GROUP HOSPITALISATION AND SURGICAL INSURANCE POLICY

WHEREAS the Insured by an application and declaration which shall be the basis of this contract and is deemed to be incorporated herein has applied to RHB INSURANCE BERHAD (hereinafter referred to as "the Company") for the insurance hereinafter contained and has paid or agreed to pay the premium stated in the Policy Schedule of Benefits ("the Schedule") as consideration for such insurance for the period stated therein.

NOW THIS POLICY OF INSURANCE WITNESSETH that if during the period of insurance stated in the Schedule attached hereto, any Sickness, Disease, Illness or Accidental Injury necessitates the Insured Person to be confined to a Hospital for treatment, the Company shall subject to the terms, provisos, exclusions and conditions or endorsements on this Policy, pay the Insured or the Insured's legal representatives the sum or sums stated in the Schedule of Benefits.

Provided always that the liability of the Company shall not exceed the Overall Annual Limit as set out in the Schedule of Benefits for any one period of insurance.

Importance of Disclosure (Statement Pursuant to Schedule 9 of the Financial Services Act 2013)

Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if the Insured is applying for this Insurance wholly for the Insured/the Insured's family/the Insured's dependents, the Insured has a duty to take reasonable care not to make a misrepresentation in answering the questions in the Proposal Form (or when the Insured applies for this insurance). The Insured must answer the questions fully and accurately.

Failure to take reasonable care in answering the questions may result in avoidance of the Insured's contract of insurance, refusal or reduction of the claim(s), change of terms or termination of the contract of insurance.

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

In addition to answering the questions in the Proposal Form (or when the Insured applies for this insurance), the Insured is required to disclose any other matter that the Insured knows to be relevant to the Company's decision in accepting the risks and determining the rates and terms to be applied.

The Insured also has a duty to tell the Company immediately if at any time after the Insured's contract of insurance has been entered into, varied or renewed with the Company, any of the information given in the Proposal Form (or when the Insured applied for this insurance) is inaccurate or has changed.

DEFINITIONS

RELATING TO CONTRACTUAL DETAILS

1. **POLICYHOLDER** shall mean the person named in the Policy as the owner. The Policyowner/Policyholder controls the Policy unless the Policy has been assigned.
2. **INSURED PERSON/INSURED** shall mean the person described in the Policy Schedule including his/her Dependent (if applicable).
3. **POLICY YEAR** shall mean the one year period including the effective date of commencement of Insurance and immediately following that date, or the one year period following the Renewal or Renewed Policy.
4. **RENEWAL OR RENEWED POLICY** shall mean a Policy which has been renewed without any lapse of time upon expiry of a preceding Policy with the same content.
5. **POLICY** shall mean this agreement together with any endorsements therein, signed by the Company, the Policy Schedule attached hereto and the application form of the Insured Person all of which constitute the entire contract between the parties.

