



**AIG MALAYSIA INSURANCE BERHAD**

**Smart Shield – Telemarketing**

**Policy Wording**

## **Schedule of Benefits**

No	Benefits	Compensation (RM)			Waiting Period
		Plan 1	Plan 2	Plan 3	
1	Critical Illness*	15,000	15,000	20,000	90 days from Policy Effective Date
2	Critical Accident*				N/A
3	Non-Invasive Cancer (Carcinoma-In-Situ or Early-Stage Cancer)*	1,500	1,500	2,000	90 days from Policy Effective Date
4	Daily Hospitalisation Income due to Injury (Aggregate Period: up to maximum 180 Days)	150 per Day	200 per Day	250 per Day	N/A
5	Medical Expenses due to an Injury	Up to 5,000	Up to 6,000	Up to 7,500	N/A

Optional Benefits		Compensation (RM)
1	Fractures & Dislocation	Up to 5,000
2	Recovery Assistance Services (Aggregate Period: up to maximum 12 visits)	100 per visit
3	Commitment Relief Benefit (due to Injury) (minimum 7 consecutive Days of Hospitalisation due to Injury)	5,000

\* If the Insured Person has been Diagnosed with 'Critical Illness' or 'Critical Accident' Benefit, the Insurance 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.

### **Notes:**

1. The Insurance Company will only pay the Insured Person for one Critical Illness or Critical Accident Diagnosed on them during a Policy Period and this Policy will terminate immediately upon such Compensation payment.
2. Aggregate Period means the maximum number of days for which a Compensation is payable as specified against the Benefit in the Schedule of Benefits.
3. For Optional Benefit 'Recovery Assistance Service' - this Benefit is payable only If a valid claim for Critical Illness or Critical Accident is paid or payable under this Policy.
4. This Schedule of Benefits must be read together with the Certificate of Insurance/Policy Schedule, policy wordings and any endorsements issued to Certificate Holder/Policyholder.

## ABOUT THIS POLICY

This policy wordings, together with the latest **Certificate of Insurance/Policy Schedule** for the applicable **Benefits**, the proposal form and any endorsements, forms the basis of the contract between the **Certificate Holder/Policyholder** and the **Insurance Company**. The **Insurance 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 **Certificate Holder/Policyholder** pays the **Premium** when due and the **Insurance Company** accepts it subject to the terms and conditions of this **Policy**.

This policy wordings should be read carefully together with the **Certificate of Insurance/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 **Certificate Holder/Policyholder/Insured Person**. If there are any questions regarding the terms and conditions of this **Policy** wordings, the **Certificate Holder/Policyholder/Insured Person** may contact the **Insurance Company**.

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 **Certificate Holder/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 '5. Benefits' should be referred to for full details of coverage.

The **Benefits** payable under eligible **Policy** is protected by PIDM up to limits. Please refer to PIDM's TIPS Brochure or contact AIG Malaysia Insurance Bhd or PIDM (visit [www.pidm.gov.my](http://www.pidm.gov.my)).

## 1. ONGOING DUTY OF DISCLOSURE

### Consumer Insurance Contract

Where the **Certificate Holder/Policyholder** have applied for this insurance wholly for purposes unrelated to their trade, business or profession, the **Certificate Holder/Policyholder** have a duty to take reasonable care not to make a misrepresentation in answering the questions in the Proposal Form or when they applied for this insurance i.e. the **Certificate Holder/Policyholder** should have answered the questions fully and accurately. Failure to have taken reasonable care in answering the questions may result in the cancellation of the contract of insurance, refusal or reduction of claim(s), change of terms or termination of the contract of insurance in accordance with Schedule 9 of the Financial Services Act 2013. The **Certificate Holder/Policyholder** is also required to disclose any other matter that they know to be relevant to the **Insurance Company's** decision in accepting the risks and determining the rates and terms

to be applied. The **Certificate Holder/Policyholder** also have a duty to inform the **Insurance Company** immediately if at any time after the contract of insurance has been entered into, varied or renewed with the **Insurance Company**, any of the information given in the Proposal Form or any other document related to this insurance is inaccurate or has changed.

## Non-Consumer Insurance Contract

Where the **Certificate Holder/Policyholder** have applied for this insurance for purposes related to their trade, business or profession, the **Certificate Holder/Policyholder** have a duty to disclose any matter that they know to be relevant to the **Insurance Company's** decision in accepting the risks and determining the rates and terms to be applied, and any matter a reasonable person in the circumstances could be expected to know to be relevant, otherwise it may result in the cancellation of their contract of insurance, refusal or reduction of claim(s), change of term(s) or termination of the contract of insurance. The **Certificate Holder/Policyholder** also have a duty to inform the **Insurance Company** immediately if at any time after the contract of insurance has been entered into, varied or renewed with the **Insurance Company**, any of the information given in the Proposal Form or any other document related to this insurance is inaccurate or has changed.

Failure to comply with the section '[Consumer Insurance Contract](#)' and '[Non-Consumer Insurance Contract](#)' may:

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

## 2. ELIGIBILITY

All requirements as specified in this section of this **Policy** must be continuously satisfied by the **Certificate Holder/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 **Certificate Holder/Policyholder**:
  - (i) Entry **Age** is 18 to 60 years (inclusive).
  - (ii) The **Policy** can be renewed up to the **Age** of 65 years (inclusive).
2. 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).

**Important Note:**

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. Military personnel including the armed forces, naval or air force service or operations;
2. Police, security personnel including any peace keeping forces;
3. Fire service;
4. Semi-professional and professional sports when an Insured Person could or would earn income or remuneration from engaging in such sport.
5. Pilots or crew of any air or water vessel;
6. Off-shore work or activities including oil rig work;
7. Loggers and sawmill workers or workers using woodworking machinery;
8. Workers handling boilers, pressure vessels or crane operators;
9. Workers engaged in construction of dams, bridges, tunnels or underground work;
10. Asbestos Workers, miners and quarry workers;
11. Work that involves heavy machinery, explosives or hazardous materials or chemicals;
12. Fisherman, stevedores, stuntman, circus performers, jockey and racing drivers;
13. Window cleaners and steeplejacks;
14. Construction workers involved in heavy machinery;
15. Any manual works at heights exceeding 24 feet; or
16. Other occupations like those characterized above and which place the Insured Person at risk of injury necessitating specialist equipment (e.g. harness) or protective gear to keep them safe.

