Policy

ALLIANZ MEDICURE

Allianz General Insurance Company (Malaysia) Berhad 200601015674 (735426-V)
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

Allianz

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WHEREAS the **Insured Person(s)** or **Policyholder** described in the **Schedule** hereto by a proposal and declaration, which shall form the basis of this contract, has applied to **Allianz General Insurance Company (Malaysia) Berhad 200601015674 (735426-V)** (hereinafter called "the **Company**") for the insurance hereinafter contained and has paid or has agreed to pay to the **Company** the premium stated in the **Schedule** or endorsement as a consideration for such insurance.

Notwithstanding any provision in this **Policy** ("**Policy**"), the above basis of contract shall not apply to the **Insured Person** who is an individual entering into, varying or renewing the contract of insurance **wholly for purposes unrelated to the Insured Person's trade**, **business or profession**.

NOW THIS POLICY OF INSURANCE WITNESSETH that if during the **Period of Insurance**, any **Sickness**, **Disease or Illness** or **Injury** necessitates the **Insured Person** to be confined to a **Hospital** for treatment, the **Company** will, subject to the terms and conditions of and endorsed on this **Policy**, pay to the **Insured Person** or to the **Insured Person's** legal representative the sum(s) stated in the **Schedule of Benefits**.

1. BENEFITS

The benefits stated hereunder are subject to the maximum limits or **Deductible** (if applicable) stated in the **Schedule of Benefits**.

Provided the total sum of all benefits paid under this **Policy** has not exceeded the limits stated under Paragraph 3 (Limitation of Benefits), the **Company** shall pay or reimburse, as the case may be, the relevant amounts for the benefits set out below according to the plan purchased if the **Insured Person** is required to be confined to a **Hospital** for treatment of a **Disability** during the **Period of Insurance**.

1.1 HOSPITAL ROOM AND BOARD

(a) ROOM

The **Company** will pay the charges for **Medically Necessary** room accommodation and meals actually incurred by the **Insured Person** during the **Insured Person's** confinement in a **Hospital** subject to a maximum of one hundred and twenty (120) days. The **Insured Person** will only be entitled to this benefit while confined to a **Hospital** as an inpatient.

(b) INTENSIVE CARE UNIT

The **Company** will pay the charges for **Medically Necessary** room accommodation and meals actually incurred by the **Insured Person** during the **Insured Person's** confinement in a **Hospital** subject to a maximum of one hundred and twenty (120) days. The **Insured Person** will only be entitled to this benefit while confined to a **Hospital** as an inpatient in the **Intensive Care Unit**. Where the period of confinement in an **Intensive Care Unit** exceeds the limits set forth in the **Schedule of Benefits**, reimbursement will be restricted to the standard daily **Hospital** room and board rate.

For avoidance of doubt, no **Hospital** room and board benefits shall be paid for the same confinement period where the daily **Intensive Care Unit** benefit is payable.

1.2 SURGICAL FEES

The **Company** will pay the **Reasonable and Customary Charges** for a **Surgery** recommended by a **Specialist**, including pre-surgical assessment **Specialist's** visits to the **Insured Person** and post-surgery care up to a maximum of sixty (60) days from the date of **Surgery**.

1.3 HOSPITAL SUPPLIES AND SERVICES

The **Company** will pay the actual charges incurred for the following services which are **Medically Necessary** whilst the **Insured Person** is confined as an inpatient in a **Hospital**:

(a) general nursing;
(b) prescribed and consumed drugs and medicines;
(c) dressings, splints, plaster casts;
(d) X-ray;
(e) laboratory examinations;
(f) electrocardiograms;
(g) physiotherapy;
(h) basal metabolism test;
(i) intravenous injections and solutions; and
(j) administration of blood and plasma excluding the cost of blood and plasma.

1.4 ANAESTHETIST FEE

The **Company** will pay the **Reasonable and Customary Charges** for the administration of anaesthesia by an anaesthetist.

1.5 OPERATING THEATRE

The **Company** will pay the **Reasonable and Customary Charges** in respect of operating theatre charges incidental to a **Surgery**.

1.6 IN-HOSPITAL MEDICAL PRACTITIONER VISIT

The **Company** will pay the **Reasonable and Customary Charges** charged by a **Medical Practitioner** for a ward visit of an inpatient while confined for a non-surgical **Disability**. The **Company** will pay for up to a maximum of two (2) visits per day and not exceeding the maximum of one hundred and twenty (120) days.

1.7 PRE-HOSPITAL DIAGNOSTIC TEST

The **Company** will reimburse the charges for the electrocardiogram ("ECG"), X-ray and laboratory tests which are **Medically Necessary** and are performed before the **Insured Person** is hospitalised due to a **Disability** for diagnostic purposes provided always the **Company** will only reimburse such charges incurred up to a maximum of sixty (60) days prior to **Hospitalisation** and such test are recommended by a **Medical Practitioner**.

The **Company** will not reimburse the cost of the diagnostic test, medication and consultation fees charged by the **Medical Practitioner** for the diagnostic test if **Hospitalisation** is not required for the treatment of the **Disability** diagnosed.

1.8 PRE-HOSPITAL SPECIALIST CONSULTATION

The **Company** will reimburse the charges for the first time consultation with a **Specialist** in connection with a **Disability** before the **Insured Person** is hospitalised for such **Disability** provided always that the **Company** will only reimburse such charges incurred up to a maximum of sixty (60) days prior to **Hospitalisation** and provided that such consultation is **Medically Necessary**.

The **Company** will not reimburse any charges for clinical treatment (including medications and subsequent consultations) after the **Disability** is diagnosed or where the **Insured Person** does not require **Hospitalisation** for the treatment of the **Disability** diagnosed.

