proMedico (Individual)

Policy Wordings – Applicable to policies effected before 2 July 2017

Please read this insurance Policy carefully to ensure that you understand the terms and conditions and that this Policy meets your requirements. If there are any changes that may affect the insurance cover provided, please notify us immediately.

Contents

Introduction

The cover provided shall be determined by the Policy wordings contained herein together with any Schedule and Memoranda. The benefit limits are stated in the Policy Schedule and any cover not shown therein is not provided. The base currency for this insurance is Singapore Dollars (S$).

The current policy replaces any other policy previously issued to cover insurance described herein. The Policy issued by Liberty Insurance Pte Ltd (the Insurer) governs the rights and obligations of all parties to the proMedico Health Plan (the Plan). The Insurance is effective only after the applicant has been accepted by the Insurer and becomes and remains insured in accordance with the terms provisions and conditions set out in the Policy.

Insurance shall commence from the date specified on the Policy. The policy is an annual contract which until terminated shall be renewed each year on the Due Date subject to the Policy being in force at the time of each renewal and any variations as may be set out in writing by the Insurer. All premiums will be payable on or before the inception date or Due Date of the Policy. If payment is not made on or before the inception date or Due Date the insurance will be terminated.

When an Insured Person undergoes medical treatment for injury or illness he can claim for the course of treatment until the exhaustion of the Stated limits as shown in the Policy schedule or the expiry of the period of insurance or the termination of this insurance whichever is the earlier event.

Upon receipt of proof of claim the Insurer will pay up to the limits shown in the Schedule of Benefits for expenses necessarily incurred as a direct result of the Insured Person suffering bodily injury sickness or disease during the period of insurance.

The legal representative of the Insured Person shall have the right to act for an Insured Person who is incapacitated or deceased. Benefits are payable to Insured Person his legal representative or executor or to the licensed providers of the insured medical treatments and/or services to the Insured Person.

Benefits are limited to the usual customary and reasonable charges in the country or area where treatment is provided.

General Definitions

The following definitions apply to the Plan:

	TERM	MEANING
1.	**Accident**	An event of violent accidental external and visible nature which shall independently of any other cause be the sole cause of bodily injury.
2.	**Illness**	A physical condition marked by a pathological deviation from the normal healthy state.
3.	**Injury**	Bodily injury caused by violent external and visible means.
4.	**Pre-Existing Illness**	Any condition which existed or have developed symptoms or there exist manifestation of illness or medical treatment have been sought on drugs and medicine have been prescribed before the effective date of cover in respect of any Insured person of which the Insured Person was aware or should reasonably have been aware or based on normal medically accepted physical or pathological development of the illness or illnesses.
5.	**Deductible/Co-insurance**	The portion of costs for which the Insured Person is liable. The Deductible will be applied to each and every ailment/diagnosed medical condition for which a claim is made within any one Policy Year. The Deductible/Co-insurance is subject to Goods & Services Tax (GST) if applicable.
6.	**Insured Person**	An individual aged below 65 years whose application for the Policy has been approved and confirmed in writing by the Insurer.
7.	**Dependants**	The legal spouse of the Insured Person (but excluding those legally separated) and/or unmarried children and legally adopted children who are dependent on the Insured Person for support. Provided always that such children are not less than 15 days and not more than 18 years old at the date of enrolment in the plan (or 24 years if the child is in continuous full-time education). The Insurer must be informed of the location of any Dependants whose Usual Country of Residence is different from that declared for the Insured Person in the Personal Health Declaration/Proposal Form and the Insurer at all times reserves the right to cover such Dependants on terms and conditions that it considers appropriate or to decline to cover such Dependants under the Policy.
8.	**Physician or Surgeon**	A person qualified by degree in Western medicine and legally

