proMedico Plus

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

3 Introduction
4 Eligibility and Scope
6 General Definitions
9 Definition of Benefits
14 Administration
17 Claims Procedures
18 Exclusions

Introduction

WELCOME NOTE

Your proMedico Plus Policy is a contract between Us, the Company and You, the Insured named in the Policy Schedule based on the proposal form, declaration and any information given to the Company by or on behalf of the Insured Persons, and consists of:

1. this Policy document

2. the Schedule, which has details relating to You, the type of cover and Period of Insurance

3. the Schedule of Benefits

The Fact Find Form, proposal form, declaration and any other information given form the basis of this contract. The Policy, conditions, exclusions, endorsements and memoranda shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part shall bear the same meaning wherever it appears.

The cover provided shall be determined by the Policy wordings contained herein together with any Schedule and Memoranda. This Policy shall become effective on the date specified in the Schedule and continue for the Period of Insurance specified, ending at 23.59 Standard Singapore Time on the last day of the Period of Insurance.

The base currency for this insurance is Singapore Dollars (S$). In consideration having received the required premium, We will indemnify You in the manner and to the extent described in the Policy and in the Policy Schedule in respect of medical or other covered expenses incurred during the Policy Year. Coverage is not extended for any benefit not shown in the Policy Schedule.

Please read this Policy carefully together with Your Schedule to ensure that You understand the terms and conditions and that the cover You require is being provided. Do keep these documents in a safe place as they are legal documents.

If you have any questions after reading these documents, please contact Your insurance adviser or You may contact us at (65) 6221 8611, or email us at feedback@libertyinsurance.com.sg.

If there are any changes that may affect the insurance provided, please notify Us immediately.

OUR ASSURANCE

1. It is our aim to provide You with a high value-added medical and protection plan for You and Your family. We endeavor to serve You to the best of our knowledge and ability and meet any claims covered by this Policy honestly, fairly and promptly. Should You for any reason have any doubts regarding the policy, please approach Your service adviser who will be most happy to help You with Your concerns.

2. The cover only applies to the Policy issued in the name of the Insured Person.

3. We will give You a “Free Look” period of 14 days from the date You receive the Policy to review it, provided that this is the first time of Your application, and the Policy is issued in the name of the Insured Person. You are assumed to have received the Policy within 7 days after We dispatched it. If You then decide that this Policy does not suit Your needs, You may return it to Us for cancellation. Provided that no claims have been made during this period, We shall then refund You the premium You paid Us.

Eligibility and Scope

1. Persons Eligible

To be eligible for cover under this Policy, You must be aged between 18 and 64 years. Your Dependants are also eligible for cover. A newly born child is eligible for cover fifteen (15) days after the date of birth or after discharge from the hospital, whichever is later. Subject to Our approval, cover may be renewed for You and Your spouse up to (and including) age 75.

The following Insured Persons are eligible for cover:

a) Residents of Singapore mean Singapore Citizens and Permanent Residents (holders of re-entry permits) as well as holders of employment passes, work permits, students' passes or dependants' passes

b) Non Residents of Singapore, provided they are not Permanently Residing in USA/Canada/Japan. "Permanently Residing" means living or intending to live in another country for a period in excess of ninety (90) consecutive days

If an eligible person is confined in a Hospital on the date when his/her cover would otherwise become effective, such cover will not become effective until the date following his/her discharge from Hospital.

For Permanent Total Disability, cover will automatically cease on the first due date of the following 65th birthday of the Insured Person or whenever the Insured Person ceases full time occupation (whichever is the earlier).

2. Addition of Dependants

Your Dependants who are eligible may be included as Insured Persons under this Policy if:

a) You request such inclusion

b) Your Dependants are eligible to be insured in accordance with our terms and standards of acceptance; and

c) the required additional premium is paid

Cover for your Dependants will only commence on the date on which We determine the above conditions have been met.

