STAMP DUTY PAID

Tune Protect Malaysia

Tune Insurance Malaysia Berhad
Company No.: 197601004719 (30686-K)
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SST Registration No.: W10-1808-31039805

PRO-Health Medical Insurance Policy

Whereas the Insured Person by an application and declaration which shall be the basis of this contract and is deemed to be incorporated herein has applied to Tune Insurance Malaysia Berhad (hereinafter called "the Company") for the insurance hereinafter contained and has paid or agreed to pay the premium stated in the Policy Schedule as consideration for such insurance for the period stated therein.

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

Provided always that

a) The liability of the Company shall not exceed the Annual Limit as set out in the Schedule of Benefits for any one period of insurance.
b) This Policy shall become effective as of the date stated in the Policy Schedule. This Policy shall be issued for one year and at the end of each period of insurance may be renewed for another year subject to Policy terms and conditions.

Our Agreement

STATEMENT Pursuant to Schedule 9 of the Financial Services Act 2013

A 'consumer insurance contract' is a contract of insurance entered into, varied or renewed by an individual wholly for purposes unrelated to Your trade, business or profession.

Consumer Insurance Contract (Insurance wholly for purposes unrelated to Your trade, business or profession)

This Policy is issued in consideration of the payment of premium as specified in the Policy Schedule and pursuant to the answers given in Your Proposal Form (or questionnaires answered when You applied for this insurance) and any other disclosures made by You between the time of submission of Your Proposal Form (or questionnaires answered when You applied for this insurance) and the time this contract is entered into. The answers and any other disclosures given by You shall form part of this contract of insurance between You and Us. However, in the event of any pre-contractual misrepresentation made in relation to Your answers or in any disclosures given by You, the remedies in Schedule 9 of the Financial Services Act 2013 will apply.

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

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

This Policy and any attached endorsement or supplement provided that the name and form number for such endorsement or supplement is listed in the Policy Schedule reflects the terms and conditions of the contract of insurance as agreed between You and Us.

DEFINITIONS

ACCIDENT means 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.

AGE means the Age on next birthday.

ANNUAL PREMIUM means the premium for the Base Plan and is shown in the Policy Schedule.

AS CHARGED means actual charges incurred for reasonable, necessary and customary medical care provided in the Treatment of a covered disability.

BODILY INJURY means an Injury caused directly and independently of all other causes by Accident of which there is evidence of a visible bruise or wound on the body.

COMPANY'S OFFICE means the Company's Service Department located in its main office, or as determined by the Company from time to time.

CONGENITAL CONDITIONS means 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. This will include all Congenital Conditions as classified and listed by the World Health Organization on Congenital, Malformations, Deformations and Chromosomal Abnormalities. They will include hernias of all types and epilepsy except when caused by a trauma which occurred after the date that the Insured was continuously covered under this Policy.

DATE APPLIED means the date the Policy is applied and is shown in the Policy Schedule.

DAY shall mean the definition of a charging day adopted by the Hospital concerned.

DAY SURGERY/ DAYCARE means a patient who needs the use of a recovery facility for a surgical procedure on a pre-planned basis at the hospital/specialist clinic (but not for overnight stay).

DENTAL TREATMENT means the Treatment required to establish or maintain oral health, tooth repair, scaling, filings, tooth extraction, malocclusion, restoration of tooth function and alignment.

DENTIST means 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.

DISABILITY means a Sickness, Disease, Illness or the entire Injuries arising out of a single or continuous series of causes. Any One Disability shall mean all of the periods of Disability arising from the same cause including any and all complications there from. However, if the Insured completely recovers and remains free from further Treatment (including drugs, medicines, special diet or injection or advice for the condition) for the Disability for at least ninety (90) days following the latest date of discharge, subsequent Disability from the same cause shall be considered as a new Disability.

