
# Ideal Care –
# Medical Health Plan
# Terms & Condition

**IDEAL CARE**

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 **LIBERTY GENERAL INSURANCE BERHAD** 197801007153 (44191-P) (hereinafter called "the Company") for the insurance hereinafter contained and has paid or agreed to pay the premium stated in the Policy Schedule as consideration for such insurance for the period stated therein.

Now this Policy of Insurance Witnesses that if during the Period of Insurance, any sickness, disease, illness or accidental injury necessitates the Insured Person to be confined to a hospital for treatment, the Company will subject to the terms, provisions, exclusions and conditions of and endorsed on this Policy, pay to the Insured or his legal personal representatives the sum or sums stated in the Schedule of Benefits.

Provided always that

a) 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 and the Overall Lifetime Limit.

b) This Policy shall become effective as of the date stated in the Policy Schedule. This Policy shall be issued for one year and at the end of each period of insurance may be renewed for another year subject to the Guaranteed Renewal Clause in the General Conditions.

**DEFINITIONS**

**RELATING TO CONTRACTUAL DETAILS**

1. **POLICYHOLDER** shall mean a person or a corporate body to whom the Policy has been issued in respect of cover for persons specifically identified as Insured Persons in this Policy.

2. **INSURED PERSON** shall mean the person described in the Policy Schedule including his/her Dependant (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 of the 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.

**RELATING TO INSURANCE COVER**

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

2. **INJURY** shall mean bodily injury caused solely by 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 there from except that if the Insured Person completely recovers and remain free from further treatment (including drugs, medicines, special diet or injection or advice for the condition) of the disability for at least ninety (90) days following the latest date of discharge and subsequent disability from the same cause shall be considered as though it were a new disability.

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 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 the policy.

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

8. **DEPENDANT** shall mean any of the following person:

   a) a legally married spouse
   b) unmarried children over 30 days old but under nineteen (19) years of age or twenty-three (23) years of age if still on full-time higher education, and who are not gainfully employed.

9. **ELIGIBLE EXPENSES** 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: -

    i) consistent with the diagnosis and customary medical treatment for a covered Disability, and
    ii) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits, and
    iii) not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient), and
    iv) not of an experimental, investigational or research nature, preventive or screening nature,
    v) for which the charges are fair and reasonable and customary for the Disability.

11. **REASONABLE AND CUSTOMARY CHARGES** shall mean charges for medical care which shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individual of the same sex and of comparable age for a similar sickness, disease or injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured Person's medical condition.

12. **PRE-EXISTING ILLNESS** shall mean 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 area or were evident; or
    d) its existence would have been apparent to a reasonable person in the circumstances;

13. **SPECIFIED ILLNESSES** shall mean the following disabilities and its related complications, occurring within the first 120 days of Insurance of the Insured Person:

    a) Hypertension, diabetes mellitus, Coronary Artery, Cardiovascular Diseases and Varicose Veins
    b) All tumours, cancers, cysts, nodules, polyps, stones of the urinary system and biliary system
    c) All ear, nose (including sinuses) and throat conditions
    d) Hernias, haemorrhoids, fistulae, hydrocele, varicocele
    e) Endometriosis including disease of the Reproduction system
    f) Vertebro-spinal disorders (including disc) and knee condition

14. **HOSPITAL CONFINEMENT** shall mean in continuous confinement as a registered inpatient to a Hospital for a period of not less than 24 hours.

15. **HOSPITALISATION** shall mean admission to a Hospital as a registered in-patient for Medically Necessary treatments for a covered Disability upon recommendation of a physician. A patient shall not be considered as an in-patient if the patient does not physically stay in the hospital for the whole period of confinement.

16. **INTENSIVE CARE UNIT** shall mean a section within a Hospital which is designated as an Intensive Care unit by the Hospital 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.

