INSURED : SAMPLE INSURED

FACE AMOUNT :	50,000.00	NOV 24, 2018	**: POLICY DATE**
PLAN :	AIA Critical Illness Cover	NOV 24, 2018	**: ISSUE DATE**
POLICY NUMBER :	0000000A00	NOV 24, 2053	**: MATURITY OR EXPIRY DATE**

We shall, subject to the provisions of this Policy, pay the benefits provided under this Policy on being satisfied that the event on which the benefit is payable has occurred while this Policy is in force.

The basic insurance plan and the supplementary contracts if any, provided by this Policy with their amounts of coverage are specified in the Schedule of Benefits and Premiums on the Policy Information Page. Entitlement to benefits, benefit exclusions, conditions for payment and other policy details are set out inside.

Executed and signed by Us on the Issue Date of this Policy as stated in the Policy Information Page.

Registrar

Chief Executive Officer

Stamp Duty Paid

POLICY INFORMATION PAGE

POLICY DATA

INSURED : SAMPLE INSURED

FACE AMOUNT : 50,000.00 **POLICY DATE :** NOV 24, 2018

PLAN : AIA Critical Illness Cover **ISSUE DATE :** NOV 24, 2018

POLICY NUMBER : 0000000A00 **MATURITY OR EXPIRY DATE:** NOV 24, 2053

AGE : 35 **Age Admitted:** NO **GENDER:** MALE **CURRENCY :** MALAYSIAN RINGGIT

OWNER : SAMPLE INSURED

THIS POLICY IS NON-PARTICIPATING

SCHEDULE OF BENEFITS AND PREMIUMS

Type of Coverage	Form No.	Maturity/ Expiry Date	Amount of Benefit* (RM)	Premiums (RM)	Premium Ceased Date
AIA Critical Illness Cover		11/24/2053	50,000	XX.XX	11/24/2053

MONTHLY PREMIUM: **RM** **XX.XX**

TOTAL AMOUNT PAYABLE: **RM** **XX.XX**

PREMIUMS ARE PAYABLE ON THE POLICY DATE AND IN ADVANCE EVERY ONE MONTH(S) THEREAFTER APPLICABLE SUBJECT TO THE TERMS AND CONDITIONS OF THE POLICY

*Denote limitations of benefit and actual benefits payable in accordance with the coverage terms

BASIC DEFINITIONS

In this Policy:

"Activities of Daily Living" are as follows:

(i) Transfer
Getting in and out of a chair without requiring physical assistance.

(ii) Mobility
The ability to move from room to room without requiring any physical assistance.

(iii) Continence
The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.

(iv) Dressing
Putting on and taking off all necessary items of clothing without requiring assistance of another person.

(v) Bathing/Washing
The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.

(vi) Eating
All tasks of getting food into the body once it has been prepared.

"Assessment Period" means the period during which We will assess a condition before deciding whether or not the condition qualifies as being permanent. The assessment period will be for the minimum period time frame stated in the relevant definition and will not be longer than twelve (12) months (provided all required evidence has been submitted).

"Close Associate" means any individual closely connected to the Entity, either socially or professionally.

"Covered Surgery" shall mean the various surgical operations or procedures defined or specified in the Definitions of Critical Illnesses.

"Critical Illnesses" shall mean illnesses the signs or symptoms of which commenced more than thirty (30) days (other than Critical Illness No. 2, 3, 4, 5 and 6 which are subject to sixty (60) days) following the Issue Date, or the Commencement Date of this Policy, whichever is the later, and shall include either the diagnosis of any of the following illnesses or performance of any of the Covered Surgeries included below, being:

1. Stroke – *resulting in permanent neurological deficit with persisting clinical symptoms*

Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolisation from an extra cranial source resulting in permanent neurological deficit with persisting clinical symptoms. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist. A minimum Assessment Period of three (3) months applies.

For the above definition, the following are not covered:

(i) Transient ischemic attacks;
(ii) Cerebral symptoms due to migraine;
(iii) Traumatic injury to brain tissue or blood vessels;
(iv) Vascular disease affecting the eye or optic nerve or vestibular functions.

2. Cancer – *of specified severity and does not cover very early cancers*

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

For the above definition, the following are not covered:

(i) All cancers which are histologically classified as any of the following:

- pre-malignant
- non-invasive
- Carcinoma in situ
- having borderline malignancy
- having malignant potential

(ii) All tumours of the prostate histologically classified as T1N0M0 (TNM classification);
(iii) All tumours of the thyroid histologically classified as T1N0M0 (TNM classification);
(iv) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM classification);
(v) Chronic Lymphocytic Leukaemia less than RAI Stage 3;
(vi) All cancers in the presence of HIV;
(vii) Any skin cancer other than malignant melanoma.

3. Heart Attack – *of specified severity*

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

(i) A history of typical chest pain;
(ii) New characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block; and
(iii) Elevation of the cardiac biomarkers, inclusive of CPK-MB above the generally accepted normal laboratory levels or Troponins recorded at the following levels or higher:
- Cardiac Troponin T or Cardiac Troponin I > / = 0.5 ng/ml

The evidence must show the occurrence of a definite acute myocardial infarction which should be confirmed by a cardiologist or physician.