**3. POLICY PERIOD**

This **Policy** starts on the **Policy Start Date** as specified on the latest **Certificate of Insurance/Policy Schedule** for this **Policy** and ends on the earlier of:

- (a) the **Policy Expiry Date** as specified on the **Certificate of Insurance/Policy Schedule** for this **Policy**;
- (b) the date this **Policy** is cancelled or not renewed; or
- (c) the date this **Policy** is automatically terminated.

## 4. FREE LOOK PERIOD

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

## 5. BENEFITS

Please note that this **Policy** has been designed to offer multiple core **Plans** and optional **Benefits**. The **Certificate Holder/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**.

### CRITICAL ILLNESS

If the **Insured Person** is **Diagnosed** to be suffering from a **Critical Illness** during the **Policy Period**, the **Insurance 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

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

- 1) **Cancer of Specified Severity - and does not cover very early cancers**
- 2) **Heart Attack - of specified severity**
- 3) **Serious Coronary Artery Disease**
- 4) **Kidney Failure – requiring dialysis or kidney transplant**
- 5) **Stroke - resulting in Permanent Neurological Deficit with persisting clinical symptoms**

#### 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 **Insurance Company** will only pay the **Insured Person** for one **Critical Illness** or **Critical Accident 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 **Critical Illness** under this **Benefit**, the **Insurance 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**.

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

The **Insurance 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 **Insurance 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**.

#### CRITICAL ACCIDENT

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

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

**Critical Accident** means any of the following medical conditions first and unequivocally **Diagnosed** by a **Doctor** during the **Policy Period** and where required by the **Insurance Company**, will be confirmed by a **Doctor** chosen by the **Insurance Company**, and they are individually defined in Appendix A of this **Policy**:

- 1) **Major Head Trauma - resulting in permanent inability to perform Activities of Daily Living**
- 2) **Paralysis of Limbs**
- 3) **Third Degree Burns – of specified severity**
- 4) **Deafness – Permanent and Irreversible**
- 5) **Blindness – Permanent and Irreversible**
- 6) **Loss of Speech**

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

1. This **Benefit** is payable if the **Insured Person** survives for at least 30 days after the date of **Accident**.
2. The **Insurance Company** will only pay the **Insured Person** for one **Critical Illness or Critical Accident Diagnosed**

during a **Policy Period** and this **Policy** will terminate immediately upon such **Compensation** payment.

3. If the **Insured Person** has been **Diagnosed** with a **Critical Accident** under this **Benefit**, the **Insurance 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 **Insurance 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 **Insurance Company** which is the same product and provides the same cover.
2. Any medical condition diagnosed prior to the **Policy Effective Date** in the same body or organ site as the **Critical Accident** or which subsequently aggravates into the **Critical Accident**.

#### 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 **Insurance 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 **Insurance 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 **Insurance Company** imposing additional conditions that the **Insurance Company** may deem as necessary.
4. In the event the **Insured Person** is subsequently **Diagnosed** with **Critical Illness** or **Critical Accident**, any **Compensation** paid under this **Benefit** shall be reduced from any amount payable under '**Critical Illness**' or '**Critical Accident**' **Benefit**.

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

The **Insurance 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 **Insurance 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**.

#### DAILY HOSPITALISATION INCOME DUE TO AN INJURY

If an **Insured Person** sustains an **Injury** and is **Hospitalised** within 30 **Days** from the date of the **Accident**, the **Insurance Company** will pay the **Compensation** as stated in the **Schedule of Benefits** for each **Day** the **Insured Person** spends as an **In-patient**.

Compensation under this **Benefit** shall continue up to the **Aggregate Period** per claim or until the **Insured Person** is discharged from the **Hospital** as an **In-patient**, whichever occurs first.

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

In addition to the conditions set out in the General Policy Conditions, the following specific conditions apply:

1. This **Benefit** is payable for only one **Injury** per **Accident**, regardless of the number of injuries sustained.
2. Any **Hospitalisation** of an **Insured Person** shall be evidenced by **Insured Person's Hospital** discharge summary or **Hospital** billing statement and medical report(s).
3. Subsequent periods of **Hospitalisation** for the same **Injury** are considered to be part of the same claim, provided that:
  - (a) each subsequent **Hospitalisation** occurs while this **Policy** is in force and the person who is the subject of the claim is an **Insured Person**.
  - (b) the time between the different **Hospitalisation** periods does not exceed 90 consecutive **Days**.

- (c) If the **Insured Person** is **Hospitalised** for the same **Injury** after 90 consecutive **Days** from their last period of **Hospitalisation**, it will be treated as a new claim with a new **Aggregate Period** applying with a maximum of 3 claims permissible for the same **Injury**.

## MEDICAL EXPENSES DUE TO AN INJURY

If an **Insured Person** suffers an **Injury**, the **Insurance Company** will reimburse the **Medical Expenses** incurred to treat an **Injury** suffered by the **Insured Person** within 365 days from the date of the **Accident**, up to the maximum **Compensation** payable for any one **Accident** as shown in the **Schedule of Benefits**.

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

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

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

In addition to the conditions set out in the General Policy Conditions, the following specific conditions apply:

1. This **Benefit** is only payable if the first medical treatment sought for the **Injury** is within 30 days from the date of the **Accident**.
2. The **Benefit** is payable only after **Medical Expenses**' supporting documents, including attending **Doctor**'s reports and referral letters, are provided to the **Insurance Company** along with original **Medical Expenses** bills or receipts.
3. If the **Insured Person** is entitled to a refund of all or part of the **Medical Expenses** stated in this **Benefit** from any other source, the **Insurance Company** will only pay the amount incurred over and above the refunded amount up to the maximum **Compensation** as shown on the **Schedule of Benefits**.
4. Any **Hospitalization** accommodation for the **Insured Person** is restricted up to the cost of a single standard private room.