RELATING TO INSURANCE COVER

1. **ACCIDENT** shall mean a sudden, unforeseen and unplanned event that results in bodily Injury.
2. **INJURY** shall mean damage to the body as a result of an Accident.
3. **SICKNESS, DISEASE OR ILLNESS** shall mean a physical condition marked by a pathological deviation from the normal healthy state.
4. **DISABILITY** shall mean a Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes.
5. **ANY ONE DISABILITY** shall mean all of the periods of Disability arising from the same cause including any and all complications therefrom except that if the Insured Person completely recovers and remains free from further treatment (including drugs, medicines, special diet or injection or advice for the condition) of the Disability for at least ninety (90) days following the latest date of discharge and subsequent Disability from the same cause shall be considered as though it was a new Disability.
6. **CONGENITAL CONDITIONS** shall mean any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within six (6) months from the time of birth. They will include hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the Insured was continuously covered under this Policy.
7. **CHILD** shall mean any person who has attained the age of thirty (30) days and is an unmarried person, is financially dependent upon the Insured and is under the age of nineteen (19), or up to the age of twenty-three (23) for those registered as full-time students at a recognized educational institution.
8. **DEPENDENT** shall mean any of the following persons:
   a) a legally married spouse; and/or
   b) unmarried children over thirty (30) days old but under nineteen (19) years of age or twenty-three (23) years of age is still on full-time higher education, and who are not gainfully employed.
9. **ELIGIBLE EXPENSES/BENEFITS** shall mean Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the Schedule.
10. **MEDICALLY NECESSARY** shall mean a medical service which is:-
    a) consistent with the diagnosis and customary medical treatment for a covered Disability;
    b) in accordance with standards of good medical practice, consistent with the current standards of professional medical care, and of proven medical benefits;
    c) not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of Hospital (if admitted as an inpatient);
    d) not of an experimental, investigational or research nature, preventive or screening nature, medical technology/procedure, which has not been proven to be effective, based on established medical practice, or which has not been approved by a recognized body in Malaysia;
    e) for which the charges are fair and reasonable and customary for the covered Disability; and
    f) provide treatment directly related to the covered Disability.
11. **REASONABLE AND CUSTOMARY CHARGES** shall mean charges for medical care which is Medically Necessary shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing within Malaysia according to 13th Schedule of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013 and its subsequent amendments if any. Such charges when incurred, taking into consideration similar or comparable treatment, services or supplies to individuals of the same gender and of comparable age of similar Sickness, Disease or Injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured Person's medical condition.
12. **ACCIDENTAL DENTAL TREATMENT** shall mean dental procedure necessary as a result of Accident. This benefit is provided within twenty-four (24) hour from the Accident and includes follow-up treatment up to the number of days as specified in the Schedule.
13. **DAY SURGERY / DAYCARE PROCEDURE** shall mean a surgical procedure performed at a Hospital or Day Surgery/Daycare Specialist Centre which required the use of a recovery facility, but without an overnight stay at the Hospital or Day Surgery/Daycare Specialist Centre.
14. **PRE-EXISTING ILLNESS** shall mean disabilities that the Insured Person has reasonable knowledge of An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:-
    a) the Insured Person had received or is receiving treatment ;
    b) medical advice, diagnosis, care or treatment has been recommended;
    c) clear and distinct symptoms are or were evident; or
    d) its existence would have been apparent to a reasonable person in the circumstances.
15. **SPECIFIED ILLNESSES** shall mean the following disabilities and its related complications, occurring within the first one hundred and twenty (120) days of Insurance of the Insured Person:
    a) Hypertension, diabetes mellitus and Cardiovascular Disease
    b) All tumours, cancers, cysts, nodules, polyps, stones of the urinary system and biliary system
    c) All ear, nose (including sinuses) and throat conditions
    d) Hernias, hemorrhoids, fistulae, hydrocele, varicoele
    e) Endometriosis including Disease of the Reproduction system
    f) Vertebra-spinal disorders (including disc) and knee conditions.

16. **HOSPITALISATION** shall mean admission to a Hospital as a registered in-patient for Medically Necessary treatments for a covered Disability upon recommendation of a Physician. A patient shall not be considered as an inpatient if the patient does not physically stay in the Hospital for the whole period of confinement.
17. **INTENSIVE CARE UNIT** shall mean a section within a Hospital which is designated as an Intensive Care Unit by the Hospital, and which is maintained on a twenty-four (24) hour basis solely for treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.
18. **OUT-PATIENT** shall mean the Insured Person who visits the Hospital, clinic or other healthcare facility for diagnosis or treatment but is not hospitalised.
19. **DEDUCTIBLE** shall mean the specified eligible amount as specified in the Schedule of Benefits that the Insured is liable before any benefits are payable under this Policy.
20. **CO-INSURANCE** shall mean a cost sharing arrangement under which the Insured is obliged to bear a specified percentage of the Eligible Expenses as specified in the Schedule of Benefits with the balance to be reimbursed under this Policy.
21. **WAITING PERIOD** shall mean the first thirty (30) days between the beginning of an Insured Person's Disability and the commencement of this Policy date/ reinstatement date and is applied only when the person is first covered. This shall not be applicable after the first year of cover. However, if there is a break in insurance, the Waiting Period will apply again.
22. **OVERALL ANNUAL LIMIT**
    Benefits payable in respect of expenses incurred for treatment provided to the Insured Person during the period of insurance shall be limited to Overall Annual Limit as stated in the Schedule of Benefits irrespective of a type/types of Disability. In the event the Overall Annual Limit having been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining Policy year.

