Policy

ALLIANZ BOOSTER CARE

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

Allianz

Protects you from A-Z

Allianz Booster Care

WHEREAS the Insured Person or Policyholder by an application and declaration which shall be the basis of this contract and is deemed to be incorporated herein has applied to **Allianz General Insurance Company (Malaysia) Berhad (200601015674)** (hereinafter called "the Company") for the insurance hereinafter contained and has paid the premium stated in the Schedule as consideration for such insurance for the period stated herein.

Notwithstanding any provision in this 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, Illness or accidental 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(s) or his legal personal representative the sum or sums stated in the Schedule of Benefits.

Provided always that :

(a) The liability of the Company shall commence once the selected Deductible amount has been exhausted and shall not exceed the Annual Limit and Lifetime Limit set out in the Schedule of Benefits for any one Period of Insurance for any one Insured Person.

(b) This Policy shall become effective as of the date stated in the Schedule. This Policy shall be issued for one year and at the end of each Period of Insurance may be renewed for another year subject to the terms and conditions set forth;

(c) In the event of any change in the Law(s) or the substitution of other legislation therefore this Policy shall remain in force but the liability of the Company shall be limited to such sum as the Company would have been liable to pay if the Law(s) had remained unaltered.

Allianz Booster Care

The General Provisions together with the terms and conditions appearing on this page and the following pages shall apply to this Policy under Allianz Booster Care.

This Policy is issued in consideration of the application and payment in advance of the premium for this Policy.

If, while this Policy is in force, the Insured Person is hospitalized and/or receives medical treatment as specified herein as a result of:

(a) Sickness, Disease or Illness occurring after the Policy date or date of reinstatement whichever is later; or

(b) Accidental Injury sustained after the Policy date.

The Company shall upon receipt and approval of satisfactory proof and subject to the provisions, conditions and limitations contained herein or which may be endorsed hereon, pay the benefits according to the Description of Benefits under this Policy.

1. DEFINITIONS

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

1.2 ACCIDENTAL DENTAL TREATMENT shall mean dental procedure necessary as a result of Accident.

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

1.4 CONGENITAL CONDITIONS shall mean any medical or physical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within six (6) months from the time of birth. They will include hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the Insured Person was continuously covered under this Policy.

1.5 DAY SURGERY
A patient who needs the use of a recovery facility for a surgical procedure on a pre-plan basis at the Hospital/ Specialist clinic (but not for overnight stay).

1.6 DEDUCTIBLE shall mean that portion of Eligible Expenses for which 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 by policy year basis for the purpose of the calculation of Deductible. The Company will be liable for the remaining Eligible Expenses that has exceeded the selected Deductible amount up to the maximum Annual Limit as set forth in the Schedule of Benefits. For the purpose of claims, the total charges incurred that forms the Deductible amount shall not be subject to the Thirteen Schedule under the Act.

1.7 DENTIST shall mean a person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided, but excluding a Physician or Surgeon who is the Insured Person himself.

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

1.9 DOCTOR OR PHYSICIAN OR SURGEON shall mean a registered Medical Practitioner qualified and licensed to practice western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice, but excluding a Doctor, Physician or Surgeon who is the Insured Person himself.

1.10 ELIGIBLE EXPENSES shall mean Medically Necessary expenses incurred due to a covered Disability but not exceeding the limits in the schedule.

1.11 EMERGENCY shall mean treatment needed in the event whereby immediate medical attention is required within twelve (12) hours for Injury, Illness or symptoms which are sudden and severe failing which the Insured Person's life could be threatened (e.g. accident and heart attack) or lead to significant deterioration of health.

1.12 HOME NURSING CARE shall mean continued medical care or other types of skilled care furnished on a visiting basis in the Insured Person's home, where he/she is recuperating.

1.13 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 Physician; 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.

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

1.15 INJURY shall mean bodily injury caused solely by Accident.

1.16 INSURED PERSON shall mean the person described in the Policy Schedule and who must be a Malaysian citizen or Malaysian Permanent Resident, permanently residing in Malaysia.

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

1.18 MEDICALLY NECESSARY shall mean a medical service which is:

(a) consistent with the diagnosis and customary medical treatment for a covered Disability; and
(b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits; and
(c) not for the convenience of the Insured Person or the Physician, and unable to be reasonably rendered out of Hospital (if admitted as an inpatient); and
(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.