DOCTOR or PHYSICIAN or SURGEON means a registered medical practitioner qualified and licensed to practice western medicine and who, in rendering such Treatment, is practising within the scope of his licence and training in the geographical area of practice, but excluding a Doctor, Physician, Surgeon or Anaesthetist who is the Insured himself.

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

EXPIRY DATE means the date when the Policy expires and is shown in the Policy Schedule.

HOSPITAL means 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 24 hour 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.

HOSPITAL CONFINEMENT means the Insured Person being duly registered and admitted as an in-patient in a Hospital for more than twelve (12) hours.

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

INJURY means bodily injury caused solely by Accident.

ILLNESS, DISEASE or SICKNESS means physical condition marked by a pathological deviation from the normal healthy state.

IN-PATIENT means an overnight admission of an Insured into a Hospital in order to receive Treatment.

INSURED PERSON means the person insured under this Policy and is named in the Policy Schedule.

INTENSIVE CARE UNIT means 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) hour basis solely for Treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.

ISSUE DATE means the date We issue this Policy as specified in the Policy Schedule, or in the case of any attached supplement or endorsement as specified in the supplement or endorsement. It is the month, day and year this Policy and any supplement or endorsement takes effect.

LIMIT means Annual Limit or Maximum Limit Per Disability, whichever is/are applicable.

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

MEDICALLY NECESSARY means 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 Physician, 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.

OUT-PATIENT means the Insured is receiving medical care or Treatment without being hospitalised and includes Treatment in a Daycare center.

POLICY ANNIVERSARY means the same day and month each year as the Policy Date.

POLICY DATE means the Policy Date as shown in the Policy Schedule.

POLICY SCHEDULE means the legal contract between the Insured Person and Us.

PRE-EXISTING ILLNESS means 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; or

b) medical advice, diagnosis, care or Treatment has been recommended; or

c) clear and distinct symptoms are or were evident; or

d) its existence would have been apparent to a reasonable person in the circumstances.

PRESCRIBED MEDICINES means 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.

REASONABLE AND CUSTOMARY CHARGES means charges for medical care which is Medically Necessary 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 individuals of the same sex and of comparable age for a similar Sickness, Disease or Injury and in accordance with accepted medical standards and practice could not have been omitted without adversely affecting the Insured's medical condition. In Malaysia, Reasonable and Customary Charges shall be deemed to be those laid down in the Malaysian Medical Association's Schedule of Fees including any amendments or enactments to it.

SPECIALIST means 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 Dentist, Physician or Surgeon who is the Insured himself.

SPECIFIED ILLNESSES means the following disabilities and its related complications, occurring within the first 120 days of Insurance of the Insured Person:

a) Hypertension, diabetes mellitus and cardiovascular disease

b) All tumours, cancers, cysts, nodules, polyps, stones of the urinary system and biliary system

c) All ear, nose (including sinuses) and throat conditions

d) Hernias, haemorrhoids, fistulae, hydrocele, varicocele

e) Endometriosis including disease of the Reproduction system

f) Vertebro-spinal disorders (including disc) and knee conditions.

SURGERY means 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

TREATMENT means Surgery or medical procedures carried out by a Specialist (other than for diagnostic procedures).

WAITING PERIOD means eligibility for benefits starts one hundred and twenty (120) days for Specified Illness and thirty (30) days for any other causes after the Issue Date, except for covered Accident occurring after the Issue Date 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.

YOU, YOUR, YOURS and OWNER means the Policy Owner named in the Policy Schedule.

We, Us, Our, Ours and Company means TUNE INSURANCE BERHAD at its registered office in Kuala Lumpur, Malaysia.