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

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

1. Any medical transportation services.
2. Any **Medical Expenses** involving:
  - (a) a routine health check;
  - (b) diagnosis, tests, examinations or x-rays where there is no objective indication of impairment of normal health;
  - (c) any treatment or investigation of a preventive nature, vaccinations, acupuncture or any treatment which is not medically necessary; or
  - (d) dental or oral care.
3. Any additional cost of single or private room accommodation at a **Hospital** for any person besides the **Insured Person**, charges in respect of special or private nursing, non-medical personal services such as radio, telephone and the like.
4. 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.

## OPTIONAL BENEFITS

### FRACTURES & DISLOCATION (DUE TO INJURY)

If an **Insured Person** suffers an **Injury** which results in one of the Events listed in the Table of Events below, the **Insurance Company** will pay the **Compensation** for the Event as specified in the Table of Events.

Table of Events:

Events	Injury resulting in:	Percentage of Compensation payable per Insured Person as shown in the Schedule of Benefits
<b>1</b>	<b>Fractures<sup>1</sup></b>	
<b>A.</b>	<b>Hip or Pelvis (excluding thigh or coccyx)</b>	
<b>i)</b>	Multiple <b>Fractures</b> , including at least one <b>Compound</b> and one <b>Complete Fracture</b>	60%
<b>ii)</b>	All other <b>Compound Fractures</b>	30%
<b>iii)</b>	Multiple <b>Fractures</b> , including at least one <b>Complete Fracture</b>	15%
<b>iv)</b>	<b>All Other Fractures</b>	12%
<b>B.</b>	<b>Thigh or Heel</b>	
<b>i)</b>	Multiple <b>Fractures</b> , including at least one <b>Compound</b> and one <b>Complete Fracture</b>	30%
<b>ii)</b>	All other <b>Compound Fractures</b>	24%
<b>iii)</b>	Multiple <b>Fractures</b> , including at least one <b>Complete Fracture</b>	15%
<b>iv)</b>	<b>All Other Fractures</b>	12%
<b>C.</b>	<b>Lower leg, skull, clavicle, ankle, elbows, upper or lower arm (including wrist but excluding Colles-type Fractures)</b>	

<b>i)</b>	Multiple <b>Fractures</b> , including at least one <b>Compound</b> and one <b>Complete Fracture</b>	24%
<b>ii)</b>	All other <b>Compound Fractures</b>	15%
<b>iii)</b>	Multiple <b>Fractures</b> , including at least one <b>Complete Fracture</b>	12%
<b>iv)</b>	<b>Depressed Fracture</b> of the skull needing surgical intervention	7%
<b>v)</b>	<b>All Other Fractures</b>	6%
<b>D.</b>	<b>Colles Type Fracture of the lower arm</b>	
<b>i)</b>	<b>Compound Fractures</b>	12%
<b>ii)</b>	All Other <b>Fractures</b>	6%
<b>E.</b>	<b>Shoulder blade, knee cap, sternum, hand (excluding fingers &amp; wrist) or foot (excluding toes or heel)</b>	
<b>i)</b>	<b>Compound Fractures</b>	12%
<b>ii)</b>	<b>All Other Fractures</b>	6%
<b>F.</b>	<b>Spinal Column (excluding Coccyx)</b>	
<b>i)</b>	All <b>Compression Fractures</b>	12%
<b>ii)</b>	All <b>Spinous Process, Transverse Process or Pedicle Fractures</b>	12%
<b>iii)</b>	<b>Fracture(s)</b> leading to <b>Permanent</b> neurological damage	12%
<b>iv)</b>	<b>All Other Fractures</b> in the <b>Spinal Column</b>	6%
<b>G.</b>	<b>Lower Jaw</b>	
<b>i)</b>	Multiple <b>Fractures</b> , including at least one <b>Compound</b> and one <b>Complete Fracture</b>	18%
<b>ii)</b>	All other <b>Compound Fractures</b>	12%
<b>iii)</b>	Multiple <b>Fractures</b> , including at least one <b>Complete Fracture</b>	10%
<b>iv)</b>	<b>All Other Fractures</b>	5%
<b>H.</b>	<b>Rib(s), cheekbone, Coccyx, upper jaw, nose, toe(s) of the same foot, thumb or finger(s) of the same hand</b>	
<b>i)</b>	Multiple <b>Fractures</b> , including at least one <b>Compound</b> and one <b>Complete</b>	10%
<b>ii)</b>	All other <b>Compound Fractures</b>	7%
<b>iii)</b>	Multiple <b>Fractures</b> , including at least one <b>Complete Fracture</b>	5%
<b>iv)</b>	<b>All Other Fractures</b>	2.5%
<b>2</b>	<b>Dislocation</b>	
	Only includes <b>Dislocations</b> requiring surgery under anaesthesia.	
<b>i)</b>	Spine or back (excluding slipped disc)	48%
<b>ii)</b>	Hip	30%
<b>iii)</b>	Knee	15%
<b>iv)</b>	Wrist or elbow	12%
<b>v)</b>	Ankle, shoulder blade or collarbone	6%
<b>vi)</b>	Any one finger or toe or jaw	2.4%
	This <b>Benefit</b> is limited to one payment for each joint dislocation as stated in 2i) to vi) above during the <b>Policy Period</b> .	

