporting documents, including the attending **Doctor's** reports and referral letters, are provided to the **Company** along with original **Medical Treatment** expenses bills or receipts.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than for the abovementioned **Critical Illness**.

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2. Any medical transportation services.
3. Any **Medical Treatment** involving;
    (i) a routine health check;
    (ii) diagnosis, tests, examinations or x-rays where there is no objective indication of impairment of normal health;
    (iii) any treatment or investigation of a preventive nature, vaccinations, acupuncture or any treatment which is not **Medically Necessary**; and
    (iv) Any routine dental or oral treatment or consultation, or any dental or oral treatment due to normal wear and tear, or the normal maintenance of dental or oral health or lack thereof.
4. Any visits which occurred after 180 days following the date of the **Insured Person's Diagnosis**.
5. Any treatment or services provided by the **Insured Person**, the **Insured Person's** business partner or agent, **Insured Person's** employer or employee or **Insured Person's Spouse**, parent, grandparent, sibling, child, grandchild, uncle or aunt.

FINANCIAL SUPPORT

If the **Insured Person**, who is not a **Child**, is **Diagnosed** with a **Critical Illness**, the **Company** will pay the **Insured Person** the **Compensation** as specified in the **Schedule of Benefits.**

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

This **Benefit** is payable if:
1. a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**; and
2. the claim is submitted to the **Company** within 180 days from the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than a **Critical Illness.**

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SECTION B: OPTIONAL BENEFITS (Only Payable due to Section A – Critical Illness)

DAILY HOSPITAL CASH

If the **Insured Person** is **Hospitalised** as an **Inpatient** due to a **Diagnosed Critical Illness**, the **Company** will pay a **Compensation** as shown in the **Schedule of Benefits** for each **Day** the **Insured Person** spends as an **Inpatient** provided the **Hospitalisations** commence within 180 days following the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

This **Policy** will only pay for a claim either under this **Benefit** or under **Benefit** 'Daily Hospital Cash for Intensive Care Unit (ICU)' (if available under this **Policy**) but not both.

Compensation under this **Benefit** shall be paid only up to the **Aggregate Period** as shown in the **Schedule of Benefits**.

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This **Benefit** is payable only if a valid claim under the Section A 'Critical Illness Benefit**'** is paid or payable under this **Policy** to the **Insured Person**.
2. This **Benefit** is payable for one **Critical Illness** per **Hospitalisation** period, regardless of the number of critical illnesses diagnosed or suffered by **the Insured Person** during the same **Hospitalisation** period.
3. Any **Hospitalisation** shall be evidenced by the **Insured Person's Hospital** discharge summary, **Hospital** billing statement and related medical report(s).
4. Subsequent periods of **Hospitalisation** for the same **Critical Illness** are considered to be part of the same claim provided that all **Hospitalisations** occur within 180 days following the date of the **Insured Person's Diagnosis.**

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than a **Critical Illness.**
2. Any **Hospitalisation** in an **Intensive Care Unit**.

DAILY HOSPITAL CASH FOR INTENSIVE CARE UNIT(ICU)

If the **Insured Person** is **Hospitalised** as an **Inpatient** in the **Intensive Care Unit** due to a **Diagnosed Critical Illness**, the **Company** will pay the **Compensation** for this **Benefit** as specified in the **Schedule of Benefits** for each **Day** the

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Insured Person spends as an **Inpatient** in the **Intensive Care Unit** provided that all **Hospitalisations** in the **Intensive Care Unit** commence within 180 days following the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

This **Policy** will only pay for a claim either under this **Benefit** or under **Benefit** 'Daily Hospital Cash' (if available under this **Policy**) but not both.

Compensation under this **Benefit** shall be paid up to the **Aggregate Period** as shown in the **Schedule of Benefits**

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

1. This **Benefit** is payable only if a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**.

2. This **Benefit** is payable for one **Critical Illness** per **Hospitalisation** period, regardless of the number of critical illnesses diagnosed or suffered by the **Insured Person** during the same **Hospitalisation** period.

3. Any **Hospitalisation** shall be evidenced by the **Insured Person's Hospital** discharge summary, **Hospital** billing statement and related medical report(s).

4. Subsequent periods of **Hospitalisation** for the same **Critical Illness** are considered to be part of the same claim provided that all **Hospitalisations** occur within 180 days following the date of the **Insured Person's Diagnosis**.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than a **Critical Illness.**

SURGICAL CASH

If the **Insured Person** undergoes any **Medically Necessary Surgery** directly due to a **Diagnosed Critical Illness**, and which was performed by a **Doctor**, the **Company** will pay the **Insured Person** a **Compensation** per **Surgery** as specified in the **Schedule of Benefits.**

This **Benefit** is payable up to a maximum of 2 **Surgeries** performed within 180 days from the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

SPECIFIC DEFINITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS

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Surgery means an operation performed by a **Doctor** in a **Hospital** under an anesthetic (general, intravenous sedation, local or spinal) requiring a surgical incision to remove or repair damaged or diseased tissue. For the purpose of this **Benefit**, this does not include injections of any type.

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

This **Benefit** is payable:

1. If a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**.
2. If the **Surgery** undergone is **Medically Necessary** and is directly related to the **Critical Illness Diagnosed** on the **Insured Person**; and
3. Any **Surgery** undergone shall be evidenced by a **Doctor's** written recommendation, **Insured Person's Hospital** discharge summary, **Hospital** billing statement and related medical report(s).

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. A surgery directly or indirectly relating to any injury or sickness other than a **Diagnosed Critical Illness**.
2. Any surgery done after 180 days following the date of the **Insured Person's Diagnosis**.

RECOVERY ASSISTANCE SERVICES

If the **Insured Person** is **Diagnosed** with a **Critical Illness,** the **Company** will pay **Compensation** per visit up to the maximum number of visits as specified in the **Schedule of Benefits** for each **Recovery Assistance Service**, provided the visits have occurred within 180 days from the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

SPECIFIC DEFINITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS

Recovery Assistance Services means the following services which are specifically prescribed for the **Critical Illness** by the **Doctor** to be **Medically Necessary** for the **Insured Person's** recovery upon the **Insured Person** being **Diagnosed** with a **Critical Illness**:

a) Physiotherapy
b) Psychological counselling
c) Dietician/nutritionist
d) Occupational therapy
e) Speech therapy
f) Smoking cessation program

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These services must be provided by a registered practitioner licensed under any applicable laws and acting within the scope of his/her license and training. Such attending practitioner cannot be the **Insured Person**, the **Insured Person**'s business partner or agent, **Insured Person**'s employer or employee or **Insured Person**'s immediate family member.

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

This **Benefit** is only payable:

1. If a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**.
2. If the receipts, billing statement and summary reports from the **Recovery Assistance Services'** service provider(s) provided to the **Company** to support the claim.
3. Either until
    1. the **Doctor** certifies that the **Insured Person** no longer require to attend the **Recovery Assistance Services**;
    2. when the maximum **Compensation** as specified in the **Schedule of Benefits** has been paid; or
    3. 180 days have lapsed from the date of the **Insured Person's Diagnosis**

    whichever occurs first.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than a **Critical Illness**.
2. Any **Recovery Assistance Service** sought which is not related to the **Critical Illness Diagnosed.**
3. Any visits which occurred after 180 days following the date of the **Insured Person's Diagnosis**.
4. Any **Recovery Assistance Service** provided by the **Insured Person**, the **Insured Person's** business partner or agent, the **Insured Person's** employer or employee or the **Insured Person's Spouse**, parent, grandparent, sibling, child, grandchild, uncle or aunt.