SCHEDULE OF BENEFITS

BENEFIT	Plan A-30	Plan A-60	Plan B-100	Plan B-150
Section A In-Patient & Daycare Surgical Procedure				
Hospital Room and Board (per day up to 150 days)	RM150		RM250	
Intensive Care Unit (per day up to 50 days)	As Charged, subject to annual limit with reasonable and customary charges			
Pre-Hospital Specialist Consultation (within 60 days prior to hospitalisation and first time consultation only)				
Pre-Hospital Diagnostic Tests (60 days prior to hospitalisation)				
Ambulance Fees (by road only)				
Hospital Supplies & Services				
Surgical Fees (post-surgery care up to 60 days following date of discharge)				
Anaesthetist Fee				
In-Hospital Physician Visit (maximum 2 visits per day up 150 days)				
Operating Theatre				
Daycare Surgical Procedure (post surgery care up to 60 days after discharge)				
Medical Report	RM100		RM100	
Government Hospital Allowance	RM100/day, max 60days		RM100/day, max 60 days	

Mosquito-Borne Disease Allowance (Dengue, Zika Virus Fever, Malaria, Chikungunya Fever, Japanese Encephalitis)	RM750		RM1,500	
Section B Out-Patient Treatment & Others				
Post Hospitalisation Treatment (within 60 Days from hospital discharge)	As Charged, subject to annual limit with reasonable and customary charges			
Out-Patient Physiotherapy Treatment (within 60 Days from hospital discharge)				
Emergency Accidental Out-patient Treatment (within 24 hours of Accident, follow-up treatment up to 30 days from date of Accident)				
Alternative & Chiropractic Treatment	RM500		RM1,000	
Annual Limit	RM30,000	RM60,000	RM100,000	RM150,000

DESCRIPTION OF BENEFITS

HOSPITAL ROOM AND BOARD

Reimbursement of the Reasonable and Customary Charges Medically Necessary for room accommodation and meals, subject to the maximum number of days and the Limit of the plan as stated in the Schedule of Benefits. The amount of the benefit shall be equal to the actual charges made by the Hospital during the Insured's confinement, but in no event shall the benefit exceed, for any 1 day, the rate of Room and Board Benefit as stated in the Schedule of Benefits. The Insured will only be entitled to this benefit while confined to a Hospital as an In-Patient or for Day Surgery.

INTENSIVE CARE UNIT

Reimbursement of the Reasonable and Customary Charges Medically Necessary for actual room and board incurred during confinement as an inpatient in the Intensive Care Unit of the Hospital, subject to the maximum number of days and the Limit of the plan as stated in the

Schedule of Benefits. This benefit shall be payable equal to the actual charges made by the Hospital. 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.

PRE-HOSPITAL SPECIALIST CONSULTATION

Reimbursement of the Reasonable and Customary Charges for the first time consultation by a Specialist in connection with a Disability within the maximum number of days and amount 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 hospital confinement for the Treatment of the medical condition diagnosed.

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 number of days and amount as set forth in the Schedule of Benefits in a Hospital 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 hospital confinement for the Treatment of the medical condition diagnosed. Medications and consultation charged by the medical practitioner will not be payable.

AMBULANCE FEES

Reimbursement of the Reasonable and Customary Charges incurred for necessary domestic ambulance road services (inclusive of attendant) to and/or from the Hospital of confinement subject to the Limit of the plan as stated in the Schedule of Benefits. Payment will not be made if the Insured Person is not hospitalized.

HOSPITAL SUPPLIES & SERVICES

Reimbursement of the Reasonable and Customary Charges actually incurred for Medically Necessary general nursing, Government Service Tax on eligible Hospital Room and Board charges, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, x-ray, laboratory examinations, electrocardiograms, physiotherapy, basal metabolism tests,

intravenous injections and solutions, administration of blood and blood plasma but excluding the cost of blood and plasma which relate directly to the Treatment whilst the Insured Person is confined as an in-patient in a Hospital or for Day Surgery, subject to the Limit of the plan as stated in the Schedule of Benefits. Payment will not be made for the acquisition, extraction procedure and cultivation of tissues and cells (inclusive of stem cells) required for Treatment.