1.9 SECOND SURGICAL OPINION

The **Company** will reimburse the actual charges for a consultation or opinion with a second **Specialist** within sixty (60) days from the date of the first consultation with the first **Specialist** to determine whether a surgical operation is **Medically Necessary** or required in view of the **Insured Person's Disability**. This benefit is payable only if the **Insured Person** is admitted to a **Hospital** subsequently.

1.10 DAILY CASH ALLOWANCE AT GOVERNMENT HOSPITAL

The **Company** will pay a daily allowance for each day of **Hospitalisation** for a covered **Disability** in a Malaysian Government **Hospital**, provided that the room and board charges incurred by the **Insured Person** does not exceed the amount shown in the **Schedule of Benefits** for the room and board benefit.

This benefit is not subject to any **Deductible**.

1.11 POST HOSPITALISATION TREATMENT

The **Company** will reimburse the charges incurred for the **Medically Necessary** follow-up treatment by the same attending **Medical Practitioner**, up to a maximum of sixty (60) days immediately following discharge from the **Hospital**. This benefit shall include coverage for medicines prescribed during the follow-up treatment up to a maximum of sixty (60) days' supply of medicine.

1.12 DAYCARE PROCEDURE

The **Company** will pay the actual charges incurred inclusive of all incidental costs levied by the **Hospital** or daycare specialist centre for a **Daycare Procedure** which requires the use of a recovery facility for the **Medically Necessary** procedure referred by a **Medical Practitioner**.

1.13 AMBULANCE FEE

The **Company** will reimburse the actual charges incurred for **Medically Necessary** domestic ambulance services by land (inclusive of attendant) to and/or from the **Hospital**. Reimbursement will not be made if the **Insured Person** does not require **Hospitalisation**.

1.14 MEDICAL REPORT FEE REIMBURSEMENT

The **Company** will reimburse the actual charges incurred for any medical reports required by the **Company**.

1.15 HOME NURSING CARE

The **Company** will reimburse the actual charges incurred for the **Home Nursing Care** rendered by a State-registered or Government-licensed nurse for the continued treatment of the specific **Disability** which the **Insured Person** was hospitalised provided that such services are considered **Medically Necessary** and are prescribed by the original attending **Medical Practitioner**.

The benefit payable shall not exceed the maximum limit as stated in the **Schedule of Benefits**. The **Home Nursing Care** must be provided within seven (7) days following the **Insured Person's** discharge from the **Hospital** subject to a minimum of three (3) days of **Hospitalisation**.

1.16 EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT

The **Company** will reimburse the charges incurred for treatment which is **Medically Necessary** as an **Out-Patient** at any registered clinic or **Hospital** due to an **Injury** within twenty-four (24) hours of the occurrence of an **Accident**. Charges incurred from follow-up treatments by the same **Medical Practitioner** at the same registered clinic or **Hospital** for the same **Injury** will be covered under this benefit up to a maximum of sixty (60) days.

1.17 OUTPATIENT CANCER TREATMENT

The **Company** will pay the **Reasonable and Customary Charges** incurred for the treatment of **Cancer** performed at a legally registered **Cancer** treatment centre or **Hospital**. This benefit does not cover the charges incurred for consultation and examination tests relating to the **Cancer**.

The treatment must be received as an **Out-Patient** at a **Hospital** or a registered **Cancer** treatment centre immediately following discharge from the **Hospital**.

1.18 OUTPATIENT KIDNEY DIALYSIS TREATMENT

The **Company** will reimburse the **Reasonable and Customary Charges** incurred for kidney dialysis and performed at a registered dialysis centre or **Hospital**. This benefit does not cover the charges incurred for consultation, examination tests and take home drugs relating to dialysis.

The dialysis must be received at the **Out-Patient** department of a **Hospital** or a registered dialysis treatment centre immediately following discharge from **Hospital**.

1.19 COMPASSIONATE ALLOWANCE

In the event of death of the **Insured Person** as a result of an **Accident**, the **Company** will pay the **Insured Person's** legal representative a lump sum amount as stated in the **Schedule of Benefits**.

This benefit is not subject to any **Deductible**.

2. OPTIONAL DEDUCTIBLE PLANS AND CASHLESS FACILITY

2.1 DEDUCTIBLE

If the **Policyholder** had opted for **Deductible** to apply, the **Company** will reimburse the remaining **Eligible Expenses** (if any) which has not been reimbursed by any other policy after deducting the **Deductible** from the **Eligible Expenses** incurred during the **Period of Insurance**, subject to the terms specified in this **Policy**.

The liability of the **Company** shall only commence once the **Eligible Expenses** has exceeded the selected **Deductible** amount during the **Period of Insurance**.

The **Policyholder** can choose to increase or decrease the **Deductible** amount upon **Policy** renewal only. **Insured Persons** under the same **Policy** may opt for different **Deductible** amounts.

The **Deductible** limit does not apply to benefits 1.10 (Daily Cash Allowance At Government Hospital) and 1.19 (Compassionate Allowance).

2.2 CASHLESS HOSPITAL ADMISSION AND DISCHARGE

This **Policy** is extended to provide the **Insured Person** with a cashless facility allowing the **Insured Person** to be admitted into a **Hospital** on a cashless basis provided admission is to the **Company's** panel **Hospitals** and subject to the terms and conditions of this **Policy**. This cashless facility is available for all benefits stated in the **Schedule of Benefits** except for **Out-Patient** treatment benefits, pre-hospitalisation consultations, diagnostic procedures, post-hospitalisation costs, Daily Cash Allowance at Government Hospital and Compassionate Allowance which must be claimed on a reimbursement basis.

The **Insured Person** is required to obtain pre-authorization from our authorized **TPA** for all planned admissions at least forty-eight (48) hours prior to the actual admission.

