AIA FLEXI VITAL CARE PLUS POLICY WORDING – Sept 2019

AIA Flexi Vital Care Plus

Group Hospitalization & Surgical Policy

- PROVISIONS -

- SCHEDULES -

PART I - DEFINITIONS

In this Policy where consistent with the contents the singular shall include the plural and the plural the singular; words importing the masculine gender shall include the feminine gender; and each of the following words and expressions shall have the following meanings:

1. "**Accident**" shall mean an unforeseen event, which is caused solely and directly by external, violent, sudden and accidental means.

2. "**Active Service**" shall mean for an employee reporting to work at the place assigned by the Policyholder and performing, in a customary manner, all regular duties of his employment with the Policyholder, and includes such employee on entitled annual leave for reasons other than on medical grounds.

3. **"Any One Disability"** shall mean:
   (a) all disabilities arising from the same cause including any and all complications therefrom. Subsequent disability from the same cause shall be treated as a new disability if it is separated by at least thirty (30) calendar days following the latest discharge from the hospital; or
   (b) concurrent disabilities from different causes during the same confinement.

4. "**Company**" shall mean AIA Singapore Private Limited.

5. "**Dependant**" shall mean:
   (a) the spouse of an Insured Member of this Policy, provided such spouse is below the Maximum Age of Coverage as stated in the Policy Schedule and is not already insured under the Policy; or
   (b) each child of an Insured Member, provided such child is at least 2 weeks old and is below the Maximum Age of Coverage as stated in the Policy Schedule, unmarried and unemployed.

6. "**Employee's Compensation Legislation**" shall mean the Work Injury Compensation Act, Chapter 354, Singapore, as may be amended or re-enacted, or equivalent legislation.

7. "**Entry Date**" shall mean the date an individual becomes an Insured Member under this Policy.

8. "**Hospital**" shall refer exclusively to an institution duly licensed as such and operated pursuant to law for the care and treatment of sick and injured persons as registered bed patients, with facilities for diagnosis and major surgery, which is under the supervision of one or more Registered Medical Practitioners, and which has 24 hours a day professional nursing service. "Hospital" does not include any institution or that portion of any institution which is operated as a convalescent or nursing home, rest home, home for the aged, a place for alcoholics or drug addicts, or for any similar purpose.

9. "**Hospital Confinement**" shall mean confinement in a Hospital:
   (a) for no minimum duration as long as the Hospital makes a charge for room and board; or
   (b) for any duration for the purpose of surgery and any preparations and procedures in connection therewith without incurring room and board charges.

10. "**Injury**" shall mean bodily injury which is caused solely and directly by Accident.

11. "**Insured Members**" shall mean Members who, having completed the required Waiting Period and are not otherwise disqualified from coverage under the terms of this Policy, are participating in the insurance plan under this Policy.

12. "**Maximum Age of Coverage**" shall mean the maximum age of coverage so defined in the Policy Schedule attached hereto.

13. "**Medically Necessary**" shall mean a medical treatment, services and/or supply provided by a Registered Medical Practitioner and/or Specialist covered under this Policy which are:
    (a) consistent with the diagnosis and customary medical treatment, service and/or supply for Sickness or Injury;
    (b) in accordance with standards of good medical practice; consistent with the current standard of professional medical care and with proven medical benefits;
    (c) not for the convenience of the insured, Registered Medical Practitioner or the Specialist, and unable to be reasonably rendered out of Hospital (if admitted for confinement); and
    (d) not of an experimental, investigational or research nature, preventing or screening nature.

14. "**Members**" shall mean the persons so defined in the Policy Schedule attached hereto.

15. "**Panel Specialist**" shall mean a Specialist who has been appointed by the Company.

16. "**Policy**" shall mean this agreement, the attached Policy Schedule, any riders or endorsements therein, any amendments thereto signed by the Company, therein the application attached hereto to the Policyholder, and the individual enrolment forms, if any, of the insured, which together constitute the entire contract between the parties.

17. "**Policy Anniversary Date**" shall mean the anniversary of the Policy Effective Date or such other date as may be agreed in writing between the Policyholder and the Company.

18. "**Policy Effective Date**" shall mean the date from which the coverage under this Policy becomes effective.

19. "**Policy Period**" shall mean a period of one year or such other periods as may be agreed in writing between the Company and the Policyholder, starting with the Policy Effective Date and the subsequent Policy Anniversary Dates.

20. "**Registered Medical Practitioner**" shall mean only a person qualified by a degree in western medicine and legally authorized in the geographical area of his practice to render medical or surgical services, and who is not: (i) the insured, or (ii) a member of his immediate family, or (iii) other relative of the insured.

21. "**Sickness**" shall mean a physical condition marked by a pathological deviation from the normal healthy state.

22. "**Specialist**" shall mean a Registered Medical Practitioner who specializes in a specific area in a medical field, and who is not: (i) the insured, or (ii) a member of his immediate family, or (iii) other relative of the insured.

23. "**Surgery**" shall mean the types of surgical operations listed in the "Table of Surgical Procedures" under the Medisave Scheme operated by the Ministry of Health of Singapore excluding all surgical operations stated in the General Exclusions under this Policy and any other surgical operations that are not specified in the said "Table of Surgical Procedures".

24. "**Traditional Chinese Medicine (TCM) Practitioner**" shall mean a person who is qualified to provide a prescribed practice of TCM and is registered and issued with a license to practice the TCM by the TCM Practitioners Board of Singapore, and who is other than the insured, a member of his immediate family or other relative.

25. "**Singapore Government Restructured Hospital**" shall mean the privatized Singapore Government Hospital.

26. "**Waiting Period**" shall mean the period so defined in the Policy Schedule attached hereto.

PART II - PARTICIPATION AND TERMINATION

Section A - Participation

1. The Policyholder shall declare to the Company full particulars of Members and Dependants (as may be the case) prior to the Policy Effective Date and within ninety (90) days of the Entry Date for each new Member and of the date the Dependant becomes eligible to participate in the insurance plan.

2. Members and Dependants already eligible on the Policy Effective Date shall be eligible for participation on the Policy Effective Date.

3. Members and Dependants not eligible as of the Policy Effective Date and new Members and Dependants shall become eligible for participation hereunder on the day following the Member's completion of the required Waiting Period as specified in the Policy Schedule.

4. An individual who becomes a Dependant after the Policy Effective Date shall become eligible to participate in the insurance plan on the date such person becomes a Dependant.

5. Members whose participation has been terminated and who re-apply for participation shall be considered as new Members.

6. Any Member who is not in Active Service on the date he would otherwise become eligible for participation hereunder shall not be eligible until the day he returns to Active Service.

7. Any Dependant who is in Hospital Confinement on the date he would otherwise become eligible for insurance hereunder shall not be eligible until the date he is no longer in Hospital Confinement.

Section B - Termination

The insurance hereunder of any insured shall automatically cease on the earliest of the following dates:

1. The date on which the Policy is terminated.

2. The date of the expiration of the period for which the last premium payment is made on account of the insured's insurance.

3. The end of the Policy Period during which the insured attains the Maximum Age of Coverage as stated in the Policy Schedule.

4. The date on which the Insured Member resigns, retires or terminates his employment with the Policyholder, or ceases to be covered under the Policy for any other reason.

5. The date communicated to the Policyholder by the Company as the date the Policy ceases on account of war, or an act of war, such date being determined at the discretion of the Company.

6. On the expiry of twelve (12) months from the start of the Insured Member being continuously:
   (a) on temporary leave of absence;
   (b) on vacation without pay; or
   (c) sick or injured (with or without continued uninterrupted absence from work).

7. The date the Dependant ceases to fulfill the conditions that have permitted him to become insured as a Dependant.

PART III - BENEFIT PROVISIONS

Section A - Extent of Benefits

1. The Company will pay the benefits described below for the expenses incurred in connection with the insured's Hospital Confinement or Surgery under this Policy, which had resulted directly from a Sickness or Injury.

   His coverage shall be subject to the benefit limits set forth in the Policy Schedule and all terms and conditions of this Policy.

2. All benefits are applicable without geographical limitation subject only to the limitation and exclusions specified under Sections A and B of Part IV hereof.

Section B - Benefits

1. (a) Daily Room & Board

This benefit shall be paid when, upon recommendation of a Registered Medical Practitioner or Specialist, an insured is registered as a bed patient in a Hospital and incurs a Room and Board charge.

(b) Intensive Care Unit

This benefit shall be paid when, upon recommendation of a Registered Practitioner or Specialist, an insured is registered as a bed patient in a Hospital and incurs charges in connection with an Intensive Care Unit (ICU), Intermediate Care Area (ICA) and High Dependency Ward (HDW) in the Hospital.

2. Other Hospital Services

This benefit shall be paid when an insured incurs charges for the following supplies and services rendered during such Hospital Confinement which are customarily supplied by the Hospital.

- *Administration of Blood Plasma, but not the cost of Blood or Blood Plasma;*
- *Ambulance Services to and / or from the Hospital not to exceed for any trip the rate of the Daily Room & Board benefit;*
- *Anesthesia and Oxygen and their administration including anesthetist's fee;*
- *Basal Metabolism Tests;*
- *Dressings Ordinary Splints and Plaster Casts;*
- *Drugs and Medicine consumed on premises;*
- *Electrocardiograms;*
- *Intravenous Infusion;*
- *Laboratory Examinations;*
- *Physical Therapy;*
- *Use of Operation Room;*
- *X-ray Examinations;*
- *Implants*

3. Surgical

This benefit shall be paid when an insured incurs charges in connection with an operation performed by one or more Registered Medical Practitioners and/or Specialists, including any assistant surgeons.

Each operation is subject to the amount obtained by multiplying the appropriate percentage shown for that operation in the Surgical Schedule of Fees by the maximum Surgical Benefit shown in the Policy Schedule, except:

(a) for surgical operation charges that fall below the Minor Surgical Benefit Limit as shown in the Policy Schedule; or
(b) if the attending surgeon is an Panel Specialist; or
(c) if the surgery is performed at a Singapore Government Restructured Hospital.

If two or more surgical procedures are performed through a single incision, reimbursement for expenses for all such procedures shall not exceed the amount indicated for the one surgical procedure performed for which the largest amount is payable.

4. In-Hospital Doctor's Consultation

This benefit shall be paid when an insured incurs charges for consultation by Registered Medical Practitioners and/or Specialists while he is hospitalized. For this benefit only one visit per day shall be covered.

5. Emergency Out-Patient Treatment (Accident)

This benefit shall be paid when, as a result of an Accident and within twenty-four (24) hours following such an Accident an insured incurs charges for emergency out-patient treatment in the out-Patient department of a Hospital or at a Registered Medical Practitioner's office and follow-up treatment within thirty-one (31) days thereafter.

6. (a) Pre Hospitalization Specialist Consultation, Diagnostic X-ray and Laboratory Test

This benefit shall be paid when the insured incurs charges for Specialist consultations, diagnostic x-ray and laboratory examinations in the period commencing ninety (90) days before hospitalization or surgery.

(b) Post Hospitalization Specialist Consultation, Diagnostic X-ray and Laboratory Test and TCM consultations

This benefit shall be paid when the insured incurs charges for Specialist consultations, TCM consultations, diagnostic x-ray and laboratory examinations and physiotherapy which are recommended by a Registered Medical Practitioner or Specialist in the period ending ninety (90) days after hospitalization or surgery.

7. Overseas Hospitalization (Accident)

This benefit shall be paid if an insured sustains Injury from an Accident while traveling outside of Singapore and as a result of such Injury incurs hospitalization charges overseas within 180 days of departure from Singapore.

This benefit applies to Insured Members who reside and work in Singapore.

8. Death

This benefit shall be paid to the Policyholder upon receipt of due proof of death of any insured in the form required by the Company.

9. Outpatient Kidney Dialysis/Cancer Treatment

This benefit applies only if the coverage has been applied for by the Policyholder and the Benefit Limit is shown in the Policy Schedule.

This benefit shall be paid, if an Insured Member or his Dependant incurs outpatient expenses (excluding medical or preventive health screening) for the following treatments:

(a) Kidney dialysis including home peritoneal dialysis as recommended by a Registered Medical Practitioner.

(b) Cancer treatment by a Registered Medical Practitioner. "Cancer" shall mean a focal autonomous new growth of tissue that has no useful function and the new growth has the characteristics of marginal invasion, relentless growth or distant spread with a lethal effect. Such cancer must be positively diagnosed by a Registered Medical Practitioner who is also a certified Pathologist, upon the basis of a Microscopic Examination of fixed tissues, or preparations from the Hemic System. Such diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspect tumour, tissue or specimen. Clinical diagnosis does not meet this standard.

10. Rehabilitation

This benefit shall be paid if an insured is recommended by the attending Registered Medical Practitioner and/or Specialist to recuperate in a community/ rehabilitation hospital registered and approved by the Ministry of Health of Singapore.

11. Extended Major Medical Benefit

(a) If the insured suffers from an Injury or Sickness, and incurs in-hospital expenses which are covered under the Benefit Provisions above and for which benefits have been paid up to their maximum amount as stated in the Policy Schedule, the Company shall, under this benefit, reimburse an amount equivalent to ninety per cent (90%) of the expenses which are in excess of the maximum amounts payable under the above in-hospital benefits provided that:

(1) the insured shall have either:

(i) been confined in a Hospital for a period in excess of twenty (20) days; or
(ii) undergone one surgical operation for which at least seventy-five per cent (75%) of the maximum amount for the Surgical Benefit under the Policy Schedule is reimbursable.

AND

(2) reimbursement of any Daily Room and Board Benefit shall be subject to ninety per cent (90%) of the maximum amount for the Daily Room and Board Benefit stated in the Policy Schedule and shall cover only those room and board expenses incurred subsequent to the maximum number of days covered by the Daily Room and Board Benefit under Part III, Section B, items 1(a) & 1(b) of this Policy.

(b) This Extended Major Medical Benefit is not reimbursable if the Injury or Sickness is caused directly or indirectly, wholly or partly, by Acquired Immune Deficiency Syndrome (AIDS) or any Human Immunodeficiency Virus (HIV), unless the insured:

(1) receives a Medically Necessary blood transfusion and as a result of such a transfusion becomes infected with HIV. Proof of the blood transfusion must be made available to the Company and in which the institution providing the transfusion admits liability for the HIV infection; or

(2) the insured becomes infected with HIV while carrying out the normal duties of his usual occupation either as a medical practitioner, nurse, laboratory technician, dental surgeon or nurse, ambulance paramedical worker. Proof of the infection involving a definite source of the HIV infected fluids must be made available to the Company, including a negative HIV antibody test within five (5) days of the Accident and a subsequent test showing sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented Accident.