For the above definition, the following are not covered:
- occurrence of an acute coronary syndrome including but not limited to unstable angina.
- a rise in cardiac biomarkers resulting from a percutaneous procedure for coronary artery disease.

4. Coronary Artery By-Pass Surgery

Refers to the actual undergoing of open-chest surgery to correct or treat Coronary Artery Disease (CAD) by way of coronary artery by-pass grafting.

For the above definition, the following are not covered:

(i) angioplasty;
(ii) other intra-arterial or catheter based techniques;
(iii) keyhole procedures;
(iv) laser procedures.

5. Serious Coronary Artery Disease

The narrowing of the lumen of Right Coronary Artery (RCA), Left Anterior Descending Artery (LAD) and Circumflex Artery (not inclusive of their branches) occurring at the same time by a minimum of sixty percent (60%) in each artery as proven by coronary arteriography (non-invasive diagnostic procedures are not covered). A narrowing of sixty percent (60%) or more of the Left Main Stem will be considered as a narrowing of the Left Anterior Descending Artery (LAD) and Circumflex Artery. This covered event is payable regardless of whether or not any form of coronary artery surgery has been performed.

6. Angioplasty and Other Invasive Treatments for Coronary Artery Disease

The actual undergoing for the first time of Coronary Artery Balloon Angioplasty, artherectomy, laser treatment or the insertion of a stent to correct a narrowing or blockage of one or more coronary arteries as shown by angiographic evidence.

Intra-arterial investigative procedures are not covered.

7. Heart Valve Surgery

The actual undergoing of open-heart surgery to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities.

For the above definition, the following are not covered:

(i) Repair via intra-arterial procedure;
(ii) Repair via key-hole surgery or any other similar techniques.

8. Fulminant Viral Hepatitis

A sub-massive to massive necrosis (death of liver tissue) caused by any virus as evidenced by all of the following diagnostic criteria:

(i) A rapidly decreasing liver size as confirmed by abdominal ultrasound;
(ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework;
(iii) Rapidly deteriorating liver functions tests; and
(iv) Deepening jaundice.

Viral hepatitis infection or carrier status alone (inclusive but not limited to Hepatitis B and Hepatitis C) without the above diagnostic criteria is not covered.

9. End-Stage Liver Failure

End-stage liver failure as evidenced by all of the following:

- Permanent jaundice;
- Ascites (excessive fluid in peritoneal cavity); and
- Hepatic encephalopathy.

Liver failure secondary to alcohol or drug abuse is not covered.

10. Primary Pulmonary Arterial Hypertension – *of specified severity*

A definite diagnosis of primary pulmonary arterial hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in permanent physical impairment to the degree of at least Class III of the New York Heart Association (NYHA) classification of cardiac impairment.

Pulmonary arterial hypertension resulting from other causes shall be excluded from this benefit.

The NYHA Classification of Cardiac Impairment for Class III and Class IV means the following:

Class III: Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes symptoms.
Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

11. End-Stage Lung Disease

End-stage lung disease causing chronic respiratory failure. All of the following criteria must be met:

(i) The need for regular oxygen treatment on a permanent basis;
(ii) Permanent impairment of lung function with a consistent Forced Expiratory Volume (FEV) of less than 1 litre during the first second;
(iii) Shortness of breath at rest; and
(iv) Baseline Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less.

12. Kidney Failure – *requiring dialysis or kidney transplant*

End-stage kidney failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular dialysis is initiated or kidney transplantation is carried out.

13. Surgery to Aorta

The actual undergoing of surgery via a thoracotomy or laparotomy (surgical opening of thorax or abdomen) to repair or correct an aortic aneurysm, an obstruction of the aorta or a dissection of the aorta. For this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

For the above definition, the following are not covered:

(i) angioplasty;
(ii) other intra-arterial or catheter based techniques;
(iii) other keyhole procedures;
(iv) laser procedures.

14. Chronic Aplastic Anaemia – *resulting in permanent Bone Marrow Failure*

Irreversible permanent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring at least two (2) of the following treatments:

(i) Regular blood product transfusion;
(ii) Marrow stimulating agents;
(iii) Immunosuppressive agents; or
(iv) Bone marrow transplantation.

The diagnosis must be confirmed by a bone marrow biopsy.

15. Major Organ / Bone Marrow Transplant

The receipt of a transplant of:

- Human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation; or
- One of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ.

Other stem cell transplants are not covered.

16. Blindness – Permanent and Irreversible

Permanent and irreversible loss of sight as a result of accident or illness to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in both eyes using a Snellen eye chart or equivalent test and the result must be certified by an ophthalmologist.

17. Deafness – Permanent and Irreversible

Permanent and irreversible loss of hearing as a result of accident or illness to the extent that the loss is greater than 80 decibels across all frequencies of hearing in both ears. Medical evidence in the form of an audiometry and sound-threshold tests result must be provided and certified by an Ear, Nose, and Throat (ENT) specialist.

18. Loss of Speech

Total, permanent and irreversible loss of the ability to speak as a result of injury or illness. A minimum Assessment Period of six (6) months applies. Medical evidence to confirm injury or illness to the vocal cords to support this disability must be supplied by an Ear, Nose, and Throat specialist.

All psychiatric related causes are not covered.