17. **OUTPATIENT** shall mean the Insured Person is receiving medical care or treatment without being hospitalised and includes treatment in a Daycare centre.

18. **WAITING PERIOD** shall mean the first 30 days between the beginning of an Insured Person's disability and the Commencement of this Policy date/reinstatement date and is applied only when the person is first covered. This shall not be applicable after the first year of cover. However, if there is a break in insurance, the Waiting Period will apply again.

19. **OVERALL ANNUAL LIMI**T

    Benefits payable in respect of expenses incurred for treatment provided to the Insured Person during the period of insurance shall be limited to Overall Annual Limits as stated in the Schedule of Benefits irrespective of a type/types of disability. In the event the Overall Annual Limit having been paid, all insurance for the Insured Person hereunder shall immediately cease to be payable for the remaining policy year.

20. **OVERALL LIFETIME LIMIT** shall mean the maximum amount payable in the lifetime of the Insured Person. Once the Lifetime Limit is reached, the policy is automatically terminated. Renewal / Reinstatement of the policy is no longer allowed.

**RELATING TO MEDICAL SUPPLIES**

1. **DAY-SURGERY** shall mean 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 only an establishment duly constituted and registered as a hospital for the care and treatment of sick and injured persons as paying bed-patients, and which:-
    i) has facilities for diagnosis and major surgery,
    ii) provides 24 hour a day nursing services by registered and graduate nurses,
    iii) is under the supervision of a Physician, and
    iv) is not primarily a clinic; a place for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.

3. **MALAYSIAN GOVERNMENT HOSPITAL** shall mean a hospital which charges of services are subject to the Fee Act 1951 Fees (Medical) Order 1982 and/or its subsequent amendments if any.

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 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 electrocauterize 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.

**DESCRIPTION OF BENEFITS**

**1. HOSPITAL ROOM AND BOARD**

Reimbursement of the Reasonably 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 Benefits is payable.

3 **HOSPITAL SERVICES & SUPPLIES**

Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, laboratory examinations, electrocardiograms, physiotherapy, basal metabolism tests, intravenous injections and solutions, administration of blood and blood plasma but excluding the cost of blood and plasma whilst the Insured Person is confined as in-patient in a Hospital, up to the amount stated in the Schedule of benefits

Reimbursement for the medically necessary devices such as lens and stent, will be limited to RM700.00 per lens and RM5, 000.00 per stent.

4. **OPERATING THEATRE**

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

5. **SURGICAL FEES**

Reimbursement of the Reasonable and Customary charges for 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.

**6. ANAESTHETIST FEE**

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medical Necessary administration of anaesthesia not exceeding the limits as set forth in the Schedule.

7. **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 Benefit in a hospital 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.

8. **PRE-HOSPITAL SPECIALIST CONSULTATION**

Reimbursement of the Reasonable and Customary Charges for the first time consultation by a Specialist in connection with a Disability within the maximum number of days as set forth in the Schedule of Benefit preceding confinement in a Hospital for 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.

9. **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.

10. **DAILY IN-HOSPITAL PHYSICIAN VISIT**

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

11. **EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT**

Reimbursement of Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily injury arising from an Accident for Medically Necessary treatment as an outpatient at any registered clinic or hospital within 24 hours of the Accident causing the covered bodily Injury. Follow-up treatment will be provided up to the maximum number of 14 days and up to the maximum amount as set forth in the Schedule of Benefits.

12. **OUTPATIENT PHYSIOTHERAPY TREATMENT**

Reimbursement of Reasonable and Customary charges for out-patient physiotherapy treatment referred in writing by a licensed specialist Physician after Surgery or in-Hospital treatment, within thirty one (31) days from the date of Hospital discharge/Surgery for Any One Disability. However no payment will be made for medication/treatment and subsequent consultations with the same specialist Physician.

13. **AMBULANCE FEES**

Reimbursement of the Reasonable and Customary Charges incurred for necessary domestic ambulance service 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.