RELATING TO MEDICAL SUPPLIERS

1. **DAY SURGERY/DAYCARE PROCEDURE**
   A patient who needs the use of a recovery facility for a surgical procedure on a pre-plan basis at the Hospital/ specialist clinic (but not for overnight stay).
2. **HOSPITAL** shall mean a registered institution established for the purpose of providing treatment and care of bed paying sick or injured patients and has facilities for:
   a) Twenty-four (24) hour a day nursing services by registered and graduate nurses;
   b) Diagnostic and major surgery; and
   c) Under the supervision of a Physician.

   A Hospital is expressly NOT:
   a) Primarily a clinic;
   b) A convalescent, nursing or rest home;
   c) A rehabilitation center for alcoholics or drug addicts; or
   d) A home for the elderly or infirmed.
3. **MALAYSIAN GOVERNMENT HOSPITAL** shall mean a Hospital established, maintained, operated or provided by the Malaysian Government but excludes privatized or corporatized Malaysian Government Hospitals.
4. **PRESCRIBED MEDICINES** shall mean medicines that are dispensed by a Physician, a Registered Pharmacist or a Hospital and which have been prescribed by a Physician or Specialist in respect of treatment for a covered Disability.
5. **DOCTOR or PHYSICIAN or SURGEON** shall mean a registered medical practitioner qualified and licensed to practice western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice, but excluding a Doctor, Physician or Surgeon who is the insured himself.
6. **DENTIST** shall mean a person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided, but excluding a Physician or Surgeon who is the insured himself.
7. **SPECIALIST** shall mean a medical or dental practitioner registered and licensed as such in the geographical area of his practice where treatment takes place and who is classified by the appropriate health authorities as a person with superior and special ,expertise in specified fields of medicine or dentistry, but excluding a Physician or Surgeon who is the insured himself.
8. **SURGERY** shall mean any of the following medical procedures:
   a) To incise, excise or electro cauterize any organ or body part, except for dental services.
   b) To repair, revise, or reconstruct any organ or body part.
   c) To reduce by manipulation a fracture or dislocation.
   d) Use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or urethra.