1.19 OUT-PATIENT shall mean the Insured Person is receiving medical care or treatment without being hospitalized and include treatment in a daycare centre.

1.20 OVERSEAS shall mean any foreign country outside Malaysia, but excluding Singapore.

1.21 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.

1.22 POLICY YEAR shall mean the one (1) year period including the effective date of commencement of Insurance and immediately following that date, or the one (1) year period following the Renewal or Renewed Policy.

1.23 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.

1.24 PRESCRIBED MEDICINES shall mean medicines that are dispensed by a Physician, a Registered Pharmacist or a Hospital and which have been prescribed by a Physician or Specialist in respect of treatment for a covered Disability.

1.25 REASONABLE AND CUSTOMARY CHARGES shall mean charges for medical care which is Medically Necessary shall be considered Reasonable and Customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individual of the same sex and of

comparable age for a similar Sickness, Disease, 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.

1.26 RENEWAL OR RENEWED POLICY shall mean a Policy which has been renewed without any lapse of time upon expiry of a preceding Policy with the same content.

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

1.28 SPECIALIST shall mean a medical or dental practitioner registered and licensed as such in the geographical area of his practice where treatment takes place and who is classified by the appropriate health authorities as a person with superior and special expertise in specified fields of medicine or dentistry, but excluding a Physician or Surgeon who is the Insured Person himself.

1.29 SPECIFIED ILLNESSES shall mean the following Disabilities and its related complications, occurring within the first one hundred and twenty (120) days of Insurance of the Insured Person:

(a) Hypertension, diabetes mellitus and cardiovascular disease;
(b) All tumours, cancers, cysts, nodules, polyps, stones in the urinary system and biliary system;
(c) All ear, nose (including sinuses) and throat conditions;
(d) Hernias, haemorrhoids, fistulae, hydrocele, varicocele;
(e) Endometriosis including disease of the reproduction system;
(f) Vertebro-spinal disorders (including disc) and knee conditions.

1.30 SURGERY shall mean any of the following medical procedures:

(a) To incise, excise or electrocauterize any organ or body part, except for dental services;
(b) To repair, revise, or reconstruct any organ or body part;
(c) To reduce by manipulation a fracture or dislocation;
(d) Use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or urethra.

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

2. DESCRIPTION OF BENEFITS

The benefit stated hereunder is subject to the limits of the Schedule of Benefits and in compliance with the Private Healthcare Facilities and Services Act 1998 (Private Hospitals and Other Private Health Care Facilities) Regulations 2006 (hereinafter referred to as "ACT").

Provided the sum total of all benefits paid under this Policy has not exceeded the Limits stated under Para 3 (Limitation of Benefits) and its sub-para thereof, the Company shall reimburse the following benefits according to the plan purchased.

2.1 HOSPITAL ROOM AND BOARD

(A) ORDINARY ROOM

Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured Person's confinement subject to a maximum of one hundred and fifty (150) days as set forth in the Schedule of Benefits. The Insured Person will only be entitled to this benefit while confined to a Hospital as an inpatient.

(B) INTENSIVE CARE UNIT

Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual Room and Board incurred during confinement as an in-patient in the Intensive Care Unit of the Hospital. This benefit shall be payable equal to the actual charges made by the Hospital subject to a maximum of one hundred and fifty (150) days, as set forth in the Schedule of Benefits. Where the period of confinement in an Intensive Care Unit exceeds the maximum set forth in the Schedule of Benefits, reimbursement will be restricted to the standard Daily Hospital Room and Board rate.

No Hospital Room and Board Benefits shall be paid for the same confinement period where the Daily Intensive Care Unit Benefits is payable.

2.2 SURGICAL FEES

Reimbursement of the Reasonable and Customary Charges for a Medically Necessary Surgery by the Specialists, including pre-surgical assessment Specialist's visits to the Insured Person and post-surgery care up to the maximum sixty (60) days.

2.3 ANAESTHETIST FEE

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia.

2.4 OPERATING THEATRE

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

2.5 HOSPITAL SUPPLIES AND SERVICES

Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary:

(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 tests;
(i) intravenous injections and solutions;
(j) administration of blood and blood plasma but excluding the cost of blood and plasma.

whilst the Insured Person is confined as an in-patient in a Hospital, up to the amount stated in the Schedule of Benefits.