14. **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 Benefit.

No payment will be made for any transfer to or from any Private Hospital to Malaysian Government Hospital for the covered disability.

15. **OUTPATIENT CANCER TREATMENT**

If an Insured Person is diagnosed with Cancer as defined below, the company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of cancer performed at a legally registered cancer treatment centre subject to the limit of this disability as specified in the Schedule of Benefits.

Such treatment (radiotherapy or chemotherapy excluding consultation, examination tests, and take home drugs) must be received at the out-patient department of a Hospital or a registered cancer treatment centre immediately following discharge from Hospital confinement or surgery.

Cancer is defined as the uncontrolled growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered necessary. The cancer must be confirmed by histological evidence of malignancy. The following conditions are excluded:

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

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

16. **OUT-PATIENT KIDNEY DIALYSIS TREATMENT**

If the insured is diagnosed with Kidney failure as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of Kidney dialysis performed at a legally registered dialysis centre subject to the limit of this disability as specified in the Schedule of Benefit.

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 centre immediately following discharge from Hospital confinement or surgery.

Kidney failure means end stage renal failure presenting as chronic, irreversible failure of both kidneys to function as a result of which renal dialysis in initiated.

It is a specific condition of this Benefit that notwithstanding the exclusion of pre-existing conditions, this Benefits will not be payable for any Insured who has developed chronic renal disease 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 Benefit. The costs of acquisition of the organs and all costs incurred by the donors are not covered.

18. **INSURED CHILD'S DAILY GUARDIAN BENEFIT**

Reimbursement (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 years) in the hospital up to a maximum of days set forth in the schedule of Benefits.

19. **HOME NURSING**

Daily charges for the services of licensed and qualified nurse in the Insured's home for the continued treatment of the specific medical condition within the maximum number of days as set forth in the Schedule of Benefit for which he/she was hospitalised. Such services must be recommended by the attending Physician.

20. **MEDICAL REPORT**

Reimbursement of expenses for pursuing the medical report but shall not exceed the amount as stated in the Schedule of Benefit.

21. **ACCIDENTAL DEATH BENEFIT**

This benefit is payable to a dependant of a deceased Insured member in the event of accident death while Insured under the policy

22. **GOODS AND SERVICES TAX (GST)**

Charges imposed by the Malaysian Government for service tax levied on Hospital Room & Board.

23. **NO CLAIM DISCOUNT**

In the event of no claim being made or arising under the policy during a period of insurance specified hereunder immediately preceding the renewal of this policy, the renewal premium shall be reduced as follows:

| Period of Insurance | Discount |
|---|---|
| The preceding two consecutive years | 10% |
| The preceding three consecutive years | 15% |
| The preceding four or more consecutive years | 20% |

**FAMILY DISCOUNT (FD) :**

This is a special discount to be given if your dependants are insured under the same policy:

| Family Members | Discount |
|---|---|
| Insured + Spouse | 5% |
| Insured + Children | 5% |
| Insured + Spouse + Children | 10% |

**GENERAL CONDITIONS**

1. **ELIGIBILITY**

**i) ENROLMENT**

Person eligible to be covered under this Policy are:-

a) Anyone between the ages of 30 days to 60 years and renewable up to age 70
b) Persons who reside in Malaysia only

**ii) ADDITION OF DEPENDANTS INCLUDING OF NEWLYBORN CHILDREN**

Application to enrol dependant/s must be made at inception or upon renewal of the policy only (other than newly born children who are below 2 (two) months old but eligibility for insurance cover will commence only after 30 days of birth).

Application for insurance including for inclusion of dependants or for a change of benefits or plan shall be made on the prescribed form. The Company reserves the right to reject any application without giving any reasons or to require evidence of age or be subject to submission of medical report or state of health of any person in the application. On acceptance, applicants will be informed if there is any special conditions or terms imposed on the insured person.