	TERM	MEANING
		licensed and duly qualified to practice medicine and surgery authorized in the geographical area of his practice.
9.	**Hospital**	An establishment duly constituted and registered as a hospital for the care and treatment of sick and injured persons as bed-paying patients, and which: a) has facilities for diagnosis and major surgery b) provides 24 hours a day nursing services by registered graduated nurses c) is under the supervision of a physician; and d) is not primarily a nature cure clinic, a place for alcoholics or drug addicts, a nursing rehabilitation or convalescent home or similar establishment or home for the aged
10.	**Reasonable and Customary**	Charges for medical care that do not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred when giving like or comparable treatment services or supplies to individuals of the same sex and of comparable age for a similar disease or injury.
11.	**Usual Country of Residence**	The country in which the Insured Person is usually residing as stated in the Policy and which is declared in the Personal Health Declaration/Proposal Form. The Insurer must be informed in writing of any permanent change in the Insured Person's Usual Country of Residence. A permanent change in the Usual Country of Residence shall be deemed to mean the Insured Person's living or intending to live in another country for a period in excess of three consecutive months. The Insurer reserves the right to continue cover on terms and conditions it considers appropriate to the new Country of Residence or to decline to continue cover under the Policy.
12.	**Home Country**	The country of citizenship declared on the Personal Health Declaration/Proposal Form under the heading of "Nationality". In the event of dual nationality the Home Country will be taken to mean the country which the Insured Person has declared on the Personal Health Declaration/Proposal Form. Where dependants are included under the Plan the Home Country for all dependants will be deemed to be the same Home Country as declared for that Insured Person in the Personal Health Declaration/Proposal Form.
13.	**Serious Medical Condition**	A condition which in the opinion of the Insurer or its authorised representatives constitutes a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to the Insured Person's immediate or long term health prospects. The seriousness of the medical condition will be judged within the context of the Insured Person's geographical location the nature of the medical emergency and

	TERM	MEANING
		the local availability of appropriate medical care or facilities.
14.	**Due Date**	The renewal date of cover as shown on the Schedule or the dale on which any subsequent instalment of premium falls due.

Definition of Benefits

Please refer to the Schedule to determine the coverage (Benefits) enrolled.

1. **Hospital Services**
   Medical services rendered to the Insured Person for appropriate treatment procedures and when admitted as a registered in-patient to a hospital. Reasonable and customary charges in the area where treatment is provided for hospital services and surgery including the cost of the room meal charges all hospital medical facilities and all medical treatments and medical services prescribed by a Physician intensive care unit accommodation where this is medically required operating theatre anaesthesia and oxygen and its administration and surgeon's physician's fee. Day surgery performed on an out-of-hospital basis or in an ambulatory surgical facility attached to a hospital shall be payable accordingly.

2. **Local Ambulances Services**
   The medically necessary road transportation provided by a recognized ambulance service provider to a local hospital.

3. **Pre-Hospital Diagnostic Services**
   Costs of specialist opinion/physician or all medically necessary diagnostic procedures ordered by a medical practitioner within 90 days preceding hospital admission as a registered in-patient for the treatment of the specific medical condition diagnosed and provided that such medical condition is covered by the Policy. The same benefit is payable in relation to day surgery. Payment will not be made for any subsequent consultations after an illness is diagnosed, or if the Insured Person is not subsequently hospitalized or surgically treated after such consultations or examinations.

4. **Post-Hospitalization Treatment**
   Expenses for follow-up treatment by the same physician up to a period of 90 days immediately following discharge from hospital. Cover is restricted to follow-up treatments of the specific medical condition for which the Insured Person received in-patient treatment covered by the Policy.

5. **Organ Transplantation**
   The medical treatment costs incurred in respect of kidney heart lung and liver transplants only.

   Transplantation costs may only be claimed under this section of the Policy when the Benefit is indicated on the Schedule. No other Policy Benefits would apply to this Organ Transplantation. The cost of acquisition of the organ and all costs incurred by the donor are not covered under the Plan.

6. **Emergency Medical Evacuation**
   The medically necessary expenses of emergency evacuation and medical care en route to move an Insured Person who has a serious medical condition to the nearest Hospital where appropriate care and facilities are available and not necessarily to Insured Person's Home Country. In the event of such an emergency the nearest designated 24-hours Assistance Centre should be contacted immediately to approve and arrange any Emergency Medical Evacuation. The Policy will not pay to evacuate an Insured Person from his/her Home Country or Country of Residence to a foreign destination. In dire emergencies in remote or primitive areas where the Assistance Centre cannot be contacted in advance the Emergency Medical Evacuation must be reported as soon as possible.