DESCRIPTIONS OF BENEFITS

1. **HOSPITAL ROOM AND BOARD**
   Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Person's confinement, but in no event shall the benefit exceed, for any one day, the rate of Room and Board benefit, and the maximum number of days as set forth in the Schedule of Benefits. The Insured Person will only be entitled to this benefit while confined to a Hospital as an in-patient.
2. **INTENSIVE CARE UNIT**
   Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an in-patient in the Intensive Care Unit of the Hospital. This benefit shall be payable equal to the actual charges made by the Hospital subject to the maximum benefit for any one day, and maximum number of days, as set forth in the Schedule of Benefits. Where the period of confinement in an Intensive Care Unit exceeds the maximum set forth in the Schedule of Benefits, reimbursement will be restricted to the standard Daily Hospital Room and Board rate.
   No Hospital Room and Board benefit shall be paid for the same confinement period where the Daily Intensive Care Unit benefit is payable.
3. **SURGICAL FEES**
   Reimbursement of the Reasonable and Customary Charges for a Medically Necessary surgery by the Specialists, including pre-surgical assessment Specialist's visits to the Insured Person and post-surgery care up to the maximum number of days from the date of surgery, but within the maximum indicated in the Schedule of Benefits. If more than one surgery is performed for Any One Disability, the total payments for all the surgeries performed shall not exceed the maximum stated in the Schedule of Benefits.
4. **ANAESTHETIST FEE**
   Reimbursement of the Reasonable and Customary Charges by the Anesthetist for the Medically Necessary administration of anesthesia not exceeding the limits as set forth in the Schedule of Benefits.
5. **OPERATING THEATRE**
   Reimbursement of the Reasonable and Customary Operating Room charges incidental to the surgical procedure.
6. **HOSPITAL SUPPLIES & SERVICES**
   Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, laboratory examinations, electrocardiograms, physiotherapy, basal metabolism tests, intravenous injections and solutions, administration of blood and blood plasma but excluding the cost of blood and plasma whilst the Insured Person is confined as an in-patient in a Hospital, up to the amount stated in the Schedule of Benefits.
7. **IN-HOSPITAL PHYSICIAN VISIT**
   Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visiting an in-paying patient while confined for a non-surgical Disability subject to a maximum of two (2) visits per day not exceeding the maximum number of days as set forth in the Schedule of Benefits.
8. **PRE-HOSPITAL DIAGNOSTIC TESTS**
   Reimbursement of the Reasonable and Customary Charges for Medically Necessary ECG, X-ray and laboratory tests which are performed for diagnostic purposes on account of an Injury or Illness when in connection with a Disability preceding Hospitalisation within the maximum number of days and amount as set forth in the Schedule of Benefits in a Hospital and which are recommended by a qualified medical practitioner. No payment shall be made if upon such diagnostic services, the Insured does not result in Hospital confinement for the treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.
9. **PRE-HOSPITAL SPECIALIST CONSULTATION**
   Reimbursement of the Reasonable and Customary Charges for the first time consultation by a Specialist in connection with a Disability within the maximum number of days as set forth in the Schedule of Benefits preceding confinement in a Hospital and provided that such consultation

is Medically Necessary and has been recommended in writing by the attending general practitioner.
Payment will not be made for clinical treatment (including medications and subsequent consultation after the Illness is diagnosed) or where the Insured does not result in Hospital confinement for the treatment of the medical condition diagnosed.

10. EMERGENCY ACCIDENTAL OUT-PATIENT TREATMENT
Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily Injury arising from an Accident for Medical Necessary treatment as an out-patient at any registered clinic or Hospital within twenty-four (24) hour of the Accident causing the covered bodily Injury. Follow up treatment by the same Doctor or same registered clinic or Hospital for the same covered bodily Injury will be provided up to the maximum amount and the maximum number of days as set forth in the Schedule of Benefits.

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

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

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

14. OUT-PATIENT PHYSIOTHERAPY TREATMENT
Reimbursement of Reasonable and Customary Charges for out-patient physiotherapy treatment referred to in writing by a licensed specialist Physician after Surgery or in-Hospital treatment, within ninety (90) days from the date of Hospital discharge/surgery for Any One Disability. However, no payment shall be made for medication/treatment and subsequent consultations with the same specialist Physician.

15. ANNUAL OUT-PATIENT CANCER TREATMENT
If an Insured is diagnosed with Cancer as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of cancer performed at a legally registered cancer treatment center subject to the limit of this Disability as specified in the Schedule of Benefits.
Such treatment (radiotherapy or chemotherapy excluding consultation, examination tests, take home drugs) must be received at the out-patient department of a Hospital or a registered cancer treatment center immediately following discharge from Hospital confinement or surgery.
Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered necessary. The cancer must be confirmed by histological evidence of malignancy. The following condition are excluded:-

a) Carcinoma in situ including of the cervix:
b) Ductal Carcinoma in situ of the breast;
c) Papillary Carcinoma of the bladder & Stage 1 Prostate Cancer ;
d) All skin cancers except malignant melanoma;
e) Stage 1 Hodgkin's Disease;
f) Tumours manifesting as complications of AIDS.