<b>Maximum Compensation payable in any one Accident or any one Policy Period</b>	100%
<p><sup>1</sup>The percentage of <b>Compensation</b> reflected in the Table of Events above is payable for each Event under Events A to H, regardless of the number of <b>Fractures</b> sustained on each bone or <b>Bone Site</b>. For example, in Event (1)(H)(iv), where an <b>Insured Person</b> suffers <b>All Other Fractures</b> on all three bones which make up a finger or suffers <b>Fractures</b> on more than one finger of the same hand, the <b>Insurance Company</b> will only pay the <b>Compensation</b> of 2.5% regardless of the number of <b>Fractures</b> sustained on the <b>Bone Site</b> (ie. a finger) or the number of fingers fractured on the same hand.</p>	

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

1. **All Other Fractures** means any Fracture other than a **Complete Fracture, Compound Fracture** or **Hairline Fracture** and not otherwise excluded by this **Policy**.
2. **Bone Site** means the bone and area as titled in Events A to H in the Table of Events (e.g. Event A. Hip or Pelvis (excluding thigh or coccyx)).
3. **Coccyx** means the four fused vertebrae located at the bottom of the spine.
4. **Colles Type Fracture** means a wrist Fracture that occurs when the radius bone in your forearm breaks. It's also known as a distal radius **Fracture**, transverse wrist **Fracture**, or a dinner-fork deformity of the wrist.
5. **Complete Fracture** means a Fracture in which the bone is broken completely across with no connection left between the bone pieces.
6. **Compound Fracture** means a **Fracture** where the bone breaks through the skin. This is also known as an open **Fracture**.
7. **Compression Fracture** means a vertebral bone in the spine that has decreased at least 15% to 20% in height due to a **Fracture**.
8. **Depressed Fracture** means a break in the skull in which bone fragments are pushed below the normal surface of the skull.
9. **Dislocation** means an abnormal separation in a joint, where two or more bones meet, which is diagnosed by a **Doctor** through radiological evidence and diagnostic techniques.
10. **Fracture** means a complete or incomplete break in the continuity of a bone and is diagnosed by a **Doctor** through radiological evidence and diagnostic techniques.
11. **Hairline Fracture** means small or thin crack(s) on the outer layer of the bone. This is also called a fissure fracture.
12. **Pathological Fracture** means a bone fracture caused by disease that result in weakness of the bone structure.

13. **Pedicle** means a stub of bone that connects the lamina to the vertebral body to form the vertebral arch and is on the posterior side (back) of your vertebrae.
14. **Spinal Column** refers to the vertebrae consisting of 33 individual bones that interlock with each other to form the spinal column.
15. **Spinous Process** means the bones that make up the spine which are called vertebrae. Each vertebra has a bony section that points out towards the back. These sections are called the spinal process. A spinous process fracture is a break in one or more of these sections.
16. **Transverse Process** refers to the small bony protrusions of the right and left side of each vertebrae of the spinal column. A transverse process fracture is a break or crack in one or more of these protrusions and which can occur along the **Spinal Column**.

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

In addition to the conditions set out in the General Policy Conditions, the following specific conditions apply:

1. The diagnosis of a listed Event from the Table of Events above must be made by a **Doctor** within 30 days from the date of **Accident**.
2. The **Insurance Company** will only pay for one **Fracture** in respect to each **Bone Site**, even if it is fractured in several areas of the same **Bone Site**.

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

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

1. Any **Fracture** caused by osteoporosis or any **Pathological Fracture**. If osteoporosis or **Pathological Fracture** is first diagnosed by a **Doctor** during the Policy Period, the **Insurance Company** will pay **Compensation** for the initial **Fracture** after diagnosis; however all subsequent **Fractures** will not be covered by this **Policy**.
2. Any **Hairline Fractures** and other **Fractures** classed as stress or fatigue fractures.
3. Any **Fractures** involving **Bone Sites** not listed in the Table of Events above.
4. Any repeat **Dislocations** arising from the same **Accident**.

## RECOVERY ASSISTANCE SERVICES

If the **Insured Person** is **Diagnosed** with a **Critical Illness** or **Critical Accident**, the **Insurance 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** or **Critical Accident** by the **Doctor** to be **Medically Necessary** for the **Insured Person's** recovery upon the **Insured Person** being **Diagnosed** with a **Critical Illness** or **Critical Accident**:

- a) Physiotherapy;
- b) Psychological counselling;
- c) Dietician/nutritionist;

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 for **Critical Illness** or **Critical Accident** 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) are provided to the **Insurance Company** to support the claim.
3. Either until
  1. the **Doctor** certifies that the **Insured Person** no longer requires 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 **Insurance Company** will not pay any claim under this **Policy** in connection with:

1. Any injury or sickness, other than a **Critical Illness** or **Critical Accident**.
2. Any **Recovery Assistance Service** sought which is not related to the **Critical Illness** or **Critical Accident 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.

## COMMITMENT RELIEF BENEFIT (DUE TO AN INJURY)

If the **Insured Person** is **Hospitalised** for a minimum period of 7 consecutive **Days** as a result of sustaining an **Injury** and upon discharge from the **Hospital** the **Doctor** prescribes post-hospitalisation recuperation, the **Insurance Company** will pay **Compensation** as shown in the **Schedule of Benefits**.

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

In addition to the conditions set out in the General Policy Conditions, the following specific conditions apply:

1. The **Hospitalisation** must commence during a valid **Policy Period**.
2. For this **Benefit** to be payable, the **Insured Person** must be confined in a **Hospital** as an **In-patient** for a minimum period of 7 consecutive **Days**.
3. **Hospitalisation** of an **Insured Person** shall be evidenced by **Insured Person's Hospital** discharge summary or **Hospital** billing statement and medical report.
4. This **Benefit** is payable upon **Insured Person's** discharge from the **Hospital** with a **Doctor's** report prescribing post-hospitalisation recuperation.
5. There will only be one payment for this **Benefit** regardless of successive **Hospitalisation** periods for the same **Injury**.

## 6. 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;
- 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**.

## Assessment Period

It is the period during which the **Insurance 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' of this **Policy** 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 **Certificate of Insurance/Policy Schedule**:

- a) Self : covers the **Certificate Holder/Policyholder**
- b) Parent – Child : covers the **Certificate Holder/Policyholder's Child**

as named in the **Certificate of Insurance/Policy Schedule** or endorsement, whichever is issued last.

## 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.

## Certificate Holder/Policyholder

**Certificate Holder/Policyholder** means the person named as the **Certificate Holder/Policyholder** in the **Certificate of Insurance/Policy Schedule** to whom this policy is issued to. Also, the **Certificate Holder/Policyholder** owns this insurance policy, is responsible for premium payments and has the right to exercise all privileges under this policy.