The Insurer reserves the right to decide the place to which the Insured Person shall be transported. The Insurer will pay reasonable costs of only one other person accompanying the patient on an Emergency Medical Evacuation when this is deemed necessary for medical reasons.

This benefit does not apply to any Maternity Care or pregnancy related complications.

Subject to International SOS Terms & Conditions.

7. **Emergency Outpatient Accidental Treatment**
Charges for services and medical supplies provided by the hospital or clinic for emergency treatment of an injury as a result of an accident and received as an outpatient within 24 hours after the accident.

Eligible expenses incurred thereafter for follow-up treatment of the specific medical condition will be reimbursed up to 31 days from the date of accident.

8. **Emergency Dental Treatment**
Charges for dental procedures necessary to restore or replace sound natural teeth lost or damaged in an accident and received as an outpatient within 24 hours after the accident Eligible expenses incurred thereafter for follow-up treatment of the specific medical condition will be reimbursed up to 31 days from the date of accident.

9. **Maternity Care**
Covers pre-natal childbirth and post-natal treatment for the Insured Person with respect to miscarriage abortion due to medical reasons normal or complicated delivery.

Where this benefit is included in the Schedule of Benefits it will apply to pregnancies whose actual date of birth is at least 12 months after the effective/inception elate of cover for the Insured Person.

In the event the Maternity Benefit is deleted in respect of any Insured Person and the Company subsequently agrees to re-introduce Maternity Care for the same Insured Person the waiting period of 12 months shall be re-applied.

Maternity Care is only provided if all members of an Insured's family are insured under the same Plan in the Policy.

10. **Nursing at Home**
The services of a government licensed nurse in the Insured Person's abode when prescribed by a Physician for continued treatment of the specific medical condition for which the Insured Person was hospitalized and only when such services are essential for medical as distinct from domestic reasons. Cover will be limited to a maximum of 26 weeks in any one insurance period.

11. **Repatriation or Local Burial**
The expenses of preparation and the air transportation of the mortal remains of the Insured Person from the place of death to the Home Country or the preparation and Local Burial of the mortal remains of an Insured Person who dies outside his/her Home Country.

12. **Outpatient Cancer Treatment**
Cancer means a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The term cancer also includes leukemia and malignant disease of the lymphatic system such as Hodgkin's disease. Any non-invasive cancer in situ and all skin cancers except invasive melanoma are excluded.

The Insurer shall pay the amount actually charged for outpatient cancer treatment provided by the outpatient department of a hospital or a registered cancer treatment centre including examinations and tests ordered by a medical practitioner but this benefit shall not exceed the maximum limit per year as stated in the Schedule.

13. **Outpatient Kidney Dialysis Treatment**
The Insurer shall pay the amount actually charged for kidney dialysis performed at a legally registered dialysis centre or unit but this benefit shall not exceed the maximum limit per year as stated in the Schedule.

14. **Lodger Benefit**
If on account of an ailment or medical condition an insured child who is not more than 12 years old is hospitalized the Insurer will pay the expenses incurred for one accompanying adult during such hospitalization.

15. **Outpatient Services**
Medical treatment provided lo the Insured Person who is not a registered in-patient in a Hospital or in any other facility for medical care.

16. **General Outpatient Services**
Outpatient Services ordered prescribed or performed by a Physician who is licensed as a General Practitioner.

17. **Specialist Outpatient Services**
Outpatient Services prescribed and provided by a specialist or consultant to whom the Insured Person has been referred to by another Physician.

18. **Laboratory and X-Ray Services**
Laboratory testing radiographic and nuclear medicine procedures used to diagnose and treat medical conditions. Such services must be prescribed by a Physician/Specialist.

19. **Prescribed Drugs**
Drugs and medications the sale and use of which are legally restricted to prescription by a Physician not including items that may be purchased without a Physician's prescription.

20. **Territorial Scope**
Worldwide however treatment in USA/ Canada/Japan is subject to a 20% co-insurance of the first S$16,000 of covered medical expenses incurred.