19. Coma – *resulting in permanent neurological deficit with persisting clinical symptoms*

A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously for at least ninety six (96) hours, requiring the use of life support systems and resulting in a permanent neurological deficit with persisting clinical symptoms. A minimum Assessment Period of thirty (30) days applies. Confirmation by a neurologist must be present.
The following is not covered:

(i) Coma resulting directly from alcohol or drug abuse.

20. Third Degree Burns – *of specified severity*

Third degree (i.e. full thickness) skin burns covering at least twenty percent (20%) of the total body surface area.

21. Multiple Sclerosis

A definite diagnosis of multiple sclerosis by a neurologist. The diagnosis must be supported by all of the following:

- Investigations which confirm the diagnosis to be Multiple Sclerosis;
- Multiple neurological deficits resulting in impairment of motor and sensory functions occurring over a continuous period of at least 6 months; and
- Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

22. Paralysis of Limbs

Total, permanent and irreversible loss of use of both arms or both legs, or of one arm and one leg, through paralysis caused by illness or injury. A minimum Assessment Period of six (6) months applies.

23. Muscular Dystrophy

The definite diagnosis of a Muscular Dystrophy by a neurologist which must be supported by all of the following:

(i) Clinical presentation of progressive muscle weakness;
(ii) No central/peripheral nerve involvement as evidenced by absence of sensory disturbance;
(iii) Characteristic electromyogram and muscle biopsy findings.

No benefit will be payable under this covered event before the Insured/You has/have reached the age of 12 years next birthday.

24. Alzheimer's Disease / Severe Dementia

Deterioration or loss of intellectual capacity confirmed by clinical evaluation and imaging tests arising from Alzheimer's Disease or Severe Dementia as a result of irreversible organic brain disorders. The covered event must result in significant reduction in mental and social functioning requiring continuous supervision of the Insured/You. The diagnosis must be clinically confirmed by a neurologist.

From the above definition, the following are not covered:

(i) Non organic brain disorders such as neurosis;
(ii) Psychiatric illnesses;
(iii) Drug or alcohol related brain damage.

25. Motor Neuron Disease – *permanent neurological deficit with persisting clinical symptoms*

A definite diagnosis of motor neuron disease by a neurologist with reference to either spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be permanent neurological deficit with persisting clinical symptoms.

26. Parkinson's Disease – *resulting in permanent inability to perform Activities of Daily Living*

A definite diagnosis of Parkinson's Disease by a neurologist where all the following conditions are met:

(i) Cannot be controlled with medication;
(ii) Shows signs of progressive impairment; and
(iii) Confirmation of the permanent inability of the Insured/You to perform without assistance three (3) or more of the Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinsonism are not covered.

27. Terminal Illness

The conclusive diagnosis of a condition that is expected to result in death of the Insured/You within twelve (12) months. The Insured/You must no longer be receiving active treatment other than that for pain relief. The diagnosis must be supported by written confirmation from an appropriate specialist and confirmed by Our appointed Doctor.

28. Encephalitis – *resulting in permanent inability to perform Activities of Daily Living*

Severe inflammation of brain substance, resulting in permanent functional impairment. The permanent functional impairment must result in an inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of thirty (30) days applies. The covered event must be certified by a neurologist.

Encephalitis in the presence of HIV infection is not covered.

29. Benign Brain Tumour – *of specified severity*

A benign tumour in the brain or meninges within the skull, where all of the following conditions are met:

(i) It is life threatening.
(ii) It has caused damage to the brain.
(iii) It has undergone surgical removal or has caused permanent neurological deficit with persisting clinical symptoms; and
(iv) Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on MRI, CT or other reliable imaging techniques.

The following are not covered:

(i) Cysts;
(ii) Granulomas;
(iii) Malformations in or of the arteries or veins of the brain;
(iv) Haematomas;
(v) Tumours in the pituitary gland;
(vi) Tumours in the spine;
(vii) Tumours of the acoustic nerve.

30. Major Head Trauma – *resulting in permanent inability to perform Activities of Daily Living*

Physical head injury resulting in permanent functional impairment verified by a neurologist. The permanent functional impairment must result in an inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of three (3) months applies.

31. Bacterial Meningitis – *resulting in permanent inability to perform Activities of Daily Living*

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent functional impairment. The permanent functional impairment must result in an inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of thirty (30) days applies.

The diagnosis must be confirmed by:
(i) an appropriate specialist; and

(ii) the presence of bacterial infection in the cerebrospinal fluid by lumbar puncture.

For the above definition, other forms of meningitis, including viral meningitis are not covered.

32. Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy (surgical opening of skull) is performed.

For the above definition, the following are not covered:

(i) Burr hole procedures;
(ii) Transphenoidal procedures;
(iii) Endoscopic assisted procedures or any other minimally invasive procedures;
(iv) Brain surgery as a result of an accident.

33. Medullary Cystic Disease

A progressive hereditary disease of the kidney characterised by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anaemia, polyuria and renal loss of sodium, progressing to chronic kidney failure. Diagnosis must be supported by a renal biopsy.

34. Loss of Independent Existence

Confirmation by an appropriate specialist of the loss of independent existence and resulting in a permanent inability to perform at least three (3) of the Activities of Daily Living. A minimum Assessment Period of six (6) months applies.

