QBE Insurance (Malaysia) Berhad
(Licensed under Financial Service Act 2013, regulated by Bank Negara Malaysia)
Registration No. 198701002415 (161086-D)
SST No. B16-1808-31042744
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QBE MEDI CHARGE Insurance
POLICY

QBE INSURANCE (MALAYSIA) BERHAD welcomes you as a policyholder and we take this opportunity to recommend that you thoroughly examine this Document which sets out the limitations and benefits of the Insurance. Please store it in a safe place.

Should you have any query, please contact your Registered Agent/Broker or our QBE office, especially if the Insurance is not completely in accordance with your intentions.

"WE WOULD REMIND YOU THAT YOU MUST DISCLOSE TO US, FULLY AND FAITHFULLY, THE FACTS YOU KNOW OR OUGHT TO KNOW, OTHERWISE YOU MAY NOT RECEIVE ANY BENEFITS FROM YOUR POLICY."

The benefit(s) payable under eligible certificate/policy/product is(are) protected by PIDM up to limits. Please refer to PIDM's TIPS Brochure or contact QBE Insurance (Malaysia) Berhad or PIDM (visit www.pidm.gov.my).

Contents

A. THE COVER

Preamble

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

This Policy reflects the terms and conditions of the contract of insurance as agreed between you and us.

IN CONSIDERATION OF the payment of the premium to QBE INSURANCE (MALAYSIA) BERHAD (hereafter called QBE), QBE agrees to pay the Policyholder or his/her legal representatives, in accordance with the definitions, conditions and exclusions of this Policy, if the Insured Person shall incur any of the Insured Benefits set out in the Schedule during the Period of Insurance.

Provided that the liability of QBE shall not exceed the Overall Annual Limit as set out in the Schedule of Benefits.

"Policy" includes this document, the Schedule and each endorsement issued by QBE attached or intended to be attached to it.

The written application form on which the insurance is based is deemed to be incorporated in this Policy as if it were fully set out in this Policy.

Cooling-off Period

If this Policy shall have been issued and for any reason whatsoever the Policyholder shall decide not to take up the Policy, the Policyholder may return the Policy to QBE for cancellation provided such request for cancellation is delivered by the Policyholder to QBE within fifteen (15) days from the date of delivery of the Policy. The Policyholder is entitled to the return of the full premium paid less deduction of administrative expenses incurred by QBE in the issue of the Policy.

B. DESCRIPTION OF BENEFITS

1. Ambulance Fee
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.

2. 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 Benefit.

3. 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 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.

4. Emergency Accidental Dental Treatment
Reimbursement of the Reasonable and Customary charges incurred for emergency accidental dental treatment up to the maximum amount and number of days stated in the Schedule of Benefits as a result of an injury provided treatment is sought within twenty-four (24) hours of the accident.

5. 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 Medically Necessary treatment as an outpatient at any registered clinic or hospital within 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 a maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

6. Home Nursing
Reimburses up to the limit set forth in the Schedule of Benefits the actual costs for the full time or part time services of a state registered or government licensed nurse in your home immediately after your discharge from hospital confinement up to seventy-five (75) days provided:

(a) the Insured Person covered have undergone surgery during the period of hospitalisation.
(b) the services ordered by the treating physician as medically necessary for the

continued treatment of the specific condition for which the Insured Person had surgery.

(c) A nurse is needed for medical reasons as distinct from domestic reasons.

7. 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.

8. Hospital Services & Supplies

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.

9. In-Hospital Physician Visit

Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visiting an in-paying patient while confined for a non-surgical disability subject to a maximum of 1 visit per day not exceeding the maximum number of days as set forth in the Schedule of Benefit.

10. 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.

11. Insured Child's Daily Guardian Benefit

Reimburses (up to stipulated limits set forth on the Schedule of Benefits the expenses for meals and lodging incurred to accompany an insured Child (aged below fifteen (15) years) in the hospital up to the maximum number of days set forth in the Schedule of Benefits.

12. Medical Report Fee

Reimburses up to the limit as set forth in the Schedule of Benefit for fees incurred provided that such medical condition is covered by this policy.

13. Operating Theatre

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

14. Out-Patient Cancer Treatment

If an Insured 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 of Insurance.

15. Out-Patient Kidney Dialysis Treatment

If an Insured 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 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 who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the effective date of insurance.

16. Organ Transplant (Extended Benefit)

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 Benefit. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

17. 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.