21. **Overall Limits**
The total aggregate benefits that may be claimed in any one insurance period by an Insured Person as listed in the Schedule of Benefits.

Administration

1. **Arbitration**
Any difference in respect of medical opinion in connection with the treatment of an Accident or Illness shall be settled between two medical experts appointed in writing by the parties to the dispute. Any difference of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing by the two medical experts at the outset. Should the two medical experts fail to agree despite the mediation of the umpire then the decision of the umpire shall be final and binding.

2. **Fraud**
If any claim shall in any respect be false or fraudulent or if any fraudulent means or devices are used by the Insured or anyone acting on his behalf to obtain benefits hereunder then the Policy shall be canceled immediately and all benefits and premiums will be forfeited.

3. **Co-ordination of Benefits/Subrogation**
The Plan will not provide indemnity other than on a proportional basis if the Insured Person has any other Insurance in force or is entitled to indemnity from any other source in respect of the same bodily Injury Illness disease death or expenses.

The Insurer must be informed without delay of circumstances where a claim against a third party can be made. The recipients of benefits shall use their best endeavors to recover the amount of benefit paid from any third party against whom a claim for recovery can be made and shall account to the Insurer for any amount so recovered from the third party.

4. **Eligibility**
The maximum age for enrolment is 64 years. Renewals are available between age 65 to 75 on yearly review basis.

Employees of all nationalities and their Dependants (other than new born children) are eligible to join except for persons residing in USA/Canada/Japan provided they at all times meet such eligibility criteria as may be agreed in writing with the Insurer.

Dependants (other than newly-born children) shall be eligible for insurance on the same elate that the Insured Person to whom they are related becomes eligible or the date the Insured Person acquires such Dependants, whichever is the later.

Newborn children shall be eligible for insurance 15 days after the date of birth or 15 days after discharge from Hospital where birth took place whichever is the later.

5. **Examination**
The Insurer shall have the right through his medical representative to examine any Insured Person whenever and as often as may be reasonably required within the duration of any claim. In addition, the Insurer shall have the right to require an autopsy to be done in the case of death where this is not forbidden by law or religious beliefs.

6. **Legal Proceedings**
No action in law or equity shall be brought to recover under the Plan prior to the expiration of sixty (60) days after proof of claim has been furnished in accordance with the requirements of the Policy. Nor shall any such action be brought at all unless commenced within six years from the date of claim.

The parties hereto agree that the Laws of Singapore shall govern and control in the event of any conflict or dispute between the parties with regard to the Plan and that the parties submit themselves to the exclusive venue and jurisdiction of the courts of Singapore for the resolution of any such conflict or dispute.

7. **Proof of Claim**
Written proof of claim must be submitted to the Insurer within thirty days starting from the first date of treatment of the insured disability for which the claim is made. Failure to claim within the time required by the Policy shall invalidate or reduce the claim unless it can be shown that it was not reasonably possible to furnish such proof within the required time and that it was furnished as soon as reasonably possible.

Original documents supporting invoices and receipts must be submitted with a fully completed claim form signed by the treating Physician. Affirmative proof of Illness or Injury must be submitted at the expense of the Claimant. Photocopies are not admissible.

The Maternity Care Benefit becomes payable only after delivery.

8. Co-operation

As a condition precedent to the Insurer's liability, the Policyholder or the Insured Person or his representatives shall co-operate fully with the Insurer and its medical advisers and will fully and faithfully disclose all material facts and matters which the Policyholder or the Insured Person knows or ought to know and will upon request execute any document to empower the Insurer to obtain relevant information at the Insured Person's expense from any doctor or Hospital or other source as may from time to time be required.

9. Return to Home Country

For citizens of the USA/Canada/Japan who return to their Home Country for a period in excess of three consecutive months the Plan will be terminated automatically. The Employer of Insured Person should notify the Insurer of the date of his return to the Home Country within thirty days of the date of such return. The Insurer will then refund a portion of the premium paid from the elate of return up to the next Due Date.

10. Cancelation

This Policy may be canceled by either the Insurer or the Insured giving 30 days in notice in writing. No premium will be refunded if claims have already been made by the Insured.

