Great Eastern General Insurance (Malaysia) Berhad (102249-P)
(Formerly known as Overseas Assurance Corporation (Malaysia) Berhad)
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Easi Health – SME

STAMP DUTY PAID

SCHEDULE OF BENEFITS

HOSPITALISATION & SURGICAL BENEFITS

Insured Benefits (RM)	Plan / Sum Insured (RM)				
	SM400	**SM300**	**SM250**	**SM160**	**SM120**
1. Hospital Room & Board *(Limit per day, subject to a maximum of 180 days per disability)*	400	300	250	160	120
2. Intensive Care Unit *(Subject to a maximum of 30 days)* 3. Hospital Supplies and Services 4. Surgical Fees *(Subject to a maximum of 90 days)* 5. Anaesthetist Fees 6. Operating Theatre 7. In Hospital Physician Visit *(limited to two visits per day and subject to a maximum of 180 days)* 8. Pre-hospital Diagnostic Tests *(within 90 days preceding Hospitalisation)* 9. Pre-hospital Specialist Consultation *(within 90 days preceding Hospitalisation)* *10.* Second Surgical Opinion 11. Post-hospitalisation Treatment *(within 90 days from discharge)* 12. Organ Transplant 13. Outpatient Cancer Treatment 14. Outpatient Kidney Dialysis Treatment 15. Ambulance Fees *(by road only)* *16.* Day Surgery Benefit *(Subject to a maximum of 90 days per disability)* *17.* Emergency Accidental Outpatient Treatment *(within 24 hours after the accident and follow-up to 90 days)* *18.* Emergency Accidental Dental Treatment *(within 24 hours after the accident and follow-up to 14 days)*	As charged subject to Overall Annual Limit provided the charges made are Reasonable and Customary subject further to the ACT* ** ACT refers to the Fee Schedule – Professional Fee Schedule specified in the Thirteenth Schedule under the Private Healthcare Facilities and Services Act 1998, Private Healthcare Facilities and Services(Private Hospitals and Other Private Health Care Facilities) (Amendment) Order 2013.*				
19. Daily Cash Allowance at Government Hospital *(Subject to a maximum of 180 days)*	250	200	150	100	80
20. Accidental Death Benefit	15,000	15,000	10,000	10,000	10,000
21. Bereavement Allowance *(accidental cause only)*	2,000	1,500	1,500	1,000	1,000
22. Medical Report	100	100	100	100	100
23. Prevailing Goods and Service Tax (GST) or other prevailing value added tax or consumption tax	Yes	Yes	Yes	Yes	Yes
Overall Annual Limit (Benefits 1 to 23)	**100,000**	**80,000**	**50,000**	**30,000**	**20,000**

OPTIONAL CLINICAL BENEFITS
OUTPATIENT GENERAL PRACTITIONER AND SPECIALIST CARE
(Applicable to Group size with twenty (20) employees and above)

These benefits cover General Practitioner (GP) and Specialist Practitioner (SP) care at outpatient levels and allow cashless access to GP Panel and SP Panel.

SCHEDULE OF BENEFITS (RM)	GP1	GP2
A) OUT-PATIENT GENERAL PRACTITIONER CARE (GP)		
Consultation	Cashless Covered only at GP Panel Clinics	
Medication		
Diagnostic Test		
Out-Patient Surgical Procedure		
Preventive Screening: Pap Smear (Once per policy year)		
Child Mandatory Immunisation (As per MOH protocol)		
Emergency Non-Panel Clinic GP Visit	On Reimbursement Basis	
Emergency Overseas GP Visit	On Reimbursement Basis Maximum up to RM60 per Visit	
OVERALL ANNUAL LIMIT	**Unlimited**	**Unlimited**
B) OUT-PATIENT SPECIALIST CARE (SP)		
Consultation	Cashless Covered only with Written Referral from GP Panel Clinic at Panel SP	
Medication		
Diagnostic Test		
Out-Patient Surgical Procedure		
Emergency Overseas SP Visit	On Reimbursement Basis Maximum up to RM200 per Visit	
OVERALL ANNUAL LIMIT	**2,000**	**1,300**

WHEREAS the Policyholder named in the Policy Schedule hereto has applied to **Great Eastern General Insurance (Malaysia) Berhad** (hereinafter called "the Company") for the insurance herein described and has paid or agreed to pay the premium stated in the Policy Schedule as consideration for the insurance hereinafter contained.

Now this Policy of Insurance Witnesses that if the Insured Person is confined to a hospital for treatment during the Period of Insurance necessitated by any sickness, disease, illness or accidental injury, the Company will subject to the terms and conditions of and endorsed on this Policy, pay to the Insured Person(s) or his legal personal representative the sum or sums stated in the Schedule of Benefits.

Provided always that

(a) the liability of the Company shall not exceed the Overall Annual Limit set out in the Schedule of Benefits for any one period of insurance for any one Insured Person and in compliance with the fee schedule – Professional Fee specified in the Thirteenth Schedule under Private Healthcare Facilities and Services ACT 1998, Private Healthcare Facilities and Services (Private Hospitals and Other Private Health Care Facilities) (Amendment) Order 2013 [*herein referred to as the ACT*].

(b) this Policy shall become effective as of the date stated in the Policy Schedule. This Policy shall be issued for one year and at the end of each period of insurance may be renewed for another year subject to the terms and conditions set forth.

(c) in the event of any change in the Law(s) or the substitution of other legislation therefore this Policy shall remain in force but the liability of the Company shall be limited to such sum as the Company would have been liable to pay if the Law(s) had remained unaltered.

THIS POLICY is subject to provisions, conditions and limitations as contained herein or as may be endorsed hereon.

DEFINITIONS

In this Policy where the context so admits the words used in singular shall include plural and masculine shall include the feminine. The following words and expressions shall have the following meaning.

1. **"Policyholder"** shall mean a person or a corporate body to whom the Policy has been issued in respect of cover for persons specifically identified as Insured Persons in this Policy.

2. **"Insured Person"** shall mean the person described in the Policy Schedule including his/her Dependant (if applicable).

3. **"Employee's Dependants"** shall mean:-

   (a) a legally married spouse who is nineteen (19) years of age and up to sixty (60) years of age

(b) unmarried children over thirty (30) days old and up to nineteen (19) years of age or up to twenty-four (24) years of age if still on full-time higher education, and who are not gainfully employed.