2. **PERIOD OF COVER AND GUARANTEED 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 any change in the renewal premium shall be notified by writing at least 30 days before change is affected.

Application for change of benefits to higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.

The renewal of the policy is guaranteed after the completion of two consecutive years of the policy, provided that there is no claim incurred in the previous 2 years.

This Policy will be renewable at the option of policyholder subject to the terms, conditions and termination at each of the anniversary of the Policy date.

The renewal premium payable is not guaranteed and the Company reserves the right to determine the premium applicable specifically to each Insured Person at the time of renewal.

During renewal, the terms and conditions of coverage shall not be amended, except where a particular disability has reached the maximum limit per disability. In such situation, the Company reserves the right to specifically exclude such disability form the policy.

This policy is renewable at the option of policyholder until the occurrence of any of the following:

(a) non payment of premium or premium not made on time
(b) fraud or misrepresentation of material fact during application
(c) the policy is cancelled at the request of the policyholder
(d) total claim of the policy have reached the lifetime limit specified and/or on the death of the Insured Person
(e) the Insured Person ceases to qualify as a dependant based on the definition of the policy
(f) the Insured Person attains the coverage age limit specified
(g) termination of coverage for all policies in a certain market and the Company withdraws this policy completely form the market in accordance with the Portfolio Withdrawal Condition.

Should there be any claims in subsequent years, the Company will not impose any exclusion upon the Insured. Renewal is guaranteed up to the age of 70 years and is subject to the Overall Lifetime Limit. Furthermore, the premium will be in accordance to the Premium Table and age of the Insured.

If there is a claim incurred within the first 2 years of policy inception, the Insured Person would still qualify for the guaranteed renewal subject to exclusions, excess or premium loading.

3. **PREMIUM PAYMENT (CASH BEFORE COVER ("CBC")**

This policy shall automatically terminate or lapse if no premium is received from the inception or renewal date of policy ('CBC') unless otherwise agreed and endorsed herein. The Company reserves the right to determine new premium rates at the end of any policy year, whenever the terms of this Policy are changed or in view of adverse claims experience of Insured Person.

4. **GEOGRAPHICAL TERRITORY**

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

5. **OVERSEAS TREATMENT**

If the Insured Person seeks treatment overseas, benefits in respect of the treatment shall be covered subject to the

exclusions, limitations and conditions specified in this policy and all benefits will be payable based on the official exchange rate ruling on the last day of the period of Confinement and shall exclude the cost of transport to the place of treatment provided;

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

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

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

6. **ALTERATIONS**

The Company reserves the right to amend the terms and provisions of this policy by giving a 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 30 days prior written notice to the policyholder according to the last recorded address for any alterations made.

7. **CANCELLATION OF POLICY**

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 refund of the premium as follow:-

| Period Not exceeding: | **Refund of Annual Premium** (applicable to renewal only) |
|---|---|
| 15 days | 90% |
| 1 month | 80% |
| 2 months | 70% |
| 3 months | 60% |
| 4 months | 50% |
| 5 months | 40% |
| 6 months | 30% |
| 7 months | 25% |
| 8 months | 20% |
| 9 months | 15% |
| 10 months | 10% |
| 11 months | 5% |
| Period exceeding 11 months | No refund |

8. **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.

9. **GOVERNING LAW**

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

10. **MISSTATEMENT OF AGE**

If the age of the Insured Person has been misstated and the premium paid as a result thereof is insufficient, any claim payable under this Policy shall be prorated based on the ratio of the actual premium paid to the correct premium which should have been charged for the year. Any excess premium, which may have been paid as a result of such misstatement of age, shall be refunded without interest.

If at the correct age the Insured Person would not have been eligible for cover under this Policy, no benefit shall be payable.

11. **CHANGES IN RISK, OCCUPATION, BUSINESS OR SPORTS**

The Insured Person shall give immediate notice in writing to the Company of any material changes in his or her occupation, business, duties or pursuits and pay any additional premium that may be required by the Company.