HOME NURSING

If the **Insured Person** is **Hospitalised** as a result of a **Critical Illness Diagnosed** and upon discharge, the attending **Doctor** certifies in writing that the **Insured Person** is unable to perform at least 3 out of 6 **Activities of Daily Living** and requires to engage the services of a **Nurse** to care for the **Insured Person** at their **Home** post-hospitalisation, the **Company** will pay **Compensation** for each **Nurse's** visit up to the maximum number of visits by the **Nurse** to the **Insured Person's Home** as specified in the **Schedule of Benefits** provided that:

1. the **Hospitalisation** is for a minimum period of 2 consecutive **Days**;
2. the first visit by the **Nurse** occurs within 7 days following the date of the **Insured Person's** discharge from the **Hospital**; and
3. all visits have occurred within 180 days from the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

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Compensation under this **Benefit** shall continue up to the **Aggregate Period** or until such nursing care is no longer **Medically Necessary** as determined by a **Doctor** for the **Insured Person**, whichever occurs first.

SPECIFIC DEFINITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS

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 **Insured Person's Spouse**, parent, grandparent, sibling, child, grandchild, uncle or aunt.

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

This **Benefit** is payable:

1. If a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**;

2. Once per **Policy**, regardless of successive **Hospitalisation** periods for the same **Critical Illness Diagnosed**;

3. After evidence of the **Insured Person's Hospital** discharge summary or **Hospital** billing statement and medical report(s) are shown to the **Company**;

4. If the **Company** is provided with:
   i) the **Insured Person's** attending **Doctor's** report stating that the **Insured Person** is unable to perform at least 3 out of 6 **Activities Of Daily Living** for a continuous and uninterrupted period of time; and
   ii) the receipts from the nursing care service provider for the expenses incurred; and

5. Either until
   i) the **Doctor** certifies that the **Insured Person** does not require nursing care;
   ii) when the maximum **Compensation** as specified in the **Schedule of Benefits** has been paid; or
   iii) 180 days have lapsed from the date of the **Insured Person's Diagnosis**

   whichever occurs first.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than a **Critical Illness.**
2. Any visits which occurred after 180 days following the date of the **Insured Person's Critical Illness Diagnosis**.

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BILL PROTECTION

If the **Insured Person**, who is not a **Child**, is **Hospitalised** for a minimum period of 7 consecutive **Days** due to a **Diagnosed Critical Illness**, the **Company** will pay **Compensation** as specified in the **Schedule of Benefits,** to assist the **Insured Person** financially with their regular expenses, provided such **Hospitalisations** commence within 180 days following the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

This **Benefit** is payable:

1. If a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**.
2. If the **Insured Person** is **Hospitalised** for a minimum period of 7 consecutive **Days**; and
3. Up to 2 times per **Policy**, regardless of successive **Hospitalisation** periods for the same **Critical Illness Diagnosed**.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness other than a **Critical Illness**.

HOME ALTERATION AND VEHICLE MODIFICATION

If the **Insured Person** is **Diagnosed** with a **Critical Illness**, the **Company** will reimburse the actual expenses incurred by the **Insured Person** up to the maximum **Compensation** as specified in the **Schedule of Benefits** to make necessary modification and installations to the **Insured Person's** residence, or necessary modification and installations to the **Insured Person's** personal vehicle, for the sole purpose of assisting with their mobility, provided the expenses have been incurred within 180 days following the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

This **Benefit** is payable only:

1. If a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**.

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2. Upon the attending **Doctor's** written confirmation that any modification and installation in the **Insured Person's** home or personal vehicle is necessary to assist the **Insured Person** with their mobility.

3. For modifications and installations carried out at only one residence which the **Insured Person** usually resides at and to one personal vehicle only.

4. For modifications and installations in the **Insured Person's** residence that include but are not limited to the installation of ramps for wheelchair access, internal guide rails, emergency alert system and similar disability aids that are necessary for the **Insured Person** to perform the **Activities of Daily Living** in their residence.

5. If expenses for modifications and installations in the **Insured Person's** home or personal vehicle are incurred within 180 days from the date of the **Insured Person's Diagnosis**.

6. If the hired renovation contractor is not the **Insured Person**, the **Insured Person's** business partner or agent, **Insured Person's** employer or employee or **Insured Person's** spouse, parent, grandparent, sibling, child, grandchild, uncle or aunt.

7. If the **Company** agrees that the modification and installations to the **Insured Person's** residence and personal vehicle are necessary and reasonable.

8. Once per **Policy** upon an **Insured Person's Diagnosis**.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than a **Critical Illness**.
2. Any modification and installation done in a home which the **Insured Person** does not permanently reside in.
3. Any modification and installation that was already ongoing at the **Insured Person's** residence or personal vehicle prior to the **Insured Person's Critical Illness Diagnosis**.
4. Any modification and installation that is not **Medically Necessary**, not as advised by the **Doctor** or does not aid in the **Insured Person's** mobility.
5. Any damages arising from the modification and installations work.
6. Any expenses for modifications and installations in the **Insured Person's** home or personal vehicle which are incurred after 180 days from the date of the **Insured Person's Diagnosis**.

RECOVERY SUPPORT - HOUSEKEEPING SERVICES

If the **Insured Person** is **Hospitalised** as a result of a **Critical Illness Diagnosed** during the **Policy Period** and upon discharge, the attending **Doctor** certifies in writing that the **Insured Person** is unable to perform at least 3 out of 6 **Activities of Daily Living** and requires to engage the services of a housekeeper to perform **Household Duties** at the

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Insured Person's Home post-hospitalisation, the **Company** will pay **Compensation** per visit up to the maximum number of visits as specified in the **Schedule of Benefits** provided that:

1. the **Hospitalisation** is for a minimum period of 2 consecutive **Days**;
2. the first visit by the housekeeper occurs within 7 days following the date of the **Insured Person's** discharge from the **Hospital**; and
3. all visits have occurred within 180 days from the date of the **Insured Person's Diagnosis** irrespective of whether the **Policy** expires or is terminated.

SPECIFIC DEFINITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY DEFINITIONS APPLYING TO ALL SECTIONS

Household Duties means the management of chores involved in the running of a household, including but not limited to cleaning, cooking, home maintenance, grocery shopping, laundry and other similar household tasks. A housekeeper is specifically hired to assist with these duties, and they cannot be the **Insured Person**, the **Insured Person's** business partner or agent, **Insured Person**'s employer or employee or **Insured Person's Spouse,** parent**,** grandparent, sibling**,** child**,** grandchild, uncle or aunt.

SPECIFIC CONDITIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY CONDITIONS APPLYING TO ALL SECTIONS

This **Benefit** is payable:

1. If a valid claim under Section A: 'Critical Illness Benefit' is paid or payable under this **Policy** to the **Insured Person**.