If the **Insured Person** has opted for a **Deductible**, the **Insured Person** will have to pay for the medical bills until the selected **Deductible** amount has been met for the **Period of Insurance**. If the **Deductible** has been met during the **Period of Insurance**, the **TPA** will arrange for the **Eligible Expenses** to be paid to the **Hospital**.

3. LIMITATION OF BENEFITS

3.1 BENEFIT LIMIT

The liability of the **Company** shall not exceed the Overall Annual Limit set out in the **Schedule of Benefits** for any one **Period of Insurance** for any one **Insured Person** and in compliance with the fee schedule – Professional Fee specified in the Thirteenth Schedule under Private Healthcare Facilities and Services ACT 1998 (Private Hospitals and Other Private Health Care Facilities) Regulations 2006 (herein referred to as the "**ACT**") when ascertaining the fees charged by the **Medical Practitioners** or **Hospitals**.

Further, the benefits payable in respect of expenses incurred for treatment provided to the **Insured Person** shall be limited to the:

(a) **Reasonable and Customary Charges** for the treatment provided;

(b) selected plan for which this **Policy** is issued and the premium has been paid for;

(c) Overall Annual Limit as stated in the **Schedule of Benefits** irrespective of the type(s) of **Disability**. If there is more than one (1) **Insured Person** under this **Policy**, the Overall Annual Limit shall apply separately to each **Insured Person** for the **Period of Insurance**. In the event the Overall Annual Limit has been paid during the **Period of Insurance**, all benefits hereunder shall immediately cease to be payable for the **Insured Person** for the remaining year;

(d) medical expenses which are not fully reimbursed under any other medical insurance, employee benefit or law or government program under which the **Insured Person** has received compensation or reimbursement for such medical expenses provided that the **Company** will only be liable for the **Eligible Expenses** exceeding the limit of such other insurance subject always to the applicable limit stated in the **Schedule of Benefits**.

4. CONDITIONS

4.1 ADDITION OF INSURED PERSON

Individuals who are eligible to be insured shall, from time to time while this **Policy** is in-force, be included as an **Insured Person** of this **Policy** if:

(a) the **Policyholder** requests such inclusion;
(b) the individual is eligible to be an **Insured Person** in accordance with the eligibility criteria of acceptance of the **Company**; and
(c) the required additional premium is paid.

The liability of the **Company** does not commence until an endorsement has been issued to include the individual as an **Insured Person** under this **Policy**.

4.2 ALTERATIONS

The **Company** reserves the right to amend the terms and conditions of this **Policy** and such alteration shall only be valid if authorised in writing by the **Company** and endorsed hereon. Any alteration shall take effect from the next **Renewal** of this **Policy**.

The **Company** shall give thirty (30) days prior written notice to the **Policyholder** according to the last recorded address before any alteration is to take effect.

4.3 APPLICABLE TAX

In the event that any sales and services tax, value added tax or any similar tax and any other duties, taxes, levies or imposts (collectively "**Applicable Tax**") whatsoever are introduced by any authority and are payable under the laws of Malaysia in connection with any supply of goods and/or services made or deemed to be made under this **Policy**, the **Company** will be entitled to charge any **Applicable Tax** as allowed by the laws of Malaysia. Such **Applicable Tax** payable shall be paid in addition to the applicable premiums and other charges. All provisions in this **Policy** on payment of premiums and default hereof shall apply equally to the **Applicable Tax**.

4.4 CERTIFICATION, INFORMATION AND EVIDENCE

All certificates, information and evidence as required by the **Company** shall be furnished at the expense of the **Insured Person**, and in such a form that the **Company** may require. In any event all notices which the **Company** shall require the **Insured Person** to give must be in writing and addressed to the **Company**. The **Company** shall have the right to examine the person whose **Injury** or **Sickness**, **Disease or Illness** is the basis of the claim and as often as it may reasonably require during pendency of the claim hereunder. Pursuant to this, an **Insured Person** shall, at the **Company's** request and expense, submit to a medical examination whenever such is deemed necessary.

4.5 CHANGE IN RISK

The **Policyholder** or **Insured Person**, as the case may be, shall give immediate notice in writing to the **Company** of any change in the information given to the **Company** when this **Policy** was first applied for.

4.6 CLAIMS

(a) Notice & Claims Procedure

Notice of Claims – The **Insured Person** shall within thirty (30) days of a **Disability** that incurs claimable expenses, give written notice to the **Company** stating full particulars of such event, including all original bills and receipts, and a full **Medical Practitioner's** report stipulating the diagnosis of the **Disability** treated and the date the **Disability** commenced in the **Medical Practitioner's** opinion and the **Medical Practitioner's** summary of the cost of treatment including medicines and services rendered.

Proof of Loss/Claims – Affirmative proof of **Hospitalisation** for which a claim is made must be furnished to the **Company** within ninety (90) days from the discharge of the **Insured Person** from the **Hospital**. Failure to furnish such proof within the time provided shall not invalidate any claim if it can be shown that it would not have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

The **Company** may require as part of the proof original bills and receipts of **Hospitalisation** and the charges and fees incurred.

If an **Insured Person** has opted for **Deductible**, the **Insured Person** must furnish the proof of claim by submitting original bills, receipts and payment settlement/discharge note for:

(i) Incurred **Eligible Expenses** up to the selected **Deductible** amount; and
(ii) Incurred **Eligible Expenses** in excess of the selected **Deductible** amount.

(b) Payment of Claims

In the event the **Company** has guaranteed payment to the **Hospital**, the **Company** shall pay the claim directly to the **Hospital**.

It is further agreed that any authorization to effect payment to the **Hospital** shall be deemed as part of the cashless facility granted to the **Insured Person**.

(c) Incomplete Claims

All claims must be submitted to the **Company** within thirty (30) days of completion of the events for which the claim is being made. Claims are not deemed complete and eligible benefits are not payable unless all bills/invoices 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.