4. **"Child"** shall mean any person who has attained the age of thirty (30) days and is an unmarried person, is financially dependent upon the Insured Person and up to nineteen (19) years of age, or up to twenty four (24) years of age if still on full time higher education, and who are not gainfully employed.

5. **"Spouse"** shall mean your legally married wife or husband named in the Policy Schedule. For the purpose of this Policy, a common law marriage is not considered a legal marriage except as provided under the Law Reform (Marriage & Divorce) Act 1976. For marriage in accordance with Islamic Law the term "Spouse" is limited to one (1) Spouse as named in the Policy Schedule.

6. **"Accident"** shall mean a sudden, unintentional, unexpected, unusual, and specific event that occurs at an identifiable time and place which shall, independently of any other cause, be the sole cause of bodily injury.

7. **"Injury"** shall mean bodily injury caused solely by **Accident.**

8. **"Sickness, Disease or Illness"** shall mean a physical condition marked by a pathological deviation from the normal healthy state.

9. **"Emergency"** shall mean treatment needed in the event whereby immediate medical attention is required within twelve (12) hours for injury, illness or symptoms which are sudden and severe failing which will be life-threatening (e.g. accident and heart attack), or lead to significant deterioration of health.

10. **"Hospital"** shall mean only an establishment duly constituted and registered as a hospital for the care and treatment of sick and injured persons as paying bed-patients, and which:-
    (a) has facilities for diagnosis and major surgery,
    (b) provides twenty-four (24) hour a day nursing services by registered and graduate nurses,
    (c) is under the supervision of a Physician, and
    (d) is not primarily a clinic; a place for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.

11. **"Hospitalisation" or "Confined in a Hospital"** shall mean admission to a Hospital as a registered in-patient for Medically Necessary treatments for a covered Disability upon recommendation of a Physician. A patient shall not be considered as an in-patient if the patient does not physically stay in the hospital for the whole period of confinement.

12. **"Intensive Care Unit"** shall mean a section within a Hospital which is designated as an Intensive Care Unit by the Hospital, and which is maintained on a twenty-four (24) hour basis solely for treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.

13. **"Malaysian Government Hospital"** shall mean a hospital which charges of services are subject to the Fee Act 1951 Fees (Medical) Order 1982 and/or its subsequent amendments if any.

14. **"Out-patient"** shall mean the Insured Person is receiving medical care or treatment without being hospitalised and includes treatment in a Daycare centre.

15. **"Reasonable and Customary Charges"** shall mean charges for medical care which is medically necessary shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individual of the same sex and of comparable age for a similar sickness, disease or injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured Person's medical condition.

16. **"Eligible expenses"** shall mean Medically Necessary expenses incurred during the Period of Insurance due to a covered Disability but not exceeding the limits in the Schedule of Benefits

17. **"Medically Necessary"** shall mean a medical service which is:-
    (a) consistent with the diagnosis and customary medical treatment for a covered Disability, and
    (b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits, and
    (c) not for the convenience of the Insured Person or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient), and
    (d) not of an experimental, investigational or research nature, preventive or screening nature, and
    (e) for which the charges are fair and reasonable and customary for the Disability.

18. **"Doctor or Physician or Surgeon"** shall mean a registered medical practitioner qualified and licensed to practice western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice, but excluding a doctor, physician or surgeon who is the insured himself.

19. **"Specialist"** shall mean a medical or dental practitioner registered and licensed as such in the geographical area of his practice where treatment takes place and who is classified by the appropriate health authorities as a person with superior and special expertise in specified fields of medicine or dentistry, but excluding a physician or surgeon who is the insured himself.

20. **"Dentist"** shall mean a person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided, but excluding a physician or surgeon who is the insured himself.

21. **"Policy Year"** shall mean the one year period including the effective date of commencement of Insurance and immediately following that date, or the one year period following the Renewal or Renewed Policy.

22. **"Renewal or Renewed Policy"** shall mean a Policy which has been renewed without any lapse of time upon expiry of a preceding Policy with the same content.

23. **"Disability"** shall mean a Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes.

24. **"Any one Disability"** shall mean all of the periods of disability arising from the same cause including any and all complications there from except that if the Insured Person completely recovers and remain free from further treatment (including drugs, medicines, special diet or injection or advice for the condition) of the disability for at least ninety (90) days following the latest date of discharge and subsequent disability from the same cause shall be considered as though it were a new disability.

25. **"Pre-existing Illness"** shall mean disabilities that existed before the effective date of insurance that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:-
    (a) the Insured Person had received or is receiving treatment; or
    (b) medical advice, diagnosis, care or treatment has been recommended; or
    (c) clear and distinct symptoms are or were evident; or
    (d) its existence would have been apparent to a reasonable person in the circumstances.

26. **"Specified Illnesses"** shall mean the following disabilities and its related complications, occurring within the first one hundred twenty (120) days effective date of insurance of the Insured Person:
    (a) Hypertension, diabetes mellitus and Cardiovascular disease
    (b) All tumours, cancers, cysts, nodules, polyps, stones of the urinary system and biliary system
    (c) All ear, nose (including sinuses) and throat conditions
    (d) Hernias, haemorrhoids, fistulae, hydrocele, varicocele
    (e) Endometriosis including disease of the Reproduction system
    (f) Vertebro-spinal disorders (including disc) and knee conditions.

27. **"Congenital Conditions"** shall mean any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within six (6) months from the time of birth. This will include hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the insured was continuously covered under this Policy.

28. **"Waiting Period"** shall mean the first thirty (30) days between the beginning of an Insured Person's disability and the commencement of this Policy date/ reinstatement date and is applied only when the person is first covered. This shall not be applicable after the first year of cover. However, if there is a break in insurance, the Waiting Period will apply again.

29. **"Surgery"** shall mean any of the following medical procedures:

(a) To incise, excise or electrocauterize any organ or body part, except for dental services.

(b) To repair, revise, or reconstruct any organ or body part.

(c) To reduce by manipulation a fracture or dislocation.

(d) Use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or urethra.

30. **"Day Surgery"** A patient who needs the use of a recovery facility for a surgical procedure on a pre-plan basis at the hospital/ specialist clinic (but not for overnight stay).