## Certificate of Insurance/Policy Schedule

**Certificate of Insurance / Policy Schedule** means the document showing details of the **Policy Period**, benefits under this **Policy** and the particulars of the **Certificate Holder/Policyholder** and eligible **insured persons**.

## Child/Children

A **Certificate Holder/Policyholder's** child who is either:

- a) A natural child of the **Certificate Holder/Policyholder**;
- b) Legally adopted by the **Certificate Holder/Policyholder**; or
- c) A legal stepchild of the **Certificate Holder/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 **Certificate Holder/Policyholder, Insured Person** or their legal representative, as applicable, making a claim against this **Policy**.

## Compensation

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

## 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 Accident

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

- 1) Major Head Trauma - resulting in permanent inability to perform Activities of Daily Living
- 2) Paralysis of Limbs
- 3) Third Degree Burns – of specified severity
- 4) Deafness – Permanent and Irreversible
- 5) Blindness – Permanent and Irreversible
- 6) Loss of Speech

## Critical Illness

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

- 1) Cancer of Specified Severity - and does not cover very early cancers
- 2) Heart Attack - of specified severity
- 3) Serious Coronary Artery Disease
- 4) Kidney Failure – requiring dialysis or kidney transplant
- 5) Stroke - resulting in Permanent Neurological Deficit with persisting clinical symptoms

## Day

It is a completed period of 24 hours.

## Diagnosis / Diagnosed

It is the definitive first diagnosis of a **Critical Illness, Non-Invasive Cancer (Carcinoma-In-Situ Or Early-Stage Cancer)** or **Critical Accident** on the **Insured Person** made by a **Doctor** based upon such specific evidence, as referred to in the definition of the particular **Critical Illness, Non-Invasive Cancer (Carcinoma-In-Situ Or Early-Stage Cancer)** or

**Critical Accident** concerned, or in the absence of such specific evidence, based upon radiological, clinical, histological or laboratory evidence acceptable to the **Insurance Company**.

Such **Diagnosis** must be supported by the **Insurance 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 **Insurance 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 **Insurance Company** and the opinion of such expert as to such **Diagnosis** shall be binding to both the **Insured Person** and the **Insurance 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 **Insurance Company** have the right to confirm all **Diagnosis** made by a **Doctor** with the **Insurance 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.

### Financial Markets Ombudsman Service (FMOS)

This is an independent body that provides a free and efficient avenue to help resolve financial disputes between the **Certificate Holder/Policyholder/Insured Person** and the **Insurance Company** under this **Policy** as an alternative to the Malaysian courts.

### 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** during the **Policy Period**. For the avoidance of doubt, **Hospitalisation** shall be evidenced by daily boarding charges imposed by a **Hospital**.

## **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**.

## **Insurance Company**

Insurance Company refers to AIG Malaysia Insurance Berhad (200701037463).

## **Insured Person**

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

## **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.

## **Master Policyholder**

**Master Policyholder** means the legal entity named as master policyholder in the **Master Policy Schedule**.

## **Master Policy Schedule**

**Master Policy Schedule** means the document issued together with this **Policy** detailing the particulars of the **Master Policyholder**, **Policy Period** and **Benefits** under this Policy.

## **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.

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### Monthly Renewable Policy

It is a policy:

- a) Where the **Certificate Holder/Policyholder** pays **Premium** on a monthly basis prior to the **Policy Start Date**;
- b) Where coverage under the policy is for 1 calendar month following the **Policy Start Date** and continues for each calendar month for which **Premium** is received by the **Insurance Company** ; and
- c) Which is renewable on a monthly basis.

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### 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.

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### Overseas

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

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### Parent or Legal Guardian

Anybody who:

- 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 **Certificate Holder/Policyholder** and approved by the **Insurance Company** for this **Policy**, as shown in the **Certificate of Insurance/Policy Schedule**.

## Policy

Refers to this insurance contract which consists of the Policy wording, the latest **Certificate of Insurance/Policy Schedule** and any other documents the **Insurance Company** may issue to the **Certificate Holder/Policyholder** or **Insured Person** that will form part of this **Policy** (e.g. endorsements).

## Policy Effective Date

It refers to the later of:

- a) the **Policy Start Date** as specified on the first **Certificate of Insurance/Policy Schedule** issued to the **Certificate Holder/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 **Certificate of Insurance/Policy Schedule** for this **Policy**;
- (b) the date this **Policy** is cancelled or not renewed; or
- (c) the date this **Policy** is automatically terminated as provided under section '9. 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 **Certificate of Insurance/Policy Schedule**.

### Policy Start Date

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

### Premium

It is the payment due to be paid to the **Insurance Company** by the **Certificate Holder/Policyholder** for this insurance **Policy** on the **Premium Due Date**.

### Premium Due Date

- i. First **Premium** - The first **Premium** is due on the next working day following the day the **Certificate Holder/Policyholder** agrees to purchase this **Policy**.
- ii. Monthly Renewal **Premium** - Monthly renewal **Premiums** are due on the first day of each month.

### Pre-Existing Condition

Any illness or injury,

- (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 Medical Condition** or cancer diagnosed before the **Policy Effective Date**.

### Schedule of Benefits

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

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### Spouse

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

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### 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**.

## 7. GENERAL POLICY CONDITIONS

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### 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**.

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### 2) COVER SELECTION

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

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### 3) REASONABLE CARE

To receive **Compensation** under this **Policy**, the **Certificate Holder/Policyholder** and **Insured Person** must at all times take reasonable precautions and act in a prudent way to prevent and mitigate accident or loss.

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### 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**.

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### 5) DISPUTE RESOLUTION

Any dispute or difference which may arise between the **Certificate Holder/Policyholder/Insured Person** and the **Insurance Company** on any matters relating to this **Policy** involving amounts exceeding RM250,000 shall be referred to the Malaysian courts. Any dispute or difference where the disputed amount is less than or equal to RM250,000, the **Certificate Holder/Policyholder/Insured Person** may refer the matter to the **Financial Market Ombudsman Services (FMOS)** to resolve the dispute. All disputes or differences which may arise between the **Certificate Holder/Policyholder/Insured Person** and the **Insurance Company** must be referred to the Malaysian courts and / or

the **Financial Market Ombudsman Services (FMOS)** within a reasonable time from the date the decision of the claim is communicated to the **Certificate Holder/Policyholder/Insured Person**.