For the purpose of this Policy, the definition of AIDS shall be that used by the World Health Organisation in 1987, or subsequent revision by the World Health Organisation of that definition. Infection by HIV shall be deemed to have occurred where blood tests indicate in the opinion of the Company either the presence of any Human Immunodeficiency Virus or antibodies to such a virus.

(c) The Extended Major Medical Benefit is subject to the overall maximum benefit limit Per Any One Disability shown in the Policy Schedule.

Section C - Reasonable & Customary Charges

Notwithstanding anything in the Policy to the contrary, no benefit shall be paid for charges specified under Section B which are in excess of the general charges published by or under the authority of the Ministry of Health, Singapore in any prevailing guidelines, recommendations, directives or circulars for such treatment, services or supplies in respect of the Sickness or Injury or similar condition sustained.

PART IV - LIMITATION & EXCLUSIONS & CLAIMS PROCEDURES

Section A - Limitation

When an insured is entitled to benefits payable under the Employee's Compensation legislation, any government or public programme of medical benefits, or other group or individual insurance, the benefits payable under this Policy shall be limited to the balance of expenses not covered by benefits payable under such legislation, programme or other insurance, or that computed in accordance with the Policy Schedule of this Policy, whichever is less.

Section B - Exclusions

No benefit shall be payable under this Policy for any one of the following occurrences:

1. Pre-existing conditions which have existed during the twelve (12) months prior to the commencement of insurance coverage in respect of the insured under this Policy, whether known or unknown to the insured in so far as the cause and pathology of the conditions have already existed, unless the insured has already been covered under this Policy continuously for twelve (12) months.

   For voluntary plan upgrade, pre-existing conditions which have existed during the twelve (12) months prior to the plan upgrade, unless the insured has already been covered under the upgraded plan continuously for twelve (12) months.

2. Investigation and treatment of psychological, emotional, mental and behavioral conditions; alcoholism or drug addiction, intentional self-inflicted injuries while sane or insane; injuries sustained as a result of a criminal act of the insured.

3. Injuries arising from direct participation in a strike, riot, insurrection or war, declared or undeclared.

4. General physical or medical check-up or health screening or tests not incidental to treatment or diagnosis of an actual Sickness or Injury; treatment which is not Medically Necessary or treatment of an optional or preventive nature; immunization, vaccination or inoculation; non-prescribed medication, over-the-counter items such as but not limited to vitamins, supplements, shampoos and moisturizers even if recommended by the attending doctor.

5. Treatment of xanthelasma, skin tags, vitiligo, acne, alopecia, weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition otherwise admissible under the Policy.

6. Investigation for sleep apnea except if the insured subsequently undergoes a surgical procedure as recommended by a Specialist.

7. Procurement and rental of/or use of special braces, any appliances, any equipment or prosthetic devices, wheel-chair, walking aids, hearing aids or the fitting of the same and non-medical services such as government taxes, television, telephone and the like.

8. Any eye examination, treatment, surgical procedure for the correction of eye refraction; procurement of contact lenses and eye glasses, surgical procedure for correction of squint or other eye misalignment for ages 8 years old and above.

9. Cosmetic procedure or plastic surgery except to the extent that such surgery is necessary for the repair or damage caused solely by accidental bodily injuries covered under the Policy.

10. Dental or oral treatment except when payable under the above-mentioned benefit, Emergency Out-Patient Treatment (Accident).

11. Any investigation, treatment or surgical operation for congenital anomalies or complications arising from such congenital anomalies, or physical defects present at and existing from the time of birth regardless of the time of discovery or the time of such treatment or surgical treatment.

12. Treatment relating to birth control; investigation or treatment occasioned by or resulting from pregnancy, childbirth, abortion, except ectopic pregnancy and non-elective miscarriage; all consultations and treatments including surgical procedures required or recommended subsequent to consultations for the purpose of treating subfertility, infertility or at in-vitro fertilization clinics, reproductive assistance clinics or centres, clinics or centres for reproductive medicine and the like.

13. Treatment by Physiotherapist and Traditional Chinese Medical Practitioner; except if the treatment is within ninety (90) days of discharge from the Hospital.

14. Acupuncture, acupressure, bonesetting, herbalist treatment, hypnotism, massage therapy, aroma therapy and other forms of alternative treatments such as but not limited to podiatry, osteopathy and chiropractic treatment.

15. Educational treatments such as speech therapy, diabetic classes and nutritional treatments or group support treatments.

16. Special or private duty nursing care; clinical home care; custodial care in any setting; day care; hospice; respite care.

17. Acquired Immuno-Deficiency Syndrome (AIDS), AIDs related complexes and all illnesses or diseases associated with the Human Immuno-Deficiency Virus (HIV), unless acquired due to Medically Necessary blood transfusions or occupational related infections (where proof of which must be made available to the Company).

18. Any treatment to prevent illness, promote health or improve bodily function or appearance including but not limited to vitamins, supplements, scar creams, soaps, shampoos and moisturizers.

19. The costs and expenses incurred in acquiring an organ for organ transplant or the costs and expenses incurred by the donor of such organ.

20. Hospital Confinement if the treatment, according to the general opinion of Specialists, could have been provided on an outpatient basis.

21. Costs arising out of any litigation or dispute between the insured and any medical person or establishment from whom treatment has been sought or given, or any other costs not directly or specifically related to the payment of the medical expenses covered by the Policy.

Section C - Notice and Proof of Claim

1. Written notice of claim must be given to the Company within ninety (90) days of the date of discharge from the Hospital.

2. Written notice given by or on behalf of the insured to the Company with particulars sufficient to identify the insured shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in the Policy shall not invalidate any claim if it is proven by or on behalf of the claimant that it was not reasonably possible to give such notice within the prescribed period, and that such notice was given as soon as it was reasonably possible to do so.

3. All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Policyholder or the Policyholder's legal representative and shall be in such form and of such nature as the Company may prescribe, within ninety (90) days from the date of discharge from Hospital or date of death.

Section D - Blood Test

The Company reserves the right to require any claimant hereunder to undergo a blood test including a test for HIV as a condition precedent to the liability of the Company to make any payment.

Section E - Currency and Payment of Claim

Payment of all benefits will be made in the currency in which this Policy is effected. Charges incurred in any other currency shall be payable in Singapore Dollars, or currency of the Policy on the basis of the prevailing rate used by the Company on the date the claims were processed.

All benefits that pertain to an insured shall be paid by cheque or bank giro to the order of the Insured Member, unless the Policyholder for reasons acceptable to the Company requests otherwise. Payment of any sum made by the Company as provided by this Section shall be a valid discharge to the Company and shall release the Company of all claims, demand, liabilities and damages, whatsoever in respect thereto.

PART V - GENERAL PROVISIONS

Section A - Premium Payments

The premium is payable to the Company on each premium due date, unless otherwise specified by the Company in writing.

Section B - Grace Period, Termination and Reinstatement of Policy

1. Any premium due must be paid and actually received in full by the Company within the time period stipulated below ('Grace Period'):

   (a) Where the premium is payable on an annual basis, thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the company, whichever is later, or

   (b) Where premium is payable other than on an annual basis,
   (i) Thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is later, for the first premium of each Policy Period; and
   (ii) on the agreed premium due dates for subsequent premiums.

2. In the event that any premium is not paid to the Company within the Grace Period or the agreed premium payment date, the Company reserves the right to terminate this Policy from the respective Premium Due Date as specified in the Policy Schedule and the Company shall be discharged from all liabilities therefrom.

3. Where the Policyholder has confirmed its intention to renew this Policy but has not provided the Company with the complete data necessary for the renewal of the Policy on or before the Policy Anniversary Date, the Company shall issue a premium tax invoice for the estimated renewal premium. The payment of the estimated premium under the premium tax invoice shall be paid within the Grace Period, failing which the Policy may be terminated by the Company.

4. No benefits for any covered event occurring after the Policy Effective Date or Policy Anniversary Date shall be paid until premiums due on the respective Premium Due Date are received in full by the Company.

5. The Company reserves the right to terminate this Policy on any Premium Due Date when fewer than the total number of Members then eligible for insurance are insured hereunder, if the insurance plan is non-contributory; or less than seventy-five (75) percent of the total number of Members then eligible are insured hereunder, if the insurance plan is contributory; or if the total number of insured is less than five (5).

6. This Policy may be terminated as at any Premium Due Date by either the Policyholder or the Company by mailing written notice of termination on the other party, not later than thirty-one (31) days before the Premium Due Date on which such termination shall be effective. Termination shall be without prejudice to any claim arising prior to the effective date of termination.

7. After termination of the Policy, the Policyholder may apply for reinstatement which shall be subject to the consent of the Company and to the terms and conditions which the Company may impose including the payment of any premium due and not paid together with the interest at a rate to be decided upon by the Company.

Section C - Renewal Privilege

This Policy is issued for the term of one (1) year and at the end of each Policy Period, may be renewed on such terms as the Policyholder and Company may agree to. The Company reserves the right not to invite the Policyholder to renew this Policy should there be any due and unpaid premiums.

Section D - Premium Rate

1. The Company shall have the right to change the rate at which the premiums are payable, such change to be effective on a Policy Anniversary Date, provided that the Company notifies the Policyholder at least thirty-one (31) days in advance of such Premium Due Date of such change.

2. Premium adjustments involving return of unearned premiums to the Policyholder shall be limited to the period starting with the latest Policy Anniversary preceding the date of receipt by the Company of evidence that such adjustments should be made.

Section E - The Contract

1. All statements in writing relating to material facts made by the Policyholder, or by the insured, whether contained in this Policy or the documents referred to in Section G of this Part V, shall in the absence of fraud be deemed representations and not warranties.

2. The rights of the Policyholder or of any insured or of any beneficiary under the Policy shall not be affected by any provision other than those contained in this Policy or in the copy of the Policyholder's application attached hereto, or in the individual enrolment form of an insured, or in any other document which constitutes part of the entire contract.

3. No agent or third party is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this Policy shall be valid unless approved by the Company and evidenced by the endorsement thereon, or by amendment hereto signed by the Policyholder and by the Company.

4. Any reference in this Policy to an insured in respect of his rights, obligations, benefits or entitlement under this Policy shall be construed to include the Policyholder through whom the insured has acquired such rights, obligations, benefits or entitlement, as the context may require.

Section F - Data Required

1. The Policyholder shall maintain a record with respect to each insured under this Policy, showing the Member’s name, sex, age or date of birth, amount of insurance, the date insurance becomes effective, the date insurance is terminated, changes, with dates noted and other pertinent information as may be necessary to carry out the terms of this Policy.

2. Clerical errors in keeping the records shall not invalidate insurance otherwise in force nor reinstate insurance otherwise validly terminated, but upon the discovery of such error, an equitable adjustment shall be made.

3. The Policyholder shall furnish the Company with all information and proof which the Company may reasonably require with regard to any matters pertaining to the Policy. All document furnished to the Policyholder by any Member in connection with the insurance, and other records as may have a bearing on the insurance under this Policy, shall be opened for inspection by the Company at all reasonable times.

Section G - Full Disclosure

All material facts and circumstances relating to any insurance coverage to be effected under this Policy in respect of any insured, shall, up to the date coverage is provided to that insured by the Company, be fully disclosed to the Company by the Policyholder or insured. Any non-disclosure, misrepresentation or fraud shall entitle the Company to avoid all liabilities existing under this Policy in respect of that insured.

Without prejudice to the generality of the above provisions and the provisions in Section H of this Part V relating to an insured, the Company will rely on the information and statements provided by the Policyholder in the Group Insurance Fact-Finding Form or the equivalent of such document, the application form and all other documents required by the Company to be completed and executed by the Policyholder for the purpose of needs analysis or as part of the sales process relating to the Policy. The Policyholder acknowledges that all statements and information provided in such documents must be complete, true and accurate. If any statement or information in such documents is incomplete, untrue or inaccurate, the Company may deny a claim under the Policy, declare the Policy void, or vary the terms and conditions of the Policy.

If any claim has been admitted and benefits paid before the Company became aware of a statement or information being incomplete, untrue or inaccurate, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section H - Misstatement

1. If the age or date of birth or other relevant facts relating to an insured shall be found to have been misstated and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of this Policy, the true age and facts shall be used in determining whether insurance is in force under the terms of this Policy and the benefits payable therefrom, and an equitable adjustment of premiums shall be made.

2. Where a misstatement of age or other relevant facts have caused an individual to be insured hereunder where he is otherwise ineligible for any insurance, or where such statement has caused an individual to remain insured when he would otherwise be disqualified in accordance with the terms and limitations of this Policy, the Company may in its absolute discretion declare the insurance to be void, annul such insurance and there shall be a return of premiums paid in respect of the individual, provided always that where there is fraud on the part of the Policyholder or insured, no premiums paid will be returned. If any claim has been admitted and benefits paid before the Company was made aware of the misstatement, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section I - Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and may be enforced in accordance with the law of the Place of Issue.

Section J - Legal Proceedings

No action in law or in equity shall be brought to recover on this Policy prior to the expiration of ninety (90) days after proof of claim has been filed in accordance with the requirements of this Policy, nor shall such action be brought at all unless brought within two years from the expiration of time within which such proof of claim is required by the Policy.

Section K - Incontestability

Notwithstanding anything to the contrary stated heretofore in this Policy, the validity of the Policy shall be incontestable, except for non-payment of premiums or for fraud, after it has been in force for one year from its Date of Issue or date of any reinstatement whichever is later. The insurance of any insured and any subsequent additional insurance shall be incontestable except for non-payment of premium or for fraud, after such insured's insurance has been in force during his lifetime for one year from his Entry Date and the date of each subsequent increase of insurance respectively.

Section L - Policy Non-Participating

This Policy shall not participate in any surplus distribution by the Company.

Section M - Limitation of Coverage

This Policy shall not cover or provide for the payment of claims or benefits to specific persons or entities as a result of any of the following:
The application of or compliance with certain laws and regulations which prohibit performance based on the identity, domicile, place of incorporation or nationality of the Policyholder, insured, claimant, insurer, or the parent company and ultimate controlling entity of the Policyholder, insured, claimant or insurer, or the country where the claim arises.

Should any person or entity be found to have been erroneously enrolled under this Policy, insurance coverage for such person or entity shall cease with immediate effect and any unearned premiums paid in respect of such person or entity shall be refunded by the Company to the Policyholder.

Should any claim for payment of any nature be found to have been made under this Policy by a person or entity excluded by this provision, no such payment will be made.

Section N - Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC).

Section O – Contracts (Rights of Third Parties) Act, Chapter 53B

Save and except where contrary to Singapore law governing any of the benefits granted under this Policy, or where expressly provided otherwise, a person who is not a party to this Policy has no right under the Contracts (Rights of Third Parties) Act, Chapter 53B, Singapore, to enforce any term of this Policy.

Notwithstanding anything in this Policy, the consent of any third party (including a Member) is not required for any variation (including any release or compromise of any liability) or termination of this Policy.