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 number of days from the date of discharge, but within the maximum indicated in the Schedule of Benefits. If more than one surgery is performed for Any One Disability, the total payments for all the surgeries performed shall not exceed the Limit of the plan as stated in the Schedule of Benefits.

ANAESTHETIST FEE

Reimbursement of the Reasonable and Customary Charges by the Anaesthetist for the Medically Necessary administration of anaesthesia, subject to the Limit of the plan as stated in the Schedule of Benefits.

IN-HOSPITAL PHYSICIAN VISIT

Reimbursement of the Reasonable and Customary Charges by a Physician for Medically Necessary visiting an in-paying patient while confined for a non-surgical disability subject to a maximum of 2 visit per day up to the Limit of the plan as stated in the Schedule of Benefits.

OPERATING THEATRE

Reimbursement of the Reasonable and Customary Operating Room charges incidental to the surgical procedure, subject to the Limit of the plan as stated in the Schedule of Benefits.

DAYCARE SURGICAL PROCEDURE

Reimbursement of fees actually charged by the Hospital or Specialist centre and for all professional fees charged for minor Day Surgery or Daycare surgical procedures performed as an Out-Patient without confinement in a Hospital. Such fees or charges shall include all incidental services and supplies provided for the procedures up to the maximum number of days from the date of discharge and Limit of the plan as stated in the Schedule of Benefits. The Day Surgery or Daycare surgical procedures should include minor operations such as but not limited to: Adenoidectomy, Arthroscopy, Broncoscopy, Bunionectomy, Cataract removal, Cholecystectomy, Colonoscopy, Coronary Angiography, Digestive tract endoscopy, Dilatation and curettage of uterus, simple excision of pilonodal cyst, Haemorrhoidectomy,

Hammer toe repair, Laparascopy, Laryngoscopy and tracheoscopy, Lumbosacral manipulation, Myringotomy, Prostate biopsy, Reduction of nasal fracture, Strabismus repair and Tonsillectomy, that is commonly performed safely on an Out–Patient basis.

Any Day Surgery or Daycare surgical procedures done for investigative and diagnostic purpose not related to Treatment for any specified Disabilities is not covered.

MEDICAL REPORT FEES

An amount equal to actual charges for any Medical Report required is payable up to the maximum limit per disability subject to the Limit of plan as stated in the Schedule of Benefits.

GOVERNMENT HOSPITAL ALLOWANCE

Pays a daily allowance for each day of confinement for a covered Disability in a Malaysian Government Hospital, provided that the Insured Person shall confine to a Room and Board rate subject to the Limit of the plan as stated in the Schedule of Benefits. No Payment will be made for any transfer to or from any Private Hospital and Malaysian Government Hospital for the covered disability.

MOSQUITO-BORNE DISEASE ALLOWANCE

Pays an allowance of a lump sum per Any One Disability as per Schedule of Benefit in the event that Insured is diagnosed with Dengue Virus, Zika Virus, Malaria, Chikungunya and Japanese Encephalitis, with confirmation of a diagnosis by a medical practitioner, subject to the Limit of the plan as stated in the Schedule of Benefits. Insured Person must have had been confined as an In-Patient to claim under this benefit.

POST-HOSPITALISATION TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred in Medically Necessary follow-up Treatment by the same attending Physician or post-Surgery Care by the Specialist, within the number of days and Limit of the plan as stated 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 the total supply needed shall not exceed the maximum number of days of the plan as stated in the Schedule of Benefits.

OUT-PATIENT PHYSIOTHERAPY TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred for out-patient physiotherapy Treatment referred in writing by a licensed specialist Physician after Surgery or in-hospital Treatment, within the number of days and the Limit of the plan as stated in the Schedule of Benefits. However, no payment will be made for medication or Treatment and

subsequent consultations with the same Specialist or Physician.