18. Pre-Hospital Diagnostic Tests

Reimbursement of the Reasonable and Customary Charges fro 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 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.

19. 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 Benefit 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 does not result in hospital confinement for the treatment of the medical condition diagnosed.

20. Surgeon Fee

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 from the date of surgery, but within the maximum 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.

C. EXCLUSIONS

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

1. Pre-existing illness.

2. Specified Illnesses occurring during the first 120 days of continuous cover.

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, sterilisation, venereal disease and its sequelae, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related diseases, 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), 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 sterilisation.

9. Hospitalisation primarily for investigatory purposes, diagnosis, X-ray examination, 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 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 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 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.

D. CLAIMS PROCEDURES

1. 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 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 QBE for any claim hereunder must be referred to an Arbitrator with twelve (12) calendar months from date of such disclaimer.

2. Condition Precedent to Liability

The due observance and the fulfilment of the terms, provisions and conditions of this Policy by the Insured Person and in s far as they relate to anything to be done or complied with by the Insured Person shall be conditions precedent to any liability of QBE.

3. 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 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.

4. Events Leading to Claims

(a) The Insured shall within 30 days of a Disability that incurs claimable expenses, give written notice to QBE 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 shall immediately procure and act on proper medical advice and QBE shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured to do so.

5. Incomplete Claims

All claims must be submitted to QBE within 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 QBE. Only actual costs incurred shall be considered for reimbursement. Any variation or waiver of the foregoing shall be at QBE's sole discretion.

6. 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 QBE 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 QBE. After such grace period has expired, QBE will not accept, for any reason whatsoever, such written proof of loss.

7. Misstatement or Omission of Material Fact

If:

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

(b) before this contract of insurance is entered into, varied or renewed, You have failed to disclose any fact You knew to be relevant to Our decision on whether to accept 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.

8. Notice

Every notice or communication to QBE shall be in writing and sent to QBE. 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 QBE.

E. GENERAL CONDITIONS

1. Duty of Disclosure

Where you have applied for this Insurance wholly for yourself/family/dependants, you had a duty to take reasonable care not to make a misrepresentation in answering the questions in the Proposal Form (or when you applied for this insurance) i.e. you should have answered the questions fully and accurately. Failure to have taken reasonable care in answering the questions may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance in accordance with the remedies in Schedule 9 of the Financial Services Act 2013. You were also required to disclose any other matter that you knew to be relevant to our decision in accepting the risks and determining the rates and terms to be applied.

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

2. Arbitration

QBE reserves the right to amend the terms and provisions of this Policy by giving a 30 day prior notice in writing by ordinary post to the Owner's last know address in the Company's records, and such amendment will be applicable from the next renewal of this Policy.

No alteration in this Policy shall be valid unless authorised by QBE and such approval is endorsed thereon. The insurer should give 30 days prior written notice to the policyholder according to the last recorded address for any alterations made.

3. Automatic Termination

The insurance of an Insured Person shall automatically terminate on the earliest happening of the following events :

a) on the death of an Insured Person; or
b) on the Policy Anniversary following the 65th birthday of an Insured Person; or
c) for a dependant child, on his/her 19th birthday on his/her 23rd birthday if in full-time tertiary institution in Malaysia; or
d) if the total benefits paid under the Policy since the last Policy Anniversary exceeds the Overall Annual Limit for the respective period of insurance; or
e) at mid-night standard Malaysian time on the last day of the Period of Insurance unless an Insured Person is confined to a Hospital at such time. If this being the case, the time of termination shall be extended to:-
   (i) the time the Insured Person is discharged from Hospital; or
   (ii) the time the Overall Annual Limit shall have been exhausted; whichever is the first to occur

4. Cancellation of Policy

This Policy may be cancelled by the Policyholder at any time by giving a written notice to QBE; 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 follow:-

	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	

5. Certification, Information and Evidence

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

6. Change in Risk

The Insured Person shall give immediate notice in writing to QBE of any material change in his or her occupation, business,

duties or pursuits and pay any additional premium that may be required by QBE.

7. Contribution

If an Insured Person carries other insurance covering any illness or injury insured by this Policy, QBE 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.

8. Conversion Policies (This condition shall only apply if stated in the Schedule)

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 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.

9. **Optional Deductible:**

A deductible refers to the amount of Eligible Expenses payable by you before we pay the benefit on a reimbursement basis only as stated in your selected plan. You have the option to choose a Deductible in return for a reduction of premium. The maximum amount of the Deductible that you have to bear depends on the option that you have chosen and the items of cover to which it applies is as stated in the Policy Schedule.