## 6) GEOGRAPHICAL LIMITS & TERRITORIAL LIMITS

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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 '7. General Policy Conditions, Item 7 – Overseas Hospitalisation and Treatment' and '7. General Policy Conditions, Item 21– Sanction'.

## 7) OVERSEAS HOSPITALISATION AND TREATMENT

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The **Insurance Company** will only cover the **Insured Person's** overseas treatment if the **Overseas** travel is not for the purpose of 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 an illness diagnosed or **Injury** sustained in Malaysia where treatment can reasonably be postponed until return to Malaysia.

## 8) DUPLICATION OF COVER

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No person shall be insured under more than one **Policy** issued by the **Insurance Company** under this product. In the event the person is insured under more than one such **Policy**, the **Insurance Company** shall consider that 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. The **Insurance Company** shall refund any duplicated **Premium** payment which may have been made by or on behalf of that **Insured Person**.

## 9) OFFSET CLAUSE

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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 **Insurance 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 **Certificate of Insurance/Policy Schedule**. This condition is only applicable to **Benefits** whereby payment is on a reimbursement basis.

## 10) PREMIUM

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This condition applies as each and every **Premium** payment becomes due and cannot be disregarded by the **Certificate holder/Policyholder** because the **Insurance Company** have previously accepted a **Premium** payment for their insurance cover.

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## A. PREMIUM PAYABLE

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### **Monthly Renewable Policy**

The **Premium** is payable monthly. The **Premium** for this **Policy** will be paid to the **Insurance Company** by the **Certificate Holder/Policyholder** on each **Premium Due Date**. The **Premium** payable and the **Insurance Company's** billing arrangement is as specified by the **Insurance Company** and agreed to by the **Master Policyholder** or **Certificate Holder/Policyholder** during the application process.

The **Insurance Company** will cancel this **Policy** if the **Certificate Holder/Policyholder** fails to make the **Premium** payment in the time and manner required by the **Insurance Company**. No benefits will be payable for any claim that occurs during a period for which **Premium** was not received.

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## B. FAILURE OF PREMIUM PAYMENT

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The **Insurance Company** will cancel this **Policy** if the **Certificate Holder/Policyholder** fails to make the **Premium** payment in the time and manner required by the **Insurance Company**. The **Insurance Company** will provide cover under this **Policy** for the period for which premium had been received and this **Policy** shall terminate upon the expiry of such period. No **Benefits** will be payable for any claim that occurs during a period for which premium was not received.

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## C. CHANGES TO PREMIUM PAYABLE

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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 renewal date.
2. The **Insurance Company** may vary **Premium** payments for the **Policy** due to underwriting reasons. In such instance the **Insurance Company** will notify the **Certificate Holder/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 **Insurance Company** are acceptable, the **Certificate Holder/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 **Certificate Holder/Policyholder** on the **Premium Due Date**.

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## 11) RENEWAL

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Unless otherwise stated by **us** and as agreed with the **Master Policyholder**, this is a monthly renewable policy and is automatically renewed on a monthly basis subject to the terms and conditions of the policy and successful collection of premium by the **Insurance Company**. The **Certificate holder/policyholder's** payment of the monthly premium and the receipt and acceptance of payment by the **Insurance Company** will constitute consent to renewal of this

policy. In the event the **Insurance Company** elect to not renew this policy due to underwriting reasons, **we** will notify the **Certificate holder/Policyholder** in writing at least 30 days before their next **Premium Due Date**.

## 12) MISSTATEMENT OF AGE

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

## 13) MISREPRESENTATION OR FRAUD

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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 **Insurance Company** will not refund any **Premiums** paid and the **Insurance Company** will not consider making payments for any claims submitted to the **Insurance Company**. The **Insurance Company** will report the matter to the police if deemed necessary. The **Insurance Company** also reserves the right to recover any amount paid to the **Insured Person** in respect to any fraudulent claims submitted.

## 14) POLICY CHANGES

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### A. CHANGES OF THE TERMS OR CONDITIONS BY THE INSURANCE COMPANY

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The **Insurance Company** reserves the right to change the terms or conditions of this **Policy** by giving the **Certificate Holder/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**.

#### **Important note:**

1. If the changes in terms or conditions by the **Insurance Company** are acceptable to the **Certificate Holder/Policyholder**, then this **Policy** will continue. If the changes are not acceptable, the **Insured Person** may cancel this **Policy** under section '[8. Cancellation & Refund](#)'.
2. No alteration to this **Policy** shall be valid unless approved in writing by the **Insurance 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

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The **Policyholder** will give immediate written notice to the **Insurance 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 **Injury** or illness arising out of or in the course of an occupation of greater risk than the occupation disclosed in **Certificate Holder/Policyholder's** application, unless the **Insurance Company** had agreed to the change in occupation; or
- (b) Any **Injury** or illness where the **Insurance Company** has been prejudiced by the non-disclosure of change in occupation.

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### C. CHANGE OF USUAL COUNTRY OF RESIDENCE

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The **Certificate Holder/Policyholder** must inform the **Insurance 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 **Insurance Company** will determine at its sole discretion to either cover the **Insured Person** on the same terms and conditions or terminate this **Policy**.

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### D. CHANGES IN PLAN

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#### **Renewable Policy-**

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

- a) that no claim has been paid under this **Policy**;
- b) the **Policy** must have been continuously renewed for the preceding 12 consecutive months without interruption from the date of request for change of **Plan** or optional **Benefits**; and
- c) the **Insured Person** is below the age of 60 years at time of renewal.

Change of Plan is allowed once during the policy lifetime.

Any change in **Plan** is subject to the **Insurance 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 **Insurance 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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## 15) MEDICAL EXAMINATION AND TREATMENT

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The **Insurance 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 **Insurance 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, Non-Invasive Cancer** or **Injury** whichever is appropriate, obtain and follow the advice of a duly qualified **Doctor** and the **Insurance 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.