Pro-rata refund of premium will be made to the Insured if the Policy is canceled by the Company during its currency.

The Policy shall terminate automatically if the Insured Person is living or intending to live in USA/Canada/Japan for a period in excess of three (3) consecutive months.

Cancelation shall be without prejudice to any claim originating prior to the effective date of cancelation.

If the Insured terminates the Policy the premium charged will be based on the following:

Period of Cover	Premium Charged
1 month	3 months rate
2 months	4 months rate
3 months	6 months rate
4 & 5 months	7 months rate
6 & 7 months	9 months rate
8 months	1 full year premium

11. Contracts (Rights of Third Parties) Act 2001

It is hereby noted and agreed that a person who is not a party to this Policy contract shall have no right under the Contracts (Rights of Third Parties) Act 2001 to enforce any of its terms.

12. Non-Guaranteed Premium

Premiums payable for this coverage are not guaranteed and may be revised at policy renewal at the full discretion of the Company.

13. Change of Occupation/Country of Residence

In the event of a change in occupation/ country of residence of the Insured, the Insured shall notify the Company in writing of the new occupation/country of residence. The Company shall increase or reduce the premium rates according to the risk classification for the new occupation/country of residence.

14. Right to Return Policy/Free Look

In the event that the Insured is not satisfied with the Policy for any reason, it may be returned to the Company for cancelation

within fourteen days of receipt, deemed as the free look period.

a) any premium paid or billed will be refunded in full

b) this Policy is deem to be voided from inception; and

c) the Company shall not be liable for any claims occurring prior to the return of the Policy

This condition shall however only apply to Policies issued in the name of the Insured Person. The Policy document is deemed to have been received by the Insured 3 days after the Company has dispatched it.

15. Payment Before Cover Warranty (Individual)

a) Notwithstanding anything herein contained but subject to clauses b) and c) hereof, it is hereby agreed and declared that the total premium due must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date ("the inception date") of the coverage under the Policy, Renewal Certificate, Cover Note or Endorsement

b) In the event that the total premium due is not paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date referred to above, then the Policy, Renewal Certificate, Cover Note and Endorsement shall not attach and no benefits whatsoever shall be payable by the Company. Any payment received thereafter shall be of no effect whatsoever as cover never attached on the Policy, Renewal Certificate, Cover Note and Endorsement

c) In respect of insurance coverage with "Free Look" provision, the Insured may return the original policy document to the Company or intermediary within the "Free Look" period if the Insured decides to cancel the cover during the "Free Look" period. In such an event, the Insured will receive a full refund of the premium paid to the Company provided that no claim has been made under the insurance

16. Premium Payment Warranty (Corporate)

a) Notwithstanding anything herein contained but subject to clause b) hereof, it is hereby agreed and declared that if the period of insurance is sixty (60) days or more, any premium due must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) within sixty (60) days of the:

i) inception date of the coverage under the Policy, Renewal Certificate or Cover Note; or

ii) effective date of each Endorsement, if any, issued under the Policy, Renewal Certificate or Cover Note

b) In the event that any premium due is not paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) within the sixty (60) day period referred to above, then:

i) the cover under the Policy, Renewal Certificate, Cover Note or Endorsement is automatically terminated immediately after the expiry of the said sixty (60) day period

ii) the automatic termination of the cover shall be without prejudice to any liability incurred within the said sixty (60) day period; and

iii) the Company shall be entitled to a pro-rata time or risk premium subject to a minimum of S$25.00

c) If the period of insurance is less than sixty (60) days, any premium due must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) within the period of insurance.

17. **Breach of Premium Warranty**
It is a condition precedent that this insurance Policy is issued on the basis that the named Insured has never had any insurance (for the risk insured) canceled due solely or in part to a breach of premium payment warranty in the last 12 months.

