Allianz

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

Allianz Hospital Income

Policy

The benefit(s) payable under eligible product is (are) protected by PIDM up to limits. Please refer to PIDM's TIPS Brochure or contact Allianz General Insurance Company (Malaysia) Berhad or PIDM (visit www.pidm.gov.my)

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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 for this **Policy** 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 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 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. Benefit – Daily Hospital Income

The **Company** will pay a daily allowance according to the plan stated in the **Schedule of Benefits** subject to a maximum of sixty (60) days for each day of **Hospitalisation** of the **Insured Person** as an inpatient for a **Medically Necessary** treatment in a **Hospital** located within Malaysia for **Any One Disability**.

2. Conditions

2.1 Addition Or Deletion Of Insured Person

(a) Addition of Insured Person
Individuals who are eligible to be insured under this **Policy** shall, from time to time while this Policy is in-force, be included as an **Insured Person** of this coverage if:
(i) the **Policyholder** requests such inclusion in writing;
(ii) the individual is eligible to be an **Insured Person** in accordance with the eligibility criteria of acceptance of the **Company**; and
(iii) the required additional premium is paid.

(b) Deletion of Insured Person
Following the resignation, termination of employment or death of an **Insured Person**, the **Policyholder** may request for a deletion of such **Insured Person** from the coverage under this **Policy** by providing the **Company** a notice in writing. The **Policyholder** shall be entitled to a pro-rated refund of the premium paid for the **Insured Person** provided that no claim has been made in respect of the coverage for the **Insured Person** during the current **Period of Insurance**.

(c) Effective Date of Addition or Deletion
(i) The addition of an **Insured Person** shall be effective on the commencement of the **Insured Person's** employment provided the written notice from the **Policyholder** is received by the **Company** within thirty (30) days from the date of commencement of employment. Failing which, the addition of the **Insured Person** shall be from the date that is thirty (30) days prior to the **Company's** receipt of the written notice from the **Policyholder**.
(ii) The effective date of deletion of an **Insured Person** shall follow the effective date of resignation, termination of employment or death of the **Insured Person** as notified to the **Company** in writing, regardless of the date of receipt of such written notice by the **Company**.

2.2 Alterations

The **Company** reserves the right to amend the terms and conditions of this **Policy** and such alteration to this **Policy** shall only be valid if authorized 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.

2.3 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**.

2.4 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 **Insured 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.

2.5 Change In Risk

The **Policyholder** or the **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.

2.6 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.

Proof of Loss/Claims – Affirmative proof of **Hospitalisation** including a discharge summary and medical report 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 the original bill and receipts of **Hospitalisation** and the charges and fees incurred.

(b) 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.

(c) Payment of Claims
Payment of claim will be made to the **Policyholder**, or the **Insured Person** at the request of the **Policyholder** but subject to approval of the **Company**. Benefits shall be payable only after **Hospitalisation** has ceased.

2.7 Conditions Precedent To Liability
The due observance and the fulfillment of the terms, provisions and conditions of this **Policy** by the **Policyholder** or **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**.

2.8 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**.

2.9 Change In Plan
The **Policyholder** may not change the plan selected for this **Policy** during the subsistence of the **Period of Insurance**.

2.10 Duty Of Disclosure

(a) Consumer Insurance Contract
Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if the **Policyholder** had applied for this Insurance wholly for **purposes unrelated to the Policyholder's Person trade, business or profession,** the **Policyholder** 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** 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 **Policyholder** had applied for this insurance for **purposes related to Policyholder's trade, business or profession,** the **Policyholder** had a duty to disclose any matter that the **Policyholder** 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 **Policyholder** 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.

2.11 Eligibility
All Malaysian citizens, Malaysian permanent resident permanently residing in Malaysia, work permit holders and pass holders with a local bank account and legally residing in Malaysia, all of whom are within the ages of sixteen (16) years up to sixty-five (65) years based on the age of next birthday (inclusive of both ages) and their respective **Dependants** are eligible to be covered under this **Policy**.

2.12 Geographical Territory
The benefit provided under this **Policy** is applicable within Malaysia only.

2.13 Governing Law
This **Policy** is issued under the laws of Malaysia and is subject and governed by the laws of Malaysia.

2.14 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 is 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.

2.15 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.

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

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

2.18 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**.