Section P - Personal Data

The Policyholder represents and warrants that it has obtained the consent of all individual Members and Dependants (as the case may be), except to the extent such consent is not required under relevant laws, for the Company, its associated persons and organisations, agents, brokers and other intermediaries, business partners, third party service providers and representatives, whether within or outside Singapore (collectively "AIA Persons") to collect, use, store, retain and/or process (collectively "Use") all personal data and information ("Personal Data") provided to AIA Persons or which AIA Persons possess about the Members, in the manner and for the purposes described in the AIA Personal Data Policy ("PD Policy") as may be amended from time to time, and which is available on the Company's website. The Policyholder shall indemnify AIA Persons from and against all claims, actions, losses, penalties, damages, costs and expenses arising from its breach of the provisions of this Section P. AIA Persons shall have the right to enforce any benefit under this Section P under the Contracts (Rights of Third Parties) Act, Chapter 53B.

Section Q – Subcontractors and Delegates

Notwithstanding any other agreement to the contrary, the Company may in its sole and absolute discretion subcontract or delegate any of its services in the administration of the Policy or the performance of its other obligations under this Policy to a third party appointed by the Company at its own cost and expense, subject that the Company will remain responsible and liable to the Policyholder for the work and activities of each subcontractor or delegated person for the Company's obligations under this Policy.

SURGICAL SCHEDULE OF FEES

Surgical Code Table	Surgical Percentage
1A	5%
1B	10%
1C	15%
2A	20%
2B	25%
2C	30%
3A	40%
3B	45%
3C	50%
4A	55%
4B	60%
4C	65%
5A	70%
5B	75%
5C	80%
6A	85%
6B	90%
6C	95%
7A	100%
7B	100%
7C	100%

Note: Detailed surgical procedures under each category shown above shall be based on the prevailing "Table of Surgical Procedures" under the Medisave Scheme operated by the Ministry of Health of Singapore, which may be amended from time to time. Any amendments to the above Surgical Codes or Surgical Percentage under the Medisave Scheme operated by the Ministry of Health of Singapore shall automatically apply to the above table.

Clinical Outpatient

- PROVISIONS -

- SCHEDULES -

PART I - DEFINITIONS

In this Policy where consistent with the contents the singular shall include the plural and the plural the singular; words importing the masculine gender shall include the feminine gender; and each of the following words and expressions shall have the following meanings:

1. "**Accident**" shall mean an unforeseen event, which is caused solely and directly by external, violent, sudden and accidental means.

2. "**Active Service**" shall mean for an employee reporting to work at the place assigned by the Policyholder and performing, in a customary manner, all regular duties of his employment with the Policyholder, and includes such employee on entitled annual leave for reasons other than on medical grounds.

3. "**Company**" shall mean AIA Singapore Private Limited.

4. "**Dependant**" shall mean:
   (a) the spouse of an Insured Member of this Policy, provided such spouse is below the Maximum Age of Coverage as stated in the Policy Schedule and is not already insured under the Policy; or
   (b) each child of an Insured Member, provided such child is at least 2 weeks old and is below the Maximum Age of Coverage as stated in the Policy Schedule, unmarried and unemployed.

5. "**Employee's Compensation Legislation**" shall mean the Work Injury Compensation Act, Chapter 354, Singapore, as may be amended or re-enacted, or equivalent legislation.

6. "**Entry Date**" shall mean the date an individual becomes an Insured Member under this Policy.

7. "**Hospital**" shall refer exclusively to an institution duly licensed as such and operated pursuant to law for the care and treatment of sick and injured persons as registered bed patients, with facilities for diagnosis and major surgery, which is under the supervision of one or more Registered Medical Practitioners, and which has 24 hours a day professional nursing service. "Hospital" does not include any institution or that portion of any institution which is operated as a convalescent or nursing home, rest home, home for the aged, a place for alcoholics or drug addicts, or for any similar purpose.

8. "**Hospital Confinement**" shall mean confinement in a Hospital:
   (a) for no minimum duration as long as the Hospital makes a charge for room and board; or
   (b) for any duration for the purpose of surgery and any preparations and procedures in connection therewith without incurring room and board charges.

9. "**Injury**" shall mean bodily injury which is caused solely and directly by Accident.

10. "**Insured Members**" shall mean Members who, having completed the required Waiting Period and are not otherwise disqualified from coverage under the terms of this Policy, are participating in the insurance plan under this Policy.

11. "**Maximum Age of Coverage**" shall mean the maximum age of coverage so defined in the Policy Schedule attached hereto.

12. "**Medically Necessary**" shall mean a medical treatment, services and/or supply provided by a Registered Medical Practitioner and/or Specialist covered under this Policy which are:
    (a) consistent with the diagnosis and customary medical treatment, service and/or supply for Sickness or Injury;
    (b) in accordance with standards of good medical practice; consistent with the current standard of professional medical care and with proven medical benefits;
    (c) not for the convenience of the insured, Registered Medical Practitioner or the Specialist, and unable to be reasonably rendered out of Hospital (if admitted for confinement); and
    (d) not of an experimental, investigational or research nature, preventing or screening nature.

13. "**Members**" shall mean the persons so defined in the Policy Schedule attached hereto.

14. "**Panel General Practitioner**" shall mean a Registered Medical Practitioner who has been appointed by the Company.

15. "**Panel Traditional Chinese Medicine (TCM) Practitioner**" shall mean a Registered TCM Practitioner who has been appointed by the Company.

16. "**Policy**" shall mean this agreement, the attached Policy Schedule, any riders or endorsements therein, any amendments thereto signed by the Company, therein the application attached hereto to the Policyholder, and the individual enrolment forms, if any, of the insured, which together constitute the entire contract between the parties.

17. "**Policy Anniversary Date**" shall mean the anniversary of the Policy Effective Date or such other date as may be agreed in writing between the Policyholder and the Company.

18. "**Policy Effective Date**" shall mean the date from which the coverage under this Policy becomes effective.

19. "**Policy Period**" shall mean a period of one year or such other periods as may be agreed in writing between the Company and the Policyholder, starting with the Policy Effective Date and the subsequent Policy Anniversary Dates.

20. "**Registered Medical Practitioner**" shall mean only a person qualified by a degree in western medicine and legally authorized in the geographical area of his practice to render medical or surgical services, and who is not: (i) the insured, or (ii) a member of his immediate family, or (iii) other relative of the insured.

21. "**Sickness**" shall mean a physical condition marked by a pathological deviation from the normal healthy state.

22. "**Specialist**" shall mean a Registered Medical Practitioner who specializes in a specific area in a medical field, and who is not: (i) the insured, or (ii) a member of his immediate family, or (iii) other relative of the insured.

23. "**Traditional Chinese Medicine (TCM) Practitioner**" shall mean a person who is qualified to provide a prescribed practice of TCM and is registered and issued with a license to practice the TCM by the TCM Practitioners Board of Singapore, and who is other than the insured, a member of his immediate family or other relative.

24. "**Singapore Government Restructured Hospital**" shall mean the privatized Singapore Government Hospital.

25. "**Waiting Period**" shall mean the period so defined in the Policy Schedule attached hereto.

PART II - PARTICIPATION AND TERMINATION

Section A - Participation

1. The Policyholder shall declare to the Company full particulars of Members and Dependants (as may be the case) prior to the Policy Effective Date and within ninety (90) days of the Entry Date for each new Member and of the date the Dependant becomes eligible to participate in the insurance plan.

2. Members and Dependants already eligible on the Policy Effective Date shall be eligible for participation on the Policy Effective Date.

3. Members and Dependants not eligible as of the Policy Effective Date and new Members and Dependants shall become eligible for participation hereunder on the day following the Member's completion of the required Waiting Period as specified in the Policy Schedule.

4. An Individual who becomes a Dependant after the Policy Effective Date shall become eligible to participate in the insurance plan on the date such person becomes a Dependant.

5. Members whose participation has been terminated and who re-apply for participation shall be considered as new Members.

6. Any Member who is not in Active Service on the date he would otherwise become eligible for participation

hereunder shall not be eligible until the day he returns to Active Service.

7. Any Dependant who is in Hospital Confinement on the date he would otherwise become eligible for insurance hereunder shall not be eligible until the date he is no longer in Hospital Confinement.

Section B - Termination

The insurance hereunder of any insured shall automatically cease on the earliest of the following dates:

1. The date on which the Policy is terminated.

2. The date of the expiration of the period for which the last premium payment is made on account of the insured's insurance.

3. The end of the Policy Period during which the insured attains the Maximum Age of Coverage as stated in the Policy Schedule.

4. The date on which the Insured Member resigns, retires or terminates his employment with the Policyholder, or ceases to be covered under the Policy for any other reason.

5. The date communicated to the Policyholder by the Company as the date the Policy ceases on account of war, or an act of war, such date being determined at the discretion of the Company.

6. On the expiry of twelve (12) months from the start of the Insured Member being continuously:
   (a) on temporary leave of absence;
   (b) on vacation without pay; or
   (c) sick or injured (with or without continued uninterrupted absence from work).

7. The date the Dependant ceases to fulfill the conditions that have permitted him to become insured as a Dependant.

PART III - BENEFIT PROVISIONS

Section A – Extent of Benefits

The Company will pay the benefits described below for the expenses incurred at outpatient clinics as a result of Sickness or Injury while insured under this Policy.

His coverage shall be subject to the limits set forth in the Policy Schedule and all terms and conditions of this Policy.

1. **Outpatient treatment at Panel General Practitioner clinics, Panel TCM Practitioner clinics & Government Polyclinics**

   If an insured shall receive care and treatment included in the Schedule of Covered Benefits attached hereto from a Panel General Practitioner at his clinic, Panel TCM Practitioner at his clinic or from a Government Polyclinic, the Company shall:

   (a) pay the expenses incurred at Panel GP clinics or Panel TCM clinics directly to the Panel clinics; or
   (b) reimburse the Insured Member for expenses incurred at Government Polyclinics.

2. **Outpatient treatment by non-Panel General Practitioners (Local & Overseas)**

   If an insured shall incur expenses for care and treatment performed by non-Panel Registered Medical Practitioners (local or overseas) and if such services are included in the Schedule of Covered Benefits attached hereto, the Company shall reimburse the Insured Member for such expenses.

3. **Emergency Outpatient Treatment**

   If an insured shall require outpatient treatment at the Accident & Emergency Department of a Hospital and if such services are included in the Schedule of Covered Benefits attached hereto, the Company shall reimburse the Insured Member for such expenses.

PART IV - LIMITATION & EXCLUSIONS & CLAIMS PROCEDURES

Section A - Limitation

When an insured is entitled to benefits payable under the Employee's Compensation Legislation, any government or public programme of medical benefits, or other group or individual insurance, the benefits payable under this Policy shall be limited to the balance of expenses not covered by benefits payable under such legislation, programme or other insurance, or that computed in accordance with the Policy Schedule of this Policy, whichever is less.

Section B - Exclusions

No benefit shall be payable under this Policy for any one of the following occurrences:

1. General physical or medical check-up or health screening or tests not incidental to treatment or diagnosis of an actual Sickness or Injury; treatment which is not Medically Necessary or treatment of an optional or preventive nature; immunization, vaccination or inoculation; non-prescribed medication, over-the-counter items such as but not limited to vitamins, supplements, shampoos and moisturizers even if recommended by the attending doctor.

2. Care and treatment performed by a Specialist.

3. Specialised investigations such as but not limited to MRI, CT Scan, Barium Test.

4. Any expenses incurred in relation to any type of therapy including but not limited to physiotherapy or dialysis.

5. Investigation and treatment of psychological, emotional, mental and behavioral conditions; alcoholism or drug addiction, intentional self-inflicted injuries while sane or insane; injuries sustained as a result of a criminal act.

6. Treatment relating to birth control; investigation or treatment occasioned by or resulting from pregnancy, infertility, childbirth, abortion, except ectopic pregnancy and non-elective miscarriage.

7. Treatment of xanthelasma, skin tags, vitiligo, acne, alopecia, weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition otherwise admissible under the Policy.

8. Cosmetic procedure or plastic surgery except to the extent that such surgery is necessary for the repair or damage caused solely by accidental bodily injuries covered under the Policy.

9. Any investigation or treatment for congenital anomalies or complications arising from such congenital anomalies, or physical defects present at and existing from the time of birth regardless of the time of discovery or the time of such treatment or surgical treatment.

10. Acquired Immuno-Deficiency Syndrome (AIDS), AIDs related complexes and all illnesses or diseases associated with the Human Immuno-Deficiency Virus (HIV), unless acquired due to Medically Necessary blood transfusions or occupational related infections (where proof of which must be made available to the Company.

11. Any eye examination or treatment for the correction of eye refraction; procurement of contact lenses and eye glasses. Procurement and rental of/or use of special braces, any appliances, any equipment or prosthetic devices, wheel-chair, walking aids, hearing aids or the fitting of the same.

12. Any expenses, including investigations, incurred in relation to Sickness and Injury during or in the course of employment which constitutes a valid claim under the Employee's Compensation Legislation.

13. Any surcharge incurred due to visits outside the normal operating hours of the clinic.

14. Drugs purchased without a doctor's prescription.

Section C - Notice and Proof of Claim

Claims must be submitted to the Company within ninety (90) days of date incurred.

Original copies of receipts and itemized bills, together with a fully completed claim form supplied by the Company must be furnished by the Policyholder to the Company within ninety (90) days after the termination of the period for which the claim is made, or as soon thereafter as may be consistent with the Policyholder's internal administrative procedures.

Section D – Currency and Payment of Claim

Payment of all benefits will be made in the currency in which this Policy is effected. Charges incurred in any other currency shall be payable in Singapore Dollars, or currency of the Policy on the basis of the prevailing rate used by the Company on the date the claims were processed.

All benefits that pertain to an insured shall be paid by cheque or bank giro to the order of the Insured Member, unless the Policyholder for reasons acceptable to the Company requests otherwise. Payment of any sum made by the Company as provided by this Section shall be a valid discharge to the Company and shall release the Company of all claims, demand, liabilities and damages, whatsoever in respect thereto.

Section E - Individual Membership Card

1. The Company shall issue to the Policyholder, for delivery to each insured, an individual membership card certifying that such insured has become insured under this Contract.

2. The insured is required to present the individual membership card and identity card at Panel General Practitioner Clinics and Panel TCM Practitioner Clinics at the point of registration.

3. A penalty of ten (10) dollars shall be payable to the Company by the Policyholder for the replacement of each individual membership card.

Section F – Cashless Facility

The Company agrees to provide a cashless facility whereby the insured does not have to make payment for care and treatment stated in the Schedule of Covered Benefits at AIA panel General Practitioner Clinics, and the following terms shall form the basis for the above mentioned facility:

1. The Policyholder undertakes to reimburse the Company for any amounts not payable or not covered under the Policy. Such sums should be settled within fourteen (14) days of the date of the notification from the Company.