31. **"Prescribed Medicines"** shall mean medicines that are dispensed by a Physician, a registered pharmacist or a Hospital and which have been prescribed by a Physician or Specialist in respect of treatment for a covered Disability.

32. **"Overall Annual Limit"** Benefits payable in respect of expenses incurred for treatment provided to the Insured Person during the period of insurance shall be limited to Overall Annual Limits as stated in the Schedule of Benefits irrespective of a type/types of disability. In the event the Overall Annual Limit having been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining policy year.

SPECIAL PROVISIONS

1. **PARTICIPATION REQUIREMENT**

This insurance is afforded on a non-contributory basis, where the premium payments are borne solely by the Employer, All eligible employees shall participate.

2. **PERSONS ELIGIBLE**

(a) the Policyholder's full-time permanent employees below sixty (60) and renewable up to seventy (70) years of age at next birthday.

(b) the Employee's Dependants

(i) Dependants may only be included in the Policy upon the date the employee becomes eligible.

(ii) The spouse of a newly married employee becomes eligible on the date of his/ her marriage to the employee already covered;

(iii) A new born child becomes eligible on the thirtieth (30th) day following the date of its birth.

3. **EFFECTIVE DATE OF COVER OF EMPLOYEE & DEPENDANT**

The insurance of each eligible employee and/ or his Dependants shall take effect on the date the Employer notifies the Company and approved by the Company.

4. **TERMINATION OF COVER**

Cover under this Policy shall automatically cease either: -

(a) at midnight standard Malaysian Time on the last day of the Period of Insurance unless an Insured Person is confined to a Hospital at such time, in which case, the time of termination

in respect of that Insured Person shall be extended to the time he is discharged from Hospital,

(b) on the date this Policy is terminated by either the Policyholder or the Company,

(c) on the due date the required premium is not paid

whichever shall first occur.

Cover for an Employee shall automatically cease on the earliest happening of the following events: -

(a) on the Policy Anniversary Date immediately following the Employee's seventh (70^{th})birthday,

(b) on the date of termination of the Employee's employment,

(c) on the death of the Employee,

(d) on the date the Overall Annual Limit is exhausted

Cover for an Employee's Dependants shall automatically cease on the earliest of the following events:

(a) on the date of termination of cover of the Employee,

(b) on the death of such Dependant,

(c) on the Policy Anniversary Date immediately following the date such dependant ceases to be a Dependant as herein defined or the spouse's seventh (70^{th})birthday,

(d) on the date the Overall Annual Limit is exhausted

5. **MINIMUM GROUP SIZE**

In all cases the number of employees to be insured under the Policy shall not be less than the minimum requirement of five (5) employees.

DESCRIPTIONS OF BENEFITS

HOSPITALISATION & SURGICAL

1. **HOSPITAL ROOM AND BOARD**

Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Person's confinement, but in no event shall the benefit exceed, for any one day, the rate of Room and Board Benefit, and the maximum number of days as set forth in the Schedule of Benefits. The Insured Person will only be entitled to this benefit while confined to a Hospital as an in-patient.

2. **INTENSIVE CARE UNIT**

Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an in-patient in the Intensive Care Unit of the Hospital. This benefit shall be payable equal to the actual charges made by the Hospital subject to the maximum benefit for any one day, and maximum number of days, as set forth in the Schedule of Benefits. Where the period of confinement in an Intensive Care Unit exceeds the maximum set forth in the Schedule of Benefits, reimbursement will be restricted to the standard Daily Hospital Room and Board rate.

No Hospital Room and Board Benefits shall be paid for the same confinement period where the Daily Intensive Care Unit Benefits is payable.

3. **HOSPITAL SUPPLIES AND SERVICES**

Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, laboratory examinations, electrocardiograms, physiotherapy, basal metabolism tests, intravenous injections and solutions, administration of blood and blood plasma but excluding the cost of blood and plasma whilst the Insured Person is confined as an in-patient in a Hospital, up to the amount stated in the Schedule of Benefits.

4. **SURGICAL FEES**

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary surgery by the Specialists, including pre-surgical assessment Specialist's visits to the Insured Person and post-surgery care up to the maximum number of days as indicated in the Schedule of Benefits. If more than one surgery is performed for Any One Disability, the total payments for all the surgeries performed shall not exceed the maximum stated in the Schedule of Benefits.

5. **ANAESTHETIST FEE**

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia not exceeding the limits as set forth in the Schedule of Benefits.

6. **OPERATING THEATRE**

Reimbursement of the Reasonable and Customary Operating Room charges incidental to the surgical procedure.

7. **IN-HOSPITAL PHYSICIAN VISIT**

Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visiting a in-paying patient while confined for a non-surgical disability subject to a maximum of two (2) visits per day not exceeding the maximum number of days as set forth in the Schedule of Benefits.

8. **PRE-HOSPITAL DIAGNOSTIC TESTS**

Reimbursement of the Reasonable and Customary Charges for Medically Necessary ECG, X-ray and laboratory tests which are performed for diagnostic purposes on account of an injury or illness when in connection with a Disability preceding hospitalisation within the maximum number of days and amount as set forth in the Schedule of Benefits in a Hospital and which are recommended by a qualified medical practitioner. No payment shall be made if upon such diagnostic services, the Insured Person does not result in hospital confinement for the treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.

9. **PRE-HOSPITAL SPECIALIST CONSULTATION**

Reimbursement of the Reasonable and Customary Charges for the first time consultation by a Specialist in connection with a Disability within the maximum number of days as set forth in the Schedule of Benefits preceding confinement in a Hospital and provided that such consultation is

Medically Necessary and has been recommended in writing by the attending general practitioner.

Payment will not be made for clinical treatment (including medications and subsequent consultation after the illness is diagnosed) or where the Insured Person does not result in hospital confinement for the treatment of the medical condition diagnosed.

10. SECOND SURGICAL OPINION

Reimbursement of the Reasonable and Customary Changes of the consultation or opinion with a second Specialist to determine whether a surgical operation for the same disease or injury is required in view of the Insured Person's medical condition. When considered medically necessary by the second Specialist and such that this reaffirms the opinion expressed by the first Specialist, the consultation fee incurred shall be payable but not exceed the maximum limit as stated in the Schedule of Benefits. The second consultation must be rendered within ninety (90) days of the first consultation preceding Hospitalisation for this benefit to be payable.