2.6 IN-HOSPITAL PHYSICIAN VISIT

Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visiting an inpatient while confined for a non-surgical disability subject to a maximum of two (2) visits per day not exceeding the maximum of one hundred and fifty (150) days as set forth in the Schedule of Benefits.

2.7 PRE-HOSPITAL DIAGNOSTIC TESTS

Reimbursement of the Reasonable and Customary Charges for Medically Necessary ECG, X-ray and laboratory tests which are performed for diagnostic purposes on account of an Injury or Illness when in connection with a Disability preceding hospitalization within the maximum of sixty (60) days and which are recommended by a qualified Medical Practitioner.

No payment shall be made if upon such diagnostic services, the Insured Person does not result in Hospitalisation for the treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.

2.8 PRE-HOSPITAL SPECIALIST CONSULTATION

Reimbursement of the Reasonable and Customary Charges for the first time consultation by a Specialist in connection with a Disability within the maximum of sixty (60) days as set forth in the Schedule of Benefits preceding confinement in a Hospital and provided that such consultation is Medically Necessary and has been recommended in writing by the attending general practitioner.

Payment will not be made for clinical treatment (including medications and subsequent consultation after the illness is diagnosed) or where the Insured Person does not result in Hospitalisation for the treatment of the medical condition diagnosed.

2.9 SECOND SURGICAL OPINION

An amount equal to actual charges for consultation or opinion with a second Specialist within thirty-one (31) days from the first consultation by the first Specialist to determine whether a surgical operation is necessary or required in view of the Insured Person's medical condition. This benefit is payable only if the Insured Person is admitted subsequently.

2.10 EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred for up to the maximum stated in the Schedule of Benefits, as a result of a covered bodily Injury arising from an Accident for Medically Necessary treatment as an outpatient at any registered clinic or Hospital within twenty-four (24) hours of the Accident causing the covered bodily Injury. Follow up treatment by the same Doctor or same registered clinic or Hospital for the same covered bodily Injury will be provided up to the maximum thirty-one (31) days as set forth in the Schedule of Benefits.

2.11 DAYCARE PROCEDURE

An amount equal to the actual charges which is inclusive of all incidental costs levied by the Hospital or Daycare Specialist Centre for Daycare Procedure (Surgical and Medical) performed in an outpatient setting (without Hospital admission). Medical procedures shall include Endoscopy (all types), Intravenous Phyelography (IVP/IVU), Barium Studies and Angiographic Studies and other such diagnostic procedures as deemed Medically Necessary and duly referred by a qualified Medical Practitioner.

2.12 OUTPATIENT CANCER TREATMENT

If an Insured Person is diagnosed with Cancer as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of Cancer performed at a legally registered Cancer treatment centre.

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

Cancer is defined as the 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) Carcinorma in situ including of the cervix;
(b) Ductal Carcinorma in situ of the breast;
(c) Papillary Carcinorma of the bladder and Stage 1 Prostate Cancer;

(d) All skin Cancers except malignant melanoma;
(e) Stage 1 Hodgkin's disease;
(f) Tumours manifesting as complications of AIDS.

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

2.13 OUTPATIENT KIDNEY DIALYSIS TREATMENT

If an Insured Person is diagnosed with Kidney Failure as defined below, the Company will reimburse the Reasonable and Customary Charges incurred for the Medically Necessary treatment of kidney dialysis performed at a legally registered dialysis centre.

Such treatment (dialysis excluding consultation, examination tests, take home drugs) must be received at the outpatient department of a Hospital or a registered dialysis treatment centre immediately following discharge from Hospital confinement or surgery.

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

It is a specific condition of this benefit that notwithstanding the exclusion of pre-existing conditions, this benefit will not be payable for any Insured Person who has developed chronic renal diseases and/or is receiving dialysis treatment prior to the effective date of commencement of insurance.

2.14 POST HOSPITALIZATION TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up treatment by the same attending Physician, within the maximum of sixty (60) days as set forth in the Schedule of Benefits immediately following discharge from Hospital for a non-surgical disability. This shall include medicines prescribed during the follow-up treatment but shall not exceed the supply needed for the maximum number of days as set forth in the Schedule of Benefits.

2.15 AMBULANCE FEES (BY ROAD ONLY)

Reimbursement of the Reasonable and Customary Charges incurred for necessary domestic ambulance services inclusive of attendant to and/or from the Hospital of confinement. Payment will not be made if the Insured Person is not hospitalized.