EMERGENCY ACCIDENTAL OUTPATIENT TREATMENT

Reimbursement of the Reasonable and Customary Charges incurred for up to the Limit of the plan as stated in the Schedule of Benefits, as a result of a covered Bodily Injury arising from an Accident for Medically Necessary Treatment as an outpatient at any registered clinic or hospital within 24 hours of the Accident causing the covered Bodily Injury. Follow up Treatment by the same doctor or same registered clinic or Hospital for the same covered Bodily Injury will be provided up to the maximum number of days as stated in the Schedule of Benefits.

If as a result of an Accident on sound natural teeth, we will reimburse charges for pain relieving dental Treatment excluding restorative procedure such as crowning, bridging, as well as root canal Treatment and implant of teeth.

ALTERNATIVE & CHIROPRACTIC TREATMENT

Reimbursement for alternative treatment expenses by a traditional medicine practitioner, osteopath, chiropractor, herbalist and/or bonesetter services, after confinement as an In-Patient covered under this policy, subject to the Limit of the plan as stated in the Schedule of Benefits per Any One Disability. The treatments payable under this benefit must be reasonable and related to the Disability for which the Insured has been hospitalised for. The fees must be incurred in Malaysia and within 60 days after discharge from hospital.

ANNUAL LIMIT

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

SPECIAL PROVISIONS

PERSONS ELIGIBLE

Persons eligible to be covered under this Policy are:-

a) Anyone between the ages of 18 years and 45 years and renewable up to age 65

b) Persons who legally reside in Malaysia only. Persons become ineligible when they have resided continuously for ninety (90) days, or spend more than one hundred and eighty (180) days in a calendar year, outside Malaysia.

PERIOD OF COVER AND RENEWAL

This Policy shall become effective as of the date stated in the Schedule. The Policy Anniversary shall be one year after the effective date and annually thereafter. On each such anniversary, this Policy is renewable at the premium rates in effect at that time as notified by the Company.

This Policy is renewable at the option of the 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 we reserve the right to revise the premium rate applicable at the time of renewal. We shall write to inform You of the change in premium by giving You thirty (30) days notice. Application for change of benefits to a higher plan can only be made on renewal and is subject to acceptance by the Company upon renewal.

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

a) Non-payment of premium or premium not made in 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

f) Termination of coverage for all policies in a certain market and we withdraw this product completely from the market in accordance with the Portfolio Withdrawal Condition.

GEOGRAPHICAL TERRITORY

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

OVERSEAS TREATMENT

If the Insured Person elects to or is referred to be treated outside Malaysia by the Attending Physician, benefits in respect of the Treatment shall be limited to the reasonable and customary and medically necessary charges for such equivalent local Treatment in Malaysia and shall exclude the cost of transport to the place of Treatment. Reasonable and Customary and Medically Necessary Charges shall be deemed to be those listed in the Malaysian Medical Association's Schedule of Fees inclusive of any amendment/enactment made to it.

This benefit is not applicable to non-Malaysian citizen. Only Treatment sought in Malaysia would be covered for non-Malaysian citizens.

OVERSEAS RESIDENCE

No benefit whatsoever shall be payable for any medical Treatment received by the Insured Person outside Malaysia, if the Insured Person resides or travels outside Malaysia for more than ninety (90) consecutive days.

For non-Malaysian citizen, no benefit shall be payable for any medical Treatment received by the Insured outside Malaysia regardless the period of resides or travels.

WAITING PERIOD

Eligibility for benefits starts one hundred and twenty (120) days for Specified Illness and thirty (30) days for any other causes after the Issue Date, except for covered Accident occurring after the Issue Date.

EXCLUSIONS

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

1. Pre-existing illness prior to policy issue date.
2. Specified Illnesses occurring during the first one hundred and twenty (120) days of continuous cover.
3. Any medical or physical conditions arising within the first thirty (30) days following the Issue Date, except for Bodily Injury due to accidental causes.
4. Plastic/Cosmetic surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness (Radial Keratotomy or Lasik) and the use or acquisition of external prosthetic appliances or devices such as artificial limbs, hearing aids, implanted pacemakers and prescriptions thereof.