Payment will not be made for clinical treatment (including medications) or the treatment of the medical condition diagnosed or where the Insured Person does not result in hospital confinement.

11. POST-HOSPITALISATION TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up treatment by the same attending Physician, within the maximum number of days and amount as set forth in the Schedule of Benefits immediately following discharge from Hospital for a non-surgical disability. This shall include medicines prescribed during the follow-up treatment but shall not exceed the supply needed for the maximum number of days as set forth in the Schedule of Benefits.

12. ORGAN TRANSPLANT

Reimburses Reasonable and Customary Charges incurred on transplantation surgery for the Insured Person being the recipient of the transplant of a kidney, heart, lung, liver or bone marrow. Payment for this Benefit is applicable only once per lifetime whilst the policy is in force and shall be subject to the limit as set forth in the Schedule of Benefits. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

13. OUT-PATIENT CANCER TREATMENT

If an Insured Person is diagnosed with Cancer as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of cancer performed at a legally registered cancer treatment centre subject to the limit of this disability as specified in the Schedule of Benefits.

Such treatment (radiotherapy or chemotherapy excluding consultation, examination tests, take home drugs) must be received at the out-patient department of a Hospital or a registered cancer treatment centre immediately following discharge from Hospital confinement or surgery.

Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered necessary. The cancer must be confirmed by histological evidence of malignancy. The following conditions are excluded:

(a) Carcinoma in situ including of the cervix;

(b) Ductal Carcinoma in situ of the breast;

(c) Papillary Carcinoma of the bladder & Stage 1 Prostate Cancer;

(d) All skin cancers except malignant melanoma;

(e) Stage 1 Hodgkin's disease;

(f) Tumours manifesting as complications of AIDS.

It is a specific condition of this Benefit that notwithstanding the exclusion of pre-existing conditions, this Benefit will not be payable for any Insured who had been diagnosed as a cancer patient and/or is receiving cancer treatment prior to the effective date of Insurance.

14. OUT-PATIENT KIDNEY DIALYSIS TREATMENT

If an Insured Person is diagnosed with Kidney Failure as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of kidney dialysis performed at a legally registered dialysis centre subject to the limit of this disability as specified in the Schedule of Benefits.

Such treatment (dialysis excluding consultation, examination tests, take home drugs) must be received at the out-patient department of a Hospital or a registered dialysis treatment centre immediately following discharge from Hospital confinement or surgery.

Kidney Failure means end stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis is initiated.

It is a specific condition of this Benefit that notwithstanding the exclusion of pre-existing conditions, this Benefit will not be payable for any Insured Person who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the effective date of Insurance.

15. AMBULANCE FEES (BY ROAD ONLY)

Reimbursement of the Reasonable and Customary Charges incurred for necessary domestic ambulance services (inclusive of attendant) to and/or from the Hospital of confinement. Payment will not be made if the Insured Person is not hospitalised and subject to the limits set forth in the Schedule of Benefits.

16. DAY SURGERY BENEFIT

Reimbursement of Reasonable and Customary medical expenses for medical and professional charges incurred in respect of a Day Surgery without Hospitalisation. Follow up treatment by the same doctor or same registered clinic or Hospital for the same covered disability will be provided up to the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

17. EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily injury arising from an Accident for Medical Necessary treatment as an outpatient at any registered clinic or hospital within twenty four (24) hours of the Accident causing the covered bodily Injury. Follow up treatment by the same doctor or same registered clinic or Hospital for the same covered bodily injury will be provided up

to the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

18. **EMERGENCY ACCIDENTAL DENTAL TREATMENT**

Reimbursement of actual cost of dental and medical expenses necessarily incurred in a Hospital or registered dental clinic for treatment of injury of or damage to sound natural teeth as a result of an Accident including follow-up treatment of the injury by the same attending Physician or Dentist or any other recommended physician or dentist for a period of not exceeding, immediately from the date of Accident, the number of days or the amount set forth in the Schedule of Benefits.

19. **DAILY-CASH ALLOWANCE AT GOVERNMENT HOSPITAL**

Pays a daily allowance for each day of confinement for a covered Disability in a Malaysian Government Hospital, provided that the Insured Person shall confine to a Room and Board rate that does not exceed the amount shown in the Schedule of Benefits. No Payment will be made for any transfer to or from any Private Hospital and Malaysian Government Hospital for the covered disability.

20. **ACCIDENTAL DEATH BENEFIT**

An amount set forth in the Schedule of Benefits shall be payable if the Insured Person shall suffer injury caused by Accident which injury shall solely and independently of any other cause result in death within six (6) calendar months from the date of Accident.

21. **BEREAVEMENT ALLOWANCE (ACCIDENTAL CAUSE ONLY)**

An amount as stated in the Schedule of Benefits will be paid to Employer as trustee within forty eight (48) hours upon presentation of sufficient proof of death of an Insured Person due to Accidental cause.

22. **MEDICAL REPORT**

An amount equal to the actual charges for any medical report required will be reimbursed by the Company up to the maximum limit as stated in the Schedule of Benefits. This is applicable for any claim falling under the benefits for hospitalisation.

23. **MALAYSIAN GOODS AND SERVICE TAX**

Reimbursement of eligible prevailing Goods and Service Tax (GST) or other prevailing value added or consumption tax on eligible incurred medical charges subject to the benefits and amount as set forth in the Schedule of Benefits

OPTIONAL CLINICAL BENEFITS
OUTPATIENT GENERAL PRACTITIONER AND SPECIALIST PRACTITIONER CARE

These benefits cover General Practitioner (GP) and Specialist Practitioner (SP) care at outpatient levels and allow cashless access to GP Panel and SP Panel.

1. **OUT-PATIENT GENERAL PRACTITIONER CARE (PANEL CLINIC)**

The benefits include:

a) Consultation, treatment and procedure for usual out-patient ailments.
b) Supply of prescription drugs for the necessary treatment not exceeding one (1) month supply.
c) Diagnostic test including laboratory test, X-rays and Pap smear examination.
d) Child immunisation stated under the guideline of Ministry of Heath Malaysia (MOH).