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## 16) PERSONAL DATA USE

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The **Certificate Holder/Policyholder** is deemed to have read, understood, and consented to the collection and subsequent processing of their personal information by the **Insurance Company** (whether obtained during the

application process or administration of this **Policy**) in accordance with, the **Insurance Company's** Privacy Notice as from time to time published on the website at <https://www.aig.my/privacy-notice>. If the **Certificate Holder/Policyholder** submits information relating to other individuals, the **Certificate Holder/Policyholder** further represents and warrants that they have the authority to provide information relating to the other individuals to the **Insurance Company**, that the **Certificate Holder/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 **Insurance Company**, and that the other individuals agree and consent that the **Insurance Company** may collect, use and process his/her personal information in accordance with the Privacy Notice. The **Certificate Holder/Policyholder** reserves the right to obtain access, request correction or withdraw their consent to the use of any of their personal information held by the **Insurance Company**. Such request can be made by writing to the **Insurance Company** at:

Attn: Customer Care  
AIG Malaysia Insurance Berhad  
P O Box 11768,  
50756 Kuala Lumpur

Email: AIGMYCare@aig.com  
Phone: 1800-88-8811 / 603 2118 0188  
Fax: 603-21180288

## 17) CURRENCY

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- (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 **Certificate Holder/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 **Certificate Holder/Policyholder** will bear all the administration and costs of conversion.

## 18) CONTRACT RIGHTS OF 3RD PARTIES

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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**.

## 19) NOMINATION

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All **Benefits** payable following the death of the **Insured Person** is payable to the nominee(s) elected by the **Certificate Holder/Policyholder** and in the event of failure of the **Certificate Holder/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 **Insurance Company** and the **Certificate Holder/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 **Insurance 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 **Certificate Holder/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 **Insurance Company** at the address provided below or to insurance agent (if applicable).

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

## 20) RIGHTS OF ASSIGNMENT

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

## 21) SANCTION

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The **Insurance 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 **Insurance Company**, the **Insurance 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.

## 22) NOTICES TO THE CERTIFICATE HOLDER/POLICYHOLDER

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

# 8. CANCELLATION & REFUND

## CANCELLATION RIGHT OF INSURANCE COMPANY

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The **Insurance Company** can cancel this **Policy**:

1. by giving 30 Days' prior written notice to the **Certificate Holder/Policyholder's** last known address or via email.
2. immediately if the **Certificate Holder/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 **Certificate Holder/Policyholder** in the event of **War** in Malaysia.

On cancellation of the **Policy**:

- (a) If no claim has been made - unless otherwise advised by the **Insurance Company** and the **Certificate Holder/Policyholder** agrees, the **Insurance Company** will continue to provide cover under this **Policy** for the remaining **Policy Period** for which **Premium** had been received and this **Policy** shall terminate upon the expiry of such period.
- (b) If a claim has been paid by the **Insurance 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 **Insurance Company** and the **Certificate Holder/Policyholder** finalise the claim and subsequently, if the claim is paid, no return **Premium** will be paid to the **Certificate Holder/Policyholder**.

## CANCELLATION RIGHT OF THE CERTIFICATE HOLDER/POLICYHOLDER

Provided there is no claim made on the **Policy**, the **Certificate Holder/Policyholder** can cancel this **Policy** by giving 30 days' prior written notice to the **Insurance 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 **Certificate Holder/Policyholder** - unless otherwise advised by the **Insurance Company** and the **Certificate Holder/Policyholder** agrees, the **Insurance Company** will continue to provide cover under this **Policy** for the remaining **Policy Period** for which **Premium** had been received and this **Policy** shall terminate upon the expiry of such period.

### Contact Information:

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

Telephone: 1800 88 8811 / 603 2118 0188

Facsimile: 603- 2118 0288

Email: [AIGMYCare@aig.com](mailto:AIGMYCare@aig.com)

## 9. 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 '[8. Cancellation & Refund](#)';
- b) of the **Insured Person's** death, from any cause;
- c) the **Certificate holder/Policyholder** requests that an **insured person** be removed from this **Policy**;
- d) the **Insured Person** ceases to satisfy any of the requirements as specified under section '[2. Eligibility](#)';
- e) 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

- f) any fraud or misrepresentation to the **Insurance Company** discovered as mentioned under section '7. [General Policy Conditions – Item 13. Misrepresentation or Fraud](#)'.

## 10. GENERAL POLICY EXCLUSIONS

The following exclusions apply to all sections of this Policy.

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

1. Any **Critical Illness** or **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**, **Non-Invasive Cancer** or **Critical Accident**.
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** 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** or **Non-Invasive Cancer**, but the **Diagnosis** does not meet our definition of **Critical Illness** or **Non-Invasive Cancer**.
7. Any **Critical Illness** or **Non-Invasive Cancer** resulting directly from alcohol or drug abuse.
8. Any effects or influence of drugs and alcohol in an **Insured Person**, unless administered by a **Doctor** and taken in accordance with the directions of a **Doctor**;
9. Any injury, **Critical Illness** or **Non-Invasive Cancer** due to a self-inflicted injury, suicide or attempted suicide whether sane or insane, deliberate or reckless exposure to danger.
10. Any injury, **Critical Illness** or **Non-Invasive Cancer** contributed or aggravated or prolonged by childbirth or pregnancy before cover started under this **Policy**.
11. When the **Insured Person**, the **Certificate Holder/Policyholder** or their legal representatives do not give the **Insurance Company** medical or other evidence that the **Insurance Company** requires to confirm an **Insured Person's** claim.