The Company must be informed of the location of any Dependants whose Usual Country of Residence is different from that declared for the Insured in the proposal form and We at all times reserve the right to cover such Dependants on terms and conditions that is consider appropriate or to decline to cover such Dependants under the Policy.

3. Geographical Scope

This Policy covers an Insured Person in his/her Usual Country of Residence on a twenty four (24) hours basis. This Policy also covers an Insured Person while outside his/her Usual Country of Residence, subject always to the limits specified in the Policy Schedule, and subject to the following conditions:

a) An Insured Person, who is not Permanently Residing in USA/Canada/ Japan, is covered for any treatment received in USA/Canada/Japan due to Illness or Injury subject to a 20% Co-Insurance of the first S$16,000 of covered medical expenses

b) Where an Insured Person, who is domiciled in Singapore but lives/travels outside Singapore for a continuous

period of more than sixty (60) days, the eligible expenses subsequently incurred outside Singapore will be limited to the charges for equivalent treatment in Singapore General Hospital, if these are lower than the charges originally incurred

c) If the treatment is available and any Insured Person chooses to be treated outside the Usual Country of Residence, our liability is limited to the charges for equivalent medical treatment in Singapore General Hospital, if these are lower than the charges originally incurred. This Policy will reimburse the cost of covered treatment subject always to the limits specified in the Policy Schedule. Benefits shall always be 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 Policy:

	TERM	MEANING
1.	**The Company, We, Our, Us**	Liberty Insurance Pte Ltd.
2.	**You, Your**	The Insured Person named in the Policy Schedule
3.	**Accident**	An event of violent, accidental, external and visible nature, which independently of any other cause, is the sole cause of bodily injury.
4.	**Age**	Age next birthday, unless the context otherwise requires.
5.	**Chinese Physician**	A person (other than any Insured Person or a member of the Insured Person's immediate family, relatives, siblings, parent) engaging in the practice of traditional Chinese medicine, who is duly licensed or registered to do so (where necessary) according to the laws and regulations applicable in the geographical area of his/her practice.
6.	**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.
7.	**Dependants**	Any of the following persons: a) Legal spouse aged between 18 and 64 years old b) An unmarried and unemployed child aged between 15 days and 18 years c) An unmarried and unemployed child between 19 and 25 years (inclusive) if he or she is enrolled in an educational institution or full time higher education
8.	**Endorsement**	An authorized amendment to the Policy.
9.	**Home Country**	The country of citizenship declared on the 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 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 proposal form.
10.	**Hospital**	An establishment duly constituted and registered subject to the applicable national laws and regulations as a hospital for the care and treatment of sick and injured persons as bed-paying patients, and which:

	TERM	MEANING
		a) has organized facilities for diagnosis, treatment and major surgery b) provides twenty-four (24) hours a day nursing services by registered graduate nurses c) is under the supervision of one or more Physicians at all times; and d) is not primarily a clinic, a place for custodial care for alcoholics or drug addicts, a nursing or rest or convalescent home, or a home for the aged, or similar establishment
11.	**Illness**	A physical condition marked by a pathological deviation from the normal healthy state.
12.	**Injury**	Bodily injury caused solely and directly by an accident.
13.	**Inpatient**	A patient admitted to a Hospital for treatment and for which the Hospital charge a daily room and board charge.
14.	**Insured**	The Policyholder named as Insured in the Policy Schedule.
15.	**Insured Person**	An individual person/persons so described in the Policy Schedule, whose name is included in the proposal form for the Policy and in respect of whom commencement of cover has been approved and confirmed in writing by the Insurer.
16.	**Period of Insurance**	The period of cover shown in the Policy Schedule and any following period, for which cover is extended by mutual agreement.
17.	**Physician or Surgeon**	A person (other than the Insured Person or a member of the Insured Person's immediate family, relatives, siblings, parent) and qualified by degree in Western medicine and legally licensed and duly qualified to practice medicine and surgery authorized in the geographical area of his practice.
18.	**Policy Inception Date**	The date Cover under the Policy commences for the Insured Person.
19.	**Policy Year**	A period of twelve (12) months starting from this Policy and each consecutive 12 months period for which this Policy is renewed.
20.	**Pre-Existing Condition**	An injury, illness or condition which existed (or symptoms or manifestations of which existed) prior to the Policy Inception Date of cover with respect to an Insured Person based on normal medically accepted pathological development of the illness, or of which the Insured Person was aware or should reasonably have been aware, irrespective of whether or not treatment or medication or advice was sought or received.
21.	**Reasonable and Customary Changes**	Charges for medical care which do not exceed the general level of charges being made by others of similar standing in the locality where the charges are incurred, when furnishing like or comparable treatment, services or supplies to individuals of the