5. 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.

6. 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, except those specifically covered in this policy.

7. Any Treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.

8. Pregnancy, pregnancy related condition or its complications, child birth (including surgical delivery), miscarriage, abortion and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or Treatment pertaining to infertility, erectile dysfunction and tests or Treatment related to impotence or sterilisation..

9. 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.

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

11. 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.

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

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

14. 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 acupressure, reflexology, massage or aromatherapy or other alternative Treatment (other than the alternative treatments covered in the Alternative & Chiropractic Treatment benefit).

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

16. Psychotic, mental or nervous disorders (including any neuroses and their physiological or

psychosomatic manifestations) and any and any other conditions classified under the "Diagnostic and Statistical Manual of Mental Disorders (DSM-IV Codes)' as published by American Psychiatric Association.

17. 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

18. 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.

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

20. Expenses incurred for sex changes.

21. Biological or chemical contamination.

GENERAL CONDITIONS

This Policy and the Schedules shall be read together as one contract and any words or expression to which a specific meaning has been attached in any part of this Policy or the Schedules shall bear such specific meaning wherever it may appear.

NOTICE

Every notice or communication to the Company shall be in writing and sent to the Company at Our authorized e-mail address or as specified otherwise. Any notice to be given to You under this Policy will be sent to You via the e-mail address that You have registered with Us during the proposal or change request in Our records at the Company's Office. Any such notice will run from the time such notice is sent. In the case that any notice is returned undelivered to You, the Company may, at its sole and absolute discretion, at Your own risk, withhold all subsequent notice until the Company has been notified by You of Your new e-mail address. No alterations in the terms of this Policy or any endorsement thereon, will be held valid unless the same is signed or initialed or issued by an authorised representative of the Company.

CONDITION PRECEDENT TO LIABILITY

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

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

MISSTATEMENT OF AGE

Subject to Our rights in the case of fraud, if the Insured's Age has been misstated, the benefits, the premiums and the coverage terms under this Policy will be adjusted according to the correct Age.

a) If the Age of the Insured is understated, the Company will pay the benefits that the premium paid would have purchased according to the rate at the true Age, and not the benefits as shown in Policy Schedule or any subsequent endorsement issued by the Company;

b) If the Age of the Insured is overstated, the Company will refund the excess of premium paid without interest;

c) If the Insured was not insurable under this Policy according to the Company's requirements, this Policy (including any attached endorsement and supplement) will be void from the Policy Date and all premiums paid without interest will be refunded.

Proof of Age of the Insured shall be required prior to payment of any benefit under this Policy.

PREMIUM

Premium as specified in the Policy Schedule is the first premium payable to the Company. Premium must be paid in the same payment frequency and is payable to Us on or before the due date. During the Period of Insurance, the premium for insurance under this Policy is not guaranteed and shall be based on the premium rates in force at the time of renewal. Premiums are payable at the premium rate according to Insured Person's age next birthday on each Policy year anniversary.

The Company shall have the right to change the rate at which premiums shall be calculated, at the start of any Policy Year, provided that the Company notifies the Insured Person at least thirty (30) days in advance of the date such premium is due. The premium rate shall also increase if the Insured Person's age, at the Policy year anniversary, falls under a new rating band.

CHANGE IN RISK

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

CHANGE OF PLAN

Any increase or decrease in the insurance coverage for the Insured which is due to a change in plan will become effective only on the next Policy Anniversary date provided we approved such change.

If the Eligible Benefits to any Insured Person under the terms of this Policy be increased while it is in force or at the time of Renewal or replacement and if such Insured Person shall have been afflicted with a Disability prior or at the time the Benefits were increased, the Limits of Benefits payable in respect of such Disability shall not exceed the Limit of Benefits prior to the date the Benefits were upgraded. However, the Waiting Period shall be re-applied from the approval date for the additional benefits (newly added benefits) on the Insured Person.