12. **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 bring a suit in the name of the Insured Person.

13. **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.

14. **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.

15. **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.

16. **WAITING PERIOD**

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

17. **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.

**18. TAKE-OVER POLICIES**

If the 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.

19. **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.

20. **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 covered.

21. **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 on the issue of the Policy.

22 **PORTFOLIO WITHDRAWAL CONDITION**

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

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

The Company shall give the Policyholder 30 days written notice in the event of portfolio withdrawal.

23. **CONDITIONS PRECEDENT TO LIABILITY**

The due observance and the fulfillment 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 / FRAUD**

If the proposal or declaration of the Insured Person is untrue in any respect or if any material fact affecting the risk be incorrectly stated herein or omitted therefrom or if this insurance or any renewal thereof shall have been obtained through any misstatement, misrepresentation or suppression or any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support thereof, then in any of these cases, this Policy shall be void.

26. **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 requirement 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.

27. **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 difference 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.

**22. SANCTION LIMITATION AND EXCLUSION**

We shall not be liable to pay any benefit under this Policy to the extent that such cover, payment of such claim or such benefit would expose Us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

**EXCLUSIONS**

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

   a) Pre-existing illness.

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

   c) Any medical or physical condition arising within the first thirty (30) days of the Insured person's cover or date reinstatement whichever is latest except for accident injuries.

   d) Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.

   e) Dental conditions including dental treatment or oral surgery except as necessitated by Accidental Injuries to sound nature teeth occurring wholly during the Period of Insurance.

   f) Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilisation, venereal disease and its sequelae, AIDS (Aquired Immune Deficiency Syndrome) or ARC (AIDA Related Complex) and HIV related disease/s, and any communicable disease required quarantine by law.

   g) Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.

   h) Pregnancy, child birth (including surgical delivery), miscarriage, abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility. Erectile dysfunction and tests treatment related to impotence or sterilisation.

   i) Hospitalisation primarily for investigatory purpose, diagnosis, X-ray examination, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for weight reduction or gain.

   j) Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.

   k) 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.

   l) Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.

   m) Expenses incurred for donation of any body organ by an Insured Person and costs of acquisition of the organ including all costs incurred by the donor during organ transplant and its complications.

   n) Investigation and treatment of sleep and snoring

disorders, hormone replacement therapy and alternative therapy such as treatment, medical services or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bonesetting, herbalist treatment, massage or aroma therapy or other alternative treatment.

o) Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance.

p) Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manifestation).

q) Costs/expenses of services of a non-medical nature, such as television telephones, telex services, radios or similar facilities, admission kit/pack and other ineligible non-medical item.

r) 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.

s) Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes.

t) Expenses incurred for sex changes.

2. CYBER LOSS LIMITED EXCLUSION CLAUSE

1. Notwithstanding any provision to the contrary within this Policy, this Policy excludes any Cyber Loss.

2. Cyber Loss means any loss, damage, liability, expense, fines or penalties or any other amount directly caused by:

2.1 the use or operation of any Computer System or Computer Network;
2.2 the reduction in or loss of ability to use or operate any Computer System, Computer Network or Data;
2.3 access to, processing, transmission, storage or use of any Data;
2.4 inability to access, process, transmit, store or use any Data;
2.5 any threat of or any hoax relating to 2.1 to 2.4 above;
2.6 any error or omission or accident in respect of any Computer System, Computer Network or Data.

3. Computer System means any computer, hardware, software, application, process, code, programme, information technology, communications system or electronic device owned or operated by the Insured or any other party. This includes any similar system and any associated input, output or data storage device or system, networking equipment or back up facility.

4. Computer Network means a group of Computer Systems and other electronic devices or network facilities connected via a form of communications technology, including the internet, intranet and virtual private networks (VPN), allowing the networked computing devices to exchange Data.