4.7 CONDITIONS PRECEDENT TO LIABILITY

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

4.8 COOLING-OFF PERIOD

If the **Policyholder** decides not to take up this **Policy** after it has been issued, the **Policyholder** may return the **Policy** to the **Company** for cancellation provided such request for cancellation is delivered by the **Policyholder** to the **Company** within fifteen (15) days from the date of the **Policyholder's** receipt of the **Policy**. The **Policyholder** is entitled to a refund of the full premium paid less deduction of medical examination fee, if any, incurred by the **Company** in the issuance of this **Policy**. For the avoidance of doubt, the cooling-off period is only applicable for the first issuance of this **Policy** and not applicable for any subsequent issuances of this **Policy**.

4.9 CHANGE IN PLAN

The **Policyholder** may not change the plan selected for this **Policy** during the subsistence of the **Period of Insurance**. Any changes requested for by the **Policyholder** shall be subject to underwriting by the **Company** and shall only be effective from the subsequent **Renewal**.

4.10 CURRENCY OF PAYMENT

All payments under this **Policy** shall be made in the legal currency of Malaysia. Should the **Insured Person** request for payment 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.

4.11 DUTY OF DISCLOSURE

(a) Consumer Insurance Contract

Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if the **Policyholder** and/or **Insured Person** had applied for this Insurance wholly for **purposes unrelated to the Policyholder's** and **Insured's Person trade**, **business or profession**, **the Policyholder** and **Insured Person** had a duty to take reasonable care not to make a misrepresentation in answering the questions in the proposal form and all the questions required by the **Company** fully and accurately and also disclose any other matter that the **Policyholder** and **Insured Person** know to be relevant to the **Company's** decision in accepting the risks and determining the rates and terms to be applied, otherwise it may result in avoidance of contract, claim denied or reduced, terms changed or varied, or contract terminated. **This duty of disclosure continued until the time the contract was entered into, varied or renewed**.

(b) Non-Consumer Insurance Contract

Pursuant to Paragraph 4(1) of Schedule 9 of the Financial Services Act 2013, if the **Policyholder** and/or **Insured Person** had applied for this insurance for **purposes related to Policyholder's** and **Insured Person's trade**, **business or profession**, the **Policyholder** and **Insured Person** had a duty to disclose any matter that the **Policyholder** and **Insured Person** know to be relevant to the **Company's** decision in accepting the risks and determining the rates and terms to be applied and any matter a reasonable person in the circumstances could be expected to know to be relevant, otherwise it may result in avoidance of contract, claim denied or reduced, terms changed or varied, or contract terminated. **This duty of disclosure continued until the time the contract was entered into, varied or renewed**.

(c) The **Policyholder** and **Insured Person** also have a duty to tell the **Company** immediately if at any time, after this **Policy** contract has been entered into, varied, or renewed with the **Company**, any of the information given for this **Policy** contract is inaccurate or has changed.

4.12 ELIGIBILITY

All Malaysian citizens, Malaysian permanent residents permanently residing in Malaysia, work permit holders and pass holders legally residing in Malaysia and with a local bank account, all of whom are from thirty (30) days up to a maximum of sixty-nine (69) years based on the age of next birthday, and their respective **Dependants** are eligible to be covered under this **Policy**. The **Insured Person's** coverage is renewable up to the age seventy-nine (79) based on the age of his/her next birthday.

Where this **Policy** is purchased to cover the **Policyholder's** employees, the minimum age of the employees to be covered shall be sixteen (16) years based on the age of next birthday.

4.13 GEOGRAPHICAL TERRITORY

All benefits provided in this **Policy** are applicable worldwide for twenty-four (24) hours a day subject to Conditions 4.19 (Overseas Treatment) and 4.24 (Travelling Overseas).

4.14 GOVERNING LAW

This **Policy** is issued under the laws of Malaysia and is subject to and governed by the laws of Malaysia.

4.15 LEGAL PROCEDURE

No action at law or in equity shall be brought to recover on this **Policy** prior to expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this **Policy**. If the **Insured Person** shall fail to supply the requisite proof of loss as stipulated by the terms of this **Policy**, the **Insured Person** may, within a grace period of one (1) 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 terms of this **Policy**. 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.

4.16 MISSTATEMENT OR OMISSION OF MATERIAL FACT

Subject to the relevant duty of disclosure of the **Policyholder** or **Insured Person**, as the case maybe, if any answer, disclosure or representation by the **Policyholder** or **Insured Person** in or to any proposal or declaration or query, has been deliberately or recklessly stated in any respect before this contract of insurance is entered into, varied or renewed, or if the **Policyholder** or **Insured Person** shall have failed to disclose any fact that the **Policyholder** or **Insured Person** knew to be relevant to the **Company's** decision on whether to accept this risk or not and on the rates and the terms to be applied, then, this **Policy** shall be void.

If any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support of such claim, then the **Company** reserves the right to terminate this **Policy** or the **Insured Person's** coverage, as the case may be.

4.17 MISSTATEMENT OF AGE

If the age of the **Insured Person** has been misstated and the premium paid as a result thereof is insufficient, any claims 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.

4.18 NOTICE

Every notice or communication to the **Company** shall be in writing and sent to the **Company**.

4.19 OVERSEAS TREATMENT

If the **Insured Person** seeks treatment **Overseas**, the relevant benefits under this **Policy** shall cover such treatment subject to the terms specified in this **Policy** provided that:

(a) the **Insured Person** was travelling **Overseas** for reasons other than medical treatment but subsequently needed to be confined to a **Hospital Overseas** as a consequence of an **Emergency**; or

(b) the **Insured Person**, upon recommendation of a **Medical Practitioner**, has to be transferred to a **Hospital Overseas** because the specialized nature of the treatment, aid, information or decision required cannot be rendered, furnished or obtained in Malaysia.