35. HIV Infection Due To Blood Transfusion

Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:

(i) The blood transfusion was medically necessary or given as part of a medical treatment;
(ii) The blood transfusion was received in Malaysia or Singapore after the commencement of the Policy;
(iii) The source of the infection is established to be from the institution that provided the blood transfusion and the institution is able to trace the origin of the HIV tainted blood;
(iv) The Insured/You does/do not suffer from haemophilia; and
(v) The Insured/You is/are not a member of any high risk groups including but not limited to intravenous drug users.

36. Cardiomyopathy – *of specified severity*

A definite diagnosis of cardiomyopathy by a cardiologist which results in permanently impaired ventricular function and resulting in permanent physical impairment of at least Class III of the New York Heart Association's classification of cardiac impairment. The diagnosis has to be supported by echocardiographic findings of compromised ventricular performance.

The NYHA Classification of Cardiac Impairment for Class III and Class IV means the following:
Class III: Marked limitation of physical activity. Comfortable at rest but less than ordinary activity causes symptoms.
Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

Cardiomyopathy directly related to alcohol or drug abuse is not covered.

37. Full-blown AIDS

The clinical manifestation of AIDS (Acquired Immune Deficiency Syndrome) must be supported by the results of a positive HIV (Human Immunodeficiency Virus) antibody test and a confirmatory test. In addition, the Insured must have a CD4 cell count of less than two hundred (200)/µL and one or more of the following criteria are met:

(i) Weight loss of more than 10% of body weight over a period of six (6) months or less (wasting syndrome);
(ii) Kaposi Sarcoma;
(iii) Pneumocystis Carinii Pneumonia;
(iv) Progressive multifocal leukoencephalopathy;
(v) Active Tuberculosis;
(vi) Less than one-thousand (1000) Lymphocytes/µL;
(vii) Malignant Lymphoma.

38. Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection

Infection with the Human Immunodeficiency Virus (only if the Insured is a Medical Staff as defined below), where it was acquired as a result of an accident occurring during the course of carrying out normal occupational duties with seroconversion to HIV infection occurring within six (6) months of the accident. Any accident giving rise to a potential claim must be reported to Us within thirty (30) days of the accident taking place supported by a negative HIV test taken within seven (7) days of the accident.

"Medical Staff" is defined as doctors (General Physicians and Specialists), traditional practitioners, nurses, paramedics, laboratory technicians, dentists, dental nurses, ambulance workers who are working in a medical centre or hospital or dental clinic/polyclinic in Malaysia. Doctors, traditional practitioners, nurses and dentists must be registered with the Ministry of Health of Malaysia.

39. Systemic Lupus Erythematosus with Severe Kidney Complications

A definite diagnosis of Systemic Lupus Erythematosus confirmed by a rheumatologist.

For this definition, the covered event is payable only if it has resulted in Type III to Type V Lupus Nephritis as established by renal biopsy. Other forms such as discoid lupus or those forms with only haematological or joint involvement are not covered.

WHO Lupus Classification:

Type III - Focal Segmental glomerulonephritis
Type IV - Diffuse glomerulonephritis
Type V - Membranous glomerulonephritis

"Diagnosis" shall mean the definitive diagnosis made by a Physician, as defined below, based upon such specific evidence, as referred to above in the definition of the particular Critical Illness concerned or, in the absence of such specific evidence, based upon radiological, clinical, histological or laboratory evidence acceptable to Us. Such diagnosis must be supported by Our medical doctor who may base his opinion on the medical evidence submitted by the Insured/You and/or any additional evidence which the former may require.

In the event of any dispute or disagreement regarding the appropriateness or correctness of the diagnosis, We shall have the right to call for an examination, of either the Insured/You or the evidence used in arriving at such diagnosis, by an independent acknowledged expert in the field of medicine concerned selected by Us and the opinion of such expert as to such diagnosis shall be binding on both the Insured/You and Us.

"Entity" means any individual, body, organisation, institution, establishment, operation that is:-
(a) sanctioned, prohibited or restricted under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America, or any of its states, and/or any other applicable economic or trade sanction laws or regulations ("Sanctioned Entity"); or
(b) employed, employs, trades, or conducts business with a Sanctioned Entity in any manner whatsoever.

"Expiry Date" for Policy means the date as shown in the Policy Information Page, upon which the Policy shall expire and for the respective benefit under the Policy means the date, as shown in the Schedule of Benefits and Premiums of the Policy Information Page, when the benefit shall terminate.

"Face Amount" means the amount of the insurance of the Policy when it is issued and is shown on the Policy Information Page. If the Face Amount is subsequently reduced according to the terms and conditions of this Policy, the reduced amount after such alteration will become the Face Amount.

"Insured" refers to the person whose name and personal particulars are identified on the Policy Information Page.

"Irreversible" means cannot be reasonably improved upon by medical treatment and/or surgical procedures consistent with the current standard of the medical services available in Malaysia.

"Issue Date" or **"Commencement Date"** is the date when coverage under this Policy takes effect. The Issue Date is shown on the Policy Information Page and the Commencement Date is the date of issue of any endorsement indicated in the relevant endorsement whenever the original terms and coverage of this Policy are changed subsequently. Commencement Date is also the approval date of reinstatement of the Policy in case of any reinstatement.

"Non-participating" means Your Policy does not participate in the profits of Our life insurance business.

"Owner" means the person effecting this Policy.