2. If the services of such housekeeper are engaged through a registered housekeeping service provider.

3. The housekeeper is engaged to do **Household Duties** at only one residence which **Insured Person** usually resides at.

4. Only once regardless of successive **Hospitalisation** periods for the same **Critical Illness Diagnosed.**

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

6. If the **Company** is provided with
   a. the **Insured Person's** attending **Doctor's** report stating that the **Insured Person** are unable to perform at least 3 out of 6 **Activities of Daily Living** for a continuous and uninterrupted period of time; and
   b. the receipts from the housekeeping service provider for the expenses incurred.

7. Either until
   a. the **Doctor** certifies that the **Insured Person** does not require housekeeping services;
   b. when the maximum **Compensation** as specified in the **Schedule of Benefits** has been paid; or
   c. 180 days have lapsed from the date of the **Insured Person's Diagnosis**.

   whichever occurs first.

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SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than a **Critical Illness.**
2. Any housekeeper visits which occurred after 180 days following the date of the **Insured Person's Diagnosis**.

FUNERAL EXPENSES

If the **Insured Person** is **Diagnosed** with a **Critical Illness** during the **Policy Period** that directly results in death within 30 days from the date of the **Insured Person's Diagnosis**, the **Company** will pay **Compensation** as specified in the **Schedule of Benefits** upon submission of relevant documents required by the **Company**.

This **Benefit** is payable only if the **Insured Person** is diagnosed with a **Critical Illness** after the **Waiting Period** as specified in the **Schedule of Benefits**.

SPECIFIC EXCLUSIONS FOR THIS BENEFIT – IN ADDITION TO THE GENERAL POLICY EXCLUSIONS APPLYING TO ALL SECTIONS

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

1. Any injury or sickness, other than a **Critical Illness.**
2. The **Insured Person**'s death which occurred after 30 days from the date of the **Insured Person's Diagnosis.**

7. GENERAL POLICY DEFINITIONS

Wherever the following words or phrases appear in this **Policy** and begin in uppercase and in **bold**, 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 **Plans** and therefore not all the Definitions listed herein will be relevant to the selected **Plan** shown in the **Schedule of Benefits**.

Accident

It means a sudden, fortuitous, visible and specific event, caused external to the body which occurs at an identifiable time and place during the **Policy Period**.

Activities of Daily Living

It means the following activities which an **Insured Person** can undertake on their own (whether aided or unaided):

a) Washing - the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

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b) Dressing - the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
c) Feeding - the ability to feed oneself once food has been prepared and made available;
d) Toileting - the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
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;

For the above definition, inability to perform any of the activity must be confirmed and be given a clear prognosis for by a **Doctor**.

Age

It means the **Insured Person's** age as on their last birthday.

Aggregate Period

It is the maximum number of **Days** for which a **Compensation** is payable as specified against the **Benefit** in the **Schedule of Benefits.**

Anniversary Date

It means the date after 12 consecutive months following the **Policy Start Date** and the date after each 12 consecutive months thereafter provided the **Policy** has been renewed.

Assessment Period

It is the period during which the **Company** will assess a condition before deciding whether or not the condition qualifies as being **Permanent**. The assessment period will be for the minimum period time frame as stated in the relevant definitions in 'Appendix A' and will not be longer than twelve (12) months (provided all required evidence has been submitted).

Benefit

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

Category

This refers to the person who is insured under this **Policy**. The **Categories** are as listed below and stated in the **Policy Schedule**:

a) Self : covers the **Policyholder**
b) Parent – Child : covers the **Policyholder's Child**

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c) Corporate – Employee : covers the **Policyholder's Employee**

Carcinoma-In-Situ

It is the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane.

The **Diagnosis** of the **Carcinoma-In-Situ** must always be supported by a histopathological report. Furthermore, the **Diagnosis** of **Carcinoma-In-Situ** must always be positively **Diagnosed** upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. A Clinical diagnosis would not suffice.

The following conditions are specifically excluded from coverage:
a) Cervical Dysplasia, CIN-1, CIN-2 and CIN-3 and low grade & high grade squamous epithelial lesions.
b) Prostatic Intraepithelial Neoplasia (PIN).
c) Vulvar Intraepithelial Neoplasia (VIN).
d) All tumours in the presence of Human Immunodeficiency Virus (HIV) infection

Child/Children

A **Policyholder's** child who is either:
a) A natural child of the **Policyholder;**
b) Legally adopted by the **Policyholder;** or
c) A legal stepchild of the **Policyholder** following marriage to the **Child's** biological **Parent** ,

and who is aged between 15 days and 17 years old (inclusive).

Chronic Medical Condition

A medical condition that is diagnosed or treated or is expected to persist for the remainder of the **Insured Person's** natural life.

Claimant

The person(s) legally entitled to claim the **Benefit**(s) under this **Policy**. This may be the **Policyholder**, **Insured Person** or their legal representative, as applicable, making a claim against this **Policy**.

Company

Company refers to AIG Malaysia Insurance Berhad.

Compensation

The amount payable for a **Benefit** under this **Policy** as specified in the **Schedule of Benefits**.

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Congenital Conditions

It refers to any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within 6 months from the time of birth. This includes hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the **Insured Person** was continuously covered under this **Policy**.

Critical Illness

It is any of the following illnesses or medical conditions first and unequivocally **Diagnosed** by a **Doctor** during the **Policy Period** and where required by the **Company**, will be confirmed by a **Doctor** chosen by **Us,** and they are individually defined in Appendix A:

1) **Cancer of Specified Severity - and does not cover very early cancers**
2) **Heart Attack - of specified severity**
3) **Serious Coronary Artery Disease**
4) **Heart Valve Surgery**
5) **Coronary Artery By-pass Surgery**
6) **Surgery to Aorta**
7) **Cardiomyopathy - of specified severity**
8) **Kidney Failure – requiring dialysis or kidney transplant**
9) **Medullary Cystic Disease**
10) **Primary Pulmonary Arterial Hypertension - of specified severity**
11) **End-Stage Lung Disease**
12) **Stroke - resulting in Permanent Neurological Deficit with persisting clinical symptoms**
13) **End-Stage Liver Failure**
14) **Major Head Trauma - resulting in permanent inability to perform Activities of Daily Living**
15) **Angioplasty and other invasive treatments for Coronary Artery Disease**
16) **Encephalitis – resulting in permanent inability to perform Activities of Daily Living**
17) **Parkinson's Disease – resulting in permanent inability to perform Activities of Daily Living**
18) **Brain Surgery**
19) **Benign Brain Tumor - of specified severity**
20) **Coma - resulting in Permanent Neurological Deficit with persisting clinical symptoms**
21) **Major Organ / Bone Marrow Transplant**
22) **Paralysis of Limbs**
23) **Third Degree Burns – of specified severity**
24) **Muscular Dystrophy**
25) **Loss of Independent Existence**
26) **Chronic Aplastic Anemia - resulting in permanent Bone Marrow Failure**
27) **Multiple Sclerosis**
28) **Motor Neuron Disease – Permanent Neurological Deficit with persisting clinical symptoms**
29) **Bacterial Meningitis - resulting in permanent inability to perform Activities of Daily Living**
30) **Deafness – Permanent and Irreversible**
31) **Blindness – Permanent and Irreversible**
32) **Loss of Speech**
33) **Fulminant Viral Hepatitis**
34) **Alzheimer's Disease/Severe Dementia**
35) **Systemic Lupus Erythematosus With Severe Kidney Complications**
36) **Terminal Illness**

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37) HIV Infection Due To Blood Transfusion
38) Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection

Day

It is a completed period of 24 hours.