2. The aforementioned cashless facility will be suspended if the Policyholder fails to settle with the Company within the time specified. The Policyholder will still be liable to the Company for outstanding sums in arrears including any interest charged by the clinic even though the cashless facility is suspended or terminated.

3. In the event that the Policyholder fails to settle the outstanding sums within the time specified, the Company reserves the right to terminate the Policy and use the unused premium to settle the outstanding sums.

4. The Company reserves the right to terminate the cashless facility by giving one month notice in advance to the Policyholder.

PART V - GENERAL PROVISIONS

Section A - Premium Payments

The premium is payable to the Company on each premium due date, unless otherwise specified by the Company in writing.

Section B - Grace Period, Termination and Reinstatement of Policy

1. Any premium due must be paid and actually received in full by the Company within the time period stipulated below ("Grace Period"):
   (a) Where the premium is payable on an annual basis, thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the company, whichever is later, or

   (b) Where premium is payable other than on an annual basis,
      (i) Thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is later, for the first premium of each Policy Period; and
      (ii) on the agreed premium due dates for subsequent premiums.

2. In the event that any premium is not paid to the Company within the Grace Period or the agreed premium payment date, the Company reserves the right to terminate this Policy from the respective Premium Due Date as specified in the Policy Schedule and the Company shall be discharged from all liabilities therefrom.

3. Where the Policyholder has confirmed its intention to renew this Policy but has not provided the Company with the complete data necessary for the renewal of the Policy on or before the Policy Anniversary Date, the Company shall issue a premium tax invoice for the estimated renewal premium. The payment of the estimated premium under the premium tax invoice shall be paid within the Grace Period, failing which the Policy may be terminated by the Company.

4. No benefits for any covered event occurring after the Policy Effective Date or Policy Anniversary Date shall be paid until premiums due on the respective Premium Due Date are received in full by the Company.

5. The Company reserves the right to terminate this Policy on any Premium Due Date when fewer than the total number of Members then eligible for insurance are insured hereunder, if the insurance plan is non-contributory; or less than seventy-five (75) percent of the total number of Members then eligible are insured hereunder, if the insurance plan is contributory; or if the total number of insured is less than five (5).

6. This Policy may be terminated as at any Premium Due Date by either the Policyholder or the Company by mailing a written notice of termination on the other party, not later than thirty-one (31) days before the Premium Due Date on which such termination shall be effective. Termination shall be without prejudice to any claim arising prior to the effective date of termination.

7. After termination of the Policy, the Policyholder may apply for reinstatement which shall be subject to the consent of the Company and to the terms and conditions which the Company may impose including the payment of any premium due and not paid together with the interest at a rate to be decided upon by the Company.

Section C - Renewal Privilege

This Policy is issued for the term of one (1) year and at the end of each Policy Period, may be renewed on such terms as the Policyholder and Company may agree to. The Company reserves the right not to invite the Policyholder to renew this Policy should there be any due and unpaid premiums.

Section D - Premium Rate

1. The Company shall have the right to change the rate at which the premiums are payable, such change to be effective on a Policy Anniversary Date, provided that the Company notifies the Policyholder at least thirty-one (31) days in advance of such Premium Due Date of such change.

2. Premium adjustments involving return of unearned premiums to the Policyholder shall be limited to the period starting with the latest Policy Anniversary preceding the date of receipt by the Company of evidence that such adjustments should be made.

Section E - The Contract

1. All statements in writing relating to material facts made by the Policyholder, or by the insured, whether contained in this Policy or the documents referred to in Section G of this Part V, shall in the absence of fraud be deemed representations and not warranties.

2. The rights of the Policyholder or of any insured or of any beneficiary under the Policy shall not be affected by any provision other than those contained in this Policy or in the copy of the Policyholder's application attached hereto, or in the individual enrolment form of an insured, or in any other document which constitutes part of the entire contract.

3. No agent or third party is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this Policy shall be valid unless approved by the Company and evidenced by the endorsement thereon, or by amendment hereto signed by the Policyholder and by the Company.

4. Any reference in this Policy to an insured in respect of his rights, obligations, benefits or entitlement under this Policy shall be construed to include the Policyholder through whom the insured has acquired such rights, obligations, benefits or entitlement, as the context may require.

Section F - Data Required

1. The Policyholder shall maintain a record with respect to each insured under this Policy, showing the Member's name, sex, age or date of birth, amount of insurance, the date insurance becomes effective, the date insurance is terminated, changes, with dates noted and other pertinent information as may be necessary to carry out the terms of this Policy.

2. Clerical errors in keeping the records shall not invalidate insurance otherwise in force nor reinstate insurance otherwise validly terminated, but upon the discovery of such error, an equitable adjustment shall be made.

3. The Policyholder shall furnish the Company with all information and proof which the Company may reasonably require with regard to any matters pertaining to the Policy. All documents furnished to the Policyholder by any Member in connection with the insurance, and other records as may have a bearing on the insurance under this Policy, shall be opened for inspection by the Company at all reasonable times.

Section G - Full Disclosure

All material facts and circumstances relating to any insurance coverage to be effected under this Policy in respect of any insured, shall, up to the date coverage is provided to that insured by the Company, be fully disclosed to the Company by the Policyholder or insured. Any non-disclosure, misrepresentation or fraud shall entitle the Company to avoid all liabilities existing under this Policy in respect of that insured.

Without prejudice to the generality of the above provisions and the provisions in Section H of this Part V relating to an insured, the Company will rely on the information and statements provided by the Policyholder in the Group Insurance Fact-Finding Form or the equivalent of such document, the application form and all other documents required by the Company to be completed and executed by the Policyholder for the purpose of needs analysis or as part of the sales process relating to the Policy. The Policyholder acknowledges that all statements and information provided in such documents must be complete, true and accurate. If any statement or information in such documents is incomplete, untrue or inaccurate, the Company may deny a claim under the Policy, declare the Policy void, or vary the terms and conditions of the Policy.

If any claim has been admitted and benefits paid before the Company became aware of a statement or information being incomplete, untrue or inaccurate, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section H - Misstatement

1. If the age or date of birth or other relevant facts relating to an insured shall be found to have been misstated and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of this Policy, the true age and facts shall be used in determining whether insurance is in force under the terms of this Policy and the benefits payable therefrom, and an equitable adjustment of premiums shall be made.

2. Where a misstatement of age or other relevant facts have caused an individual to be insured hereunder where he is otherwise ineligible for any insurance, or where such statement has caused an individual to remain insured when he would otherwise be disqualified in accordance with the terms and limitations of this Policy, the Company may in its absolute discretion declare the insurance to be void, annul such insurance and there shall be a return of premiums paid in respect of the individual, provided always that where there is fraud on the part of the Policyholder or insured, no premiums paid will be returned. If any claim has been admitted and benefits paid before the Company was made aware of the misstatement, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section I - Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and may be enforced in accordance with the law of the Place of Issue.

Section J - Legal Proceedings

No action in law or in equity shall be brought to recover on this Policy prior to the expiration of ninety (90) days after proof of claim has been filed in accordance with the requirements of this Policy, nor shall such action be brought at all unless brought within two years from the expiration of time within which such proof of claim is required by the Policy.

Section K - Incontestability

Notwithstanding anything to the contrary stated heretofore in this Policy, the validity of the Policy shall be incontestable, except for non-payment of premiums or for fraud, after it has been in force for one year from its Date of Issue or date of any reinstatement whichever is later. The insurance of any insured and any subsequent additional insurance shall be incontestable except for non-payment of premium or for fraud, after such insured's insurance has been in force during his lifetime for one year from his Entry Date and the date of each subsequent increase of insurance respectively.

Section L - Policy Non-Participating

This Policy shall not participate in any surplus distribution by the Company.

Section M - Limitation of Coverage

This Policy shall not cover or provide for the payment of claims or benefits to specific persons or entities as a result of any of the following:

The application of or compliance with certain laws and regulations which prohibit performance based on the identity, domicile, place of incorporation or nationality of the Policyholder, insured, claimant, insurer, or the parent company and ultimate controlling entity of the Policyholder, insured, claimant or insurer, or the country where the claim arises.

Should any person or entity be found to have been erroneously enrolled under this Policy, insurance coverage for such person or entity shall cease with immediate effect and any unearned premiums paid in respect of such person or entity shall be refunded by the Company to the Policyholder.

Should any claim for payment of any nature be found to have been made under this Policy by a person or entity excluded by this provision, no such payment will be made.

Section N - Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC).

Section O – Contracts (Rights of Third Parties) Act, Chapter 53B

Save and except where contrary to Singapore law governing any of the benefits granted under this Policy, or where expressly provided otherwise, a person who is not a party to this Policy has no right under the Contracts (Rights of Third Parties) Act, Chapter 53B, Singapore, to enforce any term of this Policy.

Notwithstanding anything in this Policy, the consent of any third party (including a Member) is not required for any variation (including any release or compromise of any liability) or termination of this Policy.

Section P - Personal Data

The Policyholder represents and warrants that it has obtained the consent of all individual Members and Dependants (as the case may be), except to the extent such consent is not required under relevant laws, for the Company, its associated persons and organisations, agents, brokers and other intermediaries, business partners, third party service providers and representatives, whether within or outside Singapore (collectively "AIA Persons") to collect, use, store, retain and/or process (collectively "Use") all personal data and information ("Personal Data") provided to AIA Persons or which AIA Persons possess about the Members, in the manner and for the purposes described in the AIA Personal Data Policy ("PD Policy") as may be amended from time to time, and which is available on the Company's website. The Policyholder shall indemnify AIA Persons from and against all claims, actions, losses, penalties, damages, costs and expenses arising from its breach of the provisions of this Section P. AIA Persons shall have the right to enforce any benefit under this Section P under the Contracts (Rights of Third Parties) Act, Chapter 53B.

Section Q – Subcontractors and Delegates

Notwithstanding any other agreement to the contrary, the Company may in its sole and absolute discretion subcontract or delegate any of its services in the administration of the Policy or the performance of its other obligations under this Policy to a third party appointed by the Company at its own cost and expense, subject that the Company will remain responsible and liable to the Policyholder for the work and activities of each subcontractor or delegated person for the Company's obligations under this Policy.

Specialist Outpatient

- PROVISIONS -

- SCHEDULES -

PART I - DEFINITIONS

In this Policy where consistent with the contents the singular shall include the plural and the plural the singular; words importing the masculine gender shall include the feminine gender; and each of the following words and expressions shall have the following meanings:

1. "**Accident**" shall mean an unforeseen event, which is caused solely and directly by external, violent, sudden and accidental means.

2. "**Active Service**" shall mean for an employee reporting to work at the place assigned by the Policyholder and performing, in a customary manner, all regular duties of his employment with the Policyholder, and includes such employee on entitled annual leave for reasons other than on medical grounds.

3. "**Company**" shall mean AIA Singapore Private Limited.

4. "**Dependant**" shall mean:
   (a) the spouse of an Insured Member of this Policy, provided such spouse is below the Maximum Age of Coverage as stated in the Policy Schedule and is not already insured under the Policy; or
   (b) each child of an Insured Member, provided such child is at least 2 weeks old and is below the Maximum Age of Coverage as stated in the Policy Schedule, unmarried and unemployed.

5. "**Employee's Compensation Legislation**" shall mean the Work Injury Compensation Act, Chapter 354, Singapore, as may be amended or re-enacted, or equivalent legislation.

6. "**Entry Date**" shall mean the date an individual becomes an Insured Member under this Policy.

7. "**Hospital**" shall refer exclusively to an institution duly licensed as such and operated pursuant to law for the care and treatment of sick and injured persons as registered bed patients, with facilities for diagnosis and major surgery, which is under the supervision of one or more Registered Medical Practitioners, and which has 24 hours a day professional nursing service. "Hospital" does not include any institution or that portion of any institution which is operated as a convalescent or nursing home, rest home, home for the aged, a place for alcoholics or drug addicts, or for any similar purpose.

8. "**Hospital Confinement**" shall mean confinement in a Hospital:
   (a) for no minimum duration as long as the Hospital makes a charge for room and board; or
   (b) for any duration for the purpose of surgery and any preparations and procedures in connection therewith without incurring room and board charges.

9. "**Injury**" shall mean bodily injury which is caused solely and directly by Accident.

10. "**Insured Members**" shall mean Members who, having completed the required Waiting Period and are not otherwise disqualified from coverage under the terms of this Policy, are participating in the insurance plan under this Policy.

11. "**Maximum Age of Coverage**" shall mean the maximum age of coverage so defined in the Policy Schedule attached hereto.

12. "**Medically Necessary**" shall mean a medical treatment, services and/or supply provided by a Registered Medical Practitioner and/or Specialist covered under this Policy which are:
    (a) consistent with the diagnosis and customary medical treatment, service and/or supply for Sickness or Injury;
    (b) in accordance with standards of good medical practice; consistent with the current standard of professional medical care and with proven medical benefits;
    (c) not for the convenience of the insured, Registered Medical Practitioner or the Specialist, and unable to be reasonably rendered out of Hospital (if admitted for confinement); and
    (d) not of an experimental, investigational or research nature, preventing or screening nature.

13. "**Members**" shall mean the persons so defined in the Policy Schedule attached hereto.

14. "**Panel General Practitioner**" shall mean a Registered General Practitioner who has been appointed by the Company.

15. "**Panel Specialist**" shall mean a Specialist who has been appointed by the Company.

16. "**Panel Traditional Chinese Medicine (TCM) Practitioner**" shall mean a Registered TCM Practitioner who has been appointed by the Company.

17. "**Policy**" shall mean this agreement, the attached Policy Schedule, any riders or endorsements therein, any amendments thereto signed by the Company, therein the application attached hereto to the Policyholder, and the individual enrolment forms, if any, of the insured, which together constitute the entire contract between the parties.

18. "**Policy Anniversary Date**" shall mean the anniversary of the Policy Effective Date or such other date as may be agreed in writing between the Policyholder and the Company.

19. "**Policy Effective Date**" shall mean the date from which the coverage under this Policy becomes effective.

20. "**Policy Period**" shall mean a period of one year or such other periods as may be agreed in writing between the Company and the Policyholder, starting with the Policy Effective Date and the subsequent Policy Anniversary Dates.

21. "**Registered Medical Practitioner**" shall mean only a person qualified by a degree in western medicine and legally authorized in the geographical area of his practice to render medical or surgical services, and who is not: (i) the insured, or (ii) a member of his immediate family, or (iii) other relative of the insured.

22. "**Sickness**" shall mean a physical condition marked by a pathological deviation from the normal healthy state.

23. "**Specialist**" shall mean a Registered Medical Practitioner who specializes in a specific area in a medical field, and who is not: (i) the insured, or (ii) a member of his immediate family, or (iii) other relative of the insured.