"Permanent" means expected to last throughout the lifetime of the Insured/You.

"Permanent neurological deficit with persisting clinical symptoms" means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Insured/You. Symptoms that are covered include numbness, paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

"Physician" 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 physician or surgeon who is the Insured/You himself/Yourself.

"Policy" refers to AIA Critical Illness Cover.

"Policy Anniversary" refers to the same date each year as the Policy Date.

"Policy Date" as shown on the Policy Information Page is the date from which Policy Anniversaries, Policy Years, Policy Months and premium due dates are determined.

"Policy Year" refers to the twelve (12) months duration between two (2) Policy Anniversaries.

"Pre-Existing Conditions" shall mean illnesses/disabilities prior to the Issue Date or Commencement Date, whichever is later, of the Policy and that the Insured/You has/have reasonable knowledge of. An Insured/You may be considered to have reasonable knowledge of a Pre-Existing Condition where the condition is one for which:

(a) the Insured/You 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.

“Relative” means spouse, partner, sibling, child, parent or parent of the spouse or partner of the Entity. Sibling, child, parent or parent of the spouse or partner includes both biological and non-biological relationship.

"We", **"Us"**, **"Our"** or **"Company"** refers to AIA Bhd.

"You" or **"Your"** means the Owner of this Policy as shown in the Policy Information Page.

Whenever the context requires, masculine form shall apply to feminine and singular term shall include the plural.

AIA CRITICAL ILLNESS COVER PROVISIONS

Your Policy is called AIA Critical Illness Cover. It is a critical illness insurance Policy which expires on the Expiry Date as stated on the Policy Information Page. Premium shall be payable until the premium ceased date stated on the Policy Information Page or upon the termination of this Policy, whichever occurs earlier.

Your Policy provides the following benefits subject to the terms and conditions stated below.

BENEFITS

We will provide the following benefits if, while this Policy is in force, the Insured is diagnosed to be suffering from a Critical Illness; or actually undergoes a Covered Surgery, subject to the Insured survive for at least fifteen (15) days from the date being diagnosed to be suffering from a Critical Illness or actually undergoes a Covered Surgery, and the following terms and conditions:

1. **LUMP SUM PAYMENT FOR CRITICAL ILLNESS**

   In the event the Insured is diagnosed to have suffered from Critical Illness or underwent the Covered Surgeries, We shall pay to You the Face Amount in lump sum (the "Lump Sum Payment").

   This Lump Sum Payment is payable once only. This Policy shall terminate upon payment of the Lump Sum Payment.

2. **LIMITED PAYMENT FOR ANGIOPLASTY AND OTHER INVASIVE TREATMENTS FOR CORONARY ARTERY DISEASE**

   In the case of Angioplasty and Other Invasive Treatments for Coronary Artery Disease, Our liability is limited to ten percent (10%) of the Lump Sum Payment (the "Limited Payment") subject to a maximum of RM25,000. This Limited Payment is payable once only. This Policy shall then continue with the reduced Face Amount.

PERIOD OF COVER AND RENEWAL

This Policy will be renewable on each Policy Anniversary of this Policy of this Policy, by payment of the premium in advance at the premium rate determined by Us at the time of renewal, subject to the terms and conditions of this Policy.

The premium payable for this Policy is not guaranteed and We reserve the right to revise or adjust it at the time of such renewal by giving You a three (3) months' prior notice in writing by ordinary post to Your last known address or electronic mail in Our record. The revised premium will be applicable from the next renewal of this Policy.

Any revision in premiums shall be applicable to all Owners irrespective of their claim experience according to Our risk assessment.

In the event of any increase in premium of this Policy, You have to pay the revised premium.

This Policy is renewable at Your option until the occurrence of any of the following:

(a) fraud or misrepresentation of material fact during application;
(b) non payment of premium or premium not made on time;
(c) this Policy is cancelled at Your request;
(d) this Policy is expired at the Expiry Date;
(e) payment of the Lump Sum Payment;
(f) the Insured attains the coverage age limit specified; or
(g) death of the Insured.

PAYMENT OF BENEFITS

All benefits are payable to You. If You die before the settlement of the claim, the benefits shall be paid to Your legal personal representatives. Such payment is deemed to be good discharge of the moneys payable under this Policy.

The benefits provided under this Policy are not assignable.

We reserve the absolute right to request for further evidence, medical report or conduct medical history check before the benefits are payable to You.

SUBROGATION

If We shall become liable for any payment under this Policy, We shall be subrogated to the extent of such payment to all rights and remedies of the Insured/You against any party and shall be entitled at Our own expense to sue in the name of the Insured/You. The Insured/You shall give or cause to be given to Us all such assistance in his/Your power as We shall require to secure the rights and remedies and at Our request shall execute or cause to be executed all documents necessary to enable Us to effectively to bring suit in the name of the Insured/You.