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

16. ANNUAL OUT-PATIENT KIDNEY DIALYSIS TREATMENT
If an Insured is diagnosed with Kidney Failure as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of kidney dialysis performed at a legally registered dialysis center subject to the limit of this Disability as specified in the Schedule of Benefits.
Such treatment (dialysis excluding consultation, examination tests, take home drugs) must be received at the out-patient department of a Hospital or a registered dialysis treatment center immediately following discharge from Hospital confinement or surgery.
Kidney Failure means end-stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis is initiated. It is a specific condition of this benefit that notwithstanding the exclusion of pre-existing conditions, this benefit will not be payable for any Insured who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the effective date of Insurance.

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

18. INSURED CHILD'S DAILY GUARDIAN BENEFIT
Reimburses (up to stipulated limits set forth on the Schedule of Benefits the expenses for meals and lodging incurred to accompany an Insured Child (aged below fifteen (15) years) in the Hospital up to the maximum number of days set forth in the Schedule of Benefits.

19. SERVICE TAX
6% service tax on Room and Board charges actually incurred subject to maximum daily benefit limit as specified in the Schedule of Benefits shall be reimbursable.

20. MEDICAL REPORT FEE
Reimbursement of the Reasonable and Customary Charges for the completion of the medical report by the attending Physician or Surgeon up to the amount as stated in the Schedule of Benefits.

EXCLUSIONS

We shall not reimburse Charges incurred for Hospitalisation resulting directly or indirectly from any of the following risks:

1. Pre-existing Illness.
2. Specified Illnesses within one hundred twenty (120) days from the Commencement Date or Reinstatement Date whichever is the later;
3. Any Disability (except for Injury) and its signs or symptoms that appear within 30 days from the Date of Commencement or Date of Reinstatement whichever is the later;
4. Self-inflicted Injuries or suicide or attempted suicide, while sane or insane;
5. Injuries or Hospitalisation as a result of drug abuse, addictive disorders from substance misuse or while under the influence of alcohol;
6. War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes, riots and civil commotion or insurrection;
7. Ionizing radiation or contamination by radioactivity from any nuclear fuel or nuclear waste;
8. Sickness or Injury arising from racing of any kind (except foot racing) hazardous sports such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter sports, professional sports and illegal activities;
9. Participation in any form of aviation (except as a fare-paying passenger or crew member on a regular route operated by a licensed commercial airline), or aerial sports such as (but not limited to) skydiving, parachuting, bungee jumping, hang gliding or ballooning.
10. Plastic or Cosmetic surgery and related treatments.
11. Circumcision or any surgery on the foreskin.
12. Eye examination and surgical correction for visual impairments due to near-sightedness, farsightedness or astigmatism or radial keratotomy or Lasik.
13. Dental conditions including dental treatment by Dentist or oral surgery except as necessitated by Accidental Injuries to sound natural teeth occurring wholly during the period of Insurance.
14. Private nursing care, non-Hospital nursing care, rest cures, sanitaria care, hospice care and care or treatment that do not lead to a recovery, conservation of your condition or restoration to your previous state of health.
15. Venereal Disease and its sequelae.
16. HIV, AIDS or AIDS-related disease.
17. Communicable Diseases requiring quarantine by law.
18. Congenital disorders/diseases or deformities including hereditary and developmental conditions.
19. Pregnancy or pregnancy-related conditions including childbirth (whether surgical or otherwise), complications arising from pregnancy such as miscarriage, abortion, pre or post-natal care, contraceptive methods for birth

control, infertility treatments and its complications.
20. Impotence, infertility sterilization, erectile dysfunctions and its complications.
21. Sleep apnoea or snoring disorder.
22. Hyperhidrosis.
23. Hormone Replacement Therapy.
24. Mental or nervous disorders (including psychosis, neurosis and their physiological or psychosomatic manifestations).
25. Sex changes.
26. Donations of body parts or organs by the Insured Person.
27. Primarily for investigative purposes, screening, diagnosis, X-rays, scans, general physical or medical examinations that are done routinely or are not incidental to treatment or diagnosis of a Disability, treatment or investigation of a Disability that is not Medically Necessary to be hospitalised, preventive treatments and medicine.
28. Stem cell therapy, except hematopoietic blood disorders.
29. Treatments specifically for weight reduction or gain or bariatric surgery.
30. Of an experimental, investigational or research nature.