24. "**Traditional Chinese Medicine (TCM) Practitioner**" shall mean a person who is qualified to provide a prescribed practice of TCM and is registered and issued with a license to practice the TCM by the TCM Practitioners Board of Singapore, and who is other than the insured, a member of his immediate family or other relative.

25. "**Singapore Government Restructured Hospital**" shall mean the privatized Singapore Government Hospital.

26. "**Waiting Period**" shall mean the period so defined in the Policy Schedule attached hereto.

PART II - PARTICIPATION AND TERMINATION

Section A - Participation

1. The Policyholder shall declare to the Company full particulars of Members and Dependants (as may be the case) prior to the Policy Effective Date and within ninety (90) days of the Entry Date for each new Member and of the date the Dependant becomes eligible to participate in the insurance plan.

2. Members and Dependants already eligible on the Policy Effective Date shall be eligible for participation on the Policy Effective Date.

3. Members and Dependants not eligible as of the Policy Effective Date and new Members and Dependants shall become eligible for participation hereunder on the day following the Member's completion of the required Waiting Period as specified in the Policy Schedule.

4. An individual who becomes a Dependant after the Policy Effective Date shall become eligible to participate in the insurance plan on the date such person becomes a Dependant.

5. Members whose participation has been terminated and who re-apply for participation shall be considered as new Members.

6. Any Member who is not in Active Service on the date he would otherwise become eligible for participation hereunder shall not be eligible until the day he returns to Active Service.

7. Any Dependant who is in Hospital Confinement on the date he would otherwise become eligible for insurance hereunder shall not be eligible until the date he is no longer in Hospital Confinement.

Section B - Termination

The insurance hereunder of any insured shall automatically cease on the earliest of the following dates:

1. The date on which the Policy is terminated.

2. The date of the expiration of the period for which the last premium payment is made on account of the insured's insurance.

3. The end of the Policy Period during which the insured attains the Maximum Age of Coverage as stated in the Policy Schedule.

4. The date on which the Insured Member resigns, retires or terminates him employment with the Policyholder, or ceases to be covered under the Policy for any other reason.

5. The date communicated to the Policyholder by the Company as the date the Policy ceases on account of war, or an act of war, such date being determined at the discretion of the Company.

6. On the expiry of twelve (12) months from the start of the Insured Member being continuously:
   (a) on temporary leave of absence;
   (b) on vacation without pay; or
   (c) sick or injured (with or without continued uninterrupted absence from work).

7. The date the Dependant ceases to fulfill the conditions that have permitted him to become insured as a Dependant.

PART III - BENEFIT PROVISIONS

Section A – Extent of Benefits

The Company will pay the benefits described below for the expenses incurred at outpatient clinics as a result of Sickness or Injury while insured under this Policy.

His coverage shall be subject to the benefit limits set forth in the Policy Schedule and all terms and conditions of this Policy.

1. **Outpatient treatment at Panel Specialist clinics**
   This benefit shall be paid if the insured incurs expenses for care and treatment stated in the following Schedule of Covered Benefits at the clinic of a Panel Specialist as recommended by a Panel General Practitioner or recommended by the treating Specialist if the condition is in an area of a different medical field.

2. **Outpatient treatment at Specialist outpatient clinics of Singapore Government Restructured Hospitals**
   This benefit shall be paid if the insured incurs expenses for care and treatment stated in the following Schedule of Covered Benefits at the outpatient clinics of a Singapore Government Restructured Hospital as recommended by a General Practitioner or a Panel Specialist.

3. **Outpatient Diagnostic X-Ray, Laboratory test and specialized test**
   This benefit shall be paid if the insured incurs expenses for X-Ray, laboratory and specialized tests as recommended by a Registered Medical Practitioner or Specialist.

4. **Outpatient Physiotherapy**
   This benefit shall be paid if the insured incurs expenses for physiotherapy as recommended by a Registered Medical Practitioner.

PART IV - LIMITATION & EXCLUSIONS & CLAIMS PROCEDURES

Section A - Limitation

When an insured is entitled to benefits payable under the Employee's Compensation legislation, any government or public programme of medical benefits, or other group or individual insurance, the benefits payable under this Policy shall be limited to the balance of expenses not covered by benefits payable under such legislation, programme or other insurance, or that computed in accordance with the Policy Schedule of this Policy, whichever is less.

Section B - Exclusions

No benefit shall be payable under this Policy for any one of the following occurrences:

1. General physical or medical check-up or health screening or tests not incidental to treatment or diagnosis of an actual Sickness or Injury; treatment which is not Medically Necessary or treatment of an optional or preventive nature; immunization, vaccination or inoculation; non-prescribed medication, over-the-counter items such as but not limited to vitamins, supplements, shampoos and moisturizers even if recommended by the attending doctor.

2. Treatment by general practitioners, Specialists other than by the Panel Specialist and Specialists of Government Restructured Hospitals.

3. Specialist consultation, x-ray or laboratory test not recommended by a Registered Medical Practitioner for the diagnosis of Sickness or Injury.

4. Treatment by Traditional Chinese Medical Practitioner, acupuncture, acupressure, bonesetting, herbalist treatment.

5. Investigation and treatment of psychological, emotional, mental and behavioral conditions; alcoholism or drug addiction, intentional self-inflicted injuries while sane or insane; injuries sustained as a result of a criminal act.

6. Hypnotism, massage therapy, aroma therapy and other forms of alternative treatments; treatments by podiatrist and chiropractors.

7. Educational treatments such as speech therapy, diabetic classes and nutritional treatments or group support treatments.

8. Any expenses incurred in relation to any type of therapy including but not limited to occupational therapy, or dialysis, except for physiotherapy.

9. Treatment relating to birth control; investigation or treatment occasioned by or resulting from pregnancy, infertility, childbirth, abortion, except ectopic pregnancy and non-elective miscarriage.

10. Treatment of xanthelasma, skin tags, vitiligo, acne, alopecia, weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition otherwise admissible under the Policy.

11. Cosmetic procedure or plastic surgery except to the extent that such surgery is necessary for the repair or damage caused solely by accidental bodily injuries covered under the Policy.

12. Any investigation or treatment for congenital anomalies or complications arising from such congenital anomalies, or physical defects present at and existing from the time of birth regardless of the time of discovery or the time of such treatment or surgical treatment.

13. Acquired Immuno-Deficiency Syndrome (AIDS), AIDs related complexes and all illnesses or diseases associated with the Human Immuno-Deficiency Virus (HIV), unless acquired due to Medically Necessary blood transfusions or occupational related infections (where proof of which must be made available to the Company.)

14. Any eye examination or treatment for the correction of eye refraction; procurement of contact lenses and eye glasses. Procurement and rental of/or use of special braces, any appliances, any equipment or prosthetic devices, wheel-chair, walking aids, hearing aids or the fitting of the same.

15. Any expenses, including investigations, incurred in relation to Sickness and Injury during or in the course of employment which constitutes a valid claim under the Employee's Compensation Legislation.

16. Any surcharge incurred due to visits outside the normal operating hours of the clinic.

17. Drugs purchased without a doctor's prescription.

Section C - Notice and Proof of Claim

Claims must be submitted to the Company within ninety (90) days of date incurred.

Original copies of receipts and itemized bills, together with a fully completed claim form supplied by the Company must be furnished by the Policyholder to the Company within ninety (90) days after the termination of the period for which the claim is made, or as soon thereafter as may be consistent with the Policyholder's internal administrative procedures.

Section D – Currency and Payment of Claim

Payment of all claims and benefits will be made in the currency in which this Policy is effected. Charges incurred in any other currency shall be payable in Singapore Dollars, or currency of the Policy on the basis of the prevailing rate used by the Company on the date the claims were processed.

All benefits that pertain to an insured shall be paid by cheque or bank giro to the order of the Insured Member, unless the Policyholder for reasons acceptable to the Company requests otherwise. Payment of any sum made by the Company as provided by this Section shall be a valid discharge to the Company and shall release the Company of all claims, demand, liabilities and damages, whatsoever in respect thereto.

Section E – Individual Membership Card

1. The Company shall issue to the Policyholder, for delivery to each insured, an individual membership card certifying that such insured has become insured under this Contract.

2. The insured is required to present the individual membership card and identity card at Panel Specialist Clinics at the point of registration.

3. A penalty of ten (10) dollars shall be payable to the Company by the Policyholder for the replacement of each individual membership card.

Section F – Cashless Facility

The Company agrees to provide a cashless facility whereby the insured does not have to make payment for care and treatment stated in the Schedule of Covered Benefits at AIA panel Specialist Clinics, and the following terms shall form the basis for the above mentioned facility:

1. The Policyholder undertakes to reimburse the Company for any amounts not payable or not covered under the Policy. Such sums should be settled within fourteen (14) days of the date of notification from the Company.

2. The aforementioned cashless facility will be suspended if the Policyholder fails to settle with the Company within the time specified. The Policyholder will still be liable to the Company for outstanding sums in arrears including any interest charged by the clinic even though the cashless facility is suspended or terminated.

3. In the event that the Policyholder fails to settle the outstanding sums within the time specified, the Company reserves the right to terminate the Policy and use the unused premium to settle the outstanding sums.

4. The Company reserves the right to terminate the cashless facility by giving one month notice in advance to the Policyholder.

PART V - GENERAL PROVISIONS

Section A - Premium Payments

The premium is payable to the Company on each premium due date, unless otherwise specified by the Company in writing.

Section B - Grace Period, Termination and Reinstatement of Policy

1. Any premium due must be paid and actually received in full by the Company within the time period stipulated below ('Grace Period'):
   (a) Where the premium is payable on an annual basis, thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the company, whichever is later, or

   (b) Where premium is payable other than on an annual basis,
      (i) Thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is later, for the first premium of each Policy Period; and
      (ii) on the agreed premium due dates for subsequent premiums.

2. In the event that any premium is not paid to the Company within the Grace Period or the agreed premium payment date, the Company reserves the right to terminate this Policy from the respective Premium Due Date as specified in the Policy Schedule and the Company shall be discharged from all liabilities therefrom.

3. Where the Policyholder has confirmed its intention to renew this Policy but has not provided the Company with the complete data necessary for the renewal of the Policy on or before the Policy Anniversary Date, the Company shall issue a premium tax invoice for the estimated renewal premium. The payment of the estimated premium under the premium tax invoice shall be paid within the Grace Period, failing which the Policy may be terminated by the Company.

4. No benefits for any covered event occurring after the Policy Effective Date or Policy Anniversary Date shall be paid until premiums due on the respective Premium Due Date are received in full by the Company.

5. The Company reserves the right to terminate this Policy on any Premium Due Date when fewer than the total number of Members then eligible for insurance are insured hereunder, if the insurance plan is non-contributory; or less than seventy-five (75) percent of the total number of Members then eligible are insured hereunder, if the insurance plan is contributory; or if the total number of insured is less than five (5).

6. This Policy may be terminated as at any Premium Due Date by either the Policyholder or the Company by mailing a written notice of termination on the other party, not later than thirty-one (31) days before the Premium Due Date on which such termination shall be effective. Termination shall be without prejudice to any claim arising prior to the effective date of termination.

7. After termination of the Policy, the Policyholder may apply for reinstatement which shall be subject to the consent of the Company and to the terms and conditions which the Company may impose including the payment of any premium due and not paid together with the interest at a rate to be decided upon by the Company.

Section C - Renewal Privilege

This Policy is issued for the term of one (1) year and at the end of each Policy Period, may be renewed on such terms as the Policyholder and Company may agree to. The Company reserves the right not to invite the Policyholder to renew this Policy should there be any due and unpaid premiums.

Section D - Premium Rate

1. The Company shall have the right to change the rate at which the premiums are payable, such change to be effective on a Policy Anniversary Date, provided that the Company notifies the Policyholder at least thirty-one (31) days in advance of such Premium Due Date of such change.

2. Premium adjustments involving return of unearned premiums to the Policyholder shall be limited to the period starting with the latest Policy Anniversary preceding the date of receipt by the Company of evidence that such adjustments should be made.

Section E - The Contract

1. All statements in writing relating to material facts made by the Policyholder, or by the insured, whether contained in this Policy or the documents referred to in Section G of this Part V, shall in the absence of fraud be deemed representations and not warranties.

2. The rights of the Policyholder or of any insured or of any beneficiary under the Policy shall not be affected by any provision other than those contained in this Policy or in the copy of the Policyholder's application attached hereto, or in the individual enrolment form of an insured, or in any other document which constitutes part of the entire contract.

3. No agent or third party is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this Policy shall be valid unless approved by the Company and evidenced by the endorsement thereon, or by amendment hereto signed by the Policyholder and by the Company.

4. Any reference in this Policy to an insured in respect of his rights, obligations, benefits or entitlement under this Policy shall be construed to include the Policyholder through whom the insured has acquired such rights, obligations, benefits or entitlement, as the context may require.

Section F - Data Required

1. The Policyholder shall maintain a record with respect to each insured under this Policy, showing the Member's name, sex, age or date of birth, amount of insurance, the date insurance becomes effective, the date insurance is terminated, changes, with dates noted and other pertinent information as may be necessary to carry out the terms of this Policy.

2. Clerical errors in keeping the records shall not invalidate insurance otherwise in force nor reinstate insurance otherwise validly terminated, but upon the discovery of such error, an equitable adjustment shall be made.

3. The Policyholder shall furnish the Company with all information and proof which the Company may reasonably require with regard to any matters pertaining to the Policy. All documents furnished to the Policyholder by any Member in connection with the insurance, and other records as may have a bearing on the insurance under this Policy, shall be opened for inspection by the Company at all reasonable times.

Section G - Full Disclosure

All material facts and circumstances relating to any insurance coverage to be effected under this Policy in respect of any insured, shall, up to the date coverage is provided to that insured by the Company, be fully disclosed to the Company by the Policyholder or insured. Any non-disclosure, misrepresentation or fraud shall entitle the Company to avoid all liabilities existing under this Policy in respect of that insured.

Without prejudice to the generality of the above provisions and the provisions in Section H of this Part V relating to an insured, the Company will rely on the information and statements provided by the Policyholder in the Group Insurance Fact-Finding Form or the equivalent of such document, the application form and all other documents required by the Company to be completed and executed by the Policyholder for the purpose of needs analysis or as part of the sales process relating to the Policy. The Policyholder acknowledges that all statements and information provided in such documents must be complete, true and accurate. If any statement or information in such documents is incomplete, untrue or inaccurate, the Company may deny a claim under the Policy, declare the Policy void, or vary the terms and conditions of the Policy.

If any claim has been admitted and benefits paid before the Company became aware of a statement or information being incomplete, untrue or inaccurate, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section H - Misstatement

1. If the age or date of birth or other relevant facts relating to an insured shall be found to have been misstated and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of this Policy, the true age and facts shall be used in determining whether insurance is in force under the terms of this Policy and the benefits payable therefrom, and an equitable adjustment of premiums shall be made.