Diagnosis / Diagnosed

It is the definitive first diagnosis of a **Critical Illness** on the **Insured Person** made by a **Doctor** based upon such specific evidence, as referred to in the definition of the particular **Critical Illness** concerned, or in the absence of such specific evidence, based upon radiological, clinical, histological or laboratory evidence acceptable to the **Company**.

Such **Diagnosis** must be supported by the **Company** who may base their opinion on the medical evidence which the **Insured Person** submitted and/ or any additional evidence that they may require. In the event of any dispute or disagreement regarding the appropriateness or correctness of the **Diagnosis**, the **Company** will have the right to call for the **Insured Person's** examination, or the evidence used in arriving at such **Diagnosis**, by an independent acknowledged expert in the field of medicine concerned selected by **Us** and the opinion of such expert as to such **Diagnosis** shall be binding to both the **Insured Person** and the **Company**.

Doctor

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. Such **Doctor** must specialise in the area of medicine appropriate to the **Critical Illness Diagnosed** on the **Insured Person**.
The **Company** have the right to confirm all **Diagnosis** made by a **Doctor** with the **Company's Doctor**. The **Doctor** cannot be the **Insured Person**, the **Insured Person's** business partner or agent, **Insured Person's** employer or employee or **Insured Person's Spouse**, parent, grandparent, sibling, child, grandchild, uncle or aunt.

Employee

It refers to the **Insured Person** who is **Gainfully Employed** by the **Policyholder** in Malaysia under a contract of service to work for the **Policyholder**.

Gainfully Employed

Gainfully Employed means **Insured Person** receiving a regular income from any employment which requires a minimum of 20 work hours a week during the last 26 consecutive weeks at the time of the **Diagnosis**.

Home

It is **Insured Person's** usual place of residence in Malaysia.

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Hospital

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 behavioural disorders, sanatorium, any transitional care centre or home for the aged or similar establishment; even if located at the same place.

Hospitalisation/Hospitalised

Hospitalisation/Hospitalised means the admission of the **Insured Person** to a **Hospital** as an **Inpatient** after the date of **Diagnosis** of the **Critical Illness.**

Injury

Injury means a bodily injury which is sustained by an **Insured Person** during the **Policy Period** and is caused by an **Accident** solely and independently of any other causes including any sickness (except sickness directly resulting from medical or surgical treatment rendered necessary by such **Injury**), pre-existing or congenital condition.

Inpatient

Inpatient means when an **Insured Person** is confined in a **Hospital** for a continuous period as a registered patient for **Medically Necessary** treatments for at least one **Day** and such confinement is certified as necessary by the attending **Doctor**.

Insured Person

Insured Person means the person named in the **Policy Schedule** as per the corresponding **Category** specified and insured under this **Policy** during a valid **Policy Period**.

Intensive Care Unit (ICU)

Intensive Care Unit (ICU) means a section within a **Hospital** that is designated as an intensive care unit. It is solely dedicated for the treatment of patients who are in a critical medical condition who require constant and close monitoring of the vital body functions in a **Hospital**, which provides a high ratio of nursing staff to patients, which has full facilities for the resuscitation of patients and provides special nursing and medical services not available elsewhere in the **Hospital**.

Irreversible

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

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Medically Necessary

Medically Necessary means a medical service provided by a **Doctor** which is:

a) consistent with the diagnosis and customary medical treatment for the covered illness;
b) in accordance with standards of good medical practice, consistent with current standard of professional medical care and of proven medical benefits for the covered illness;
c) not for the convenience of the **Insured Person** or **Doctor** and unable to be reasonably rendered out of **Hospital** (if admitted as an inpatient);
d) not of an experimental, investigational, research, preventive or screening in nature;

and for which charges are fair and do 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 illness in accordance with accepted medical standards and practice that could not have been omitted without adversely affecting the **Insured Person's** covered illness.

Non-Invasive Cancer

It means a definite **Diagnosis** of the following:

i) **Carcinoma-In-Situ** of the following sites: Breast, uterus, ovary, fallopian tube, vulva, vagina, cervix uteri, colon, rectum, penis, testis, lung, liver, bladder, stomach or nasopharynx. The **Diagnosis** of **Carcinoma-In-Situ** must be positively established by microscopic examination of fixed tissues; or

ii) **Early-Stage Cancer:**

a) **Early Bladder Cancer** means Papillary microcarcinoma of the Bladder.
b) **Early Chronic Lymphocytic Leukemia (CLL)** means Chronic Lymphocytic Leukemia (CLL) RAI Stage 1 or 2. CLL RAI stage 0 or lower is excluded.
c) **Early Melanoma** means invasive melanomas of less than 1.5mm Breslow thickness, or less than Clark Level 3. Non-invasive melanoma histologically described as "in-situ" is excluded.
d) **Early Prostate Cancer** means Prostate Cancer that is histologically described using the TNM Classification as T1a or T1b or Prostate cancers described using another equivalent classification.
e) **Early Thyroid Cancer** means Thyroid Cancer that is histologically described using the TNM Classification as T1N0M0 as well as Papillary microcarcinoma of thyroid that is less than 1cm in diameter.

The **Diagnosis** of **Non-Invasive Cancers** must be established by histological evidence and be confirmed by a **Doctor** in the relevant field.

Overseas

It means outside any territorial limits of the country in which this **Policy** is issued in.

Parent or Legal Guardian

Anybody who:

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a) is a biological mother or father of a **Child**;
b) has legally adopted a **Child**; or
c) is a legal step-parent of a **Child** following marriage to the **Child's** biological **Parent**.

Permanent

Permanent means lasting for at least 12 consecutive months after **Diagnosis** and at the end of that time is certified by a **Doctor** as being beyond hope of improvement and expected to last throughout the lifetime of the **Insured Person**.

Permanent Neurological Deficit

Symptoms of dysfunction in the nervous system that are **Diagnosed** to be present on clinical examination by a neurologist **Doctor** and expected to last throughout the life of the **Insured Person**.

Symptoms that are covered include:
a) numbness;
b) hyperaesthesia (increased sensitivity);
c) paralysis;
d) localised weakness;
e) dysarthria (difficulty with speech);
f) aphasia (inability to speak);
g) dysphagia (difficulty in swallowing);
h) visual impairment;
i) difficulty in walking;
j) lack of co-ordination;
k) tremor;
l) seizures;
m) dementia;
n) delirium; and
o) coma.

The following are not covered:
1. An abnormality seen on brain or other scans without definite related clinical symptoms;
2. Neurological signs occurring without symptomatic abnormality; and
3. Symptoms of psychological or psychiatric origin.

Plan(s)

It refers to the **Benefits** and corresponding **Compensation** limits selected by the **Policyholder** and approved by the **Company** for this **Policy**, as shown in the **Policy Schedule**.

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).

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Policyholder

A person who is at least 18 years of **Age** or a corporate entity who is named as the **Policyholder** in the **Policy Schedule**, who may or may not be insured under this **Policy**. Also, the **Policyholder** owns this **Policy**, is responsible for **Premium** payments and has the right to exercise all privileges under this **Policy**.