GENERAL PROVISIONS

1. **PERSONS ELIGIBLE**
   a) **Employees -** Eligible Persons for insurance under the Policy are those present and future full-time employees of the Insured who are actively engaged at their usual work on the date the persons are eligible to join the Policy.
   b) **Present employees** shall be eligible to participate in the insurance on the commencement date of the Policy. Future employees shall be eligible to participate in the insurance according to the date mentioned in the application form.
   c) **Employees Not Actively Engaged** - If an employee is not actively engaged at his/her usual work on the date he/she would otherwise be eligible in accordance with the abovementioned requirements, his/her eligibility date shall be deferred to the first (1st) day of the month immediately following his/ her return to active full-time work.
2. **DEPENDENTS**
   Dependents of the employees are also eligible for insurance in accordance with the requirements stated in the application form for the same quantum of benefit as the employees on the same dates the employees themselves become eligible. If a dependent is disabled by Illness or Injury on the date he/she would otherwise be eligible, his/her eligibility date shall be deferred to the date following his/her complete recovery from the Disability.
3. **EFFECTIVE DATE OF INDIVIDUAL INSURANCE**
   a) **Employees** - The insurance of each present and future eligible employee shall take effect on the employee's eligibility date provided the employee applies to enroll for insurance by completing and returning an enrolment form provided by the Company within thirty (30) days from his/her eligibility date. Otherwise, the insurance of the employee shall take effect on the date to be specified by the Company after the employee has submitted the enrolment form and produced satisfactory medical evidence of insurability which the Company may require at no expense to the Company.
   b) **Dependents** - The insurance of a dependent shall take effect on the dependents eligibility date, provided the Insured employee applies to enroll the dependent within thirty (30) days from the dependent's eligibility date. Otherwise, the insurance of the dependent shall take effect on a date to be specified by the Company after the dependent has produced at his/her own expense, evidence of insurability satisfactory to the Company.