2. **EMERGENCY NON-PANEL CLINIC / OVERSEAS GP VISIT**

Reimbursement of charges shall only be applicable to treatment due to Emergency Illness to nearest non-panel GP clinic or Accident and Emergency Unit of the nearest hospital.
Emergency Illness is defined as illness or symptoms which are sudden and severe failing which will be life threatening (e.g Accident and heart attack) that requires serious medical emergency treatment immediately to avoid death or serious life impairment.
Reimbursement of charges for overseas GP visit is subject to the limit stated in the Schedule of Benefits for the Optional Clinical Benefits.

3. **OUT-PATIENT SPECIALIST CARE (SP)**

Such benefits are covered provided there is a referral letter by a Qualified General Practitioner from a panel clinic only.
a) Consultation, treatment and procedure for the referred disability.
b) Supply of prescription drugs for the necessary treatment not exceeding one (1) month supply.
c) Diagnostic test including laboratory test, X-rays in accordance to the disability treated.

4. **EMERGENCY OVERSEAS SP VISIT**

Reimbursement of charges subject to the limit stated in the Schedule of Benefits for Optional Clinical Benefits for outpatient specialist treatment due to Emergency Illness while overseas. Emergency Illness is defined as illness or symptoms which are sudden and severe failing which will be life threatening (eg Accident and heart attack) that requires serious medical emergency treatment immediately to avoid death or serious life impairment. Panel GP referral letter is not required for this emergency overseas specialist visit

EXCLUSIONS

HOSPITALISATION & SURGICAL

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

(1) Pre-existing illness occurring during the first twelve(12) months of continuous cover of an Insured Person

(2) Specified Illnesses occurring during the first one hundred twenty (120) days of continuous cover of an Insured Person.

(3) Any medical or physical conditions arising within the first (30) days of the Insured Person's cover or date reinstatement whichever is latest except for accidental injuries.

(4) Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.

(5) Dental conditions including dental treatment or oral surgery except as necessitated by Accidental Injuries to sound natural teeth occurring wholly during the Period of Insurance.

(6) Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilization, venereal disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related diseases, and any communicable diseases required quarantine by law.

(7) Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.

(8) Pregnancy, child birth (including surgical delivery) and its related complications, miscarriage, abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility. Erectile dysfunction and tests or treatment related to impotence or sterilization.

(9) Hospitalization primarily for investigatory purposes, screening, diagnosis, X-ray, scans, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for hyperhidrosis, weight reduction or gain.

(10) Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.

(11) War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes, riots and civil commotion or insurrection.

(12) Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.

(13) Expenses incurred for donation of any body organ by an Insured Person and costs of acquisition of the organ including all costs incurred by the donor during organ transplant and its complications.

(14) Investigation and treatment of sleep and snoring disorders, hormone replacement therapy, stem cell treatment and alternative therapy such as treatment, medical service or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bonesetting, herbalist treatment, massage or aroma therapy or other alternative treatment.

(15) Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured Person and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.

(16) Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestations).

(17) Costs/expenses of services of a non-medical nature, such as television, telephones, telex services, radios or similar facilities, admission kit/pack and other ineligible non-medical items.

(18) Sickness or Injury arising from racing of any kind (except foot racing), hazardous sports such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter sports, professional sports and illegal activities.

(19) Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes.

(20) Expenses incurred for sex changes.

(21) Terrorism.

OPTIONAL CLINICAL BENEFITS
OUTPATIENT GENERAL PRACTITIONER AND SPECIALIST CARE

No benefits shall be payable for the following services or conditions:-

(1) More than one(1) Out-patient consultation per day to a General Practitioner or Specialist

(2) Plastic/Cosmetic surgery or treatment including but not limited to double eyelids, acne, keloids,scars, skin tags, gynaecomastia, diffused alopecia/hair loss etc , or treatment of their complications

(3) Alternative therapies including but not limited to Acupuncture, Acupressure, Hormone Replacement Therapy, Homeopathy, Chiropractic, Osteopathy, Reflexology, Bonesetting, Massage, Aroma Therapy, Herbal, Podiatric, Dietetic consultation and treatment, education services/therapies and traditional Services, Bomoh or Sinseh treatment and medicine.

(4) Treatment for congenital, hereditary disease/deformities.

(5) Drugs or medicine purchased without doctor prescription and X-Ray Examination or Laboratory Tests without panel doctor's recommendation.

(6) Any routine medical check-ups and screening profiles, blood and topical allergy testing including patch test.

(7) Preventive vaccination or immunisation, Travel immunisation and Adult immunisation including Hepatitis, Nerve disorders/Degenerative diseases, Endometriosis, Transverse Myclitis or any form of preventive treatment.

(8) Pregnancy or resulting childbirth (including pre-natal and post-natal visits), abortion or miscarriage; infertility and its related treatment

(9) Treatment of injuries sustained while committing a crime or felony, or while under the influence of alcohol, narcotics or mind altering substance or self-inflicted injury, attempted suicide while sane or insane .

(10) Treatment of any functional disorder of the physics or mental constitution, such as neuropsychosis, schizophrenia and others to improve the psychological, mental or emotional well-being.

(11) Any treatment, services and supplies for smoking cessation programs and treatment for or arising from substance abuse such as alcohol, narcotics, etc.

(12) Vitamins, Food Supplements, Herbal Cures,Anti Obesity/Weight Reducing Agents, Acne treatment or Cosmetic treatment including over the counter purchases of medications or outpatient prescribed and non-prescribed medical supplies.

(13) Sonotron Therapy, Heart Scan and other new modalities not recognised by academic or government health institutions.

(14) Catastrophic diseases including out-patient cancer therapies including chemotherapy, radiotherapy and immunotherapy, organ transplant,anti-rejection and related treatment including cyclosporin and out-patient renal dialysis and erythropoeitin treatment.

(15) Speech and Occupational Therapy

(16) Any process solely for the determination of eye refraction, lazy eye and the correction of the same but not limited to Radial Keratotomy, Orthoptics. Visual training, Lasik, Intralase. Xyoptics, Phacik IOL implant or intra-ocular lenses replacement surgery.

(17) All corrective glasses or contact lens or any associated material for the correction of visual acuity.

(18) Pre-employment check-up / Dental Treatment.

(19) War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes, riots and civil commotion or insurrection.

(20) Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.