Policy Effective Date

It 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 an **Insured Person** was covered under this **Policy**, or
c) the effective date any additional cover or increased **Compensation** is granted to the **Insured Person** while they are covered under this **Policy,** only in respect to the additional cover or increased **Compensation.**

Policy Expiry Date

It is 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 '10. Automatic Termination of Policy'.

Policy Period

The period an **Insured Person** is covered for under this **Policy** and shall commence on the **Policy Start Date** and such period will end on the **Policy Expiry Date** as specified in the **Policy Schedule**.

Policy Schedule

Refers to the document showing details of the **Policy Period**, the particulars of the **Policyholder** and the **Insured Person,** the **Plan** and includes the **Schedule of Benefits** and the Renewal Policy Schedule, which should be read with this **Policy**.

Policy Start Date

It is the commencement date of this insurance **Policy** and is as specified in the **Policy Schedule**.

Premium

It is the annual payment due to be paid to the **Company** by the **Policyholder** for this insurance **Policy**.

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Premium Due Date

It is the date on which **Premium** for this **Policy** is due to be paid by the **Policyholder** on or before the **Policy Start Date** and any subsequent **Anniversary Date** for this **Policy**.

Pre-Existing Condition

Any Illness**,**

(a) for which the **Insured Person** has sought, has been recommended, received or is receiving treatment, medication or advice before the **Policy Effective Date**;
(b) for which the **Insured Person** has sought, received or is receiving diagnosis before the **Policy Effective Date**;
(c) 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
(d) which is a **Chronic Condition** or cancer diagnosed before the **Policy Effective Date**.

Renewal Bonus

It is an increase in the **Compensation** assigned to Section A: 'Critical Illness Benefit' by the 10% as stated in the **Schedule of Benefits** on every **Anniversary Date** up to a maximum of 5 consecutive years subject to the terms and conditions under section '5 - Renewal'.

Schedule of Benefits

It is the document containing the applicable **Benefits** and their corresponding **Compensation** and **Aggregate Period**.

Spouse

Someone the **Insured Person** is legally married to.

Waiting Period

It is a time period that needs to elapse from the Policy Effective Date before the **Insured Person** becomes entitled to claim a **Benefit** under this **Policy**. The applicable waiting period is as stated in the **Schedule of Benefits**. The **Waiting Period** does not apply to **Critical Illness** caused by an **Accident** as defined.

We, Us, Our or Company

It means AIG Malaysia Insurance Berhad.

You, Your or Insured Person

The person named in the **Policy Schedule** and who is insured under this **Policy** during a valid **Policy Period**.

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8. GENERAL POLICY CONDITIONS

1) CONDITION PRECEDENT TO LIABILITY

The **Insured Person** must follow the terms, provisions and conditions of this **Policy** in order to qualify for any payment under this **Policy**. The **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 **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

To receive **Compensation** under this **Policy**, the **Policyholder** and **Insured Person** must at all times take reasonable precautions and act in a prudent way to prevent and mitigate 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 and the Malaysian courts shall have exclusive jurisdiction over this **Policy**.

5) DISPUTE RESOLUTION

Any dispute or difference which may arise between the **Policyholder/Insured Person** and the **Company** shall be referred to Asian International Arbitration Center. All arbitration proceedings must take place, within 12 months from the date of disclaimer, failing which the **Company** would have no obligation over the claim.

6) GEOGRAPHICAL LIMITS & TERRITORIAL LIMITS

This **Policy** covers an **Insured Person**:

a) in Malaysia for 24 hours and 7 days a week, unless otherwise stated or endorsed under this **Policy**.

b) whilst **Overseas** subject to '8**.** General Policy Conditions, Item 7 – Overseas Hospitalisation and Treatment' and '8**.** General Policy Conditions, Item 22– Sanction'.

7) OVERSEAS HOSPITALISATION AND TREATMENT

The **Company** will only cover the **Insured Person's** overseas treatment if the **Overseas** travel is not for the purpose of

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seeking medical treatment.

The following are excluded:

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

(b) **Overseas Hospitalisation** or treatments of a **Critical Illness Diagnosed** in Malaysia where treatment can reasonably be postponed until return to Malaysia.

8) DUPLICATION OF COVER

Only one individual policy providing the product underwritten by the **Company** is allowed. If more than one policy is held, the **Company** will consider the **Insured Person** to be insured under the **Policy** with the highest **Compensation** or, where the **Compensation** under each policy is identical, under the **Policy** that was first issued.

9) OFFSET CLAUSE

If the **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 **Compensation** as specified in the **Policy Schedule**. This condition is only applicable to **Benefits** whereby payment is on a reimbursement basis.

10) 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**.

11) WAIVER OF INSURED PERSON'S RIGHTS

If the **Company** rejects liability for any claim made under this **Policy** and it is not referred to any dispute resolution/arbitration or settlement within 12 calendar months from the date of the **Company's** rejection, it shall be deemed that the **Policyholder** and the **Insured Person** have accepted the **Company's** rejection of their claim and they have waived all their rights with respect to such a claim.

12) PREMIUM

A. CASH BEFORE COVER

The **Company** must receive the **Premium** due on or before the **Premium Due Date**. No **Benefits** will be payable for any claim that occurs during a period for which **Premium** was not received.

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B. CHANGES TO PREMIUM PAYABLE

1. **Premium** rates are not guaranteed, and the **Premium** payable at renewal shall be determined based on the **Age** of the **Insured Person** at the **Anniversary Date.**

2. 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**.

3. If the changes to the **Premium** made by the **Company** are acceptable, the **Policyholder** may choose to continue with the existing **Plan** and renew their **Policy** at the new **Premium** amount applicable.

4. 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**.

5. The **Policy** is automatically cancelled if **Premium** is not paid by the **Policyholder** on the **Premium Due Date**.

13) 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 **Our** liability shall be limited to the refund of the **Premium** paid without interest.

14) 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 **Insured Person** in respect to any fraudulent claims submitted.

15) POLICY CHANGES

A. CHANGES OF THE TERMS OR CONDITIONS BY THE COMPANY

The **Company** reserves the right to change the terms or conditions of this **Policy** by giving the **Policyholder**:

1. 30 Days' written notice of such change if it is due to underwriting reasons,
2. 7 Days' written notice of such change if due to an infectious disease outbreak, or
3. Immediate written notice of such change if it is due to any Government or statutory declaration which impacts this **Policy**.

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Important note:

1. If the changes in terms or conditions by the **Company** are acceptable to the **Policyholder**, then this **Policy** will continue. If the changes are not acceptable, the **Insured Person** may cancel this **Policy** under section '9. Cancellation & Refund'.
2. No alteration to this **Policy** shall be valid unless approved in writing by the **Company's** authorised representative and reflected in an endorsement.
3. 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** will give immediate written notice to the **Company** of any change in the occupation of an **Insured Person** which falls under an excluded occupation as specified under section '2: Eligibility'.