2.16 MEDICAL REPORT FEE REIMBURSEMENT

An amount equal to the actual charges for any Medical Report required will be reimbursed by the Company. This is applicable for any claim falling under Hospitalization benefits.

2.17 HOME NURSING CARE

Reimbursement of the Reasonable and Customary Charges incurred for full-time or part-time services of a State-registered or Government-licensed nurse in the Insured Person's home when prescribed by the original attending Physician for the continued treatment of the specific medical condition for which the Insured Person was hospitalized and only when such services are considered Medically Necessary by the original attending Physician subject to a maximum number of days set forth in the Schedule of Benefits per lifetime of the Insured Person. The care must be provided within seven (7) days following discharge from Hospital subject to a minimum of three (3) days of hospitalization. The number of days of hospitalization shall refer to the number of days charged under Hospital Room and Board benefit.

Home Nursing Care provided under this Policy includes:
(a) Physical, occupational or speech therapies by a registered therapist.

2.18 ANNUAL LIMIT

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

2.19 LIFETIME LIMIT

The total accumulated benefit payable from the original Policy date shall not exceed the Lifetime Limit as stated in the Schedule of Benefits. The Lifetime Limit is taken to be five (5) times the Annual Limit.

3. SINGAPORE COVER

This Policy extends to cover treatment in Singapore. The Insured Person may seek treatment in Singapore and the benefits in respect of the treatment shall be covered subject to the exclusion, limitation and conditions specified in this Policy. The Company will reimburse the charges incurred for Medically Necessary treatment for a covered Disability based on the official exchange rate ruling on the last day of the Hospitalisation subject to the limit as set forth in the Schedule of Benefits.

For avoidance of doubt, the treatment in Singapore is not subjected to the Act. Payments under this benefit for any Eligible Expense shall be made in the legal currency of Malaysia.

4. LIMITATION OF BENEFITS

4.1 BENEFIT LIMIT

Benefit 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 and its Deductible for which this Policy is issued and the premium are paid for;
(c) Annual Limit for each Policy Year in accordance with the amount stated under the selected plan;
(d) Where the Insured Person has received the compensation or reimbursement of the medical expenses incurred from any other medical insurance, any employee benefit or any Government law and program, the benefit payable shall be limited to those medical expenses which are not fully reimbursed under such medical insurance, employee benefit or government law and program.

5. CONDITIONS

5.1 ALTERATIONS

The Company reserves the right to amend the terms and provisions of this Policy by giving a thirty (30) day prior notice in writing by ordinary post to the Policyholder last known address in the Company's records, and such amendment will be applicable from the next renewal of this Policy. No alteration to this Policy shall be valid unless authorized by the Company and such approval is endorsed thereon. The Company should give thirty (30) days prior written notice to the Insured Person according to the last recorded address for any alterations made.

5.2 ARBITRATION

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

5.3 CANCELLATION

This Policy may be cancelled by the Insured Person at any time by giving a written notice to the Company and provided that no claims have been made during the current Policy Year, the Insured Person shall be entitled to a refund of the premium as follow:

Period Not Exceeding	Refund Of Annual Premium
15 days*	90%
1 month	80%
2 months	70%
3 months	60%
4 months	50%
5 months	40%
6 months	30%
7 months	25%
8 months	20%
9 months	15%
10 months	10%
11 months	5%
Period Exceeding 11 Months	No Refund

* Applicable to renewal Policy only.

5.4 CERTIFICATION, INFORMATION AND EVIDENCE

All certificates, information, medical reports and evidence as required by the Company shall be furnished at the expense of the Insured 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. An Insured Person shall, at the Company's request and expense, submit to a medical examination whenever such is deemed necessary.

5.5 CHANGE IN RISK

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

5.6 CLAIM PROCEDURES

(a) 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 Physician's report stipulating the diagnosis of the condition treated and the date the Disability commenced in the Physician's opinion and the Physician's summary of the cost of treatment including medicines and services rendered. Failure to furnish such notice within the time allowed shall not invalidate any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible;
(b) Insured Person must furnish the Company Proof Of Claim by submitting original bills and receipts for:
  (i) Incurred Eligible Expenses up to the selected Deductible amount ; and
  (ii) Incurred Eligible Expenses in excess of the selected Deductible amount.
(c) The Insured Person shall immediately procure and act on proper medical advice and the Company shall not be held liable in the event a treatment or service becomes necessary due to failure of the Insured Person to do so.