(21) Terrorism

CONDITIONS

This Policy and the Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or of the Schedule shall bear such specific meaning wherever it may appear. The due observance and fulfillment of the terms and conditions of this Policy, in so far as they relate to anything to be done or complied with by the Policyholder or the Insured Person, and the truth of the statement and answers in the proposal form and declaration made by the Policyholder and/or the Insured Person(s) shall be a condition precedent to any liability of the Company to make payment under this Policy.

1. **LIMITATIONS AS TO PAYMENT OF BENEFITS**

   All Benefits payable under this Policy shall be limited by the amounts set forth in the Schedule of Benefits.

   No Benefits are payable with respect to a covered disability unless the entire treatment and all services and supplies so rendered and performed have been recommended by a Physician or Specialist, and in accordance with the diagnosis and treatment of the condition.

2. **PERIOD OF COVER AND RENEWAL**

   This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company.

This Policy is issued on a yearly renewal basis and is renewable at the option of the Company. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.

3. **COOLING-OFF PERIOD**

If this Policy has been issued and for any reason whatsoever the Insured Person decides not to take up the Policy, the Insured Person may return the Policy to the Company for cancellation provided such request for cancellation is delivered by the Insured Person to the Company within fifteen (15) days from the date of delivery of the Policy. The Insured Person is entitled to the return of the full premium paid less deduction of medical expenses incurred by the Company in the issue of the Policy.

4. **AUTOMATIC ADDITIONS AND DELETIONS**

Any person who is recruited by the Policyholder after the date of commencement of insurance of the policy shall automatically be covered as from his or her day of employment. The benefits will be in accordance with the scale normally followed by the Policyholder. Provided prior notice is given, benefit of Insured Person shall not exceed the benefits stated in the Schedule.

The Policyholder shall give written notification to the Company within thirty (30) days of any addition or deletion of employees and/or dependants in the particular month and pay an additional premium which may be required by the Company.

5. **CHANGE IN RISK**

The Insured Person shall give immediate notice in writing to the Company of any material change in his or her occupation, business, duties or pursuits and pay any additional premium that may be required by the Company.

6. **ALTERATIONS**

The Company reserves the right to amend the terms and provisions, including upward premium revision, of this Policy by giving a thirty (30) days prior notice in writing by ordinary post to the Policyholder's last known address in the Company's records, and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless Authorized by the Company and such approval is endorsed thereon. The Company should give thirty (30) days prior written notice to the Policyholder according to the last recorded address for any alterations made.

7. **ARBITRATION**

All differences arising out of this Policy shall be referred to an Arbitrator who shall be appointed in writing by the parties in difference. In the event they are unable to agree on who is to be the Arbitrator within one (1) month of being required in writing to do so then both parties shall be entitled to appoint an Arbitrator each who shall proceed to hear the differences together with an Umpire to be appointed by both Arbitrators. However this is provided that any disclaimer of liability by the Company for any claim hereunder must be referred to an Arbitrator within twelve (12) calendar months from date of such disclaimer.

8. **SUBROGATION**

If the Company shall become liable for any payment under this Policy, the Company shall be subrogated to the extent of such payment to all the rights and remedies of the Insured Person against any party and shall be entitled at its own expense to sue in the name of the Insured Person. The Insured Person shall give or cause to be given to the Company all such assistance in his/her power as the Company shall require to secure the rights and remedies and at the Company's request shall execute or cause to be executed all documents necessary to enable the Company to effectively to bring suit in the name of the Insured Person.

9. **CONTRIBUTION**

If an Insured Person carries other insurance covering any illness or injury insured by this Policy, the Company shall not be liable for a greater proportion of such illness or injury than the amount applicable hereto under this Policy bears to the total amount of all valid insurance covering such illness or injury.

10. **CANCELLATION**

a) This Policy may be cancelled by the Policyholder at any time by giving a written notice to the Company and provided that no claims have been made during the current policy year, the Policyholder shall be entitled to a refund of the premium as follows:-

Period Not Exceeding	Refund of Annual Premium
15 days	90% **(applicable to renewal only)**
1 month	80%
2 months	70%
3 months	60%
4 months	50%
5 months	40%
6 months	30%
7 months	25%
8 months	20%
9 months	15%
10 months	10%
11 months	5%
Period exceeding 11 months	No refund

b) The Company may cancel the Policy by giving thirty (30) days' notice in writing to the Policyholder subject to the rights of any Insured Person in respect of any covered Disability which had occurred prior to the effective date of cancellation of the Policy. In the event of cancellation the Policyholder is entitled to a refund of any premium paid by him after a deduction of a proportionate part for the period during which this Policy has been in force

11. **UPGRADED POLICIES**

If the Eligible Benefits to any Insured Person under the terms of this Policy be increased while it is in force or at the time of Renewal or replacement and if such Insured Person shall have been afflicted with a Disability prior or at the time the Benefits were increased, the Limits of

Benefits payable in respect of such Disability shall not exceed the Limit of Benefits prior to the date the Benefits were upgraded.

12. **CONVERSION POLICIES**

If the Eligible Benefits provided under this Policy shall have been converted from an existing coverage of an 'Inner Limits' to an 'As Charged/Full Reimbursement' coverage, and if such Insured Person shall have been afflicted with a Disability prior or at the time the Benefits were converted the benefits payable in respect of the Disability shall be in accordance with the Schedule of Benefits prior to the date the Eligible Benefits were converted.

13. **UPGRADED ROOM AND BOARD CO-PAYMENT**

If the Insured Person is hospitalised at a published Room & Board rate which is higher than his/her eligible benefit, the Insured Person shall bear twenty percent (20%) of the other eligible benefits described in the Schedule of Benefits.

14. **GEOGRAPHICAL TERRITORY**

All benefits provided in this policy are applicable worldwide for twenty-four (24) hours a day.

15. **OVERSEAS TREATMENT**

If the Insured Person elects to or is referred to be treated outside Malaysia by the Attending Physician, benefits in respect of the treatment shall be limited to the reasonable and customary and medically necessary charges for such equivalent local treatment in Malaysia and shall exclude the cost of transport to the place of treatment.

16. **RESIDENCE OVERSEAS**

No benefit whatsoever shall be payable for any medical treatment received by the Insured Person outside Malaysia, if the Insured Person resides or travels outside Malaysia for more than ninety (90) consecutive days.