Exclusions

The following treatments directly or indirectly condition activities items and their related expenses and any complications relating thereto are excluded from this insurance and the Insurer shall not be liable for:

1. Pre-existing conditions as defined or Injuries before the Policy Inception Date of this Policy

2. Charges which are not for actual necessary and reasonable expenses incurred for the treatment of the Illness or Injury

3. Outpatient treatment costs not related to Inpatient treatment or Day Surgery except as a result of an Accident under Emergency Outpatient Accidental Treatment or Optional Outpatient Services

4. Costs resulting from abuse of drugs or alcohol self-inflicted Injuries criminal acts of the Insured Person and sexually transmitted diseases or treatment which in anyway arises from, is attributable to, or is consequential upon Acquired Immune Deficiency Syndrome (AIDS) AIDS related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive and any communicable diseases requiring isolation or quarantine by law

5. Treatment for Injuries or diseases arising from or consequent upon war (whether declared or undeclared), riot, civil commotion, civil war, invasion, acts of foreign enemies, hostilities, rebellion, mutiny revolution, insurrection or military or usurped power, confiscation or nationalization by or under the order of any government or public or local authority, nuclear energy (nuclear reactions radiation contamination), illegal act, regular imprisonment and full-time service in any of the uniform groups except reservist duty or training

6. Routine medical examination (including vaccinations the issue of medical certificates and attestations), confinement in Hospital to facilitate the taking of x-ray or conduct of test routine eye and ear examinations, refractive errors of the eyes, cosmetics (aesthetic) or plastic surgery or any treatment which relates to or is needed because of previous cosmetic treatment, the provision of implants, medical appliances and prostheses devices including spectacles, special braces, hearing aids, lenses, wheelchairs and elective cosmetic surgery

7. Prostheses corrective devices and medical appliances which are not surgically required as well as artificial heart implantation mono or bi-ventricular assist device(s)

8. Dental care and treatment (including oral surgeries) except emergency treatment to sound natural teeth damaged during an accident

9. Pregnancy including but not restricted to normal and complicated childbirth other than as covered under Maternity Care abortion (and its consequences) miscarriage, ectopic pregnancy, hydatidiform mole, infertility, sterilization and contraception

10. Acquisition of the organ(s) itself and all costs relating to bone marrow, kidney heart lung or liver transplant from a donor to a recipient and all expenses directly or indirectly related to organ transplantation except as defined under the Organ Transplantation when this Benefit is stated on the Schedule as being covered by the Policy

11. Treatment relating to birth defects, congenital abnormalities and hereditary conditions

12. Charges for private nursing except under Nursing at Home seeing a general practitioner other than as under Optional Outpatient Services, routine health checks, precautionary services, acupuncture and inoculation and charges for telephone, television, newspapers and other ineligible non-medical items whilst as an in-patient

13. Services or treatments by any institution that is mainly long term care facility like convalescent and nursing homes nature, care clinics, spa, hydro-clinic, rehabilitation centre or sanatorium and that provides incidental or limited hospital services

14. Treatment arising from any geriatric, psycho-geriatric, psychiatric conditions, chiropractic or physiotherapy

15. Treatment by family members

16. Treatment that is not scientifically recognized

17. Racing of any form other than on foot and all professional sports

18. Expenses recoverable from a third party including Workmen's Compensation insurance or Social Security Organization

19. Treatment for obesity weight reduction and weight improvement programmes

20. The cost of Second Opinions for medical conditions unless considered by the Insurer's medical advisers to be reasonable and necessary having regard to the medical facts and circumstances

21. All transportation costs incurred for trips specifically made for the purpose of obtaining medical treatment if not part of an Emergency Medical Evacuation and except as defined under Local Ambulance Services

22. All Emergency Medical Evacuation costs not approved in advance by the appointed Assistance Centre

23. Claims for treatment costs in respect of medical expenses incurred after the expiry date of the policy arising from maternity accidental bodily injury and/or illness occurring during the insurance period unless the insurance has been renewed and the premium paid

Permanent Total Disability

This Benefit applies to the International Plan only.

Cover for the Permanent Total Disability benefit will take effect when shown in the Policy, subject to the terms below.

Definitions

1. **Insured Person**
   An employee or a self-employed person who has completed or whose name is included on a Personal Health Declaration/ Enrolment Form for the Plan and for whom commencement of cover has been confirmed by the Insurer.

2. **Permanent Total Disability**
   The Permanent Total Disability of an Insured person, as a consequence of bodily injury arising from accident or sickness which prevents the performance and exercises of the usual profession or occupation, or any occupation which by education and training the Insured Person may be qualified to perform and can reasonably be expected to do so.