2. Where a misstatement of age or other relevant facts have caused an individual to be insured hereunder where he is otherwise ineligible for any insurance, or where such statement has caused an individual to remain insured when he would otherwise be disqualified in accordance with the terms and limitations of this Policy, the Company may in its absolute discretion declare the insurance to be void, annul such insurance and there shall be a return of premiums paid in respect of the individual, provided always that where there is fraud on the part of the Policyholder or insured, no premiums paid will be returned. If any claim has been admitted and benefits paid before the Company was made aware of the misstatement, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section I - Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and may be enforced in accordance with the law of the Place of Issue.

Section J - Legal Proceedings

No action in law or in equity shall be brought to recover on this Policy prior to the expiration of ninety (90) days after proof of claim has been filed in accordance with the requirements of this Policy, nor shall such action be brought at all unless brought within two years from the expiration of time within which such proof of claim is required by the Policy.

Section K - Incontestability

Notwithstanding anything to the contrary stated heretofore in this Policy, the validity of the Policy shall be incontestable, except for non-payment of premiums or for fraud, after it has been in force for one year from its Date of Issue or date of any reinstatement whichever is later. The insurance of any insured and any subsequent additional insurance shall be incontestable except for non-payment of premium or for fraud, after such insured's insurance has been in force during his lifetime for one year from his Entry Date and the date of each subsequent increase of insurance respectively.

Section L - Policy Non-Participating

This Policy shall not participate in any surplus distribution by the Company.

Section M - Limitation of Coverage

This Policy shall not cover or provide for the payment of claims or benefits to specific persons or entities as a result of any of the following:

The application of or compliance with certain laws and regulations which prohibit performance based on the identity, domicile, place of incorporation or nationality of the Policyholder, insured, claimant, insurer, or the parent company and ultimate controlling entity of the Policyholder, insured, claimant or insurer, or the country where the claim arises.

Should any person or entity be found to have been erroneously enrolled under this Policy, insurance coverage for such person or entity shall cease with immediate effect and any unearned premiums paid in respect of such person or entity shall be refunded by the Company to the Policyholder.

Should any claim for payment of any nature be found to have been made under this Policy by a person or entity excluded by this provision, no such payment will be made.

Section N - Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC).

Section O – Contracts (Rights of Third Parties) Act, Chapter 53B

Save and except where contrary to Singapore law governing any of the benefits granted under this Policy, or where expressly provided otherwise, a person who is not a party to this Policy has no right under the Contracts (Rights of Third Parties) Act, Chapter 53B, Singapore, to enforce any term of this Policy.
Notwithstanding anything in this Policy, the consent of any third party (including a Member) is not required for any variation (including any release or compromise of any liability) or termination of this Policy.

Section P - Personal Data

The Policyholder represents and warrants that it has obtained the consent of all individual Members and Dependants (as the case may be), except to the extent such consent is not required under relevant laws, for the Company, its associated persons and organisations, agents, brokers and other intermediaries, business partners, third party service providers and representatives, whether within or outside Singapore (collectively "AIA Persons") to collect, use, store, retain and/or process (collectively "Use") all personal data and information ("Personal Data") provided to AIA Persons or which AIA Persons possess about the Members, in the manner and for the purposes described in the AIA Personal Data Policy ("PD Policy") as may be amended from time to time, and which is available on the Company's website. The Policyholder shall indemnify AIA Persons from and against all claims, actions, losses, penalties, damages, costs and expenses arising from its breach of the provisions of this Section P. AIA Persons shall have the right to enforce any benefit under this Section P under the Contracts (Rights of Third Parties) Act, Chapter 53B.

Section Q – Subcontractors and Delegates

Notwithstanding any other agreement to the contrary, the Company may in its sole and absolute discretion subcontract or delegate any of its services in the administration of the Policy or the performance of its other obligations under this Policy to a third party appointed by the Company at its own cost and expense, subject that the Company will remain responsible and liable to the Policyholder for the work and activities of each subcontractor or delegated person for the Company's obligations under this Policy.

Group Dental PPO-Plus

- PROVISIONS -

- SCHEDULES -

PART I - DEFINITIONS

In this Policy where consistent with the contents the singular shall include the plural and the plural the singular; words importing the masculine gender shall include the feminine gender; and each of the following words and expressions shall have the following meanings:

1. **"Active Service"** shall mean for an employee reporting to work at the place assigned by the Policyholder and performing, in a customary manner, all regular duties of his employment with the Policyholder, and includes such employee on entitled annual leave for reasons other than on medical grounds.

2. "**Company**" shall mean AIA Singapore Private Limited.

3. "**Dentist**" shall mean an individual holding a dental qualification that is recognized by the local authorities and legally authorized in the geographical area of his practice to render dental services.

4. "**Dependant**" shall mean:
   (a) the spouse of an Insured Member of this Policy, provided such spouse is below the Maximum Age of Coverage as stated in the Policy Schedule and is not already insured under the Policy; or
   (b) each child of an Insured Member, provided such child is at least three (3) years old and is below the Maximum Age of Coverage as stated in the Policy Schedule, unmarried and unemployed.

5. "**Employee's Compensation Legislation**" shall mean the Work Injury Compensation Act, Chapter 354, Singapore, as may be amended or re-enacted, or equivalent legislation.

6. "**Entry Date**" shall mean the date an individual becomes an Insured Member under this Policy.

7. "**Insured Members**" shall mean Members who, having completed the Waiting Period and are not otherwise disqualified from coverage under the terms of this Policy, are participating in the insurance plan under this Policy.

8. "**Maximum Age of Coverage**" shall mean the maximum age of coverage so defined in the Policy Schedule attached hereto.

9. "**Members**" shall mean the persons so defined in the Policy Schedule attached hereto.

10. "**Panel Dentist**" shall mean a Dentist who has contracted with the Company to provide dental services at preferred rates.

11. "**Policy**" shall mean this agreement, the attached Schedule of Allowances, any riders or endorsements therein, any amendments thereto signed by the Company, therein the application attached hereto to the Policyholder, and the individual enrolment forms, if any, of the insured Members, which together constitute the entire contract between the parties.

12. "**Policy Anniversary Date**" shall mean the anniversary of the Policy Effective Date or such other date as may be agreed in writing between the Policyholder and the Company.

13. "**Policy Effective Date**" shall mean the date from which the coverage under this Policy becomes effective.

14. "**Policy Period**" shall mean a period of one year or such periods as may be agreed in writing between the Company and the Policyholder, starting with the Policy Effective date and the subsequent Policy Anniversary Dates.

15. "**Waiting Period**" shall mean the period so defined in the Policy Schedule attached hereto.

PART II - PARTICIPATION AND TERMINATION

Section A - Participation

1. The Policyholder shall declare to the Company full particulars of Members and Dependants (as may be the case) prior to the Policy Effective Date and within ninety (90) days of the Entry Date for each new Member and Dependant becoming eligible to participate in the insurance plan.

2. Members and Dependants already eligible on the Policy Effective Date shall be eligible for participation on the Policy Effective Date.

3. Members and Dependants not eligible as of the Policy Effective Date and new Members and Dependants shall become eligible for participation hereunder on the day following the Member's completion of the required Waiting Period as specified in the Policy Schedule.

4. An individual who becomes a Dependant after the Policy Effective Date shall become eligible to participate in the insurance plan on the date such person becomes a Dependant.

5. Members whose participation has been terminated and who re-apply for participation shall be considered as new Members.

6. Any Member who is not in Active Service on the date he would otherwise become eligible for participation hereunder shall not be eligible until the day he returns to Active Service.

7. Any Dependant who is in Hospital Confinement on the date he would otherwise become eligible for insurance hereunder shall not be eligible until the date he is no longer in Hospital Confinement.

Section B - Termination

The insurance hereunder of any insured shall automatically cease on the earliest of the following dates:

1. The date on which the Policy is terminated.

2. The date of the expiration of the period for which the last premium payment is made on account of the insured's insurance.

3. The end of the Policy Period during which the insured attains the Maximum Age of Coverage as stated in the Policy Schedule.

4. The date on which the Insured Member resigns, retires or terminates him employment with the Policyholder, or ceases to be covered under the Policy for any other reason.

5. The date communicated to the Policyholder by the Company as the date the Policy ceases on account of war, or an act of war, such date being determined at the discretion of the Company.

6. On the expiry of 12 months from the start of the Insured Member being continuously:
   (a) on temporary leave of absence;
   (b) on vacation without pay; or
   (c) sick or injured (with or without continued uninterrupted absence from work).

7. The date the Dependant ceases to fulfill the conditions that have permitted him to become insured as a Dependant.

PART III - BENEFIT PROVISIONS

Section A - Extent of Benefits

This benefit shall be paid if an insured incurs expenses for dental services stated in the following Schedule of Allowances while he is insured under this Policy.

His coverage shall be subject to the benefit limits set forth in the following Schedule of Allowances and all terms and conditions of this Policy.

If an insured shall incur expenses for dental services performed at a:

(a) Panel Dentist clinic, the Company shall pay the expenses incurred directly to the Panel Dentist.
(b) clinic which is not a Panel Dentist clinic, the Company shall make full reimbursement for such expenses up to the Maximum Amounts specified therein.

PART IV - LIMITATION & EXCLUSIONS & CLAIM PROCEDURES

Section A - Limitation

When an Insured Member is entitled to benefits payable under the Employee's Compensation Legislation and all regulations issued thereunder, including any re-enactment or equivalent of such legislation, any government or public programme of dental or medical benefits, or other group or individual medical or dental insurance, the benefits payable under this Policy shall be limited to the balance of expenses not covered by benefits payable under such legislation, programme or other insurances, or the amount provided in this Policy, whichever is less.

Section B - Exclusions

No benefit shall be payable under this Policy for the following services, products or conditions:

1. Charges for any dental procedures which are not included in the following Schedule of Allowances.

2. Any hospital charges.

3. Injuries arising directly or indirectly, wholly or partly from war, declared or undeclared, revolution or any warlike operations.

Section C – Notice of Claim

Claims must be submitted to the Company within ninety (90) days of the date incurred.

Section D - Currency and Payment of Claim

Payment of all claims and benefits will be made in the currency in which this Policy is effected. Charges incurred in any other currency shall be payable in Singapore Dollars, or currency of the Policy on the basis of the prevailing rate used by the Company on the date the claims were processed.

All benefits that pertain to an insured shall be paid by cheque or bank giro to the order of the Insured Member, unless the Policyholder for reasons acceptable to the Company requests otherwise. Payment of any sum made by the Company as provided by this Section shall be a valid discharge to the Company and shall release the Company of all claims, demand, liabilities and damages, whatsoever in respect thereto.

Section E - Individual Membership Card

1. The Company shall issue to the Policyholder, for delivery to each insured, an individual membership card certifying that such insured has become insured under this Contract.

2. A penalty of ten (10) dollars shall be payable to the Company by the Policyholder for the replacement of each individual membership card.

Section F – Cashless Facility

The Company agrees to provide a cashless facility whereby insured do not have to make payment for dental services stated in the following Schedule of Allowances at a AIA Panel Dentist, and the following terms shall form the basis for the above mentioned facility:

1. The Policyholder undertakes to reimburse the Company for any amounts not payable or not covered under the Policy. Such sums should be settled within fourteen (14) days of the date of notification from the Company.

2. The aforementioned cashless facility will be suspended if the Policyholder fails to settle with the Company within the time specified. The Policyholder will still be liable to the Company for outstanding sums in arrears including any interest charged by the clinic even though the cashless facility is suspended or terminated.

3. In the event that the Policyholder fails to settle the outstanding sums within the time specified, the Company reserves the right to terminate the Policy and use the unused premium to settle the outstanding sums.

4. The Company reserves the right to terminate the cashless facility by giving one month's notice in advance to the Policyholder.

PART V - GENERAL PROVISIONS

Section A - Premium Payments

The premium is payable to the Company on each premium due date, unless otherwise specified by the Company in writing.

Section B - Grace Period, Termination and Reinstatement of Policy

1. Any premium due must be paid and actually received in full by the Company within the time period stipulated below ("Grace Period"):
   a) Where the premium is payable on an annual basis, thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is later, or

   b) Where premium is payable other than on an annual basis,
      (i) Thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is later, for the first premium of each Policy Period; and
      (ii) on the agreed premium payment dates for subsequent premiums.

2. In the event that any premium is not paid to the Company within the Grace Period or the agreed premium payment date, the Company reserves the right to terminate this Policy from the respective Premium Due Date and the Company shall be discharged from all liability therefrom.

3. Where the Policyholder has confirmed its intention to renew this Policy but has not provided the Company with the complete data necessary for the renewal of the Policy on or before the Policy Anniversary Date, the Company shall issue a premium tax invoice for the estimated renewal premium. The payment of the estimated premium under the premium tax invoice shall be paid within the Grace Period, failing which the Policy may be terminated by the Company.

4. No claim arising from any covered event occurring after the Policy Effective Date or Policy Anniversary Date shall be paid until premiums due on the respective Date are received in full by the Company.

5. The Company reserves the right to terminate this Policy on any Premium Due Date when fewer than the total number of Members then eligible for insurance are insured hereunder, if the insurance plan is non-contributory; or less than seventy-five (75) percent of the total number of Members then eligible are insured hereunder, if the insurance plan is contributory; or if the total number of insured is less than five (5).

6. This Policy may be terminated as at any Premium Due Date by either the Policyholder or the Company by mailing written notice of termination to the other party, not later than thirty-one (31) days before the Premium Due Date on which such termination shall be effective. Termination shall be without prejudice to any claim arising prior to the effective date of termination.

7. After termination of the Policy, the Policyholder may apply for reinstatement which shall be subject to the consent of the Company and to the terms and conditions which the Company may impose including the payment of any premiums due and not paid together with the interest at a rate to be decided upon by the Company.

Section C – Renewal Privilege

This Policy is issued for the term of one (1) year and at the end of each Policy Period, may be renewed on such terms as the Policyholder and Company may agree to. The Company reserves the right not to invite the Policyholder to renew this Policy should there be any due and unpaid premiums.

Section D - Premium Rate

1. The Company shall have the right to change the rate at which the premiums are payable, such change to be effective on a Policy Anniversary Date, provided that the Company notifies the Policyholder at least thirty-one (31) days in advance of such Premium Due Date of such change.

2. Premium adjustments involving return of unearned premiums to the Policyholder shall be limited to the period starting with the latest Policy Anniversary preceding the date of receipt by the Company of evidence that such adjustments should be made.

Section E - The Contract

1. All statements in writing relating to material facts made by the Policyholder, or by the insured, whether contained in this Policy or the documents referred to in Section G of this Part V, shall in the absence of fraud be deemed representations and not warranties.

