Liberty Insurance

Medical Coverage - Making decisions with greater assurance

proMedico

(Applicable to policies effected on or before 1 August 2019)

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.

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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 Policy). 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 Schedule of Benefits 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 or Illness 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 the Insured Person, his legal representative executor or to the licensed providers of the eligible medical treatments and/or services rendered to the Insured Person.

Benefits are limited to the usual Reasonable and Customary charges in the country or area where the 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 and be the sole cause of the 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 Injury, Illness or 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 prior to the Policy Inception Date of cover in respect of any Insured person of which the Insured Person was aware or should reasonably have been aware of based on normal

Term	Meaning
	medically accepted physical or pathological development of the Illness.
5. Deductible/Co-insurance	The portion of costs for which the Insured Person is liable. The Deductible/Co-insurance will apply 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 person/persons so described in the Policy Schedule, whose name is included in the Health Declaration/Proposal Form and in respect of whom commencement of cover has been approved and confirmed in writing by the Insurer and refers to the person covered under the Policy.
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 Policy. 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 /Surgeon/ Specialist	A person (other than the Insured Person or a member of the Insured Person's family, relatives, siblings, parents) 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.
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

Term	Meaning
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 Illness or Injury. In Singapore, Reasonable and Customary Charges reference the hospital charges published by the Singapore Ministry of Health.
11. Usual Country of Residence	The country in which the Insured Person is usually residing as stated in the Policy Schedule 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 Policy 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 the local availability of appropriate medical care or facilities.
14. Due Date	The renewal date of cover as shown on the Policy Schedule or the date on which any subsequent instalment of premium falls due.
15. Inception Date	The first commencement/effective date of insurance

Term	Meaning
16. Policy	The contract of insurance between Liberty Insurance Pte Ltd and the Insured Person which will consist of the following: **a)** the policy; **b)** the policy schedule; **c)** all endorsements; and **d)** the proposal form/personal health declaration, memoranda, medical questionnaire, notes, statement submitted by the Insured Person or on Insured Person's behalf at any time, whether upon initial Inception Date or at renewal
17. The Insurer	Liberty Insurance Pte Ltd
18. Insured	Policyholder named as Insured in the Policy Schedule.
19. Policy Year	A period of twelve (12 months) starting from the Policy Inception Date and each consecutive 12 month period for which this Policy is renewed.
20. Emergency	A sudden change in Insured Person's health which requires urgent medical or surgical intervention to avoid death or serious impairment to the Insured Person's health.

1. Definition of Benefits

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

1. All Hospital Services

Medical treatment and services prescribed by a Physician and rendered to the Insured Person for appropriate treatment procedures and when admitted as a registered in-patient in a Hospital. The Reasonable and Customary charges in the area where treatment is provided for hospital services and surgery including the cost of the room and meal charges, all hospital medical facilities, intensive care unit accommodation where this is medically required, operating theatre, anaesthesia, oxygen and its administration and Surgeon's/Physician's fee. Day surgery (including minor surgical procedure in a clinic) 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/Physician opinion or all Costs of Specialist/Physician opinion or all medically necessary diagnostic procedures ordered by a Physician within 90 days preceding Hospital admission as a registered in-patient for the treatment of a 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 (including minor surgical procedure in a clinic). 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 a specific medical condition for which the Insured Person received in-patient treatment or day surgery (including minor surgical procedure in a clinic) 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 provided the Benefit is indicated on the Schedule of Benefits. 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 by the Policy.

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 or Country of Residence. In the event of such an emergency the 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 Insured Person 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 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 delivery date is at least 12 months after the Inception Date of cover.

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 available provided if all members of an Insured's family are insured under the same Plan in the same 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 Policy Year.

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/Country of Residence, or the preparation and Local Burial of the mortal remains of an Insured Person who dies outside his/her Home Country or Country of Residence.

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 Company shall pay up to the maximum limit specified in the Schedule of Benefits for charges incurred for outpatient cancer treatment prescribed by Physician and provided by the outpatient department of a Hospital or a registered cancer treatment centre including examinations and tests ordered by the Physician.

13. Outpatient Kidney Dialysis

The Insurer shall pay up to the maximum limit specified in the Schedule of Benefit for charges incurred for kidney dialysis prescribed by Physician and performed at a legally registered dialysis centre.