PORTFOLIO WITHDRAWAL CONDITION

We reserve the right to cancel the portfolio as a whole if we decide to discontinue with the underwriting of this product. Cancellation of the portfolio as a whole shall be given within thirty (30) days by written notice to the Insured Person and we will run off all policies to expiry of the period of cover within the portfolio.

UPGRADED ROOM AND BOARD

If the Insured is hospitalised at a published Hospital Room and Board rate which is higher than his/her eligible benefit, the Insured shall bear the difference in the Room and Board rate.

CONTRIBUTION

If an Insured carries other insurance covering any Illness or Injury insured by this Policy, We shall not be liable for a greater proportion of such Illness or Injury than the amount applicable hereto under this Policy bears to the total amount of all valid insurance covering such Illness or Injury.

CERTIFICATION, INFORMATION AND EVIDENCE

All certificates, information, medical reports and evidence as required by Us shall be furnished at the expense of the Insured, and in such a form that We may require. In any event all notices which We require You to give must be in writing and addressed to Us. An Insured shall, at Our request and expense, submit to a medical examination whenever such is deemed necessary.

SUBROGATION

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

CLAIM PROCEDURES

a) The Insured Person shall within 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 invalid any claim if it is shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

b) The Insured 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.

PROOF OF LOSS

The Company, upon receipt of such notice, will furnish to the Claimant forms for filing proof of loss. If the forms are not furnished within fifteen (15) days, the Claimant by submitting written proof covering the occurrence, the character and the extent of the loss for which claim is made shall be deemed to have compiled with the requirement of this provision.

FILING PROOF OF LOSS

Proof of loss must be furnished to the Company in case of claim for disability within ninety (90) days after termination of the period of disability for which the Company is liable, and in case of claim of any other loss, within ninety (90) days after the date of such loss.

MEDICAL EXAMINATION

The Company shall have the right to examine the body of the Insured Person whenever it may reasonably require and to conduct an autopsy in case of death where it is not forbidden by law.

INCOMPLETE CLAIMS

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

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 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.

ELIGIBILITY

Eligibility of the Insured Person for benefits provided in this Policy starts upon the expiry of the Waiting Period except for a covered Accident occurring after the Issue Date.

CANCELLATION

This Policy may be cancelled by the Insured 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 shall be entitled to a refund of the premium as follow:-

Period Not Exceeding	Refund of Annual Premium
15 days	100%
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

ANTI-BRIBERY AND CORRUPTION

It is fundamental You shall comply, and/or shall procure or ensure Your directors, employees, subcontractors, agents or other third parties comply, with all applicable anti-corruption laws and regulations and any relevant anti-corruption policies and documents provided by Us and have in place adequate controls and procedures to prevent corruption.

GOVERNING LAW

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

SANTION LIMITATION AND EXCLUSION CLAUSE (SANC)

No Company shall be deemed to provide cover and no Company shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanction, laws or regulations of the European Union, United Kingdom or United States of America.

TERMINATION

The insurance of an Insured Person shall automatically terminate on the earliest happening of the following events:

a) on the death of an Insured Person; or

b) on the Policy Anniversary following the 65th birthday of an Insured Person; or

c) upon termination in accordance with the Grace Period clause; or

d) if the total benefits paid under the Policy since the last Policy Anniversary exceeds the Annual Limit for the respective Policy Year; or

e) at mid-night standard Malaysian time on the last day of the Period of Insurance unless an Insured Person is confined to a Hospital at such time. If this being the case, the time of termination shall be extended to:-

   i) the time the Insured Person is discharged from Hospital; or

   ii) the time the Annual Limit shall have been exhausted; whichever is the first to occur.

Once terminated, this Policy shall cease to be in force. 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.