17. **TAKE OVER POLICY**

If this policy shall have commenced immediately upon termination of a preceding policy and if an Insured Person shall have been afflicted with a medical disability prior or at the time this policy started (and benefits under the preceding policy would have been available to him), such Insured Person shall continue to be covered for the existing disability, but not to exceed the limits of the previous policy on condition the Company has secured a copy of the preceding policy.

18. **MISSTATEMENT OF AGE**

If the age of the Insured Person has been misstated and the premium paid as a result thereof is insufficient, any claim payable under this Policy shall be prorated based on the ratio of the actual premium paid to the correct premium which should have been charged for the year. Any excess premium, which may have been paid as a result of such misstatement of age, shall be refunded without interest.

If at the correct age the Insured Person would not been eligible for cover under this Policy, no benefit shall be payable.

19. **CURRENCY OF PAYMENT**

All payments under this Policy shall be made in the legal currency of Malaysia. Should any payment be requested by the Insured Person to be payable in any other currency, then such amount shall be payable in the demand currency as may be purchased in Malaysia at the prevailing currency market rates on the date of the claim settlement.

20. **MISSTATEMENT OR OMISSION OF MATERIAL FACT**

If:

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

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

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

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

21. **OWNERSHIP OF POLICY**

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

22. **PROOF OF CLAIM**

The Insured Person or claimant shall undertake to furnish the Company with the ORIGINAL itemised bills and receipts with respect to the medical expenses and fees incurred. The Company shall be entitled, at its own cost, to conduct any post-mortem examination as it deems fit.

23. **CERTIFICATION, INFORMATION AND EVIDENCE**

All certificates, information, medical reports and evidence as required by the Company shall be furnished at the expense of the Insured Person, and in such a form that the Company may require. In any event all notices which the Company shall require the Policyholder to give must be in writing and addressed to the Company. An Insured Person shall, at the Company's request and expense, submit to a medical examination whenever such is deemed necessary.

24. **GOVERNING LAW**

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

25. **WAITING PERIOD**

Eligibility for benefits starts thirty (30) days after the Insured Person has been included in the Policy, except for a covered Accident occurring after the effective date of coverage.

26. **CLAIM PROCEDURES**

(a) The Insured Person shall within thirty (30) days of a Disability that incurs claimable expenses, give written notice to the Company stating full particulars of such event, including all original bills and receipts, and a full Physician's report stipulating the diagnosis of the condition treated and the date the Disability commenced in the Physician's opinion and the Physician's summary of the cost of treatment including medicines and services rendered. Failure to furnish such notice within the time allowed shall not invalid any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

(b) The Insured Person shall immediately procure and act on proper medical advice and the Company shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured Person to do so.

27. **INCOMPLETE CLAIMS**

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

28. **NOTICE**

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

29. **LEGAL PROCEEDINGS**

No action at law or in equity shall be brought to recover on this Policy prior to expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. If the Insured Person shall fail to supply the requisite proof of loss as stipulated by the terms, provisions and conditions of the Policy, the Insured Person may, within a grace period of one calendar year from the time that the written proof of loss to be furnished, submit the relevant proof of loss to the Company with cogent reason(s) for the failure to comply with the Policy terms, provisions and conditions. The acceptance of such proof of loss shall be at the sole and entire discretion of the Company. After such grace period has expired, the Company will not accept, for any reason whatsoever, such written proof of loss.

30. **PORTFOLIO WITHDRAWAL CONDITION**

The company reserves the right to cancel the portfolio as a whole if it decides to discontinue underwriting this insurance product. At least thirty (30) days advance written notice shall be

given to Policyholders before cancellation of the portfolio as a whole is effected and the Company will run off all policies to expiry of the period of cover within the portfolio.

30 **SUITS AGAINST THIRD PARTIES**

Nothing in this Policy shall render the Company liable or be responsible or to be added as a party in any way whatsoever to any suit for damages which may be instituted by the Policyholder or an Insured Person nominated under this Policy against any provider of Medical or Dental Services or Treatments wherein such may sue the same for reasons of neglect, malpractice or other causes arising from his/her acts or omissions in the treatment or examination of any Insured Person under the terms of this Policy

31 **PREMIUM WARRANTY**

It is a fundamental and absolute special condition of this contract of insurance that the premium due must be paid and received by the Company within sixty (60) days from the inception date of this Policy / Endorsement / Renewal Certificate.

If this condition is not complied with then this contract is automatically cancelled and the Company shall be entitled to the pro rata premium for the period it has been on risk.

Where the premium payable pursuant to this warranty is received by an authorised agent of the Company, the payment shall be deemed to be received by the Company for the purposes of this warranty and the onus of proving that the premium payable was received by a person, including an insurance agent, who was not authorised to receive such premium shall lie on the Company.

32 **TERRORISM EXCLUSION**

This Policy does not cover death, disablement or medical expenses directly or indirectly caused by or contributed to by or arising from act of terrorism. For this purpose an act of terrorism means an act, including but not limited to the use force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public in fear.

NOTICE TO ALL POLICYHOLDERS

STATEMENT Pursuant to Schedule 9 of the Financial Services Act 2013

Consumer Insurance Contract

Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance wholly for purposes unrelated to your trade, business or profession, you have a duty to take reasonable care not to make a misrepresentation in answering the questions in this Proposal Form. You must answer the questions in this Proposal Form fully and accurately.

Failure to take reasonable care in answering the questions may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance. The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us.

In addition to answering the questions in this Proposal Form, you are required to disclose any other matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied.

You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in this Proposal Form is inaccurate or has changed.

Non-Consumer Insurance Contracts

Pursuant to Paragraph 4(1) of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance for a purpose related to your trade, business or profession, you have a duty to disclose any matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant, otherwise it may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance.

The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us.

You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in this Proposal Form is inaccurate or has changed.

GOODS AND SERVICES TAX (GST)

Your obligation to pay other prevailing value added or consumption tax shall form part of the Terms and Conditions in your insurance policy.