5.7 CONDITION PRECEDENT TO LIABILITY

The due observance and the fulfillment of the terms, provisions and conditions of this Policy by the Insured

Person and in so far as they relate to anything to be done or complied with by the Insured Person shall be conditions precedent to any liability of the Company.

5.8 RENEWAL

This Policy will be renewable subject to the terms and conditions at each of the anniversary of the Policy date. The renewal premiums payable is not guaranteed and the Company reserves the right to revise the premium rate applicable at the time of renewal. Such changes, if any shall be applicable to all Insured Persons irrespective of their claim experience according to the Company's risk assessment.

This is a yearly renewable Policy, at the option of Policyholder. Premium rates are not guaranteed and any adjustment of premiums would be based on satisfactory health condition. Whenever there arise a situation of non-disclosure, the whole Policy would be rendered null and void.

5. 9 CONTRIBUTION

The Insured Person shall be liable for the Eligible Expenses and/or obtain reimbursement from other hospital & surgical coverage from other insurance up to the maximum Deductible amount as set forth in the Schedule of Benefits. The Company shall bear the remaining Eligible Expenses above the Deductible amount up to the maximum Annual Limit as set forth in the Schedule of Benefits.

5. 10 COOLING-OFF PERIOD

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

5. 11 CHANGE OF PLAN

The Insured Person may request the Company to change from a lower Deductible plan to a higher Deductible plan during policy anniversary. However, Insured Person will not be allowed to change from a higher Deductible plan to a lower Deductible plan.

5. 12 CURRENCY OF PAYMENT

All payments under this Policy shall be made in the legal currency of Malaysia.

5. 13 ENTRY AGE PARTICIPATION

The minimum entry age is thirty (30) days and the maximum is fifty nine (59) years old based on the age of next birthday. However, once purchased Insured is allowed to renew the policy up to 80 years old based on the age of next birthday.

5. 14 ELIGIBILITY

All Malaysian citizens and Malaysian Permanent Resident permanently residing in Malaysia will be eligible to purchase.

5. 15 GEOGRAPHICAL TERRITORY

All benefits provided in this policy are applicable worldwide for twenty-four (24) hours a day subject to Conditions 23 and 30.

5. 16 GOVERNING LAW

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

5. 17 INCOMPLETE CLAIMS

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

5. 18 LEGAL PROCEEDINGS

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

5. 19 MEDICAL EXAMINATION

The Company shall have the right to examine the Insured Person when and as often as it may reasonably require while a claim is pending.

5. 20 MISSTATEMENT OR OMISSION OF MATERIAL FACT

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

exaggerated or if any false declaration or statement shall be made in support of such claim, then in any of the above cases, this Policy shall be void.

5. 21 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.

5. 22 NOTICE

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

5. 23 OVERSEAS TREATMENT (EXCLUDING SINGAPORE)

Overseas treatment (excluding Singapore) of a Sickness, Illness, Disease or Injury which is diagnosed in Malaysia and/ or Singapore and non-emergency or chronic conditions where treatment can reasonably be postponed until return to Malaysia are excluded.

If the Insured Person seeks treatment Overseas (excluding Singapore), benefits in respect of the treatment shall be covered subject to the exclusions, limitations and conditions specified in this Policy. The payment for the cost of treatment shall be in compliance with the fee schedule – Professional Fee specified in the Thirteenth Schedule under the ACT or any subsequent Schedule prevailing at that time. All benefits will be payable based on the official exchange rate ruling on the last day of the Hospitalisation and shall exclude the cost of transport to the place of treatment provided:

(a) An Insured Person travelling Overseas for a reason other than for medical treatment needs to be confined to a Hospital outside Malaysia or Singapore as a consequence of a Medical Emergency.

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

5. 24 OWNERSHIP OF POLICY

Unless otherwise expressly provided for by Endorsement in the Policy, the Company shall be entitled to treat the Insured Person 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 legal or authorized representative) alone shall be an effective discharge of all obligations and liabilities of the Company. The Insured Person shall be deemed to be responsible Principal of Agent of the Insured Person covered under this Policy.