	TERM	MEANING
		same sex and of comparable age for a similar Illness or Injury and which in accordance with accepted medical standards, could not have been omitted without adversely affecting the Insured Person's medical condition. In Singapore, Reasonable and Customary Charges shall be deemed to be those laid down in the Singapore Medical Association's Schedule of Fees.
22.	**Renewal Date**	The date on which the Policy is renewed for a further Period of Insurance.
23.	**Serious Medical Condition**	A condition which in the opinion of the Company or its authorized 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 the local availability of appropriate medical care or facilities.
24.	**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 proposal form. The Company 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 ninety (90) days. The Company 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.
25.	**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.

Definition of Benefits

1. **Annual Overall Limit**
   The total aggregate benefits that may be claimed in any one Policy Year by an Insured Person as listed in the Schedule of Benefits.

2. **Hospital Benefits**
   - **a)** All Hospital Services
     Services or materials supplied by the Hospital to the Insured Person during a Hospital confinement and provided they are medically necessary and rendered or supplied at Reasonable and Customary Charges. These include operating theatre charges; anaesthetist fee; oxygen and their administration; drugs, dressings or medicines prescribed by the attending Physician for in-hospital use; diagnostic procedures and laboratory tests, theatre consumables and other ancillary charges. The costs of non-medically necessary goods or services including items such as telephone, television and newspapers are not covered
   - **b)** Daily Hospital Room and Board
     Charges for room accommodation, meals and general nursing services
   - **c)** Intensive Care Unit
     Charges incurred during confinement as an Inpatient in the Intensive Care Unit of the Hospital
   - **d)** Surgeon's Fee
     Fees for surgery by a Surgeon, including the Surgeon's visits while in Hospital. Charges for Day Surgery are also payable
   - **e)** Day Surgery (include minor surgical procedure in a clinic)
     A surgery carried out by a Surgeon on an out-of-hospital basis. Surgical procedure performed in a clinic is subject to the same interpretation
   - **f)** Daily In-Hospital Doctor's Visit
     Fees charged by the attending Physician for daily bedside visits and limited to one (1) visit per day
   - **g)** Pre-Hospitalization/Surgery Diagnostic Services
     Charges for diagnostic procedures and laboratory examinations, which are recommended in writing by a Physician, which are incurred within ninety (90) days prior to an Inpatient treatment or Day Surgery
   - **h)** Pre-Hospitalization/Surgery Specialist's Consultation
     Charges for consultation with a General Practitioner, and a Specialist, if recommended in writing by General Practitioner, within ninety (90) days prior to an Inpatient treatment or Day Surgery
   - **i)** Post-Hospitalization Treatment
     Expenses for follow-up treatment by the same Physician up to a period of 90 days immediately following discharged from Hospital or Day Surgery. Cover is restricted to follow-up treatments of the specific medical condition for which the Insured Person received Inpatient treatment or Day Surgery covered by the Policy
   - **j)** Lodger Benefit
     Accommodation charges incurred by one (1) parent of an Insured Person under 12 years old, whom is treated for Illness or Injury at a Hospital in excess

of three (3) days, and the treating Physician has advised in writing that a parent should remain with the Insured Person

k) Local Ambulance Services
The medically necessary road transportation provided by a recognized ambulance service provider to a local Hospital

l) Home Nursing
If this benefit is specifically stated and covered under the Schedule of Benefits, we will pay for the charges incurred for the cost 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 per Policy Year