3. **Manual Worker**
   An employee whose occupation involves him/her in work of a manual or physical nature sometimes known as blue collar worker.

Administration

1. **Arbitration**
   Any difference in respect of medical opinion in connection with the treatment of an accident or illness shall be settled between two medical experts appointed in writing by the parties to the dispute. Any difference of opinion between the two medical experts shall be referred to any umpire who shall have been appointed in writing by the two medical experts at the outset. Should the two medical experts fail to agree despite the mediation of the umpire, then the decision of the umpire shall be final and binding.

2. **Enrolment**
   The cover is limited to Insured Persons who at the date of Enrolment are not more than 64 years old. Cover will automatically cease on the first Due Date following the 65th birthday of the Insured Person or whichever the Insured Person ceases fulltime occupation (whichever is the earlier).

3. **Examination**
   The Insured shall have the right through a medical representative to examine the Insured Person whenever and as often as may be reasonably required in the event of a claim.

4. **Proof of Claim**
   In the event of an occurrence likely to result in a claim under this Policy the Insured Person or his/her legal representative must notify the Insurer immediately by cable, telex or telefax if necessary, otherwise in writing and in any case not later than 8 days after the date of occurrence.

   Should the claim be due to accident the immediate notification must state the place, date, time, cause and circumstances surrounding such accident, the identity of any witnesses and a medical certificate stating the degree and nature of injury suffered must be provided so far as reasonably possible.

   The Insurer reserves the right to require the Insured Person or his/ her legal representative to furnish at his/her own expense all original documents as reasonably required with regard to the claim and to instruct any physician, hospital, etc. presently or previously treating the Insured Person to release such information to the Insurer, also concerning previous medical history of the Insured Person as may be required.

   It is explicitly stipulated that failure to perform any of the above mentioned obligations by the Insured Person or his/her legal representative results in loss of entitlement

to compensation under the terms of this Policy.

5. **Payment of Benefit**
   Upon receipt of satisfactory proof of claim the Insurer will pay the benefit up to the limits shown in the Schedule of Benefits in the Policy.

   Payment is a once in a lifetime lump sum benefit. No further payments shall be made to such Insured by reason of any policy of Permanent and Total Disability issued by the Insurer of this Policy.

6. **Termination of Cover**
   This cover automatically expires
   a) at the end of the period as stated in the Policy if not renewed

   b) if the Insured Person attains his/her 65th birthday

   c) if the Insured Person is no longer in full time occupation except from reasons which lead to a claim hereunder

Exclusions

The following items are excluded from the Permanent Total Disability cover:

1. Pre-Existing Illness-any condition which existed or have developed symptoms or there exist manifestation of illness or medical treatment have been sought on drugs and medicine have been prescribed before the effective date of cover in respect of any Insured Person of which the Insured Person was aware or should reasonably have been aware or based on normal medically accepted physical or pathological development of the illness or illnesses

2. Birth defects and congenital illnesses

3. All disorders which by their nature have to or would have to be treated by a psychologist, psychotherapist, psychiatrist or neuropsychiatrist

4. Self-inflicted injury, suicide, attempted suicide, damages to the Insured's health deliberately undertaken by the beneficiary of the Policy, alcoholism, drug addiction or abuse and sexually transmitted diseases

5. Acquired Immune Deficiency Syndrome (AIDS) AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive

6. Permanent Total Disability resulting from the performance of professional and/or hazardous sports and all kind of racing other than by foot

7. Permanent Total Disability resulting from flying other than as a passenger on a scheduled regular carrier

8. Permanent Total Disability resulting from war, riot, or participation in any illegal act including resultant imprisonment

9. All Dependants

10. Policyholders whose main and/or usual activities are deemed to be considered as those of a housewife

11. Thermal or mechanical effects or radiation or other processes following any form of alteration to the atomic structure of matter. Artificial acceleration of atomic particles and the results of radioisotopic radiation

12. Permanent Total Disability resulting from accidents or illnesses incurred after the expiration date of the Policy unless the Policy has been renewed