GENERAL CONDITIONS

1. **MEANING**
   This Policy and the Schedule shall be read together as one contract and any words or expressions to which a specific meaning has been attached in any part of this Policy or of the Schedule shall bear such specific meaning wherever it may appear.
2. **PERIOD OF COVER AND RENEWAL**
   This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time and the Company shall be notified by writing at least thirty (30) days before any change is affected.
   This Policy is renewable at the option of the Company. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.
3. **GEOGRAPHICAL TERRITORY**
   All benefits' provided in this Policy are applicable worldwide for twenty-four (24) hours a day.
4. **OVERSEAS TREATMENT**
   The Company will reimburse the Reasonable and Customary Charges incurred for overseas treatment if:
   a) The Insured Person was hospitalised for a medical emergency while travelling out of Malaysia. Such overseas travel must not be for treatment of any medical condition.
   b) The Insured Person was recommended by a Physician to seek treatment outside of Malaysia because there is no other treatment available in Malaysia for that Disability.
   The Company reserve the right to determine whether such treatment outside of Malaysia is necessary, in consultation with the Company's appointed medical Doctor.
   The Company will reimburse the actual charge according to the terms and conditions and the limits of this Policy and the amount shall be calculated at the exchange rate published by the largest local bank (determined by asset size) in Malaysia on the day of discharge from the Hospital.
   The Company will not reimburse the costs of transportation of the Insured Person (or any other person) to or from the place of treatment.
5. **ALTERATIONS**
   The Company reserves the right to amend the terms and provisions of this Policy by giving a thirty (30) days prior notice in writing by ordinary post to the Owner's last known address in the Company's records, and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless authorized by the Company and such approval is endorsed thereon. The insurer should give thirty (30) days prior written notice to the Policyholder according to the last recorded address for any alterations made.
6. **CANCELLATION**
   This Policy may be cancelled by the Policyholder at any time by giving a written notice to the Company; and provided that no claims have been made during the current Policy year, the Policyholder shall be entitled to a prorated refund of the premium.
7. **CERTIFICATION, INFORMATION AND EVIDENCE**
   All certificates, information, medical reports and evidence as required by the Company shall be furnished at the expense of the Insured, and in such a form that the Company may require. In any event, all notices which the Company shall require the Policyholder to give must be in writing and addressed to the Company. An Insured shall, at the Company's request and expense, submit to a medical examination whenever such is deemed necessary.
8. **GOVERNING LAW**
   This Policy is issued under the laws of Malaysia and is subject and governed by the laws prevailing in Malaysia.
9. **MISSTATEMENT OF AGE AND GENDER**
   If the age or gender of the Insured Person has been misstated, any benefits payable will be pro-rated on the ratio of the actual premium to the correct premium which should have been paid based on the correct age and gender. The Company will refund any excess premium paid without interest.
   If the Company do not have the rates for the corrected age or gender and the Company are therefore unable to issue the Policy, the Policy will be void. The Company will refund the premiums paid without interest.
   Example:
   If the premium paid is RM800 but the correct premium is RM1,000. When a claim arises and the amount of eligible claims reimbursed is RM10,000, then the Company will pay:
   $\frac{800}{1,000} \times 10,000 = RM8,000$
10. **CHANGE IN RISK**
    The Insured Person shall give immediate notice in writing to the Company of any material change in his or her occupation, business, duties or pursuits and pay any additional premium that may be required by the Company.
11. **SUBROGATION**
    If the Company shall become liable for any payment under this Policy, the Company shall be subrogated to the extent of such payment to all the rights and remedies of the Insured Person against any party and shall be entitled at its own expense to sue in the name of the Insured Person. The Insured Person shall give or cause to be given to the Company all such assistance in his/her power as the Company shall require to secure the rights and remedies and at the Company's request shall execute or cause to be executed all documents necessary to enable the Company to effectively to bring suit in the name of the Insured Person.
12. **CONTRIBUTION**

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

13. UPGRADED ROOM AND BOARD CO-PAYMENT

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

14. OWNERSHIP OF POLICY

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

15. WAITING PERIOD

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

16. RESIDENCE OVERSEAS

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

17. **TAKE-OVER POLICIES**

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

18. **UPGRADED POLICIES**

If the Eligible Benefits to any Insured under the terms of this Policy be increased while it is in force or at the time of Renewal or replacement and if such Insured shall have been afflicted with a Disability prior or at the time the benefits were increased, the Limits of Benefits payable in respect of such Disability shall not exceed the Limit of Benefits prior to the date the benefits were upgraded.

19. **CONVERSION POLICIES**

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

20. **COOLING-OFF PERIOD**

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

21. **PORTFOLIO WITHDRAWAL CONDITION**

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

Cancellation of the portfolio as a whole shall be given by written notice to the Policyholder at least thirty (30) days prior to portfolio withdrawal and the Company will run off all policies to expiry of the period of cover within the portfolio.

22. **CLAIM PROCEDURES**

22.1 **EVENTS LEADING TO CLAIMS**

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

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

22.2 **INCOMPLETE CLAIMS**

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

22.3 **CURRENCY OF PAYMENT**

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

23. **CONDITION PRECEDENT TO LIABILITY**

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

24. **NOTICE**

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

25. **MISREPRESENTATION**

Failure to give answers that are fully accurate may result in avoidance of the Policy, refusal or reduction of the claim(s), change of terms or termination of the Policy.

26. **FRAUD**

If any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support of such claim, this Policy shall be void.