ALTERATIONS

The Company reserves the right to amend the terms and provisions of this Policy by giving a 30 days prior notice in writing by ordinary post to the Insured Person's last known address or e-mail address in Our 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 Us and such approval is endorsed thereon. The Policy shall then be read subject to such amendment.

DISCLOSURE AND FRAUD

If the Proposal and Declaration made by Insured Person or any written statement given by the Insured Person is untrue in any respect, or if any material fact affecting the risk is incorrectly stated, misrepresented or not disclosed to us, or is omitted in these documents, the contract may be avoided, claim denied or reduced, terms changed or varied, or contract terminated.

This Policy shall also be void if the Insured Person makes any claim which is fraudulent or exaggerated, or if the Insured Person makes any false declaration or statements in support of any claim.

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 insurance cover is effective.

GRACE PERIOD

You are allowed a grace period of fifteen (15) days after the due date for payment of each premium. This Policy will continue to be in effect during this grace period.

If a premium is still unpaid at the end of the grace period, the premium is in default. If a premium is in default, this Policy is no longer in effect.

COOLING-OFF PERIOD

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

CURRENCY OF PAYMENT

All payments under this Policy shall be made in the legal currency of Malaysia. Should any payment be requested by the Insured Person 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.

BREACH of REPRESENTATIONS; COMPANY'S RIGHT TO RESCIND and IMPOSE SURRENDER CHARGES; RIGHT TO FREEZE REFUND AMOUNT

The Owner acknowledges that in the event of a violation of the foregoing Owner representation and warranty, the Owner hereby expressly acknowledges and agrees that the Company shall, to the fullest extent permitted by applicable law and regulation, have the right to:

a) terminate this Policy immediately;

b) notwithstanding the actual date of termination pursuant to the clause (a) above, impose the maximum surrender and any other charges imposable on the Owner under this Policy as if this Policy had been surrendered immediately after issuance;

c) notify relevant governmental authorities and furnish all information deemed necessary or appropriate in the entire discretion of the insurer concerning the Owner and/or this Policy; and

d) if deemed appropriate after consultation with governmental authorities and legal counsel, either

   i) refund the premiums paid less any medical expenses which may have been incurred, any applicable surrender and other charges in accordance with clause (b) above (the "Refund Amount"), or

   ii) if requested or required to do so by competent governmental authorities, freeze or pay over to relevant governmental authorities all or a portion of the Refund Amount or take such other actions as the competent governmental authorities may request or require

NOTICE

For all intents and purposes where there is a conflict or ambiguity as to the meaning in the Bahasa Malaysia provisions of any part of the Contract, it is hereby agreed that the English version of the Contract shall prevail.

This policy and its conditions should be examined and if incorrect, return at once for alteration.

IMPORTANT NOTICE

Every effort will be made by **Our Company** to fulfil **Our** obligation under the Policy. If **You** are unhappy or dissatisfied with **Our** service or have any complaints, **You** may call or write to **us** at:-

Tune Insurance Malaysia Berhad
Complaints Unit
Level 9, Wisma Tune,
No. 19, Lorong Dungun,
Damansara Heights,
50490 Kuala Lumpur.
Tel: 1800 88 5753
Fax: 603-2094 1366
Website: www.tuneprotect.com
Email: hello.my@tuneprotect.com

If **You** are not satisfied with the response of **Our** decision of **Our Company**, **You** may submit **Your** complaint either to The Ombudsman for Financial Services (OFS) or to Bank Negara Malaysia (BNM).

The following are the contact details for OFS and BNM:

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

OR

Laman Informasi Nasihat dan Khidmat (LINK)
Pengarah
Jabatan LINK & Pejabat Wilayah
Bank Negara Malaysia
P.O.Box 10922
50929 Kuala Lumpur
Tel: 1-300-88-5465
Fax: 03-21741515
Email: bnmtelelink@bnm.gov.my