The **Company** shall refer to the fee schedule – Professional Fee specified in the Thirteenth Schedule under the **ACT** or any subsequent **Schedule** prevailing at that time in ascertaining the payment to be made for the cost of the treatment pursuant to the **Insured Person's** claim and all benefits in respect of **Overseas** treatment will be payable based on the official exchange rate ruling on the last day of the **Insured Person's Hospitalisation**.

The cost of transportation incurred by the **Insured Person** to travel or commute to the place of treatment whilst **Overseas** and any repatriation costs shall be borne by the **Insured Person**.

4.20 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 recognize any equitable or other claim to or interest in the **Policy**, and the receipt of the **Policy** or a benefit by the **Insured Person** (or by his/her legal representative) alone shall be an effective discharge of all obligations and liabilities of the **Company**.

4.21 PERIOD OF COVER AND RENEWAL

This **Policy** shall become effective as of the date stated in the **Schedule**. The **Policy Anniversary** shall be one (1) 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 as notified by the **Company**.

This **Policy** will be renewable subject to the terms and conditions at each of the anniversary of the **Policy** date. The **Company** will notify the **Insured Person** in writing of any changes in premium rates by giving at least thirty (30) days notice before affecting the revision in premium rates but in any event, such revision shall only take effect from the next **Policy Anniversary**. Such changes, if any shall be applicable to all **Insured Person** irrespective of their claim experience according to the **Company's** risk assessment.

This is a yearly renewable **Policy**, at the option of the **Policyholder** subject to the terms, conditions and termination at each **Policy Anniversary**.

The renewal premiums payable is not guaranteed and any adjustment of premiums would be based on health condition of the **Insured Person** and the **Company's** claim experience.

4.22 PORTFOLIO WITHDRAWAL CONDITION

The **Company** reserves the right to cancel its medical product portfolio as it may deem fit and discontinue underwriting this insurance product.

The **Company** shall give thirty (30) days' notice in writing to the **Policyholder** of the **Company's** intention to discontinue underwriting this insurance product after which the **Company** shall stop accepting any new coverage under this **Policy** and shall not offer **Renewal** of the same upon expiry of the **Period of Insurance**. Notwithstanding this, all subsisting coverage under this **Policy** shall be allowed to run off until expiry of the **Period of Insurance**.

4.23 PAYMENT OF PREMIUM PROVISIONS

All premiums payable under this **Policy** are to be paid to the **Company** on or before the **Policy Anniversary** using one (1) of the payment methods authorized by the **Company**. Any failure to pay the outstanding premium after the due date for payment of the same shall constitute indebtedness to the **Company**.

4.24 TRAVELLING OVERSEAS

No benefits whatsoever shall be payable for any medical treatment received by the **Insured Person** outside Malaysia, if the **Insured Person** travels **Overseas** for more than ninety (90) consecutive days.

4.25 SUBROGATION

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

4.26 UPGRADED POLICY

Where the limit of the benefits under this **Policy** is increased while it is in force or at the time of a **Renewal** or reinstatement and an **Insured Person** was afflicted with a **Disability** prior to the increase of the limit, the limit of the relevant benefits payable in respect of such **Disability** shall not exceed the limit of benefits prior to the date of the upgrade and the increase in the limit of the benefits.

4.27 UPGRADED ROOM AND BOARD CO-PAYMENT

If the **Insured Person** is hospitalised and the published Room and Board rate for the **Insured Person's** room is higher than his/her eligible benefit, the **Insured Person** shall bear 20% of the other eligible benefits described in the **Schedule of Benefits**.

4.28 WAITING PERIOD

Coverage for an **Insured Person** under this **Policy** is subject to the **Waiting Period** except where the **Insured Person** is hospitalised due to a covered **Accident** occurring after the commencement of the **Period of Insurance**.

4.29 SANCTIONS LIMITATION AND EXCLUSION CLAUSES

No insurer/co-insurer shall be deemed to provide cover and no insurer/co-insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover or payment of such claim would expose that insurer/co-insurer 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.

4.30 TERMINATION OF INSURANCE

(a) Termination by the Policyholder or Insured Person

If **Policyholder** or **Insured Person**, as the case may be, gives notice to the **Company** to terminate this **Policy** or the **Insured Person's** coverage under this **Policy**, such termination shall become effective on the date when the notice is received by the **Company** from the **Policyholder** or the **Insured Person** or on the date specified in such notice, whichever is the later.

In the event premium has been paid for any period beyond the date of termination of this **Policy**, the short period rates stated below shall apply provided that no claims have been made during the current **Period of Insurance**, then subsisting.

Scale of Short Period Rates:

Period of Insurance (Not Exceeding)	Percentage of Refund of Annual Premium
One (1) month	80%
Two (2) months	70%
Three (3) months	60%
Four (4) months	50%
Five (5) months	40%
Six (6) months	30%
Seven (7) months	25%
Eight (8) months	20%
Nine (9) months	15%
Ten (10) months	10%
Eleven (11) months	5%
Period exceeding Eleven (11) months	0%

(b) Termination by the Company

In the event the **Company** terminates this **Policy** or the **Insured Person's** coverage under this **Policy**, as the case may be, pursuant to Condition 4.16 (Misstatement or Omission of Material Fact) or by order of regulatory or governmental authorities, the **Company** shall give its notice of termination by registered post to the **Policyholder** or the **Insured Person**, as the case maybe, at their respective last known correspondence address in Malaysia. Such termination shall become effective thirty (30) days following the date of such notice.

In the event premium has been paid for any period beyond the date of termination of this **Policy**, the pro-rata premium shall be refunded to the **Policyholder** or **Insured Person**, as the case may be, provided that no claim has been made during the **Period of Insurance** then then subsisting and such refund is not prohibited by any law.