2.19 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 **Policy Anniversary**. The renewal premium payable is not guaranteed, and the **Company** reserves the right to revise the premium rate. The **Company** will notify the **Insured Person** in writing of any change in premium rates by giving at least thirty (30) days' notice before effecting 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 the health condition of the **Insured Person** and the **Company's** claims experience.

2.20 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.**

2.21 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**.

2.22 Upgraded Policy

Where the limit of the benefit 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 benefit payable shall not exceed the limit of benefit prior to the date of the upgrade and the increase in the limit of the benefit.

2.23 Waiting Period

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

2.24 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 economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

2.25 Termination Of Insurance

(a) Termination by the Policyholder

If **Policyholder** gives notice to the **Company** to terminate this **Policy**, such termination shall become effective on the date when the notice is received by the **Company** from the **Policyholder** 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 2.15 (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** provided that no claim has been made during the **Period of Insurance** 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 sixty-six (66); or
iii. premium payable under this **Policy** remains unpaid on the **Policy Anniversary**; and
iv. termination of coverage under this **Policy** following the **Company's** decision to discontinue the underwriting of the same pursuant to Condition 2.20 (Portfolio Withdrawal Condition) above.

3. Exclusions

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

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

(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) Plastic/cosmetic surgery (except reconstructive surgery necessary to restore function after an **Accident** that has occurred during the **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;

(d) Dental conditions including dental treatment or oral surgery except as necessitated by an **Injury** to sound natural teeth occurring wholly during the **Period of Insurance**;

(e) 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 requiring quarantine by law;

(f) Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions;

(g) 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 treatments related to impotence or sterilisation;

(h) **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**, any preventive medicines or preventive treatments or examinations carried out by a **Medical Practitioner**, and treatments specifically for weight reduction or gain;

(i) Suicide, attempted suicide or intentionally self-inflicted **Injury** while sane or insane;

(j) 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;

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

(l) 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;

(m) 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;

(n) **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 profession that is covered under a Workmen's Compensation insurance contract;

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

(p) **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;

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

(r) Any **Disability** arising from sex reassignment surgeries or procedures.

4. 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.

Dependant shall mean any of the following persons:
(a) a legally married spouse below the age of sixty-five (65) years at time of inclusion for coverage under this **Policy**; and
(b) unmarried children aged sixteen (16) years and above 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.

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 a **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 **Hospitalisation**.

Injury shall mean bodily **Injury** caused solely by **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**.

Medical Practitioner means a registered doctor, physician, surgeon or specialist qualified and licensed to practice western medicine and who is practicing within the scope of his/her licensing and training in the geographical area of practice, but excluding a **Medical Practitioner** who is the **Insured Person** himself/herself.

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 charges which are fair and reasonable and customary for the **Disability**.

Period Of Insurance shall mean the duration during which 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** under the **Schedule**.

Policy Anniversary shall mean the same date each year the **Period of Insurance** commences.

Schedule/Schedule Of Benefits shall mean the **Schedule** attached to this **Policy** where details including the relevant particulars of the **Policyholder** and **Insured Person(s)** are stated.

Sickness, Disease Or Illness shall mean a physical condition marked by a pathological deviation from the normal healthy state.

Specified Illnesses shall mean the following **Sickness, Disease or Illness** 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.

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. The **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.

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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 customer.service@allianz.com.my allianz.com.my

Avenues to Seek Redress

You may submit your complaint to the Financial Markets Ombudsman Service (FMOS) if you are not satisfied with our final response or decision, and if your complaint is within the scope of the FMOS as well as a monetary limit of RM250,000.

FMOS can be contacted at the following address:
Financial Markets Ombudsman Service (Company No: 200401025885)
Level 14, Main Block, Menara Takaful Malaysia,
No. 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur.

03 2272 2811 fmos.org.my

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

Mailing Address:
BNMLINK
Bank Negara Malaysia
P.O. Box 10922
50929 Kuala Lumpur

BNMLINK Office:
4th Floor, Podium Bangunan AICB
No. 10, Jalan Dato' Onn
50480 Kuala Lumpur

1 300 88 5465
03 2174 1717 (Overseas)

03 2174 1515 (Fax)

bnm.gov.my (Website)
bnm.gov.my/livechat (Live Chat)
bnmlink.bnm.gov.my (eLINK Form)

For physical visits, BNMLINK will receive visitors by appointment only. The public may request for an appointment through eLINK Form or by telephone.

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

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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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