14. Lodger Benefit

If on account of an Illness 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. Daily Hospital Cash Allowance

If an Insured Person is admitted in a Singapore Government/Restructured Hospital ward which is lower than the room and board entitlement as stated in the Schedule of Benefits, and provided this hospitalization claim is payable under this Policy, the Insurer will pay the Insured Person a daily hospital cash benefit up to the sub-limits stated in the Schedule of Benefits 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.

16. Outpatient Services

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

a) Outpatient General Practitioner (GP) Services ordered, prescribed or performed by a Physician who is licensed as a General Practitioner.

Charges incurred in respect of the following are excluded under the Policy:

i) More than one outpatient visit per day;

ii) Visits at home or in office;

iii) Prescription drugs obtained without consultation;

iv) Kidney dialysis and cancer treatment;

v) Paediatric consultations and services

vi) Physiotherapy

b) Overseas outpatient cover is applicable only for first 60 days of Insured Person's travelling overseas up to the amount as specified in the Schedule of Benefit.

c) Treatment in Accident & Emergency Department is limited to visits at Singapore Government/Restructured Hospitals only and up to the maximum number of visit and limit as specified in the Schedule of Benefit.

d) Outpatient Specialist Services (SP)
Outpatient Services prescribed and provided by a Specialist to whom the Insured Person has been referred to by another Physician.

e) Laboratory and X-Ray Services
Laboratory testing, radiographic, MRI, CT Scan, Ultrasound and nuclear medicine procedures used to diagnose and treat medical conditions. Such services must be prescribed by a Physician/ Specialist. Dental X-rays are excluded under the Policy.

f) Prescribed Drugs
Drugs and medications, the sale and use of which are legally restricted to prescription by a Physician do not include items that may be purchased without a Physician's prescription.

17. Territorial Scope

Worldwide excluding Insured Person residing in USA/Canada/Japan for a period of 60 days or more.

For treatment received in USA/Canada/ Japan during the first sixty (60) days is subjected to a 20% Co-insurance on the first S$16,000 of eligible medical expenses incurred.

The Policy shall automatically terminate on day sixty one (61) when the Insured Person is living or residing in USA/Canada/Japan for a period in excess of sixty (60) days.

Where an Insured Person, who is residing 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.

18. Annual Overall Limits

The total aggregate benefit limit that may be claimed in any one Policy Year by an Insured Person as specified in the Schedule of Benefits.

2. 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 Person or anyone acting on his/her 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 Policy 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 old (age next birthday). Renewals are available between age sixty five (65) to eighty (80) on yearly review basis.

Insured Person of all nationalities and their Dependants (other than new born children) are eligible, excluding those residing in USA/Canada/Japan, provided at all times the Insured Persons meet such eligibility criteria as may be agreed in writing by the Insurer.

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

If an eligible Insured 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.

5. Examination

The Insurer shall have the right through his/her 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 Policy 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 (6) 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 regards to the Policy 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. Return to Home Country

For citizens of the USA/Canada/Japan who return to their Home Country for a period in excess of two (2) consecutive months, the Policy will be terminated automatically. The Insured or the Insured Person should notify the Insurer of the date of his return to the Home Country within thirty (30) days of the date of such return. The Insurer will then refund a portion of the premium paid based on the Short Term Premium charged from the date of return up to the next Due Date, provided there were no claim made under the current Policy Year.

8. Cancelation

This Policy may be canceled by either the Insurer or the Insured Person by giving thirty (30) days' notice in writing. No premium will be refunded if claim has already been made during the current Policy Year.

Pro-rata refund of premium will be made to the Insured or Insured Person if the Policy is canceled by the Insurer during its currency, provided no claim were made under the current Policy Year and subject to an administrative fee of S$100/- 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 two (2) 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 Short Term Premium Table, provided no claim were made under the current Policy Year:

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

9. 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.

10. 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.

11. Change of Occupation/Country of Residence

In the event of a change in occupation/ Country of Residence of the Insured Person, the Insured Person shall notify the Insurer in writing of the new occupation/Country of Residence. The Insurer shall increase or reduce the premium rates according to the risk classification of the new occupation/Country of Residence or to decline the coverage.

12. Right to Return Policy/Free Look Period

In the event that the Insured or the Insured Person is not satisfied with the Policy for any reason, it may be returned to the Company for cancelation within fourteen (14) days of receipt.