5. Data means information used, accessed, processed, transmitted or stored by a Computer System.

**CLAIMS PROCEDURES**

1. **NOTICE & PROOF OF CLAIM AND EVENTS LEADING TO A CLAIM**

a) The Insured shall within 30 days of disability that incurs claimable expenses, give written notoice 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 invalid any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

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

2. **EXAMINATIONS**

The company shall have the right and opportunity through their medical representative to examine any Insured Person whose the disability is the basis of the claim whenever and so often as may be reasonably required within the duration of claim.

3. **INCOMPLETE CLAIMS**

All claims must be submitted to the Company within 30 days of completion of the events for which the claim is being made**.** Claims are not deemed complete and Eligible Benefits are not payable unless all bills for such claims have been submitted and agreed upon by 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.

4. **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.

**IMPORTANT NOTICES**

1. Copy of police report must be submitted to the Company for any claims arising out of Motor Vehicle Accident (MVA).

2. Accidental Death Benefit

Kindly submit a certified true copy of Marriage Certificate, Burial Certificate, Post Mortem Report (if any), Police Report, Death Certificate and Identity Card of the claimant. The claim will be payable to the insured's spouse/next of kin.

3. Lodging complaints and Grievances

If you have any complaints of unfair market practices by the company, You may call or write to either:-

**a) Customer Service Executive, Customer Contact Centre**
**Liberty General Insurance Berhad**
Formerly known as AmGeneral Insurance Berhad
Liberty Insurance Tower,
CT 9, Pavilion Damansara Heights,
3, Jalan Damanlela,
50490 Kuala Lumpur.
Tel. No.: 03-2268 3333 or 1-300-888-990
E-mail : customer@libertyinsurance.com.my
Website: www.libertyinsurance.com.my

**b) BNMLINK (Laman Informasi Nasihat dan Khidmat)**
**Bank Negara Malaysia**
4th Floor, Podium Bangunan AICB,
No. 10, Jalan Dato' Onn,
50480 Kuala Lumpur.
Tel. No.: 03-2698 8044 (General Line) /
1-300-88-5465 (BNMLINK)
Fax No.: 03-2174 1515
e-Link: bnmlink.bnm.gov.my
E-mail: bnmlink@bnm.gov.my
Website: www.bnm.gov.my

**c) Ombudsman for Financial Services (664393P)**
Level 14, Main Block, Menara Takaful Malaysia,
4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur.
Tel. No.: 03-2272 2811
Fax No.: 03-2272 1577
E-mail: enquiry@ofs.org.my
Website: www.ofs.org.my

4. The Insured Person shall read this Policy carefully, and if any error or misdescription be found herein, or if the cover is not in accordance with the wishes of the Insured Person, advice should at once be given to the Company within 14 days after receiving the policy.

5. The benefit(s) payable under this eligible policy is protected by PIDM up to limits. Please refer to PIDM's TIPS Brochure or contact Liberty General Insurance Berhad or PIDM (visit www.pidm.gov.my).