Type of deductible options available:

A. Deductible per claim:-
   For each Eligible Expenses incurred, you are to pay the Deductible amount specified by the plan you have selected at inception per Insured Person for each claim and every claim. Once the Deductible amount has been satisfied, the Insurer will cover the remaining Eligible Expenses subject to the policy terms and conditions.

B. Deductible per policy year:-
   For Eligible Expenses incurred within a Policy Year, you are to pay the Deductible amount specified by the plan you have selected at inception per Insured Person per Policy Year. You shall be liable for a cumulative amount of excess of during the policy period. This means that You must pay the amount of Eligible Expenses incurred during the policy period, regardless of the number of claims made. Once the Deductible amount for the Policy Year has been satisfied, the Insurer will cover the remaining Eligible Expenses subject to the policy terms and conditions.

Do note however, that the circumstances as listed below **will not apply be subject to** the Deductible feature:

i. In cases where emergency treatment is required, including cases of accidents.
ii. In cases where follow-up outpatient treatments arising from critical illnesses is required. e.g.: cancer, kidney dialysis etc.
iii. In cases where treatment has been sought out at a Government healthcare facility.

10. Geographical Territory

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

11. Governing Law

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

12. 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 have been eligible for cover under this Policy, no benefit shall be payable.

13. Overseas Treatment

If the Insured Person seeks treatment overseas, benefits in respect of the treatment shall be covered subject to the exclusions, limitations and conditions specified in this Policy and all benefits will be payable based on the official exchange rate ruling on the last day of the Period of Confinement and shall exclude the cost of transport to the place of treatment provided:

(a) an Insured Person travelling abroad for a reason other than for medical treatment, needs to be confined to a Hospital outside Malaysia as a consequence of a Medical Emergency.

(b) an Insured Person upon recommendation of a Physician and has to be transferred to a Hospital outside Malaysia because the specialised nature of the treatment, aid, information or decision required can neither be rendered nor furnished nor taken in Malaysia.

Overseas treatment of a disease, sickness or injury which is diagnosed in Malaysia and non-emergency or chronic conditions where treatment can reasonably be postponed until return to Malaysia are excluded.

14. Ownership of Policy

Unless otherwise expressly provided for by Endorsement in the Policy, QBE shall be entitled to treat the Policyholder as the absolute owner of the Policy. QBE 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 authorised representative) alone shall be an effective discharge of all obligations and liabilities of QBE. The Policyholder shall be deemed to be responsible Principal or Agent of the Insured Persons covered under this Policy.

15. 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 QBE.

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

16. Persons Eligible

Person eligible to be covered under this Policy are:-

(a) Anyone between the ages of 30 days and 60 years and renewable up to age 65

(b) Persons who reside in Malaysia only.

16. Portfolio Withdrawal Condition

The Company reserves the right to cancel the portfolio as a whole if it decides to discontinue underwriting this insurance product.

Cancellation of the portfolio as a whole shall be given by written notice to the policyholder and the Company will run off policies to expiry of the period of cover within the portfolio.

18. Premium Warranty

It is fundamental and absolute special condition of this contract of insurance that the premium due must be paid and received by the insurer 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 insurer shall be entitled to the pro rata premium for the period they have been on risk.
Where the premium payable pursuant to this warranty is received by an authorised agent of the insurer, the payment shall be deemed to be received by the insurer 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 insurer.

19. Residence Overseas

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

20. Subrogation

If QBE shall become liable for any payment under this Policy, QBE 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 QBE all such assistance in his/her power as QBE shall require to secure the rights and remedies and at QBE's request shall execute or cause to be executed all documents necessary to enable QBE to effectively to bring suit in the name of the Insured Person.

21. Take-Over Policies (This condition shall only apply if stated in the Schedule)

If this policy shall have commenced immediately upon termination of a preceding policy and if an Insured 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 shall continue to be covered for the existing disability, but not to exceed the limits of the previous policy on condition QBE has secured a copy of the preceding policy.

22. Upgraded Policies (This condition shall only apply if stated in the Schedule)

If the Eligible Benefits to any Insured 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 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.