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

b) this Policy is deemed to be voided from the Inception Date of cover; and

c) the Insurer 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 Person three (3) days after the Insurer has dispatched it.

13. 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.

14. 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.

15. 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.

3. Claims Procedures

1. Pre-authorization must be obtained through the Company's Medical Concierge hotline: (+65) 6715 9422 for any Inpatient or Day Surgery procedure in Private Hospitals including Overseas hospitalization, otherwise a 20% Co-insurance shall be imposed on all eligible medical expenses covered under the Policy.

The 20% Co-insurance will not apply in the event of an Emergency and the Insured Person or his representative contacted the Insurer within 24 hours after admission.

To obtain pre-authorization, the Insured Person or his representative must submit the request at least 5 working days prior to his/her admission or treatment.

Pre-authorization is not a guarantee of benefits or eligibility and all services are subjected to the benefit, limitations and other Policy terms and conditions.

Pre-authorization is subject to the Indemnity Clause.

2. Submission of Non-Pre Authorized Claim

Written proof of claim must be submitted to the Insurer within thirty days starting from the first date of treatment of a medical condition for which the claim is made. Failure to submit 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.

3. Indemnity Clause

Where Letters of Guarantee are issued to the Insured or Insured Person, the following terms and conditions apply:

a) The Letters of Guarantee shall be used only for hospital admission by Insured Person insured under the Policy.

b) For medical costs which are in excess of the limits of benefits and/or which are not reimbursable under the terms and conditions of Policy, the Insured or Insured Person shall undertake to repay the Insurer within 30 days from the receipt of all expenses that are not claimable under the policy. An interest charge of 6% will be levied on any amounts outstanding after 30 days.

c) The Insured or Insured Person undertakes to furnish the Insurer details of the insured event for which the claim is made. Failure to furnish proof of claim will render the Insured or Insured Person responsible for all interest charges, if any, imposed by the Hospital for delayed settlement of hospital bills.

d) The Insured or Insured Person agrees to return all unused Letters of Guarantee to the Insurer when the Insured or Insured Person terminates the Policy with the Insurer or after the expiry of the validity period.

e) The Insured or Insured Person agrees to sign the Medisave Authorization Form and MediShield Authorization Form at the Admission Room of the Hospital notwithstanding the production of the Letter of Guarantee.

f) The Insured will be responsible on behalf of its subsidiary companies who are covered under the insurance policy for all the above-mentioned terms.

g) The Insured will be responsible for any outstanding amount due to the Insurer in the event it is not recoverable from the Insured Employee due to the resignation of the said Employee.

4. 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.

5. Co-operation

As a condition precedent to the Insurer's liability, the Insured 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 Physician or Hospital or other source as may from time to time be required.

4. 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 sustained before the Inception Date of this Policy unless it is declared in the Health Declaration/Proposal Form and specifically accepted by the Insurer during underwriting stage and endorsed herein.

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

3. Outpatient treatment costs not related to in-patient treatment or Day Surgery except as a result of an Accident as covered under Emergency Outpatient Accidental Treatment benefit 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 or any communicable diseases requiring isolation or quarantine by law.

5. Treatment for Injuries or Illnesses 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 unless it is medically necessary, medical appliances and prostheses devices including spectacles, special braces, hearing aids, lenses, wheelchairs and elective or 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 as covered under the Emergency Dental Treatment benefit.

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 of Benefits as being covered by the Policy.

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

12. Charges for private nursing except as covered under Nursing at Home, seeing a general practitioner other than as covered 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, or chiropractic. Any disorders which by their nature have to or would have to be treated by a psychologist, psychotherapist, psychiatrist or neuropsychiatrist.

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

16. Experimental medical treatment that is not scientifically recognized.

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

18. Racing of any form other than on foot and all 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.

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 Work Injury Compensation Act or Social Security Organization.

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

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

28. 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.

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

30. 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 is paid.

5. 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 the Personal Health Declaration/ Proposal Form 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 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.

3. Manual Worker
An Insured Person 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 (age next birthday). 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 Insurer 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 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 Person by reason of any Policy of Permanent and Total Disability issued by the Insurer.

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 – refers to 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 Inception 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, congenital abnormalities and hereditary conditions.

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 Person'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 Dependents.

10. Insured Person 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 occurred after the expiration date of the Policy unless the Policy has been renewed