2. The rights of the Policyholder or of any insured or of any beneficiary under the Policy shall not be affected by any provision other than those contained in this Policy or in the copy of the Policyholder's application attached hereto, or in the individual enrolment form of an insured, or in any other document which constitutes part of the entire contract.

3. No third party is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this Policy shall be valid unless approved by the Company and evidenced by the endorsement thereon, or by amendment hereto signed by the Policyholder and by the Company.

4. Any reference in this Policy to an insured in respect of his rights, obligations, benefits or entitlement under this Policy shall be construed to include the Policyholder through whom the insured has acquired such rights, obligations, benefits or entitlement, as the context may require.

Section F - Data Required

1. The Policyholder shall keep a record with respect to each insured under this Policy, showing the Member's name, sex, age or date of birth, Entry Date, the date insurance is terminated, changes, with dates noted, and other pertinent information as may be necessary to carry out the terms of this Policy.

2. Clerical errors in keeping the records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated, but upon the discovery of such error, an equitable adjustment shall be made.

3. The Policyholder shall furnish the Company with all information and proof which the Company may reasonably require with regard to any matters pertaining to the Policy. All documents furnished to the Policyholder by any insured in connection with the insurance, and other records as may have a bearing on the insurance under this Policy, shall be open for inspection by the Company at all reasonable times.

Section G - Full Disclosure

All material facts and circumstances relating to any insurance coverage to be effected under this Policy in respect of any insured, shall, up to the date coverage is provided to that insured by the Company, be fully disclosed to the Company by the Policyholder or insured. Any non-disclosure, misrepresentation or fraud shall entitle the Company to avoid all liabilities existing under this Policy in respect of that insured.

Without prejudice to the generality of the above provisions and the provisions in Section H of this Part V relating to an insured, the Company will rely on the information and statements provided by the Policyholder in the Group Insurance Fact-Finding Form or the equivalent of such document, the application form and all other documents required by the Company to be completed and executed by the Policyholder for the purpose of needs analysis or as part of the sales process relating to the Policy. The Policyholder acknowledges that all statements and information provided in such documents must be complete, true and accurate. If any statement or information in such documents is incomplete, untrue or inaccurate, the Company may deny a claim under the Policy, declare the Policy void, or vary the terms and conditions of the Policy.

If any claim has been admitted and benefits paid before the Company became aware of a statement or information being incomplete, untrue or inaccurate, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section H - Misstatement

1. If the age or date of birth or other relevant facts relating to an insured shall be found to have been misstated and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of this Policy, the true age and facts shall be used in determining whether insurance is in force under the terms of this Policy and the benefits payable therefrom; and an equitable adjustment of premiums shall be made.

2. Where a misstatement of age or other relevant facts have caused a Member to be insured hereunder where he is otherwise ineligible for any insurance, or where such statement has caused a Member to remain insured when he would otherwise be disqualified in accordance with the terms and limitations of this Policy, the Company may in its absolute discretion declare the insurance of the Member to be void and annul such insurance, and there shall be a return of premiums paid in respect of the Member, provided always that where there is fraud on the part of the Policyholder or insured, no premiums paid will be returned. If any claim has been admitted and benefits paid before the Company was made aware of the misstatement, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section I - Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and may be enforced in accordance with the law of the Place of Issue.

Section J - Legal Proceedings

No action in law or in equity shall be brought to recover on this Policy prior to the expiration of ninety (90) days after proof of claim has been filed in accordance with the requirements of this Policy, nor shall such action be bought at all unless bought within two (2) years from the expiration of time within which proof of claim is required by this Policy.

Section K - Incontestability

Notwithstanding anything to the contrary stated heretofore in this Policy, the validity of this Policy shall be incontestable, except for non-payment of premiums or for fraud, after it has been in force for one year from its Date of Issue or date of any reinstatement whichever is later. The insurance of any insured and any subsequent additional insurance shall be incontestable except for nonpayment of premium or for fraud, after such insured's insurance has been in force during his lifetime for one year from his Entry Date and the date of each subsequent increase of insurance respectively.

Section L - Policy Non-Participating

This Policy shall not participate in any surplus distribution by the Company.

Section M - Limitation of Coverage

This Policy shall not cover or provide for the payment of claims or benefits to specific persons or entities as a result of any of the following:

The application of or compliance with certain laws and regulations prohibit performance based on the identity, domicile, place of incorporation or nationality of the Policyholder, insured, claimant, insurer, or the parent company and ultimate controlling entity of the Policyholder, insured, claimant or insurer, or the country where the claim arises.

Should any person or entity be found to have been erroneously enrolled under this Policy, insurance coverage for such person or entity shall cease with immediate effect and any unearned premiums paid in respect of such person or entity shall be refunded by the Company to the Policyholder.

Should any claim for payment of any nature be found to have been made under this Policy by a person or entity excluded by this provision, no such payment will be made.

Section N - Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC).

Section O – Contracts (Rights of Third Parties) Act, Chapter 53B

Save and except where contrary to Singapore law governing any of the benefits granted under this Policy, or where expressly provided otherwise, a person who is not a party to this Policy has no right under the Contracts (Rights of Third Parties) Act, Chapter 53B, Singapore, to enforce any term of this Policy.
Notwithstanding anything in this Policy, the consent of any third party (including a Member) is not required for any variation (including any release or compromise of any liability) or termination of this Policy.

Section P - Personal Data

The Policyholder represents and warrants that it has obtained the consent of all individual Members and Dependants (as the case may be), except to the extent such consent is not required under relevant laws, for the Company, its associated persons and organisations, agents, brokers and other intermediaries, business partners, third party service providers and representatives, whether within or outside Singapore (collectively "AIA Persons") to collect, use, store, retain and/or process (collectively "Use") all personal data and information ("Personal Data") provided to AIA Persons or which AIA Persons possess about the Members, in the manner and for the purposes described in the AIA Personal Data Policy ("PD Policy") as may be amended from time to time, and which is available on the Company's website. The Policyholder shall indemnify AIA Persons from and against all claims, actions, losses, penalties, damages, costs and expenses arising from its breach of the provisions of this Section P. AIA Persons shall have the right to enforce any benefit under this Section P under the Contracts (Rights of Third Parties) Act, Chapter 53B.

Section Q – Subcontractors and Delegates

Notwithstanding any other agreement to the contrary, the Company may in its sole and absolute discretion subcontract or delegate any of its services in the administration of the Policy or the performance of its other obligations under this Policy to a third party appointed by the Company at its own cost and expense, subject that the Company will remain responsible and liable to the Policyholder for the work and activities of each subcontractor or delegated person for the Company's obligations under this Policy.

SCHEDULE OF ALLOWANCES

Benefits are payable for treatment and services when listed below only and up to the Maximum Amount as specified.

Benefits	Panel Dentist (Cashless for all procedures described below)	Non - Panel Dentist Maximum Amount Per Visit (S$)
Examination Dental Checkup		15
Medicine & Miscellaneous Treatment Analgesics, antibiotics, sterilization and disposables		15
X-Ray Intraoral Bitewing Panorex		 12 12 32
Test & Laboratory Biopsy and examination of tissue		48
Prophylaxis Routine (Scaling & Polishing) Complex (Scaling, Polishing & Fluoride)		 40 60
Filing (Tooth – Coloured Material or Amalgam) for Posterior Teeth Only One surface Two surfaces Three or more surfaces Reinforced Pin		 16 24 32 9
Filing (Tooth – Coloured Material) – for Anterior Teeth and Buccal (one surface) filling of Premolars only One surface Two surfaces Three surfaces		 30 40 50
Pulpotomy Pulpotomy Pulp Cap		 40 20
Root Canal Treatment Single root canal filing Double root canal filing Three or more canals (X-ray of the tooth involved with the diagnostic wire or wires in place must accompany claim for payment)		 150 220 350
Extractions Routine (Simple) – each tooth		 30

Benefits	Panel Dentist (Cashless for all procedures described below)	Non - Panel Dentist Maximum Amount Per Visit (S$)
Surgical Extractions		
Erupted tooth or root		120
Soft tissue impaction		160
Part bony impaction		250
Completely bony impaction		320
Alveoplasty		
Per quadrant, in connection with extractions		30
Per quadrant, not in connection with extractions		42
For a complete Alveoplasty involving more than one quadrant		160
Excision of tumour		
Excision of tumour		76
Fracture of jaw		
Simple		500
Compound		600
(X-ray of the fracture must accompany claim for payment)		
Repair of Prosthetic Appliance		
Repair of broken complete or partial denture		20
Repair of denture and replace broken tooth		40
Adding tooth to partial denture to replace extracted tooth		27
Add tooth to partial denture plus clasp		54
Space Maintainers		
Fixed band type (uni or bilateral)		135
Removal in Acrylic (uni or bilateral)		67

Group Term Life

- PROVISIONS -

- SCHEDULES -

PART I – DEFINITIONS

In this Policy where consistent with the contents of the singular shall include the plural and the plural the singular; words importing the masculine gender shall include the feminine gender; and each of the following words and expressions shall have the following means:

1. **"Accident"** shall mean an unforeseen event, which is caused solely and directly by external, violent, sudden and accidental means.

2. **"Active Service"** shall mean for an employee reporting to work at the place assigned by the Policyholder and performing, in a customary manner, all regular duties of his employment with the Policyholder, and includes such employee on entitled annual leave for reasons other than on medical grounds.

3. **"Company"** shall mean AIA Singapore Private Limited.

4. "**Dependant"** shall mean:
   (a) the spouse of an Insured Member of this Policy, provided such spouse is below the Maximum Age of Coverage as stated in the Policy Schedule and is not already insured under the Policy.
   (b) each child of an Insured Member, provided such child is at least 2 weeks old and is below the Maximum Age of Coverage, unmarried and unemployed.

5. "**Entry Date**" shall mean the date an individual becomes an Insured Member under this Policy.

6. **"Injury"** shall mean bodily injury which is caused solely and directly by Accident.

7. **"Insured Members"** shall mean Members who, having completed the required Waiting Period and are not otherwise disqualified from coverage under the terms of this Policy, are participating in the insurance plan under this Policy.

8. **"Maximum Age of Coverage"** shall mean the maximum age of coverage so defined in the Policy Schedule attached hereto.

9. **"Members"** shall mean the persons so defined in the Policy Schedule attached hereto.

10. **"Policy"** shall mean this agreement, any riders or endorsements therein, any amendments thereto signed by the Company, therein the application attached hereto to the Policyholder, and the individual enrolment forms, if any, of the insured, which together constitute the entire contract between the parties.

11. **"Policy Anniversary Date"** shall mean the anniversary of the Policy Effective Date or such other date as may be agreed in writing between the Policyholder and the Company.

12. **"Policy Effective Date"** shall mean the date from which the coverage under this Policy becomes effective.

13. **"Policy Period"** shall mean a period of one year or such other periods as may be agreed in writing between the Company and the Policyholder, starting with the Policy Effective Date and the subsequent Policy Anniversary Dates.

14. **"Registered Medical Practitioner"** shall mean only a person qualified by a degree in western medicine and legally authorized in the geographical area of his practice to render medical or surgical services, and who is not: (i) the insured, or (ii) a member of his immediate family, or (iii) other relative of the insured.

15. **"Sickness"** shall mean a physical condition marked by a pathological deviation from the normal healthy state.

16. **"Specialist"** shall mean a Registered Medical Practitioner who specializes in specific area in the medical field, and who is not: (i) the insured, or (ii) a member of his immediate family, or (iii) other relative of the insured.

17. **"Total and Permanent Disability"** for the insured prior to his 70th birthday shall mean that the disability must be total and permanent and that there is neither at the point of commencement of the disability nor at any time thereafter any work, occupation or profession that the insured can ever sufficiently do or follow to earn or obtain any wages, compensation or profit. The total and irrecoverable loss of sight of both eyes, or the loss by severance of two or more limbs at or above wrist or ankle will be considered as Total and Permanent Disability.

18. **"Terminal Illness"** shall mean a condition, which in the opinion of an appropriate Registered Medical Practitioner and/or Specialist is highly likely to lead to death within twelve (12) months from the date of diagnosis.

19. **"Waiting Period"** shall mean the period so defined in the Policy Schedule attached hereto.

PART II – PARTICIPATION AND TERMINATION

Section A – Participation

1. The Policyholder shall declare to the Company full particulars of Members and Dependants (as may be the case) prior to the Policy Effective Date and within ninety (90) days of the Entry date for each new Member and of the date the Dependant becomes eligible to participate in the insurance plan.

2. Members and Dependants already eligible on the Policy Effective Date shall be eligible for participation on the Policy Effective Date

3. Members and Dependants not eligible as of the Policy Effective Date and new Members and Dependants shall become eligible for participation hereunder on the day following the Member's completion of the required Waiting Period as specified in the Policy Schedule.

4. An individual who becomes a Dependant after the Policy Effective Date shall become eligible to participate in the insurance plan on the date such person becomes a Dependant.

5. Members whose participation has been terminated and who re-apply for participation shall be considered as new Members.

6. Any Member who is not in Active Service on the date he would otherwise become eligible for participation hereunder shall not be eligible until the day he returns to Active Service.

7. Any Dependant who is in Hospital Confinement on the date he would otherwise become eligible for insurance hereunder shall not be eligible until the date he is no longer in Hospital Confinement.

Section B – Termination

The insurance hereunder of any insured shall automatically cease on the earliest of the following dates:

1. The date on which the Policy is terminated.

2. The date of the expiration of the period for which the last premium payment is made on account of the insured's insurance.

3. The end of the Policy Period during which the insured attains the Maximum Age of Coverage as stated in the Policy Schedule.

4. The date on which the Insured Member resigns, retires or terminates his employment with the Policyholder, or ceases to be covered under the Policy for any other reason.

5. The date communicated to the Policyholder by the Company as the date the Policy ceases on account of war, or an act of war, such date being determined at the discretion of the Company.

6. On the expiry of twelve (12) months from the start of the Insured Member being continuously:
    (a) on temporary leave of absence;
    (b) on vacation without pay; or
    (c) sick or injured (with or without continued uninterrupted absence from work).

7. The date the Dependant ceases to fulfil the conditions that has permitted him to become insured as a Dependant.

8. The date of payment of the Insurance Amount for the Total and Permanent Disability Benefit, Total Disability Extended Death Benefit, Terminal Illness Benefit, or Death Benefit, whichever occurs earliest.

PART III – BENEFIT PROVISIONS

Section A – Insurance Amount

The Insurance Amount as determined in accordance with the Policy Schedule under this Policy shall be payable for Death Benefit, Total and Permanent Disability Benefit, Total Disability Extended Death Benefit or Terminal Illness Benefit, and the Company's liability ends on payment for one of the above described benefits.

Section B – No-Evidence Limit

Amount of the Insurance Amount in excess of the No-Evidence Limit as stated in the Policy Schedule may be accepted subject to evidence of insurability satisfactory to the Company. In the absence of written acceptance by the Company, the amount of insurance shall be limited to the No-Evidence Limit and the premium charged shall be based on this amount. The No-Evidence Limit shall be subject to review by the Company on each Policy Anniversary Date and the Company reserves the right to amend this limit.