12. When the **Insurance Company** finds the **Insured Person** or the **Certificate Holder/Policyholder** has given inaccurate, incomplete or false information on the application which would have affected the **Insurance Company's** decision to offer this **Cover**, or would have led the **Insurance Company** to offer it with different conditions.
13. 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. This does not apply to '[Recovery Assistance Service](#)' **Benefit**.
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.
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.
- 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. 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 luge, bobsledding, 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.
18. Any deliberate provocation of the **Insured Person** against another person that results in an injury.
  19. An **Insured Person** committing or attempting to commit any criminal or illegal act (including traffic offences).
  20. Where payment would violate a government prohibition, regulation or law.
  21. 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.
  22. Any injury sustained whilst the **Insured Person** is riding on a motorcycle without a safety helmet either as a rider or pillion-rider.
  23. Any injury arising directly or indirectly due to osteoporosis.
  24. Cosmetic, plastic surgery or elective surgery or treatment, unless necessitated by an **Injury** caused by an **Accident**.
  25. pregnancy, miscarriage, abortion, childbirth, sterilisation, contraception as well as treatment for infertility or birth control treatments or any complications;
  26. any **Hospitalisation** or expenses for:
    - i) any routine health checks;
    - ii) any 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**;
    - iv) receiving treatment not incidental to the treatment or diagnosis of an **Injury** or illness;

- v) treating an **Injury** or illness for which such treatments are provided free; or
- vi) weight reduction or gain.

## 11. CLAIM CONDITIONS

### STEPS TO MAKE A CLAIM

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1. **Step 1:** The **Certificate Holder/Policyholder** or **Insured Person** must notify the **Insurance Company** immediately after the event which could give rise to a claim under 'Claim Notification'.
  - (i) Call the Insurance Company at 1800 88 8811; or
  - (ii) Complete and submit a claim online via [this link](#).
2. **Step 2:** The **Certificate Holder/Policyholder** or **Insured Person** must prepare the relevant basic supporting documents according to the nature of claim.

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

### COMPLIANCE

---

The **Insurance 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** or **Non-Invasive Cancer**, and related additional **Benefits** when claiming **Compensation**.

### CLAIM NOTIFICATION

---

- (a) The **Insurance Company** must be notified as soon as it is reasonably practical and in any event within 30 days after the date of **Accident** or the **Diagnosis** of a **Critical Illness** or **Non-Invasive Cancer** which leads to a claim.
- (b) Failure to comply with (a) above may result in the **Insurance 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 **Insurance 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 **Insurance Company**.

### BURDEN OF PROOF

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

#### CLAIMS EVIDENCE / INFORMATION

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- (a) The **Insurance Company** must be provided with all reasonable and necessary evidence required by the **Insurance Company** to support a claim. Information provided to the **Insurance 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 **Insurance Company** will confirm the additional information required.
- (b) If the **Insurance Company** does not receive the information it requires within the time period advised, the **Insurance 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 **Insurance 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.
- (d) The **Insurance Company** may refuse to refund any expense for which the **Claimant** cannot provide original receipts or invoices.
- (e) The **Insurance Company** may require the **Insured Person** undergo a medical examination by a consultant **Doctor** appointed by the **Insurance Company** before the initial or additional **Compensation** can be paid.
- (f) The **Insurance 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

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- (a) **Compensation** will be paid in accordance with the **Policy** terms and conditions. It can only be made once the **Insurance 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 **Certificate of Insurance/Policy Schedule**. Any **Compensation** that the **Insurance Company** makes under this **Policy** will not exceed the limit shown in the **Certificate of Insurance/Policy Schedule** for the claim event. **Compensation** under each **Benefit** is included only for the events specified in the **Certificate of Insurance/Policy Schedule**.

- (c) Unless otherwise specified in this **Policy**, payments or reimbursements will be made at the **Insurance 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 **Insurance Company's** claims process, the **Claimant** is to render full cooperation to the **Insurance Company** and to its appointed service providers, vendors and experts, including providing face to face interviews, if and when required.

## SUBROGATION

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

## RIGHTS TO RECOVERY

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

## 12. COMPLAINTS PROCEDURE

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

Complaints Handling Unit  
P O Box 11768,  
50756 Kuala Lumpur

Phone: 1 800 88 8811  
Fax: 603- 2118 0288  
Email: [AIGMYComplain@aig.com](mailto:AIGMYComplain@aig.com)

- (b) Any **Certificate Holder/Policyholder** who is not satisfied with the decision of the **Insurance Company** may refer to the Financial Markets Ombudsman Service (FMOS) giving details of the dispute, the name of the insurance company and the policy number. The contact details of the FMOS are as follows:

Financial Market Ombudsman Services  
(Formerly known as Ombudsman for Financial Services)  
Level 14, Main Block  
Menara Takaful Malaysia  
No 4, Jalan Sultan Sulaiman  
50000 Kuala Lumpur

Phone: 603-2272 2811  
Fax: 603-2272 1577  
Email: [www.fmos.org.my](http://www.fmos.org.my)

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

Bank Negara Malaysia  
Laman Informasi Nasihat dan Khidmat (BNMLINK)  
4th Floor, Podium Bangunan AICB,  
No. 10, Jalan Dato' Onn,  
50480 Kuala Lumpur

Phone: 1-300-88-5465 (1300-88-LINK)/ 03-21741717(Overseas)  
Fax: 603-2174 1515  
Email: [bnm.gov.my/BNMLINK](mailto:bnm.gov.my/BNMLINK)

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

## APPENDIX A – CRITICAL ILLNESS DEFINITIONS

The following are definitions of terms used in the definition of **Critical Illness** and **Critical Accident**, 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.

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## 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:

- (i) 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.

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## 4. 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.

#### 5. 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.

#### 6. 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.

#### 7. 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 **Injury**. A minimum **Assessment Period** of 6 months applies.

#### 8. THIRD DEGREE BURNS – OF SPECIFIED SEVERITY

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

#### 9. DEAFNESS – PERMANENT AND IRREVERSIBLE

**Permanent** and **Irreversible** loss of hearing as a result of **Injury** 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**.

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## 10. BLINDNESS – PERMANENT AND IRREVERSIBLE

**Permanent** and **Irreversible** loss of sight as a result of **Injury** 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.

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## 11. LOSS OF SPEECH

Total, **Permanent** and **Irreversible** loss of the ability to speak as a result of **Injury**. A minimum **Assessment Period** of 6 months applies. Medical evidence to confirm **Injury** 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.