3. Outpatient Treatments

a) Outpatient Kidney Dialysis Treatment
Charges for treatment of an Insured Person requiring kidney dialysis performed at a legally registered dialysis centre or unit

b) Outpatient Cancer Treatment
Charges for treatment of an Insured Person for cancer at a legally cancer treatment centre including examinations and tests ordered by a Physician

c) Emergency Outpatient Accidental Treatment
Charges for services and medical supplies provided by the hospital or clinic or Chinese Physician for emergency treatment of any 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 conditions by the same Physician or Chinese Physician will be reimbursed up to 31 days from the date of Accident, provided that where treatment is received by Chinese Physician the total aggregate liability under this Section shall not exceed S$300 per event/occurrence

d) Emergency Dental Treatment
Charges for dental procedures necessary to restore or replace sound natural teeth lost or damage in an Accident within 24 hours after the Accident. Eligible expenses incurred thereafter for follow-up treatment of the specific condition will be reimbursed up to 31 days from the date of Accident

4. Organ Transplantation
The medical treatment costs, incurred in respect of bone marrow, heart, kidney, liver and lung transplants (excluding the cost of acquisition of the organ and all costs incurred by the donor). Transplantation costs may only be claimed under this Section of the Policy when the Benefit is indicated on the Policy Schedule. No other type of benefits in this Policy provides cover in connection with Organ Transplantation benefit.

5. Prosthetic Treatment
The costs of prosthetic treatment incurred if the prosthetic is surgically implanted.

6. Maternity Benefit

a) Miscarriage due to Accident
Charges incurred for necessary emergency treatment by a Physician for miscarriage suffered by an Insured Person as a result of an Accident

b) Maternity Care

If this benefit is specifically stated and covered under the Schedule of Benefits, we will pay for the charges incurred for pre-natal childbirth and post-natal treatment with respect to:

- **i)** miscarriage or abortion due to medical reasons
- **ii)** normal or complicated delivery

It will apply to pregnancies whose actual date of birth is at least twelve (12) months after the effective/inception date 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.

7. Daily Hospital Cash Allowance

If an Insured Person is admitted to a Singapore Restructured Hospital and if this hospitalization claim is payable under this Policy, We will pay You a daily hospital cash benefit up to the sub-limits stated in the Policy Schedule and for a maximum of thirty (30) days per disability. However, no benefit will be payable if the Hospital admission is for a Day Surgery.

8. Dread Disease Recuperation Benefit (Coronary Artery By-Pass, Heart Attack, Cancer, Stroke)

This benefit applies to an Insured Person who contracts Cancer, or sustains a Heart Attack or a Stroke or undergoes Coronary Artery By-pass surgery.

This benefit is not payable in respect of Cancer, Coronary Artery By-pass Surgery or Heart Attack which takes place within ninety (90) days of the date on which an Insured Person is first covered under this Policy.

a) Coronary Artery By-Pass Surgery

The actual undergoing of open-chest surgery to correct the narrowing or blockage of one or more coronary arteries with by-pass grafts. This diagnosis must be supported by angiographic evidence of significant coronary artery obstruction and the procedure must be considered medically necessary by a consultant cardiologist.

Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures are excluded.

b) Heart Attack

Death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. This diagnosis must be supported by three or more of the following criteria which are consistent with a new heart attack:

- **i)** History of typical chest pain
- **ii)** New electrocardiogram (ECG) changes proving infarction
- **iii)** Diagnostic elevation of cardiac enzyme CK-MB
- **iv)** Diagnosis elevation of Troponin (T or 1)
- **v)** Left ventricular ejection fraction less than 50% measured 3 months or more after the event

c) Cancer

A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by

histological evidence of malignancy and confirmed by an oncologist or pathologist.