No claim will be payable in respect of

(a) Any **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer** arising out of or in the course of an occupation of greater risk than the occupation disclosed in **Policyholder's** application, unless the **Company** had agreed to the change in occupation; or

(b) Any **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer** 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** country of residence. A change in their country of residence will be deemed to mean the **Insured Person** is living or intending to live in another country for more than 180 consecutive days. 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 this **Policy**.

D. CHANGES IN PLAN

The **Policyholder** can change the **Plan** or optional Benefits at the time of renewal only provided:

a) that no claim has been paid under 'Non-Invasive Cancer Benefit (Carcinoma-In-Situ Or Early-Stage Cancer)' **Benefit** of Section B of this **Policy**; and
b) the **Insured Person** is below the age of 60 years at time of renewal.

Any change in **Plan** 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 in **Plan**.

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16) MEDICAL EXAMINATION AND TREATMENT

The **Company** shall have the right and opportunity to examine the **Insured Person** when and as often as it may reasonably require during the pendency of a claim hereunder, and also the right and opportunity to make an autopsy at the **Company's** expense in case of death where it is not forbidden by law. The **Insured Person** shall as soon as possible after the occurrence of any **Diagnosis** of a **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer** whichever is appropriate, obtain and follow the advice of a duly qualified **Doctor** and the **Company** shall not be liable for any consequences arising by reason of the **Insured Person's** failure to obtain or follow such advice and use such appliances or remedies as may be prescribed.

17) 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 AIG Malaysia. Such request can be made by writing to the **Company** at:

Attn: Customer Care
AIG Malaysia Insurance Berhad
Menara Worldwide,
198, Jalan Bukit Bintang,
55100 Kuala Lumpur.

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

18) 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 will bear all the administration and costs of conversion.

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19) 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**.

20) NOMINATION

All benefits payable following the death of the **Insured Person** is payable to the nominee(s) elected by the **Policyholder** and in the event of failure of the **Policyholder** to nominate a nominee, to the **Insured Person's** estate. **Compensation** for all other benefits will be paid 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.

The original physical nomination form is a mandatory document required in the event of a claim. In the absence of the form the **Company** will be guided by Paragraph 8 and Paragraph 9 of Schedule 10 of the Financial Services Act 2013 when paying policy monies upon death of an **Insured Person**.

The **Policyholder** is encouraged to appoint a nominee to expedite processing of policy payments with minimal administrative documents. This nomination form is available for download at https://www.aig.my/content/dam/aig/apac/malaysia/documents/others/beneficiary-nomination-form.pdf and the original executed form should be submitted to the **Company** at the address provided below or to insurance agent (if applicable).

AIG Malaysia Insurance Berhad
Level 17, Menara Worldwide
198 Jalan Bukit Bintang
55100 Kuala Lumpur

21) RIGHTS OF ASSIGNMENT

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

22) 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.

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23) NOTICES TO THE POLICYHOLDER

The **Company** provides formal written notices to the **Policyholder** either by post or by electronic means using the last updated contact information provided to the **Company**. The **Company** will not be responsible for any consequences arising from **Policyholder's** failure to notify the **Company** of any change of contact information.

9. 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 by the **Premium Due Date**. 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 Malaysia.

On cancellation of the **Policy**:

(a) If no claim has been made, the **Company** will refund the pro-rated **Premium** for the remaining **Policy Period** to the **Policyholder**.
(b) If a claim has been paid by the **Company** in the current **Policy Period**, 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** finalise 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** or via email at the address provided below. 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 **Premium** as specified in the Short Period Scale below.

Short Period Scale		
No.	**Policy Period** in force (up to)	Refund of Annual **Premium**
1	15 days	90%
2	One month	80%
3	Two months	70%
4	Three months	60%
5	Four months	50%
6	Five months	40%
7	Six months	30%
8	Seven months	25%

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9	Eight months	20%
10	Nine months	15%
11	Ten months	10%
12	Eleven months	5%
13	Period exceeding eleven months	No refund

Contact Information:
AIG Malaysia Insurance Berhad
Level 17, Menara Worldwide
198 Jalan Bukit Bintang
55100 Kuala Lumpur
Email: AIGMYCare@aig.com

10. AUTOMATIC TERMINATION OF POLICY

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

a) this **Policy** is cancelled for reasons stated under section '9. Cancellation & Refund';

b) of the **Insured Person's** death, from any cause;

c) the **Insured Person** ceases to satisfy any of the requirements as specified under section '2. Eligibility';

d) the **Insured Person** is paid the maximum **Compensation** for certain **Benefits** where such termination of the **Policy** is specified under the Specific Conditions of that **Benefit**; or

e) any fraud or misrepresentation to the **Company** discovered as mentioned under section '8. General Policy Conditions – Item 14. Misrepresentation or Fraud'.

11. GENERAL POLICY EXCLUSIONS

The following exclusions apply to all sections of this Policy

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

1. Any **Critical Illness** except when caused by an **Accident** as defined**, Gender-Specific Cancer and Non-Invasive Cancer** which first manifested within the **Waiting Period** as specified in the Schedule of Benefits.

2. When the **Insured Person** dies within 30 days of being **Diagnosed** with a **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer**. This is applicable for all **Benefits** under this **Policy**, except for the **Benefit**

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‘Funeral Expenses’, if applicable.

3. Any **Pre-Existing Condition** or any complications arising from it.

4. Any cancer diagnosed prior to the **Policy Effective Date** in the same body or organ site as the **Cancer** or any cancer which subsequently metastasized into the **Cancer**.

5. Any sickness, illness or disease which is not specified as a **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer** in this **Policy**.

6. When the **Insured Person** is diagnosed with a critical illness that is not covered under this **Policy** or they are **Diagnosed** with a **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer,** but the **Diagnosis** does not meet our definition of **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer**.

7. Any **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer** resulting directly from alcohol or drug abuse.

8. Any **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer** due to a self-inflicted injury, suicide or attempted suicide whether sane or insane, deliberate or reckless exposure to danger.

9. Any **Critical Illness, Gender-Specific Cancer or Non-Invasive Cancer** contributed or aggravated or prolonged by childbirth or pregnancy before cover started under this **Policy**.

10. When the **Insured Person**, the **Policyholder** or their legal representatives do not give the **Company** medical or other evidence that the **Company** requires to confirm an **Insured Person’s** claim.

11. When the **Company** finds the **Insured Person** or the **Policyholder** has given inaccurate, incomplete or false information on the application which would have affected the **Company’s** decision to offer this **Cover**, or would have led the **Company** to offer it with different conditions.

12. An **Insured Person’s**:
    a) failure to follow medical advice given by a **Doctor**;
    b) **Congenital Conditions;**
    c) Physical impairment; and
    d) mental, psychiatric or nervous disorder (including any neuroses and their physiological or psychosomatic manifestations), sleep disturbance disorder, anxiety, stress or depression.

13. Any donation of any of the **Insured Person’s** organs.

14. 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. This exclusion does not apply to the Appendix A – Critical Illness Definitions, ’HIV Infection Due to Blood Transfusion’ and ‘Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection’.

15. Any infectious disease (if applicable under this **Policy**) declared as an epidemic or pandemic by the World Health Organisation (WHO) or the relevant government authority of Malaysia.

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In the event of an announcement or notification of an epidemic or pandemic by the health authority or government of Malaysia only, the notification shall take precedence and shall be deemed that an epidemic or pandemic has been announced.