23. Upgraded Room And Board Co-Payment

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

24. Waiting Period

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

25. Sanction Limitation and Exclusion Clause

The Company shall not provide cover nor be liable to pay any claim or provide any benefit hereunder to the extent that the

provision of such cover, payment of such claim or provision of such benefit would expose the Company or any member of the Company's group to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of any country including but not limited to the European Union, United Kingdom and United States of America.

F. DEFINITIONS

RELATING TO CONTRACTUAL DETAILS

1. **INSURED PERSON** shall mean the person described in the Policy Schedule including his/her Dependent (if applicable).

2. **PERIOD OF INSURANCE** shall mean the period of insurance specified in the Schedule or any subsequent period of insurance, for which the Policyholder shall have paid and QBE shall have accepted a Renewal Premium.

3. **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.

4. **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.

5. **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.

RELATING TO INSURANCE COVER

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

2. **CHILD** shall mean any person who has attained the age of 30 days and is an unmarried person, is financially dependent upon the Insured and is under the age of 19, or up to the age of 23 for those registered as full time students at a recognised educational institution.

3. **CONGENITAL CONDITION** shall mean 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. They 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

4. **DEPENDANT** shall mean any of the following persons:
   (a) a legally married spouse
   (b) unmarried children over 30 days old but under nineteen (19) years of age or twenty-three (23) years of age is still on full-time higher education, and who are not gainfully employed

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

6. **ELIGIBLE EXPENSES** shall mean Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the schedule.

7. **EMERGENCY TREATMENT** shall mean an event whereby immediate medical attention within twenty-four (24) hours for preservation of life or limb is required for disability which are sudden and severe failing which will be life threatening or lead to serious deterioration of health.

8. **HOSPITALISATION** 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.

9. **INJURY** shall mean bodily injury caused solely by Accident.

a) **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.

b) **LIMIT PER DISABILITY or 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.

c) **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 and 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 or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient), and

d) not of an experimental, investigational or research nature, preventive or screening nature,

e) for which the charges are fair and reasonable and customary for the Disability.

d) **OUT-PATIENT** shall mean the Insured Person is receiving medical care or treatment without being hospitalised and includes treatment in a Daycare centre.

e) **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.

f) **PRE-EXISTING ILLNESS** shall mean disabilities 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 for which:-

a) the Insured Person had received or is receiving treatment;

b) medical advice, diagnosis, care or treatment has been recommended;

c) clear and distinct symptoms are or were evident; or

d) its existence would have been apparent to a reasonable person in the circumstances

g) **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.

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

i) **SPECIFIED ILLNESSES** shall mean the following disabilities and its related complications, occurring within the first 120 days 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) Vetebro-spinal disorders (including disc) and knee conditions

j) **WAITING PERIOD** shall mean the first 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.

RELATING TO MEDICAL SUPPLIERS

1. **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 an overnight stay).

2. **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.

3. **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 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.

4. **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.

5. **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.

6. **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.

7. **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.

8. **SURGERY** shall mean any of the following medical procedures :
   a) To incise, excise or electrocauterise 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.

IMPORTANT NOTICE:

1. **You** need to read this **Policy** carefully, and if any error or incorrect description is found herein, or if the cover is not in accordance with your wishes, you should inform the **Company** immediately and return this **Policy** to the **Company** for alteration.

2. If you are not satisfied with the course of action taken by the **Company** or decision made by the **Company**, you may seek recourse through the **Company's** Complaints Management Unit and alternatively, may seek redress or assistance from the Ombudsman for Financial Services (OFS) or approach Bank Negara Malaysia's Laman Informasi Nasihat dan Khidmat (LINK) addressed below:

A) COMPLAINTS MANAGEMENT UNIT

QBE Insurance (Malaysia) Berhad
No. 638, Level 6 & 7, Block B1, Pusat Dagang Setia Jaya,
(Leisure Commerce Square),
No. 9 Jalan PJS 8/9, 46150 Petaling Jaya, Selangor
Tel: +603 7861 8400
Fax: +603 7873 7430

B) OMBUDSMAN FOR FINANCIAL SERVICES

Level 14, Main Block
Menara Takaful Malaysia
No. 4, Jalan Sultan Sulaiman
50000 Kuala Lumpur
Tel: +603-2272 2811
Fax: +603-2272 1577

C) LAMAN INFORMASI NASIHAT DAN KHIDMAT (LINK)
Tingkat Bawah, Blok C
Bank Negara Malaysia
Peti Surat 10922
50929 Kuala Lumpur
Tel : 1300 88 5465
Fax : +603-2174 1515