EXCLUSIONS

This Policy does not cover:

(a) any illness or surgery other than a diagnosis of or surgery for a Critical Illness as defined here;

(b) Critical Illness No. 1, 7 to 39 for which the signs or symptoms first occurred within thirty (30) days following, the Issue Date or Commencement Date, whichever is later;

(c) Critical Illness No. 2 to 6 for which the signs or symptoms first occurred within sixty (60) days following, the Issue Date or Commencement Date, whichever is later;

(d) any Critical Illness diagnosed due, directly or indirectly, to a congenital defect or disease which has manifested or was diagnosed before the Insured/You attains seventeen (17) years of age;

(e) any Pre-existing Conditions prior to the Issue Date or Commencement Date, whichever is later;

(f) the diagnosis of Fulminant Viral Hepatitis, Cancer, Encephalitis, Bacterial Meningitis, Alzheimer's Disease/ Severe Dementia or Terminal Illness of the Insured/You, where in Our opinion, was directly or indirectly due to an Acquired Immune Deficiency Syndrome (AIDS) or infection by any HIV. We reserve the right to require the Insured/You to undergo a blood test for HIV as a condition precedent to any acceptance of any claim. For the purpose of this Policy:

    (i) The definition of AIDS shall be that used by the World Health Organisation in 1987, or any subsequent revision by the World Health Organisation of that definition.

    (ii) Infection shall be deemed to have occurred where blood or other relevant test(s) indicate in Our opinion either the presence of any HIV or Antibodies to such a Virus.

(g) any of the Critical Illnesses or Covered Surgeries defined here which is caused by a self-inflicted injury.

ALTERATION

We reserve the right to amend the terms and provisions of this Policy by giving three (3) months' prior written notice by ordinary post to Your last known address or electronic mail in Our record, and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless authorised by Us and such approval is endorsed on this Policy.

If the Insured intends to make any alteration or waive any provisions in this Policy, the said alteration or waiver has to be made by an endorsement. The endorsement has to be signed by Our Registrar.

EXECUTED AND SIGNED BY US ON THE ISSUE DATE/COMMENCEMENT DATE OF THIS POLICY.

Chief Executive Officer

GENERAL PROVISIONS

THE POLICY CONTRACT

This Policy is issued in consideration of the payment of premium as specified in the Policy Information Page and pursuant to:

(i) the answers given by You and/or the Insured in Your application/proposal form or any subsequent questionnaires given by Us on any matters relating to Your proposal and any disclosures made by You between the time of submission of Your application/proposal and the time this contract is entered into; and

(ii) medical reports and any other reports and questionnaires;

(collectively referred to as 'the material information')

and such material information shall form part of this contract of insurance between Us and You. However, in the event of any pre-contractual misrepresentation made in relation to such material information, only the remedies in Schedule 9 of the Financial Services Act 2013 will apply.

If You are required by Us, before the Policy is renewed or varied, to answer any questions or if You are required to confirm or amend any matter previously disclosed by You to Us in relation to this Policy, it is Your duty to take reasonable care not to make a misrepresentation when answering the questions or confirming or amending any matter previously disclosed.

You must inform Us of any change to the information given to Us in Your answers or in respect of any matter previously disclosed to Us in relation to the Policy if such changes had taken place after You have submitted the application for renewal/variation but before the Policy is renewed or varied.

INDISPUTABILITY

We shall not dispute the validity of this Policy after it has been in force during the lifetime of the Insured/You for a period of more than two (2) years from the Issue Date or Commencement Date, whichever is later. However if We can show that there is a suppression of a material fact or a statement by You/Insured on a material matter was inaccurate, false, misleading and it was fraudulently made or omitted, We shall have the right to void this Policy accordingly.

Where this Policy has been in force during the lifetime of the Insured/You for two (2) years or less from the Issue Date or Commencement Date, whichever is later, We may void this Policy and refuse all claims if a misrepresentation was found to be deliberate or reckless.

If the misrepresentation was careless or innocent We may at Our absolute discretion:

(a) void this Policy and refuse all claims, in which case We shall return the premiums paid without interest. This payment shall be a complete and valid discharge of any liability under this Policy; or

(b) take any necessary remedies in accordance with the Financial Services Act 2013.

MISSTATEMENT OF AGE AND/OR GENDER

(i) The age stated on the Policy Information Page is the age of the Insured that is declared in Your application. The said age is that of the Insured's last birthday at Policy Date.

(ii) If there is a misstatement of age and/or gender, the premium and/or benefits that would be payable shall be adjusted based on the correct age and/or gender of the Insured.

If the Insured is not eligible for insurance at the correct age and/or gender, this Policy shall be void and We will refund to You the premiums paid without interest.

(iii) Payment of benefits under this Policy will only be made, provided the age and/or gender of the Insured is verified and confirmed. The Insured's age and/or gender shall be verified and confirmed if due proof is submitted to Us.

GOVERNING LAW

This Policy shall be governed by the laws of Malaysia and the Courts of Malaysia shall have the exclusive jurisdiction in respect of any claims arising out of or in relation to this Policy.

CURRENCY AND PLACE OF PAYMENT

All amounts payable either to or by Us will be paid in the currency shown on the Policy Information Page or subsequent endorsement. All amounts due from Us will be payable at any of Our Offices.

FREEDOM FROM RESTRICTIONS

Unless otherwise specified, this Policy is free from any restrictions upon the Insured as to travel, residence or occupation.