The following are excluded:

i) Tumors showing the malignant changes of carcinoma-in-situ and tumors which are histologically described as pre-malignant or noninvasive, including, but not limited to: Carcinoma in-Situ of the Breasts, Cervical Dysplasia CIN-1, CIN-2 and CIN-3

ii) Hyperkeratosis, basal cell and squamous skin cancers, and melanomas of less than 1.5mm Breslow thickness, or less than Clark Level 3, unless there is evidence of metastases

iii) Prostate cancers histologically described as TNM Classification T1a or T1b or Prostate cancers of

iv) another equivalent or lesser classification, T1N0M0 Papillary micro-carcinoma of the Thyroid less than

v) 1cm in diameter, Papillary micro-carcinoma of the Bladder, and

vi) All tumors in the presence of HIV infection

d) Stroke

A cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, cerebral embolism and cerebral thrombosis. This diagnosis must be supported by all of the following conditions:

i) Evidence of permanent neurological damage confirmed by a neurologist at least 6 weeks after the event; and

ii) Findings on Magnetic Resonance Imaging Computerized Tomography, or other reliable imaging techniques consistent with the diagnosis or a new stroke

The following are excluded:

i) Transient Ischemic Attacks

ii) Brain damage due to an Accident or Injury, infection, vasculitis and inflammatory disease

iii) Vascular disease affecting the eye or optic nerve; and

iv) Ischemic disorders of the vestibular system

9. Special Grant

Payable if an Insured Person dies from:

a) an Injury

b) an Illness during or after treatment for such Illnesses, at a Hospital or in Day Surgery

10. Permanent Total Disability

The Permanent Total Disability of an Insured Person, as a consequence of bodily Injury arising from Accident or Illness 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.

This benefit applies to the International Plan only. Cover for the Permanent Total Disability benefit will take effect when shown in the Policy.

a) Insured Person

An employee or a self-employed person who has completed or whose name is included on a proposal form for the Plan, and for whom Policy Inception Date has been confirmed by the Insurer. All Dependants and housewives are excluded from cover under the benefit.

b) Manual Worker

An employee whose occupation involves him/her in work of a manual or

physical nature sometimes known as blue collar worker.

11. Medical Evaluation/Repatriation

a) Emergency Medical Evacuation/ Repatriation

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 Company reserves the right to decide the place to which the Insured Person shall be transported. The Company 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.

b) Repatriation of Mortal Remains

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. Rider–Outpatient Services

If this benefit is specifically stated as covered under the Schedule of Benefits, we will pay for medical treatment provided to the Insured Person who is not a registered in-patient in a Hospital or in any other facility for medical care.

a) General Outpatient Services

Outpatient services ordered prescribed or performed by a Physician who is licensed as a General Practitioner

b) 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

c) 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

d) Prescribed Drugs

Drugs and medications the sale and use of which are legally restricted to prescription by a Physician and including items that may be purchased without a Physician's prescription

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. **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.

5. **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.

   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.

6. **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.

7. 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. Your receipt of any benefit under this Policy shall in all cases be deemed final and complete discharge of all our liability.

For Permanent and Total Disability claims, 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.

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. Policy Renewal

The maximum age for enrolment is 64 years old. Renewals are available between age 65 to 80 on yearly review basis.

You may renew this Policy by paying the premium applicable at the time of renewal. Premiums payable for this coverage are not guaranteed and may be revised at policy renewal at the full discretion of the Company.

10. Misstatement of Age

If the age of any Insured Person has been misstated and the premium paid as a result is insufficient, any claim payable under this Policy shall be pro-rated based on the ratio of the actual premium paid to the correct premium which should have been charged for the entire Period of Insurance. Any excess premium that may have been paid as a result of any misstatement of age shall be refunded without interest. If at the correct age an Insured Person would not have been eligible for Cover under this Policy, no benefit shall be payable, and our liability shall be limited to the refund of the premium paid without interest.