The cover for the epidemic or pandemic infectious disease shall cease from the date of such announcement or notification. This cover shall be restored when the World Health Organisation (WHO) or the relevant government authority of Malaysia announces or notifies that it is no longer an epidemic or pandemic.

16. Nuclear, biological or chemical incidents outlined below:
    a) Any Nuclear explosion including all effects thereof or radioactive contamination caused by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste caused by the combustion and/or ongoing combustion of nuclear fuel;
    b) The radioactive, toxic, explosive or other hazardous properties of any nuclear equipment or component thereof; or
    c) a terrorist, criminal or other malicious entity's dispersal or application of pathogenic or poisonous biological or chemical materials or the release of pathogenic or poisonous biological or chemical materials.

17. A benefit for **Terminal Illness** if:
    a) the **Doctor** is unable to confirm if the **Terminal Illness** will lead to death within 12 months;
    b) A **Terminal illness** occurs in the presence of HIV infection.

18. Any sickness or injuries arising from activities related to:
    a) 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 a commercial aircraft licensed to carry passengers;
    b) 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;
    c) racing of any kind except foot racing, any type of stunts, reliability trials and speed or duration testing. Training or practicing in relation to these activities is also not covered; or
    d) hazardous sports such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter 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 any mountaineering involving climbing harnesses, belay or rappel devices ropes and guides, any activity or trekking above 3000 meters, big wave surfing, power-boat racing, yacht race, winter activities like luging, bobsleighing, ski or snow board jumping or stunts, off-piste skiing, boxing, martial arts, bicycle, motor, air or sea craft speed trials or stunts, canoeing/kayaking and white and black water rafting in grade 4 or higher rapids, jet skiing, cliff jumping, horse racing or jumping, horse polo or any aerobatics and stunts, 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.;

19. Any deliberate provocation of the **Insured Person** against another person that results in an injury.

20. An **Insured Person** committing or attempting to commit any criminal or illegal act (including traffic offences).

21. Where payment would violate a government prohibition, regulation or law.

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22. Any act of war (whether war be declared or not), invasion, act of foreign enemies, hostilities or war like activities including the use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends, civil war, mutiny, rebellion, revolution, insurrection, military, protests, usurpation of power or taking part in a riot or civil commotion.

23. Any injury sustained whilst the **Insured Person** is riding on a motorcycle without a safety helmet either as a rider or pillion-rider.

24. Any injury arising directly or indirectly due to osteoporosis.

12. CLAIMS CONDITIONS

STEPS TO MAKE A CLAIM

1. **Step 1**: The **Policyholder** or **Insured Person** 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 Critical Illness Health Claims Form along with the relevant Medical Report form and email it to MYPAClaims@aig.com.

2. **Step 2**: The **Policyholder** or **Insured Person** 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/critical-illness-claims

3. **Step 3**: The **Policyholder** or **Insured Person** 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:

   Claims Department
   AIG Malaysia Insurance Berhad
   Level 16.
   Menara Worldwide,198 Jalan Bukit Bintang,
   55100, Kuala Lumpur, Malaysia
   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**.

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COMPLIANCE

The **Company** shall not be liable for any consequences arising by reason of the **Insured Person's** failure to obtain or follow a consultant **Doctor's** advice and use such appliances or remedies as may be prescribed in the event of an **Injury**, **Critical Illness, Gender-Specific Cancer, Non-Invasive Cancer,** and related additional **Benefits** when claiming **Compensation**.

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 the **Diagnosis** of a **Critical Illness, Non-Invasive Cancer** or **Terminal 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.

(c) In the event the **Insured Person** is a **Child**, all dealings in relation to any claim will be between the **Insured Person's Parent** and the **Company**.

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 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. 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 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 consultant **Doctor**. For avoidance of doubt, medical certificates or reports issued by other practitioners, including alternative and traditional medical practitioners, traditional Chinese medicine practitioner or chiropractors will not be accepted.

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

(e) The **Company** may require the **Insured Person** undergo a medical examination by a consultant **Doctor** appointed by the **Company** before the initial or additional **Compensation** can be paid.

(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) **Compensation** 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**. **Compensation** will generally be paid immediately unless there are specific terms set out in the **Benefit**.

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

(c) Unless otherwise specified in this **Policy**, payments or reimbursements will be made at the **Company's** sole discretion to the **Claimant** or directly to a service provider. If the **Insured Person** is a **Child**, the **Compensation** will be paid to their **Parent**(s).

(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**.

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13. 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.

Complaints Handling Unit,
AIG Malaysia Insurance Berhad
Service Counter,
Level 17, Menara Worldwide,
198, Jalan Bukit Bintang, 55100 Kuala Lumpur

Phone: 1 800 88 8811
Fax: 603 2685 4896
Email: AIGMYCare@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

(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:

Director

Laman Informasi Nasihat dan Khidmat (LINK)

Bank Negara Malaysia

Blok D, Jalan Dato' Onn

50480 Kuala Lumpur

Phone: 1-300-88-5465 (1300-88-LINK)

Fax: 603-2174 1515.

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APPENDIX A – CRITICAL ILLNESS DEFINITIONS

The following are definitions of terms used in the definition of **Critical Illness**, unless otherwise stated.

1. CANCER – OF SPECIFIED SEVERITY AND DOES NOT COVER VERY EARLY CANCERS

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

For the above definition, the following are not covered:

(i) All cancers which are histologically classified as any of the following:
- pre-malignant
- non-invasive
- carcinoma-in-situ
- having borderline malignancy
- having malignant potential

(ii) All tumours of the prostate histologically classified as T1N0M0 (TNM classification)
(iii) All tumours of the thyroid histologically classified as T1N0M0 (TNM classification)
(iv) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM classification)
(v) Chronic Lymphocytic Leukemia less than RAI Stage 3
(vi) All cancers in the presence of HIV
(vii) Any skin cancer other than malignant melanoma.

2. HEART ATTACK – OF SPECIFIED SEVERITY

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

A history of typical chest pain;

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

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

For the above definition, the following are not covered:

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

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3. SERIOUS CORONARY ARTERY DISEASE

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

4. HEART VALVE SURGERY

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

For the above definition, the following are not covered:

(i) Repair via intra-arterial procedure
(ii) Repair via key-hole surgery or any other similar techniques.

5. CORONARY ARTERY BY-PASS SURGERY

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

For the above definition, the following are not covered:

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

6. SURGERY TO AORTA

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

For the above definition, the following are not covered:

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

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7. CARDIOMYOPATHY – OF SPECIFIED SEVERITY

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

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

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

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

8. KIDNEY FAILURE – REQUIRING DIALYSIS OR KIDNEY TRANSPLANT

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

9. MEDULLARY CYSTIC DISEASE

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

10. PRIMARY PULMONARY ARTERIAL HYPERTHENSION – OF SPECIFIED SEVERITY

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

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

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

Class III: Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes symptoms.

Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

11. END-STAGE LUNG DISEASE

End-stage lung disease causing chronic respiratory failure.

All of the following criteria must be met:

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

12. STROKE – RESULTING IN PERMANENT NEUROLOGICAL DEFICIT WITH PERSISTING CLINICAL SYMPTOMS

Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolisation from an extra cranial source resulting in **Permanent Neurological Deficit** with persisting clinical symptoms. The **Diagnosis** must be based on changes seen in a CT scan or MRI and certified by a neurologist **Doctor**. A minimum **Assessment Period** of 3 months applies.