(c) Automatic Termination

This **Policy** shall lapse/terminate upon occurrence of any of the following:

i. at mid-night (standard Malaysian time) on the last day of the **Period of Insurance** stated in the **Schedule**; or
ii. when the **Insured Person** attains the age of eighty (80); or
iii. upon cessation or termination of the **Policy**; or
iv. premium payable under this **Policy** remains unpaid on the **Policy Anniversary**; and
v. termination of coverage under this **Policy** following the **Company's** decision to discontinue the underwriting of the same pursuant to Condition 4.22 (Portfolio Withdrawal Condition).

5. EXCLUSIONS

This **Policy** does not cover any **Hospitalisation**, **Surgery** or charges caused directly or indirectly, wholly or partly, by any one of the following occurrences:

(a) **Pre-existing Illness** unless declared by **Insured Person** and accepted by the **Company** in writing, on or prior to **Policy** commencement date;

(b) **Specified Illness** occurring during the first one hundred and twenty (120) days of continuous cover calculated from the commencement of the **Period of Insurance**;

(c) Any medical or physical conditions arising during the **Waiting Period** except where the **Insured Person** is hospitalised due to a covered **Accident** occurring after the commencement of the **Period of Insurance**;

(d) Plastic/cosmetic **Surgery** (except reconstructive **Surgery** necessary to restore function after an **Accident** that has occurred during **Period of Insurance**), circumcision, eye examination, glasses, lenses and any other eyewear 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 **Injury** to sound natural 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 (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex) and HIV related diseases, and any communicable diseases 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, prenatal or postnatal care, surgical, mechanical or chemical contraceptive methods for birth control or treatment pertaining to infertility, erectile dysfunction and tests or treatment related to impotence or sterilisation;

(i) **Hospitalisation** primarily for investigatory purposes, 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 **Medical Practitioner**, 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) 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 any complications thereof;

(n) Investigation and treatment of sleep and snoring disorders, hormone replacement therapy and alternative therapy such as treatment, medical service or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bone setting, herbalist treatment, massage or aroma therapy or other alternative treatments;

(o) **Hospitalisation** for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the **Insured Person** and **Hospitalisation** due to **Disabilities** arising out of duties of employment or the **Insured Person's** profession that is covered under a Workmen's Compensation insurance contract;

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

(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 items;

(r) **Disability** 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) **Disability** arising from private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes;

(t) Any **Disability** arising from sex reassignment surgeries or procedures; and

(u) Any person residing outside Malaysia.

6. DEFINITIONS

ACCIDENT shall mean a sudden or unexpected event, resulting directly and independently from the action of an external cause, other than any intentionally self-inflicted **Injury**.

ANY ONE DISABILITY shall mean all of the periods of **Disability** arising from the same cause including any and all complications therefrom except that if the **Insured Person** completely recovers and remains free from further treatment (including drugs, medicines, special diet or injection or advice for the condition) for such **Disability** for at least ninety (90) days following the latest date of discharge, any subsequent **Disability** suffered shall be deemed a new **Disability** even if it arises from the same cause .

CANCER shall mean the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or **Surgery** (excluding endoscopic procedures alone) is considered necessary. The **Cancer** must be confirmed by histological evidence of malignancy. The following 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 and Stage 1 Prostate Cancer;
(d) All skin Cancers except malignant melanoma;
(e) Stage 1 Hodgkin's disease; and
(f) Tumours manifesting as complications of AIDS.

DAYCARE PROCEDURE shall mean a surgical or non-surgical scheduled procedure performed at a **Hospital** or a **Specialist** clinic during which an **Out-Patient** undergoing the same would require use of a recovery facility but would not be required to stay overnight.

DEDUCTIBLE shall mean that portion of **Eligible Expenses** for which the **Insured Person** is liable before any benefits are payable under this **Policy**. The applicable **Deductible** amount is set forth in the **Schedule of Benefits**. The **Eligible Expenses** are accumulated on a **Period of Insurance** basis before deduction of the **Deductible** for the purpose of calculation of the remaining **Eligible Expenses** payable by the **Company**. The **Company** will be liable for the remaining **Eligible Expenses** that has exceeded the selected **Deductible** amount up to the maximum Overall Annual Limit as set forth in the **Schedule of Benefits**.

DEPENDANT shall mean any of the following persons:
(a) a legally married spouse below the age of seventy (70) years at time of inclusion;
(b) unmarried children over thirty (30) days but under eighteen (18) years or under twenty-four (24) years if the child is still a full-time student at a higher education institution and who is not gainfully employed.

DISABILITY shall mean a **Sickness, Disease or Illness** or the **Injuries** arising out of a single or continuous series of causes.

ELIGIBLE EXPENSES shall mean **Medically Necessary** expenses incurred due to a covered **Disability** but not exceeding the limits in the **Schedule of Benefits**.

EMERGENCY shall mean the immediate medical attention required within twelve (12) hours of a manifestation of a **Disability** or symptoms which are sudden and severe, failing which the **Insured Person's** life could be threatened (e.g. **Accident** and heart attack) or lack of treatment could lead to a significant deterioration of the **Insured Person's** health.

HOME NURSING CARE shall mean the full-time or part-time continued medical care or other types of skilled care rendered in the **Insured Person's** home, where the **Insured Person** is recuperating.

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:
(a) has facilities for diagnosis and major **Surgery**;
(b) provides twenty-four (24) hours a day nursing services by registered and graduate nurses;
(c) is under the supervision of a **Medical Practitioner**; and
(d) 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.

HOSPITALISATION shall mean admission to a **Hospital** as a registered inpatient for **Medically Necessary** treatment for a covered **Disability** upon recommendation of a **Medical Practitioner**. A patient shall not be considered as an inpatient if the patient does not physically stay in the **Hospital** for the whole period of confinement.

INJURY shall mean bodily **Injury** caused solely by an **Accident** and not **Sickness**, **Disease** or gradual physical or mental wear and tear occurring during the **Period of Insurance**.