SANCTION LIMITATION AND EXCLUSION CLAUSE (SANC)
HAD PENETAPAN DAN PENGECUALIAN (SANC)

At the sole discretion of the Company, the Company shall not be deemed to provide cover and shall not receive any payment(s) under the policy; or be liable to pay any sums (including but not limited to payment of claims, refund of premiums, surrender or cancellation payments); or provide any benefit under the policy; to the extent that the provision of such cover, payment of such sum or provision of such benefit would expose the Company to any sanction, prohibition or restriction under any laws and/or regulations, administered by any governmental, regulatory or competent authority, or any law enforcement in any country.

LODGING COMPLAINTS AND GRIEVANCES

You may refer your complaint pertaining to any insurance related matters to our Complaint Handling Unit for an amicable resolution before referring to the Ombudsman for Financial Services or BNMLINK / BNMTELELINK, Bank Negara Malaysia. The contact details of our Complaint Handling Unit: -

Complaint Handling Unit

GREAT EASTERN GENERAL INSURANCE (MALAYSIA) BERHAD
Level 18, Menara Great Eastern, 303 Jalan Ampang, 50450 Kuala Lumpur
Telephone No. : 1300-1300-88
Fax No. : 03-4813 0055
Email : GICare-MY@greateasterngeneral.com

OMBUDSMAN FOR FINANCIAL SERVICES OR BANK NEGARA MALAYSIA
OMBUDSMAN PERKHIDMATAN KEWANGAN ATAU BANK NEGARA MALAYSIA

If you are not satisfied with the respond or the decision of our Complaint Handling Unit, you may submit your complaint either to the Ombudsman for Financial Services (OFS) within six (6)months from the date of our Complaint Handling Unit's final decision, or to BNMLINK/BNMTELELINK, Bank Negara Malaysia (BNM). Kindly check with our Complaint Handling Unit on the proper avenue for dealing with your complaint. The following are the contact details of OFS or BNM: -

OFS/ OPK: Level 14, Main Block, Menara Takaful Malaysia, No.4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur.
Telephone No.: 03-2272 2811
Fax No.: 03-2272 1577

BNM: Laman Informasi Nasihat dan Khidmat (BNMLINK) (Walk-in Customer Service Centre) Ground Floor, D Block. Jalan Dato' Onn, 50480 Kuala Lumpur. Contact Centre (BNMTELELINK) Corporate Communication Department, Bank Negara Malaysia P.O. Box 10922, 50929 Kuala Lumpur.
Telephone No.: 1-300-88-5465; (Overseas: 603-2174-1717)
Fax No.: 03-2174-1515
Email: bnmtelelink@bnm.gov.my

BRANCH OFFICES OF GREAT EASTERN GENERAL INSURANCE (MALAYSIA) BERHAD (102249-P)

Kuala Lumpur	: Level 18, Menara Great Eastern, 303, Jalan Ampang, 50450 Kuala Lumpur. Tel: 03-4259 8888 Customer Service Careline: 1300 1300 88 Fax: 03-4813 0055
Penang	: Suite 2-3, Level 2, Wisma Great Eastern, No.25, Lebuh Light, 10200 Pulau Pinang. Tel: 04-261 9361 Fax: 04-261 9058
Ipoh	: 2nd Floor, Wisma Great Eastern, No.16, Persiaran Tugu, Greentown Avenue, 30450 Ipoh, Perak. Tel: 05-253 6649 Fax: 05-255 3066
Alor Setar	: 69 & 70, 1st Floor, Jalan Teluk Wanjah, 05200 Alor Setar, Kedah. Tel: 04-734 6515 Fax: 04-734 6516
Klang	: 3rd Floor, No. 10, Jalan Tiara 2A, Bandar Baru Klang, 41150 Klang, Selangor. Tel: 03-3345 1027 Fax: 03-345 1029

Melaka	: No.2-23. Jalan PM 15, Plaza Mahkota, 75000 Melaka. Tel: 06-284 3297 Fax:06-283 5478
Kuantan	: 1st Floor, No.25, Jalan Dato' Lim Hoe Lek, 25200 Kuantan, Pahang. Tel: 09-516 2849 Fax: 09-516 2848
Seremban	: 103-2, Jalan Yam Tuan, 70000 Seremban, Negeri Sembilan. Tel: 06-764 9082 Fax: 06-761 6178
Johor Bahru	: Wisma Great Eastern, 03-01 Blok A, Komersil Southkey Mozek, Persiaran Southkey 1, Kota Southkey, 80150, Johor Bahru Tel: 07-334 8988 Fax: 07-334 8977
Kota Bharu	: No. S25/5252-S, Tingkat 1, Jalan Sultan Yahya Petra, 15200 Kota Bharu. Tel: 09-748 2698 Fax: 09-744 8533
Kuching	: No.51, Level 3, Wisma Great Eastern, Lot 435 Section 54 KTLD, Travillion Commercial Centre, Jalan Padungan 93100 Kuching, Sarawak. Tel: 082-420 197 Fax: 082-248 072
Kota Kinabalu	: Suite 6.3, Level 6, Wisma Great Eastern Life, No.65, Jalan Gaya, 88000, Kota Kinabalu, Sabah. Tel: 088-235 636 Fax: 088-248 879
Sibu	: 2nd Floor, No. 10A-F Wisma Great Eastern, Persiaran Brooke, 96000 Sibu, Sarawak. Tel: 084-328 392 Fax: 084-326 392
Servicing Offices Great Eastern General Insurance (Malaysia) Berhad (102249-P)	
Sandakan	: 1st Floor, Lot 5 & 6, Block 40, Lorong Indah 15, Bandar Indah, Phase 7, Mile 4, North Road, 90000 Sandakan, Sabah. Tel: 089-228 769 Fax: 089-228 372
Tawau	: 3rd Floor, Wisma Great Eastern, Jalan Billian, 91008 Tawau, Sabah. Tel: 089-755 882 Fax: 089-767 013
Miri	: 3rd Floor, Lots 1260 & 1261 Block 10 M.C.L.D. Jalan Melayu, 98000 Miri, Sarawak. Tel: 085-421 299 Fax: 085-433 276
Batu Pahat	: 1st Floor, 109 Jalan Rahmat, 83000 Batu Pahat, Johor. Tel: 07-432 2357 Fax: 07-432 2359
Mentakab	: No. 60, 1st Floor, Jalan Orkid, 28400 Mentakab, Pahang. Tel: 09-2709 358 Fax: 09-2709359