For the above definition, the following are not covered:
(i) Transient ischemic attack.
(ii) Cerebral symptoms due to migraine
(iii) Traumatic injury to brain tissue or blood vessels
(iv) Vascular disease affecting the eye or optic nerve or vestibular functions.

13. END-STAGE LIVER FAILURE

End-stage liver failure as evidenced by all of the following:
- Permanent jaundice;
- Ascites (excessive fluid in peritoneal cavity); and
- Hepatic encephalopathy.

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

14. MAJOR HEAD TRAUMA – RESULTING IN PERMANENT INABILITY TO PERFORM ACTIVITIES OF DAILY LIVING

Physical head **Injury** resulting in **Permanent** functional impairment verified by a neurologist **Doctor**. The **Permanent** functional impairment must result in an inability to perform at least 3 of the **Activities of Daily Living**. A minimum **Assessment Period** of 3 months applies.

15. ANGIOPLASTY AND OTHER INVASIVE TREATMENTS FOR CORONARY ARTERY DISEASE

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

Intra-arterial investigative procedures are not covered.

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16. ENCEPHALITIS – RESULTING IN PERMANENT INABILITY TO PERFORM ACTIVITIES OF DAILY LIVING

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

Encephalitis in the presence of HIV infection is not covered.

17. PARKINSON’S DISEASE – RESULTING IN PERMANENT INABILITY TO PERFORM ACTIVITIES OF DAILY LIVING

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

(i) Cannot be controlled with medication;
(ii) Shows signs of progressive impairment; and
(iii) Confirmation of the **Permanent** inability of the **Insured Person** to perform without assistance 3 or more of the **Activities of Daily Living**.

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

18. BRAIN SURGERY

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

For the above definition, the following are not covered:

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

19. BENIGN BRAIN TUMOR – OF SPECIFIED SEVERITY

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

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

The following are not covered:

(i) Cysts
(ii) Granulomas
(iii) Malformations in or of the arteries or veins of the brain
(iv) Hematomas
(v) Tumours in the pituitary gland

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(vi) Tumours in the spine
(vii) Tumours of the acoustic nerve.

20. COMA RESULTING IN PERMANENT NEUROLOGICAL DEFICIT WITH PERSISTING CLINICAL SYMPTOMS

A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously for at least 96 hours, requiring the use of life support systems and resulting in a **Permanent Neurological Deficit** with persisting clinical symptoms. A minimum **Assessment Period** of 30 days applies. Confirmation by a neurologist **Doctor** must be present.

The following is not covered:

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

21. MAJOR ORGAN / BONE MARROW TRANSPLANT

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

Other stem cell transplants are not covered.

22. PARALYSIS OF LIMBS

Total, **Permanent** and **Irreversible** loss of use of both arms or both legs, or of one arm and one leg, through paralysis caused by illness or **Injury**. A minimum **Assessment Period** of 6 months applies.

23. THIRD DEGREE BURNS – OF SPECIFIED SEVERITY

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

24. MUSCULAR DYSTROPHY

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

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No benefit will be payable under this definition before the **Insured Person** has reached the age of 12 years next birthday.

25. LOSS OF INDEPENDENT EXISTENCE

Confirmation by an appropriate specialist **Doctor** of the loss of independent existence and resulting in a **Permanent** inability to perform at least 3 of the **Activities of Daily Living**. A minimum **Assessment Period** of 6 months applies.

26. CHRONIC APLASTIC ANEMIA – RESULTING IN PERMANENT BONE MARROW FAILURE

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

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

The **Diagnosis** must be confirmed by a bone marrow biopsy.

27. MULTIPLE SCLEROSIS

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

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

28. MOTOR NEURON DISEASE - PERMANENT NEUROLOGICAL DEFICIT WITH PERSISTING CLINICAL SYMPTOMS

A definite **Diagnosis** of motor neuron disease by a neurologist **Doctor** with reference to either spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be **Permanent Neurological Deficit** with persisting clinical symptoms.

29. BACTERIAL MENINGITIS - RESULTING IN PERMANENT INABILITY TO PERFORM ACTIVITIES OF DAILY LIVING

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

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The **Diagnosis** must be confirmed by:

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

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

30. DEAFNESS – PERMANENT AND IRREVERSIBLE

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

31. BLINDNESS – PERMANENT AND IRREVERSIBLE

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

32. LOSS OF SPEECH

Total, **Permanent** and **Irreversible** loss of the ability to speak as a result of **Injury** or illness. A minimum **Assessment Period** of 6 months applies. Medical evidence to confirm **Injury** or illness to the vocal cords to support this disability must be supplied by an Ear, Nose, and Throat specialist **Doctor**.

All psychiatric related causes are not covered.

33. FULMINANT VIRAL HEPATITIS

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

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

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

34. ALZHEIMER’S DISEASE / SEVERE DEMENTIA

Deterioration or loss of intellectual capacity confirmed by clinical evaluation and imaging tests arising from Alzheimer's Disease or Severe Dementia as a result of **Irreversible** organic brain disorders. The **Diagnosis** of this condition must be

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as a result of a significant reduction in mental and social functioning requiring continuous supervision of the **Insured Person**. The **Diagnosis** must be clinically confirmed by a neurologist **Doctor**.

From the above definition, the following are not covered:

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

35. SYSTEMIC LUPUS ERYTHEMATOSUS WITH SEVERE KIDNEY COMPLICATIONS

A definite **Diagnosis** of Systemic Lupus Erythematosus confirmed by a rheumatologist.

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

WHO Lupus Classification:
Type III - Focal Segmental glomerulonephritis
Type IV - Diffuse glomerulonephritis
Type V - Membranous glomerulonephritis.

36. TERMINAL ILLNESS

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

37. HIV INFECTION DUE TO BLOOD TRANSFUSION

Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:

(i) The blood transfusion was **Medically Necessary** or given as part of a medical treatment;
(ii) The blood transfusion was received in Malaysia or Singapore after the **Policy Effective Date**;
(iii) The source of the infection is established to be from the institution that provided the blood transfusion and the institution is able to trace the origin of the HIV tainted blood;
(iv) The **Insured Person** does not suffer from hemophilia; and
(v) The **Insured Person** is not a member of any high risk groups including but not limited to intravenous drug users.

38. OCCUPATIONALLY ACQUIRED HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

Infection with the Human Immunodeficiency Virus (only if the **Insured Person** is a Medical Staff as defined below), where it was acquired as a result of an accident occurring during the course of carrying out normal occupational duties with seroconversion to HIV infection occurring within 6 months of the accident. Any accident giving rise to a potential claim

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must be reported to the **Company** within 30 days of the accident taking place supported by a negative HIV test taken within 7 days of the accident.

“Medical Staff” is defined as doctors (General Physicians and Specialists), traditional practitioners, nurses, paramedics, laboratory technicians, dentists, dental nurses, ambulance workers who are working in a medical centre or hospital or dental clinic/polyclinic in Malaysia. Doctors, traditional practitioners, nurses and dentists must be registered with the Ministry of Health of Malaysia.

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