11. Alterations

We reserve our rights to amend the terms and conditions of the Policy by informing you of the intended amendments at least 30 days prior to the renewal. Unless specifically mentioned, such amendments shall not affect any special conditions or endorsements applicable at the time of commencement of cover. No Alterations to this Policy shall be valid unless approved in writing by us and reflected on an endorsement.

12. Changes in Circumstances

In the event of a change in circumstances affecting the risk, You must notify the Company in writing particular changes in occupation/country of residence, or health affecting You or any Insured Person. The Company shall increase or reduce the premium rates according to the risk classification for the new occupation/Country of Residence or to decline the coverage under the Policy.

13. 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.

14. 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 during the current Policy Year.

Pro-rata refund of premium will be made to the Insured if the Policy is canceled by the Company during its currency subject to minimum premium of S$50 plus GST.

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 ninety (90) days.

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

15. 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 cancellation 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.

16. Payment Before Cover Warranty (Individual)

a) Notwithstanding anything herein contained but subject to clauses 2 and 3 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.

17. Premium Payment Warranty (Corporate)

a) Notwithstanding anything herein contained but subject to clause 2 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.

18. 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.

Claims Procedures

1. Written notice shall be given to the Insurer or its appointed representatives as soon as possible and in any circumstances within:

a) eight (8) days in the event of a claim for Permanent Total Disability; or

b) thirty (30) days in the event of all other claims of the occurrence of any event, which may give rise to a claim under this Policy

2. A claim form obtainable from the Insurer upon request shall then be submitted accompanied by the necessary supporting evidence of the occurrence, character and

extent of loss.

The Insured has to submit the following original documents in support of his/her claim to the Insurer when making a claim for Injury, Illness or surgery:

a) Duly completed Liberty Medical Claim Form: with Section A completed by you and Section B completed by the attending doctor

b) Inpatient discharge summary (i.e. if you are admitted to a restructured hospital)

c) Final and itemized hospital bill from the Hospital for the admission

d) All other original hospital bills where appropriate such as Pre-hospitalization/ diagnostic and Post-hospitalization/ follow-up bills

Should the claim be due to Accident, the immediate notification must state the place, date, time and 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 Insured Person or his/her legal representative must notify the Insurer immediately not later than 8 days after the date of occurrence.

3. All certificates, receipts, information and evidence required by us shall be supplied free of expense to the Insurer, in the form prescribed by the Insurer.

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 compensate under the terms of this Policy.

Payment of all claims and benefits will be made in Singapore currency. Charges incurred in any other currency shall be payable in Singapore Dollars on the basis of the quoted exchange rate in effect on the date such charges were incurred.

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 unless declared in the proposal form and specifically accepted by Us during underwriting stage and endorsed here in.

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

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 Inpatient.

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. Any disorders which by their nature have to or would have to be treated by a psychologist, psychotherapist, psychiatrist or neuropsychitrist.

15. Treatment by family members, relatives, siblings or parent.

16. Illnesses or Injuries arising from racing of any kind other than on foot, professional sports, caving, mountaineering or rock climbing necessitating the use of guides or ropes, potholing, skydiving, parachuting, bungee jumping, ballooning, hang glides, any underwater activities involving the use of underwater breathing apparatus or martial arts.

17. The use, or any treatment arising therefrom, of any drugs not licensed by an official governmental control agency of the country in which the drug is given, as drugs used in any circumstances other than in accordance with their licensed medications.

18. Experimental medical treatment or is not scientifically recognized.

19. Any treatment directed towards developmental delay and/or learning disabilities in children.

20. Sleep Apnoea.

21. Treatment of varicorele, impotence or any consequence of it.

22. Treatment which arises from, or is in any way attributes to sex change.

23. Flying other than as a passenger on a scheduled regular carrier.

24. Permanent Total Disability resulting from participation in any illegal acts including resultant imprisonment.

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

26. Treatment for obesity weight reduction and weight improvement programmes.

27. 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.

28. 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.

29. 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.

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

31. 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.