5. 25 PAYMENT DEFAULT

In the event of default in payment of the agreed premium for this Policy, the Insurance hereunder would terminate automatically but may be reinstated with the consent of the Company.

5. 26 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 at the option of Insured Person subject to the terms, conditions and termination at each of the anniversary of the Policy date. The renewal premiums payable is not guaranteed and the Company reserves the right to revise the premium rate applicable at the time of renewal. Such changes, if any shall be applicable to all Insured Person irrespective of their claim experience according to the Company's risk assessment.

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

(a) Nonpayment of premium or premium not paid on time;

(b) Fraud or misrepresentation of material fact during application;

(c) The Policy is cancelled at the request of the Insured Person;

(d) Total claims of the Policy have reached the Lifetime Limit specified and/or on the death of the Insured Person;

(e) The Insured Person attains the coverage age limit specified; and

(f) Termination of coverage for all policies in a certain market and the Company withdraws this Policy completely from the market in accordance with the Portfolio Withdrawal Condition, as set out hereinafter.

5. 27 PORTFOLIO WITHDRAWAL CONDITION

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

Cancellation of the portfolio as a whole shall be given within thirty (30) days in writing to the Insured Person and the Company will run off all policies to expiry of the period of cover within the portfolio.

5. 28 PREMIUM

(a) All premiums are payable in advance on due date at the premium rates based on age of next birthday of Insured Person;

(b) Premiums shall be paid annually; and

(c) This Policy shall immediately lapse and come to an end when premiums are not paid.

The payment or acceptance of any premium hereunder subsequent to the termination of this Policy shall not create any liability on the part of the Company but the Company shall refund any such premium without interest.

The Company reserves the right to revise the premium rates applicable to all Allianz Booster Care policies of the same plan and/or occupational class. The Company will notify the Insured Person in writing at least thirty (30) days before the Policy anniversary effecting such revision of the premium rate.

5. 29 PROOF OF CLAIM

The Company requires as part of the proof of claim, original bills and receipts with respect to Hospitalisation and the charges and fees incurred. In the absence of the originals, where the bill have been used for claim with another Insurer, a certified true copy of the bills, receipts and proof of settlement from the Insurer must be provided.

5. 30 TRAVEL OUTSIDE MALAYSIA

No benefits whatsoever shall be payable for any medical treatment received by the Insured Person outside Malaysia, if the Insured Person travels outside Malaysia for more than ninety (90) consecutive days except for the purpose of seeking medical treatment in Singapore or is being Hospitalised in Singapore subject to the exclusions, limitations and conditions specified in the policy.

5. 31 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.

5. 32 TERMINATION

(A) AUTOMATIC TERMINATION

The insurance under this Policy shall automatically terminate:

(i) If the accumulated total claim paid since the original Policy date exceeds the Lifetime Limit of five (5) times the Annual Limit; or

(ii) If any premium on this Policy is not paid when due; or

(iii) Upon cessation of this Policy; or

(iv) If the Policy anniversary nearest to the 80th birthday of the Insured Person is reached.

(B) TERMINATION BY THE COMPANY

The Company may give notice of termination by registered post to the Insured Person at his or her last known address. Such termination shall become effective seven (7) 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 Insured Person provided that no claim has been made during the Period of Insurance then subsisting.

5. 33 WAITING PERIOD

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

5.34 DUTY OF DISCLOSURE

(a) Consumer Insurance Contract

Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if the Insured Person had applied for this Insurance wholly for purposes unrelated to the Insured's Person trade, business or profession, the 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 Insured Person knows 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 Insured Person had applied for this Insurance for purposes related to Insured Person's trade, business or profession, the Insured Person had a duty to disclose any matter that the Insured Person knows 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 Insured Person also has 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.

5. 35 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, We 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.