27. **LEGAL PROCEEDINGS**

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

28. **ARBITRATION**

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

CLAUSES / WARRANTY

(The following clauses and warranty are applicable to this Policy)

PWE **PREMIUM WARRANTY**

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

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

Where the premium payable pursuant to this Warranty is received by an authorized agent of the Company, the payment shall be deemed to

be received by the Company for the purposes of this Warranty and the onus of proving that the premium payable was received by a person, including an insurance agent, who was not authorized to receive such premium shall lie on the Company.
Subject otherwise to the terms, exclusions and conditions of this Policy.

NOTICE TO POLICYHOLDER

Please examine the insurance Policy to ensure that it meets your requirement. To avoid misunderstanding, it is very important that the Policy, the Schedule and any Endorsements attached therein be read thoroughly.

If you have any complaints or grievances pertaining to your Policy, please contact your agent, if any, or get in touch with our issuing office. We assure you that your complaints will be attended to promptly.

For all intents and purposes where there is a conflict or ambiguity as to the meaning in the Bahasa Malaysia provisions of any part of the Contract, it is hereby agreed that the English version of the Contract shall prevail.

As a responsible insurer, we wish to bring your attention that you could also address your dissatisfaction to Ombudsman for Financial Services (OFS) or to Bank Negara's Corporate Communications Department (CCD) as listed below.

HOW TO LODGE A COMPLAINT

If you are unhappy with any aspect of our service, we would like to hear from you.

You can make your complaint in whatever form is most convenient to you either via a phone call to our receptionist or alternatively, by writing, faxing or e-mailing your complaint to:

Complaints Handling Unit
RHB Insurance Berhad
Level 12, West Wing, The Icon
No 1, Jalan 1/68F, Jalan Tun Razak,
55000 Kuala Lumpur
Tel:1300-220-007
Fax:03-2163 7277
E-mail: complaints_unit@rhbinsurance.com.my

The Company will seek to respond to your complaint within fourteen (14) days. If the Company cannot resolve the matter within the aforesaid time frame when a matter is complex, you will be informed of the progress made with your complaint.

It will help the Company to respond promptly if you give the following details:
1. Your name, address and contact no.
2. Cover note no. / Policy no. / Claim no.

If after taking these steps, you are still dissatisfied, you may write to:

Ombudsman for Financial Services (OFS)
(Formerly known as Financial Mediation Bureau)
Level 14, Main Block
Menara Takaful Malaysia
No. 4, Jalan Sultan Sulaiman
50000 Kuala Lumpur
Tel:03-2272 2811
Fax:03-2272 1577
E-mail: enquiry@ofs.org.my
Website: www.ofs.org.my

If the Mediator makes an award against the Company, you are required to inform the Mediator of your decision to accept or deny the award within fourteen (14) days.

If you do not accept the award, you may reject the decision of the Mediator. You are free to institute a court proceeding against the Company or refer it to Arbitration.

Alternatively, you may put forward your dissatisfaction over the conduct of the Company by writing to Bank Negara Malaysia giving details of your complaint and particulars of your Policy to:

BNMTELELINK
Corporate Communications Department (CCD)
Bank Negara Malaysia
P.O. Box 10922
50929 Kuala Lumpur
Tel:1300-88-5465 (LINK)
Fax:03-2174 1515
E-mail: bnmtelelink@bnm.gov.my
Website: www.insuranceinfo.com.my

HEAD OFFICE / IBU PEJABAT	CUSTOMER RELATIONSHIP CENTRE / KAUNTER KHIDMAT PELANGGAN	CALL CENTRE / PUSAT PANGGILAN
Level 12B, West Wing, The Icon, No.1, Jalan 1/68F, Jalan Tun Razak, 55000 Kuala Lumpur Tel : 03 - 2180 3000 Fax : 03 - 9281 2729 Website: www.rhbgroup.com	**Level 1, Tower Three, RHB Centre, Jalan Tun Razak, 50400 Kuala Lumpur Tel : 1-300-220-007 Fax : 03 – 2163 7277 Email: rhbi.general@rhbgroup.com**	**Claims Inquiries: 03 - 2180 3030**