INSURED PERSON shall mean the person described in the **Schedule**.

INTENSIVE CARE UNIT shall mean a section within a **Hospital** which is designated as an **Intensive Care Unit** by the **Hospital**, and which is maintained on a twenty-four (24) hours 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**.

MEDICAL PRACTITIONER shall mean a registered doctor, physician, surgeon or **Specialist** 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 **Medical Practitioner** who is the **Insured Person** himself.

MEDICALLY NECESSARY shall mean a medical service which is:
(a) consistent with the diagnosis and customary medical treatment for a covered **Disability**;
(b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits;
(c) not for the convenience of the **Insured Person** or the **Medical Practitioner**, and unable to be reasonably rendered out of **Hospital** (if admitted as an inpatient);
(d) not of an experimental, investigational or research nature, preventive or screening nature; and
(e) for which the charges are fair and reasonable and customary for the **Disability**.

OUTPATIENT shall mean the **Insured Person** who is receiving medical care or treatment which does not require **Hospitalisation**.

OVERSEAS shall mean any foreign country outside Malaysia.

PERIOD OF INSURANCE shall mean the duration for when an **Insured Person** is insured as set out in the **Schedule**, subject to the terms, conditions and exclusions as set out in this **Policy**.

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

POLICY ANNIVERSARY shall mean the same date each year the **Period of Insurance** commences.

PRE-EXISTING ILLNESS shall mean disabilities that the **Insured Person** has reasonable knowledge of. An **Insured Person** may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:
(a) the **Insured Person** had received or is receiving treatment;
(b) medical advice, diagnosis, care or treatment has been recommended;
(c) clear and distinct symptoms are or were evident; or
(d) its existence would have been apparent to a reasonable person in the circumstances.

REASONABLE AND CUSTOMARY CHARGES shall mean charges for medical care which is **Medically Necessary** and does not exceed the general level of charges being made by **Hospitals** or **Medical Practitioner**s of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatments, services or supplies to an individual of the same sex and of comparable age for a similar **Sickness**, **Disease or Illness** 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.

RENEWAL OR RENEWED POLICY shall mean a **Policy** which has been renewed without any lapse of time upon expiry of a preceding **Period of Insurance** for the same **Policy**.

SCHEDULE/SCHEDULE OF BENEFITS shall mean the **Schedule** attached to this **Policy** where details including the relevant particulars of the **Policyholder** and **Insured Persons** are stated.

SICKNESS, DISEASE OR ILLNESS shall mean a physical condition marked by a pathological deviation from the normal healthy state.

SPECIALIST shall mean a **Medical 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 **Medical Practitioner** who is the **Insured Person** himself/herself.

SPECIFIED ILLNESSES shall mean the following **Sickness**, **Illness or Disease** and its related complications:
(a) Hypertension, diabetes mellitus and cardiovascular disease;
(b) All tumours, cancers, cysts, nodules, polyps;
(c) Stones in the urinary system and biliary system;
(d) All ear, nose (including sinuses) and throat conditions;
(e) Hernias, haemorrhoids, fistulae, hydrocele, varicocele;

(f) Endometriosis including disease of the reproduction system; and
(g) Vertebro-spinal disorders (including slipped disc) and knee conditions.

SURGERY shall mean any of the following medical procedures:
(a) To incise, excise or electrocauterise 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; and
(d) The use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or urethra.

TPA shall mean the third party administrator authorized by the **Company** to arrange for the cashless admission and discharge service into and from **Hospitals** for the **Insured Person**.

WAITING PERIOD shall mean the first thirty (30) days calculated from the commencement of the **Period of Insurance** for the first year of this **Policy** or reinstatement date, as the case may be. This **Waiting Period** shall not be applicable after the first year of cover. However, if there is a break in coverage under this **Policy**, the **Waiting Period** will apply again.

ANNUAL PREMIUM TABLE

Annual Premium for *Non-Cashless Plan

Age Band	Plan 1		Plan 2		Plan 3		Plan 4		Plan 5	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
30 days – 17 years	547	464	675	639	853	853	1,067	940	1,770	1,422
18 – 25 years	377	348	524	484	587	587	684	631	1,077	1,178
26 – 29 years	428	464	563	611	668	697	772	835	1,067	1,269
30 – 39 years	616	616	852	825	1,067	985	1,192	1,140	2,057	1,758
40 – 49 years	829	749	1,145	1,053	1,374	1,374	1,594	1,466	3,048	2,752
50 – 54 years	1,165	1,072	1,666	1,533	1,998	1,998	2,320	2,134	4,032	3,678
55 – 59 years	1,463	1,346	2,024	1,862	2,434	2,434	2,825	2,599	5,037	4,713
60 – 64 years	2,115	1,940	2,929	2,720	3,448	3,202	4,162	3,865	7,998	6,524
65 – 69 years	2,992	2,778	4,143	3,847	4,337	4,027	5,240	4,866	11,826	9,646
70 – 74 years (renewal only)	4,382	3,904	6,068	5,677	7,023	6,570	8,486	7,939	18,424	15,611
75 – 79 years (renewal only)	5,699	4,848	7,893	7,383	9,134	8,545	11,038	10,325	23,056	19,403