6. EXCLUSIONS

This contract does not cover any Hospitalization, 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 issue date;

(b) Specified Illness occurring during the first one hundred and twenty (120) days of continuous cover;

(c) Any medical or physical conditions arising within the first thirty (30) days of the Insured Person's cover or date of reinstatement whichever is latest except for Accidental Injuries;

(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 and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof;

(e) Dental conditions including dental treatment or oral Surgery except as necessitated by Accidental Injuries to sound natural teeth occurring wholly during the Period of Insurance;

(f) Private nursing, rest cures or sanitaria care, illegal drugs, intoxication, sterilization, 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 and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods or birth control or treatment pertaining to infertility. Erectile dysfunction and tests or treatment related to impotence or sterilization;

(i) Hospitalization 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 Physician, and treatments specifically for weight reduction or gain;

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

(k) War or any act of war, declared or undeclared, criminal or terrorist activities, active duty in any armed forces, direct participation in strikes, riots and civil commotion or insurrection;

(l) Ionizing radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material;

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

(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 treatment;

(o) Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured Person and disabilities arising out of duties of employment or 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) Sickness or Injury arising from racing of any kind (except foot racing), hazardous sports such as but not limited to skydiving, water skiing, underwater activities requiring breathing apparatus, winter sports, professional sports and illegal activities;

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

(t) Expenses incurred for sex changes;

(u) Terrorism; and

(v) Any person residing outside Malaysia.

6. GENERAL PROVISIONS

The General Provisions on this page and the following pages shall apply to all the policies as indicated in the respective Policy Information Statements.

6. 1 INDISPUTABILITY

Except for fraud and/or non payment of premiums, the Company shall not dispute the validity of the Policy after it has been in force during the lifetime of the Insured Person for a period of two (2) years from the date of issue or the date of reinstatement of this Policy, whichever is the later.

6. 2 THE CONTRACT

(a) This Policy and the Proposal Form, together with all relevant documentary declarations and / or statements, which make up this Policy together with any endorsements made by the Company, shall constitute the entire contract between the parties. In the absence of fraud or non payment of premium, the Company shall not avoid the Policy or contest any claim thereunder in reliance on any statements made by or on behalf of the Company and no such issue, variation, waiver, extension, representation or contract shall have effect unless it is in writing and signed by any such officer.

(b) Only the officers of the Company are duly authorized on behalf of the Company to issue this Policy, to vary or waive any of its clause or the rights of the Company thereunder, to extend the time for payment of any premium or interest, or to make any representation or contract on behalf of the Company and no such issue, variation, waiver, extension, representation or contract shall have effect unless it is in writing and signed by any such officer.

6. 3 PROOF OF AGE AND SEX

(a) This Policy is issued based on the age shown in the Policy Information Statement, which is the Insured Person's age on the nearest birthday. If the age is misstated in the Proposal, the Company may vary the sum insured or the premium according to such amount as would be payable based on the true age of the Insured Person. Where the Insured Person was not eligible for the insurance at the true age, the Company shall refund the premium paid without interest.

(b) Evidence of the age must be submitted to the Company before payment of claim is made.

6. 4 REINSTATEMENT

The Insured Person may at any time within two (2) years from the default giving rise to the lapse, apply to reinstate the Policy subject to:

(a) A written application for reinstatement by the Insured Person;

(b) Evidence of insurability satisfactory to the Company as regard to health condition.

The Company shall at its sole discretion approve or reject such application for reinstatement or impose such terms as it deems fit.

6. 5 THE INSURED PERSON

Only the Insured Person may during the lifetime of the Insured Person, exercise all rights, privileges and options provided under this Policy.

6. 6 NOTICE AND PROOF OF CLAIM

Written notice of Injury or of Sickness upon which a claim is based and a duly completed Statement of Claim Form provided by the Company must be submitted to the Company within thirty (30) days from the commencement of such Injury or Sickness. The Company shall in no circumstances give consideration for admission of any claim to be made hereunder if none of the requirements had been observed.

Affirmative proof of Hospitalisation for which a claim is made must be furnished to the Company within ninety (90) days after the termination of the period for which the claim is made. 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 of original bill and receipts to Hospitalisation and to charges and fees incurred.

The Company shall have the right to examine the person whose Injury or Sickness is the basis of the claim and as often as it may reasonably require during pendency of the claim hereunder.

6. 7 CASH BEFORE COVER

It is fundamental and absolute special condition of this contract of insurance that the premium due must be paid and received by the Company before cover commences. If this condition is not complied with, then this insurance is automatically null and void.

IMPORTANT

The Insured Person shall read this Policy carefully, and if any error or misdescription be found herein, or if the cover is not in accordance with the wishes of the Insured Person, notice should at once be given to the Company and this Policy returned for amendment.

To Attach Schedule Here

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 Center, 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 Center on the types of complaints handled by the OFS or BNM before submitting your complaint.

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

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

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