CLAIMS PROCEDURES

1. Notice of Claim

Written notice of claim must be given to Us within sixty (60) days after the diagnosis of Critical Illness or Covered Surgery, as the case may be. Such notice given to Us with particulars sufficient to identify the Insured/You, shall be deemed to be notice to Us. Failure to give notice within such time shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

2. Proof of Critical Illness

We, upon receipt of such notice, will provide to the claimant with the appropriate forms for filing proof of Critical Illness. If the forms are not given within fifteen (15) days, the claimant by submitting written proof covering the occurrence and circumstances of the occurrence, the character and the degree of the Critical Illness for which the claim is made shall be deemed to have complied with the requirements of this provision.

3. Filing Proof of Critical Illness

Proof of Critical Illness or Covered Surgery must be submitted to Us during the Insured's lifetime. Such proof must be furnished within six (6) months after the diagnosis of such Critical Illness or performance of surgery of the Insured.

FREE LOOK PERIOD

You have the right to cancel this Policy by giving Us a written notice and returning this Policy to Us. The premiums that You have paid will be refunded to You. Such notice must be signed by You and received directly by Us within fifteen (15) days after You have received the Policy.

TERMINATION

Your Policy shall automatically terminate upon the earliest occurrence of the following:

(i) death of the Insured; or
(ii) the Lump Sum Payment; or
(iii) non-payment of premium or premium not made on time; or
(iii) if this Policy becomes expired, cancelled, surrendered or terminated.

The payment or acceptance of any premium after the termination of this Policy shall not create any liability on Our part but We shall refund any such premium without interest.

NOTICES AND CORRESPONDENCE

(i) Unless provided for, any notice, request, instruction or correspondence required or permitted to be given under this Policy to Us or to You must be made in writing.

(ii) We shall send or deliver personally any notice, request, instruction or correspondence to Your last known address in Our records. It is conclusively deemed to be received:

(a) In the case of personal delivery: at the time of delivery;

(b) In the case of post, whether registered or otherwise: seven (7) days after the date of posting, if posted locally, and fourteen (14) days, if posted to an overseas address; and

(c) In the case of electronic mail, after twenty-four (24) hours from the date of the email.

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. If 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 Us for any claim under this Policy must be referred to an arbitrator within twelve (12) calendar months from the date of such disclaimer.

SANCTION LIMITATION AND EXCLUSION CLAUSE

(i) The Company shall not provide cover for any risk and/or activity and shall not be liable to pay any claim or pay any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Company 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, or any of its states, and/or any other applicable economic or trade sanction laws or regulations.

(ii) The Company shall not provide cover for any risk and/or activity and shall not be liable to pay any claim or pay any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit is for and/or to any Entity and/or Relative/Close Associate of any Entity.

(iii) The Company may terminate this Policy with immediate effect and shall not thereafter be required to transact any business with You in connection with this Policy, including but not limited to, making or receiving any payments under this Policy.

REGULATORY IMPOSED TAX, CHARGES, FEES ETC

The premium to be paid by the Owner to the Company under this Policy is exclusive of any Tax. In the event the Company is required by any applicable law to remit any Tax on the premium paid by the Owner, the Company shall calculate and collect from the Owner any amount paid or payable under this Policy on account of such Tax. Such amount as calculated by the Company, shall be paid by the Owner as additional to and without any deduction or set-off from the premium payable under this Policy to the Company. Tax is defined as any present or future, direct or indirect, tax including sales tax, service tax, any other tax of similar nature, levy, impost, duty, charge, fee, deduction or withholding of any nature, and any interest or penalties in respect thereof imposed by the Government of Malaysia.

OTHER PROVISIONS

(i) Any illegality, invalidity or unenforceability of any clause of these General Provisions under the Malaysian law shall not affect the legality, validity or enforceability of any other provisions in this Policy.

(ii) Our books and/or accounts shall be conclusive evidence of the state of accounts between the parties in this Policy. Any certificate by any of Our officers as to the moneys or liabilities for the time being due and remaining or incurred to Us by the Insured shall be binding and conclusive evidence on the Insured in all courts of law and elsewhere.

(iii) If We delay or fail to exercise any rights/remedies under this Policy, it will not be deemed as a waiver. Any single/partial exercise of any right/remedy shall not prevent Us from any other or further exercise of any other right/remedy. The rights and remedies provided in this Policy are cumulative and not exclusive of any other rights/remedies (whether provided by law or otherwise).

(iv) This Policy shall continue to be valid and binding for all purposes whatsoever despite any change by amalgamation, change of name, reconstruction or otherwise which may be made in Our constitution.

(v) The terms and conditions stated in this Policy constitute the entire terms and conditions of this Policy. No prior inconsistent representation or statement made in relation to this Policy whether orally or in writing shall form part of this Policy.

(vi) We reserve the right to alter the terms of this Policy in such a way as We deem appropriate in the event of any change in the law or in the basis of taxation levy applicable to Us or this Policy.

CANCELLATION

You may cancel this Policy at any time by giving a written notice to Us, and provided that no claims have been made during the current Policy Year, You shall be entitled to a refund of the premium as follows:

Period From Policy Anniversary, Not Exceeding	Premium Payment Mode			
	Annual	Semi-annual	Quarterly	Monthly
15 days*	90%	80%	70%	No Refund
1 month	80%	70%	50%	
2 months	70%	50%	20%	
3 months	60%	30%	No Refund	
4 months	50%	20%	50%	
5 months	40%	10%	20%	
6 months	30%	No Refund	No Refund	
7 months	25%	70%	50%	
8 months	20%	50%	20%	
9 months	15%	30%	No Refund	
10 months	10%	20%	50%	
11 months	5%	10%	20%	
Period exceeding 11 months	No Refund	No Refund	No Refund	

(Note: * not applicable to first Policy Year)

THE OWNER

You are the Owner of this Policy as shown on the Policy Information Page until changed. As the Owner, only You can, during the Insured's lifetime, exercise all rights, privileges and options provided under this Policy.