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**BENEFIT TABLE**

| PLANS | PLAN 1 | PLAN 2 | PLAN 3 | PLAN 4 |
|---|---|---|---|---|
| **1) HOSPITAL BENEFITS** | **MAXIMUM PER ANY ONE DISABILITY** | | | |
| **Daily Room & Board (Max. 150 days)** | **RM100** | **RM150** | **RM250** | **RM300** |
| **Intensive Care Unit (Max 75 days)**<br>**Hospital Supplies & Services including Operating Theatre** | **AS CHARGED** | | | |
| **2) SURGICAL BENEFITS** | | | | |
| **Pre-Admission Diagnostic Services**<br>(within 31 days before admission)<br>**Pre-Surgical Specialist Consultation**<br>(within 31 days before admission)<br>**Surgical Fees & Anaesthetic Fees Post Hospitalisation Treatment**<br>(within 31 days after discharge)<br>**Physiotherapy Treatment**<br>(within 31 days after discharge) | **AS CHARGED** | | | |
| **MAXIMUM PER ANY ONE DISABILITY** | **15,000** | **20,000** | **30,000** | **40,000** |
| **3) MEDICAL BENEFIT ( NON-SURGICAL )** | | | | |
| **Pre-Hospital Diagnostic Services**<br>(within 31 days before admission)<br>**Pre-Hospitalisation Specialist Consultation**<br>(within 31 days before admission)<br>**Daily In-Hospital Physician's Visit**<br>**Post Hospitalisation Treatment**<br>(within 31 days after discharge) | **AS CHARGED** | | | |
| **MAXIMUM PER ANY ONE DISABILITY** | **15,000** | **20,000** | **30,000** | **40,000** |
| **4) AMBULANCE FEES** | **AS CHARGED** | | | |
| **5) OUTPATIENT / EXTENDED BENEFITS** | | | | |
| **Emergency Accidental Treatment** | **AS CHARGED** | | | |
| **Outpatient Cancer Treatment (Annual Limit)** | **15,000** | **25,000** | **35,000** | **45,000** |
| **Outpatient Kidney Dialysis Treatment (Annual Limit)** | **15,000** | **25,000** | **35,000** | **45,000** |
| **Lodger Expenses (Guardian Allowance)** | **50** | **60** | **80** | **100** |
| **Medical Report Fee** | **80** | **80** | **80** | **80** |
| **Home Nursing (within 31 days after discharge)** | **100** | **125** | **150** | **175** |
| **6) ORGAN TRANSPLANTATION (ONCE PER LIFETIME)** | **20,000** | **30,000** | **40,000** | **50,000** |
| **7) GOVERNMENT HOSPITAL INCOME BENEFITS** | | | | |
| **Daily Cash Allowance** | **50** | **60** | **80** | **100** |
| **8) ACCIDENTAL DEATH BENEFIT** | **5,000** | **7,500** | **12,500** | **15,000** |
| **9) OVERALL ANNUAL LIMIT** | **40,000** | **60,000** | **100,000** | **120,000** |
| **10) OVERALL LIFETIME LIMIT** | **120,000** | **180,000** | **300,000** | **360,000** |

| ANNUAL PREMIUM RATES (AGE NEXT BIRTHDAY) | | | | |
|---|---|---|---|---|
| **Age** | **Plan 1 (RM)** | **Plan 2 (RM)** | **Plan 3 (RM)** | **Plan 4 (RM)** |
| **30 days - 10 years (children)** | **306.00** | **361.00** | **459.00** | **524.00** |
| **11 years - 18 years** | **265.00** | **312.00** | **396.00** | **452.00** |
| **19 years - 25 years** | **326.00** | **385.00** | **490.00** | **560.00** |
| **26 years - 30 years** | **367.00** | **434.00** | **553.00** | **632.00** |
| **31 years - 35 years** | **407.00** | **482.00** | **615.00** | **704.00** |
| **36 years - 40 years** | **468.00** | **555.00** | **709.00** | **812.00** |
| **41 years - 45 years** | **529.00** | **628.00** | **803.00** | **920.00** |
| **46 years - 50 years** | **631.00** | **749.00** | **959.00** | **1,099.00** |
| **51 years - 55 years** | **793.00** | **943.00** | **1,210.00** | **1,387.00** |
| **56 years - 60 years** | **915.00** | **1,088.00** | **1,397.00** | **1,602.00** |
| **61 years - 65 years (renewal only)** | **1,240.00** | **1,477.00** | **1,898.00** | **2,177.00** |
| **66 years - 70 years (renewal only)** | **1,646.00** | **1,962.00** | **2,523.00** | **2,896.00** |

* " In the event of any discrepancy, ambiguity and conflict in interpreting any term or condition of the contract, the English version shall prevail and supersede the Bahasa Malaysia version ".