Annual Premium for Cashless Plan

Age Band	Plan 1		Plan 2		Plan 3		Plan 4		Plan 5	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
30 days – 17 years	819	719	974	982	1,307	1,307	1,759	1,552	2,276	1,954
18 – 25 years	527	485	713	656	793	793	986	950	1,578	1,724
26 – 29 years	634	634	788	862	965	1,004	1,204	1,157	1,559	1,864
30 – 39 years	863	863	1,182	1,182	1,416	1,358	1,771	1,702	3,032	2,588
40 – 49 years	1,271	1,168	1,743	1,602	2,088	2,007	2,609	2,512	4,493	4,068
50 – 54 years	1,830	1,682	2,520	2,317	3,021	2,905	3,781	3,640	5,940	5,430
55 – 59 years	2,217	2,038	3,061	2,814	3,670	3,528	4,594	4,423	7,408	6,953
60 – 64 years	3,199	2,969	4,414	4,098	5,191	4,633	6,258	5,810	11,735	9,628
65 – 69 years	4,511	4,188	6,236	5,789	6,526	6,058	7,871	7,308	17,351	14,194
70 – 74 years (renewal only)	6,061	5,669	8,329	7,790	9,587	8,968	11,545	10,799	27,120	22,907
75 – 79 years (renewal only)	7,876	7,367	10,826	10,126	12,461	11,656	15,009	14,040	33,818	28,536

Notes:

1. The Premium rates are not guaranteed and are charged according to the attained age next birthday at each Policy renewal. The **Company** reserves the right to revise the Premium rate by giving thirty (30) days written notice prior to the next **Policy Anniversary**.
2. *Managed Care Organisation ("MCO") Fee RM19.08 (inclusive 6% Service Tax) will be charged separately for Cashless Plan.
3. For Corporate Policyholders, Premiums are further subject to 6% Service Tax.
4. Premium is subject to a RM10 Stamp Duty payable on the Contract of Insurance.
5. The total Premium that you pay may vary depending on your choice of Deductible, your age, gender and Company's underwriting requirements.

TABLE OF BENEFITS

Benefits	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
	RM				
Overall Annual Limit	50,000	80,000	120,000	150,000	250,000
Hospitalisation and Surgical Benefits					
Room (daily maximum up to 120 days)	150	200	300	400	500
Intensive Care Unit (up to 120 days)	As Charged				
Surgical Fees					
Hospital Supplies & Services					
Anaesthetist Fees					
Operating Theatre					
In-Hospital Medical Practitioner Visit (up to 120 days and maximum 2 visits per day)					
Pre-Hospital Diagnostic Test (within 60 days prior to hospital admission)					
Pre-Hospital Specialist Consultation (within 60 days prior to hospital admission)					
Second Surgical Opinion (within 60 days from consultation with the first Specialist)					
Post Hospitalisation Treatment (within 60 days from the date of discharge from hospital)					
Daycare Procedure					
Ambulance Fee					
Medical Report Fee Reimbursement					
Home Nursing Care (up to)	500	1,000	2,000	3,000	4,000
Outpatient Treatment Benefits					
Emergency Accidental Outpatient Treatment (includes follow-up treatment up to 60 days from date of Accident)	As Charged				
Outpatient Cancer Treatment					
Outpatient Kidney Dialysis Treatment					
Miscellaneous Benefits (Not Subject to Deductible)					
Daily Cash Allowance at Government Hospital	120	150	180	200	250
Bereavement Benefit (Not Subject to Deductible)					
Compassionate Allowance (accidental causes only)	2,000				

Optional - Deductible Plans and Cashless Facility

*Deductible (each Period of Insurance)	Option 1	Option 2	Option 3	Option 4	Option 5
	RM				
	10,000	20,000	30,000	40,000	50,000

Cashless Hospital Admission and Discharge	Available at Panel Hospitals

Note:

1. ***Deductible** is the portion of **Eligible Expenses** for which **Insured Person** is liable during the **Period of Insurance** before any benefits are payable under this **Policy**.

Lodging of Complaints
We are committed to maintaining high levels of service, honesty, integrity and trustworthiness. If you have any reason to be dissatisfied with any of our products or services, we would like to hear from you. Your feedback is very important to us as we are always looking for ways to improve and serve you better.

To provide us with your feedback, you may contact us via the following channels:

Write to:
Customer Feedback Centre, Allianz Arena, Ground Floor Block 2A, Plaza Sentral, Jalan Stesen Sentral 5, Kuala Lumpur Sentral, 50470 Kuala Lumpur.

1 300 22 5542 AllianzMalaysia customer.service@allianz.com.my allianz.com.my

Avenues to Seek Redress
You may submit your complaint to the Ombudsman for Financial Services (OFS) if you are not satisfied with our final response or decision, in the event that your complaint is within the scope of the OFS as well as the following monetary thresholds:
(1) Insurance claims not exceeding RM250,000.00; and
(2) Motor third party property damage claims not exceeding RM10,000.00.

The OFS can be contacted at the following address:
Ombudsman for Financial Services, Level 14, Main Block, Menara Takaful Malaysia, No 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur.

03 2272 2811 03 2272 1577 enquiry@ofs.org.my www.ofs.org.my

If your complaint does not fall within the purview of the OFS, you may refer your complaint to Laman Informasi Nasihat dan Khidmat (LINK) of Bank Negara Malaysia (BNM) at the following address:

Write to (BNMTELELINK):
Pengarah, LINK & Pejabat BNM, Bank Negara Malaysia, P.O. Box 10922, 50929 Kuala Lumpur.

Walk-in (BNMLINK):
Ground Floor, Block D, Bank Negara Malaysia, Jalan Dato' Onn, 50480 Kuala Lumpur.

1 300 88 5465 03 2174 1515 bnmtelelink@bnm.gov.my www.bnm.gov.my

You may check with our Customer Feedback Centre on the types of complaints handled by the OFS or BNM before submitting your complaint.

Allianz General Insurance Company (Malaysia) Berhad 200601015674 (735426-V)
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

Allianz Customer Service Centre
Allianz Arena, Ground Floor, Block 2A, Plaza Sentral, Jalan Stesen Sentral 5, Kuala Lumpur Sentral, 50470 Kuala Lumpur.
Allianz Contact Centre: 1 300 22 5542 Email: customer.service@allianz.com.my AllianzMalaysia allianz.com.my

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