PREMIUM PROVISIONS

PAYMENT

All premiums for this Policy are payable on or before their due dates to Us. We will issue an official receipt for each payment received by Our Office. However, if you pay Your premiums by credit/debit card or autodebit of Your bank account, We will not issue an official receipt for the payment. The validated deposit slip or premium deduction shown in either the credit or debit card statement or bank statement shall be considered as proof of payment.

CHANGE

You may change the frequency of premium payments by submitting a written request to Us. Subject to Our minimum premium requirements, premiums may be paid on an annual, semi-annual, quarterly or monthly mode at the premium rates applicable on the Issue Date.

DEFAULT

After payment of the first (1st) premium, failure to pay a subsequent premium on or before its due date will constitute a default in premium payment.

GRACE PERIOD

A Grace Period of thirty-one (31) days from the due date will be allowed for payment of each subsequent premium. This Policy will remain in force during the Grace Period. If any claim arises during the Grace Period, any unpaid balance of the premium due shall be deducted from the proceeds payable under this Policy. If any premium remains unpaid at the end of its Grace Period, this Policy shall lapse and have no further value.

REINSTATEMENT

If a premium is still in default after the stipulated Grace Period and if this Policy has not been surrendered, this Policy may be reinstated by Us at Our own discretion before the Expiry Date of Your Policy and it is also subject to the following:

(i) A written application is made by You to have this Policy reinstated;

(ii) The Insured is within the allowable age limits as determined by Us at the time of reinstatement;

(iii) The Insured has to produce evidence of insurability that is satisfactory to Us;

(iv) Payment of all overdue premiums; and

(v) Any other terms and conditions which We may impose at the material time.

The reinstated Policy shall only cover loss or the insured event which occurs after the reinstatement date.

POLICY INFORMATION STATEMENT

Your Policy is a valuable piece of property and serves as a useful aid to assist Your family against potential uncertainties of the future.

You may not have time to familiarise Yourself with all the Policy provisions, but it is important that You know the unique benefits of this AIA Policy. This Policy Information Statement is specially prepared in plain language to give You a better understanding of some of these benefits.

1. (a) Your premium payment is made annually, semi-annually, quarterly or monthly, whichever suits You best.

   (b) You may pay the premiums in any of the following ways at Our discretion:

      (i) A Visa/MasterCard card;

      (ii) autodebit through banks as specified by Us; or

      (iii) Direct to Us.

      If You pay Your premium by Visa/MasterCard card or autodebit, We will not send You any prior notice that Your premium is due. No official receipt will be issued, however the validated deposit slip or premium deduction shown in either the Visa/MasterCard card statement or bank statement shall be considered as proof of payment.

2. If the Insured's age has not been admitted, You are required to submit a copy of identity card for proof of age upon request by Us.

3. It is important that You advise Us of any change in Your address.

4. You have the right to cancel this Policy within the Free Look Period by giving Us a written notice and returning this Policy to Us. The premiums that You have paid will be refunded to You. Such notice must be signed by You and received directly by Us within fifteen (15) days after You have received the Policy.

5. You may surrender Your Policy, however, it would not be to Your advantage if You were to surrender Your Policy.

6. In case of any dispute arising from this Policy, You may write to:

   AIA Bhd.
   Customer Care Unit
   Menara AIA, 99, Jalan Ampang,
   50450 Kuala Lumpur
   P.O. Box 10140
   50704 Kuala Lumpur
   Care Line: 1300-88-1899
   Tel: 03-2056 1111
   Email: my.complaint@aia.com
   Website: AIA.COM.MY

   If there are disputes on Our final decision relating to this Policy involving the amounts below RM250,000 and subject to the Financial Markets Ombudsman Service (FMOS) jurisdiction which is available at www.fmos.org.my, You may refer the dispute to FMOS at the address stated below to resolve the dispute within six (6) months from the date of Our final decision.

Chief Executive Officer
Financial Markets Ombudsman Services [Reg. No: 200401025885]
(Formerly known as Ombudsman for Financial Services)
Level 14, Main Block, Menara Takaful Malaysia
No. 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur
Tel: 03-2272 2811
Website: www.fmos.org.my

If the dispute exceeds RM250,000 or if it does not come within FMOS's jurisdiction, You may refer to Bank Negara Malaysia for further enquiries at the following address:

BNMLINK
Jabatan Komunikasi Korporat
Bank Negara Malaysia
P.O Box 10922
50929 Kuala Lumpur
Tel: 1-300-88-5465
Fax: 03-2174 1515
Web Form: bnmlink.bnm.gov.my

7. If You have any enquiries pertaining to Your Policy, You may contact any of the AIA Customer Centres listed in AIA.COM.MY.

Note:
The above explanation is intended as an aid to Your understanding of the Policy terms and is not to be taken or interpreted as an alteration or amendment of the Policy provisions.