Section C – Benefits

1. Death Benefit

Upon due proof of the death of any insured in a form satisfactory to the Company, the following shall be paid to the Policyholder:

- the Insurance Amount as determined in accordance with the Policy Schedule AND
- an additional 10% of the Insurance Amount as a compassionate death allowance.

Payment for any benefit (excluding the Repatriation Expenses Benefit) other than the Death Benefit is an accelerated payment of the Death Benefit and the insured is no longer entitled to the Death Benefit or any other benefit on such payment.

2. Total and Permanent Disability Benefit

If an insured is afflicted with Total and Permanent Disability, as defined under Part I, prior to his 70th birthday, and provided that such Total and Permanent Disability has existed continuously for at least ninety (90) days, the Company shall, upon receipt of due proof, pay:

- the Insurance Amount as determined in accordance with the Policy Schedule AND
- an additional 10% of the Insurance Amount as a compassionate TPD allowance.

If the Company makes payment of the Total and Permanent Disability Benefit, the insured shall not be entitled to any other benefits under this Policy and his coverage automatically ceases.

3. Extended Benefit (Death & TPD)

In the event that the Insured Member's employment with the Policyholder is terminated on medical grounds, the Death and TPD Benefits in respect of the Insured Member shall be extended for a period of twelve (12) months beginning from the date of termination of employment provided that:

1. The Insured Member has not received any benefits under this Policy or under any Supplementary Contracts attached to this Policy;
2. The Insured Member remains continuously unemployed from the date of termination of employment;

3. The Insured Member continues to reside in the same location where he resided prior to such disability during the extended twelve (12) month period unless any new location is approved in advance by the Company;
4. The insurance coverage for the Insured Member under this Policy has not been accepted by the Company on special terms or conditions as a substandard risk;
5. Notice in writing of such termination of employment is given by the Policyholder to the Company within 14 days of the date of termination of employment, otherwise extension of cover shall not be granted;
6. This Policy continues to be in-force during the extended twelve (12) month period;
7. The coverage shall be based on the amount that was last approved by the Company for the Insured Member prior to the termination of employment.

4. Terminal Illness Benefit

If an insured is suffering from a condition, which in written opinion of an appropriate Registered Medical Practitioner and/or Specialist is likely to lead to death within twelve (12) months from the date of diagnosis of such condition by the Registered Medical Practitioner and/or Specialist, the Company shall make an advance payment, equivalent to the Insurance Amount as specified in Section A above, upon receipt of due proof of such Terminal Illness. If the Company makes payment of the Terminal Illness Benefit, the insured shall not be entitled to any other benefits under this Policy and his coverage automatically ceases.

Section D – Exclusions

No benefit shall be payable for:

1. Any loss or disability caused by pre-existing conditions which have existed during the twelve (12) months preceding the Entry date of the insured, whether known or unknown to the insured in so far as the cause and pathology of the conditions have already existed unless the insured affected by these conditions has already been covered continuously for twelve (12) months under this Policy.
2. Suicide unless the insured has been covered for twelve (12) months under this Policy.

Section E - Repatriation Provisions

1. Repatriation Expenses Benefit

If an Insured Member dies as a result of Injury or Sickness commencing while he is travelling outside of the country of his regular employment, the Company or its authorised representative shall make the necessary arrangements for the return of the Insured Member's mortal remains to the country of residence or regular employment or home country.

The Company shall also reimburse the expenses actually incurred, for services and supplies provided by a mortician or undertaker, including but not limited to the cost of a casket, embalming and cremation.

The total amount of all benefits payable under this Section E will be equal to the actual expenses incurred but subject to a cap of S$75,000.

2. Exclusions

No benefit shall be payable for:

1. Any expenses incurred for services provided by another party for which the insured is not liable to pay, or any expenses already included in the cost of a scheduled trip.

2. Any expenses incurred for the transportation of the insured's remains not approved and arranged by the Company or its authorised representative.

3. Any pre-existing conditions for which the insured received medical treatment, diagnosis, consultation, or prescribed drugs within twelve (12) months period preceding the effective date of his coverage, or a condition for which medical advice and treatment was recommended by a Registered Medical Practitioner within a period of twelve (12) months preceding the effective date of his coverage (and in the case of renewed coverage, reference to "the effective date of his coverage" includes a reference to the commencement of earlier periods of coverage).

PART IV – CLAIMS PAYMENT AND PROCEDURES

Section A – Examination

The Company reserves the right to have the insured examined by an appropriate Registered Medical Practitioner and/or Specialist of its choice before payments are made under this Policy.

Section B – Filing Proof of Loss

Written notice of death must be given to the Company within ninety (90) days of the death of an insured.

1. In the event an insured is afflicted with Total and Permanent Disability, full particulars together with the address and whereabouts of the insured must be given in writing to the Company as soon as reasonably possible and satisfactory proof of such disability must be furnished to the Company within ninety (90) days after the commencement of the disability.

2. Written notice given by or on behalf of the insured to the Company with particulars sufficient to identify the insured, shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in this Policy shall not invalidate any claim if it is proven by or on behalf of the claimant that it was not reasonably possible to give such notice within the prescribed period, and that such notice was given as soon as it was reasonably possible to do so.

   All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Policyholder or the Policyholder's legal representative and shall be in such form and of such nature as the Company may prescribe. The Company shall have the right and opportunity to examine the insured as and when and as often as it may reasonably be required pending any claim or the payment of any claims made under this Policy. The Company may also require the insured to furnish, at his expense, evidence to establish his continuing health condition, including the submission of documents and information, where applicable, to prove that the insured has not been engaged in any form of employment for the period relevant to the claim and continues to remain unemployed.

3. Any medical adviser of the Company or Registered Medical Practitioner acceptable to the Company shall be allowed to examine the insured at the insured's expense in such manner and at the times such medical adviser, Registered Medical Practitioner or the Company may require. If the insured is residing in a country outside Singapore, the Company may at its discretion require the insured to come to Singapore for medical examinations by a Registered Medical Practitioner in Singapore.

4. Proof of the date of birth of the insured must be furnished to the Company before any claim will be admitted or payable. If the date of birth and/or age of any insured notified to the Company is incorrect, the Company shall not be liable to pay more than the amount which would be payable under this Policy if the date of birth and/or age had been correctly stated.

Section C – Payment of Benefits

1. The total benefits payable (excluding the compassionate death/TPD allowance) under this Policy shall not exceed the Insurance Amount as specified in Section A of Part III. Coverage of the insured shall cease upon payment of any one of the benefits listed in the Policy Schedule.

2. All payments for benefits under this Policy shall be made to the Policyholder, unless expressly stated otherwise.

3. Payment of the Insurance Amount for a benefit (excluding the repatriation benefit) for an insured shall be in full settlement of all obligations in respect of that insured under this Policy and shall release the Company of all liabilities for that relevant insured under this Policy.

4. Payment of all claims and benefits will be made in the currency in which this Policy is effected. Charges incurred in any other currency shall be payable in Singapore Dollars, or currency of the Policy on the basis of the prevailing rate used by the Company on the date the claims were processed.

Section D – Assignment

No part of the benefits available under this Policy shall be subject to assignment or encumbrance by any Insured Member or his nominees or to garnishment or attachment by his or their creditors.

PART V - GENERAL PROVISIONS

Section A – Premium Payments

The premium is payable to the Company on each premium due date, unless otherwise specified by the Company in writing.

Section B – Grace Period, Termination and Reinstatement of Policy

1. Any premium due must be paid and actually received in full by the Company within the time period stipulated below ('Grace Period'):
   (a) Where the premium is payable on an annual basis, thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is later, or
   (b) Where premium is payable other than on an annual basis:
      (i) thirty (30) days from the Policy Effective Date or Policy Anniversary Date, or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is later, for the first premium of each Policy Period; and
      (ii) on the agreed premium payment dates for subsequent premiums.

2. In the event that any premium is not paid to the Company within the Grace Period or the agreed premium payment date, the Company reserves the right to terminate this Policy from the respective Premium Due Date as specified in the Policy Schedule and the Company shall be discharged from all liabilities therefrom.

3. Where the Policyholder has confirmed its intention to renew this Policy but has not provided the Company with the complete data necessary for the renewal of the Policy on or before the Policy Anniversary Date, the Company shall issue a premium tax invoice for the estimated renewal premium. The payment of the estimated premium under the premium tax invoice shall be paid within the Grace Period, failing which the Policy may be terminated by the Company.

4. No claims arising from any covered event occurring after the Policy Effective Date or Policy Anniversary Date shall be paid until premiums due on the respective Premium Due Date are received in full by the Company.

5. The Company reserves the right to terminate this Policy on any Premium Due Date when fewer than the total number of Members then eligible for insurance are insured hereunder, if the insurance plan is non-contributory; or less than seventy-five (75) percent of the total number of Members then eligible are insured hereunder, if the insurance plan is contributory; or if the total number of insured is less than five (5).

6. This Policy may be terminated on any Premium Due Date by either the Policyholder or the Company by giving written notice of termination to the other party not later than thirty-one (31) days before the Premium Due Date on which such termination shall be effective. Termination shall be without prejudice to any claim made on a covered event occurring prior to the effective date of termination.

7. After termination of the Policy, the Policyholder may apply for reinstatement which shall be subject to the consent of the Company and to the terms and conditions which the Company may impose including the payment of any premium due and not paid together with the interest at a rate to be decided upon by the Company.

Section C – Renewal Privilege

This Policy is issued for the term of one (1) year and at the end of each Policy Period, may be renewed on such terms as the Policyholder and Company may agree to. The Company reserves the right not to invite the Policyholder to renew this Policy should there be any due and unpaid premiums.

Section D – Premium Rate

1. The Company shall have the right to change the rate at which the premiums are payable, such change to be effective on a Policy Anniversary Date, provided that the Company notifies the Policyholder at least thirty-one (31) days in advance of such Premium Due Date of such change.

2. Premium adjustments involving return of unearned premiums to the Policyholder shall be limited to the period starting with the latest Policy Anniversary preceding the date of receipt by the Company of evidence that such adjustments should be made.

Section E – The Contract

1. All statements in writing relating to material facts made by the Policyholder, or by the insured, whether contained in this Policy or the documents referred to in Section G of this Part V, shall in the absence of fraud be deemed representations and not warranties.

2. The rights of the Policyholder or of any insured or of any beneficiary under the Policy shall not be affected by any provision other than those contained in this Policy or in the copy of the Policyholder's application attached hereto, or in the individual enrolment form of an insured, or in any other document which constitutes part of the entire contract.

3. No agent or third party is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this Policy shall be valid unless approved by the Company and evidenced by the endorsement thereon, or by amendment hereto signed by the Policyholder and by the Company.

4. Any reference in this Policy to an insured in respect of his rights, obligations, benefits or entitlement under this Policy shall be construed to include the Policyholder through whom the insured has acquired such rights, obligations, benefits or entitlement, as the context may require.

Section F – Data Required

1. The Policyholder shall maintain a record with respect to each insured under this Policy, showing the Member's name, sex, age or date of birth, amount of insurance, the date insurance becomes effective, the date insurance is terminated, changes, with dates noted and other pertinent information as may be necessary to carry out the terms of this Policy.

2. Clerical errors in keeping the records shall not invalidate insurance otherwise in force nor reinstate insurance otherwise validly terminated, but upon the discovery of such error, an equitable adjustment shall be made.

3. The Policyholder shall furnish the Company with all information and proof which the Company may reasonably require with regard to any matters pertaining to the Policy. All documents furnished to the Policyholder by any Member in connection with the insurance, and other records as may have a bearing on the insurance under this Policy, shall be opened for inspection by the Company at all reasonable times.

Section G – Full Disclosure

All material facts and circumstances relating to any insurance coverage to be effected under this Policy in respect of any insured, shall, up to the date coverage is provided to that insured by the Company, be fully disclosed to the Company by the Policyholder or insured. Any non-disclosure, misrepresentation or fraud shall entitle the Company to avoid all liabilities existing under this Policy in respect of that insured.

Without prejudice to the generality of the above provisions and the provisions in Section H of this Part V relating to an insured, the Company will rely on the information and statements provided by the Policyholder in the Group Insurance Fact-Finding Form or the equivalent of such document, the application form and all other documents required by the Company to be completed and executed by the Policyholder for the purpose of needs analysis or as part of the sales process relating to the Policy. The Policyholder acknowledges that all statements and information provided in such documents must be complete, true and accurate. If any statement or information in such documents is incomplete, untrue or inaccurate, the Company may deny a claim under the Policy, declare the Policy or coverage void, or vary the terms and conditions of the Policy.

If any claim has been admitted and benefits paid before the Company became aware of a statement or information being incomplete, untrue or inaccurate, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section H – Misstatement

1. If the age or date of birth or other relevant facts relating to an insured shall be found to have been misstated and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of this Policy, the true age and facts shall be used in determining whether insurance is in force under the terms of this Policy and the benefits payable therefrom, and an equitable adjustment of premiums shall be made.

2. Where a misstatement of age or other relevant facts have caused an individual to be insured hereunder where he is otherwise ineligible for any insurance, or where such statement has caused an individual to remain insured when he would otherwise be disqualified in accordance with the terms and limitations of this Policy, the Company may in its absolute discretion declare the insurance of the individual to be void and annul such insurance, and there shall be a return of premiums paid in respect of the individual, provided always that where there is fraud on the part of the Policyholder or insured, no premiums paid will be returned. If any claim has been admitted and benefits paid before the Company was made aware of the misstatement, the Policyholder will on demand by the Company reimburse the Company all benefits paid or the monetary equivalent of such benefits (as may be reasonably determined by the Company) if they were not paid in cash.

Section I – Enrolment Forms

For Insurance Amount greater than the No-Evidence Limit, the Policyholder shall furnish to the Company individual enrolment forms for each Member and Dependant (where the case may be) in the form prescribed by the Company.

Section J – Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and may be enforced in accordance with the law of the Place of Issue.

Section K – Legal Proceedings

No action in law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after proof of claim has been filed in accordance with the requirements of this Policy, nor shall such action be brought at all unless brought within two (2) years from the expiration of time within which such proof of claim is required by the Policy, unless the Company agrees to otherwise in writing.

Section L – Incontestability

Notwithstanding anything to the contrary stated heretofore in this Policy, the validity of the Policy shall be incontestable, except for non-payment of premiums or for fraud, after it has been in force for one (1) year from its Date of Issue or date of any reinstatement whichever is later. The insurance of any insured and any subsequent additional insurance shall be incontestable except for non-payment of premium or for fraud, after such insured's insurance has been in force during his lifetime for one (1) year from his effective date of coverage and the date of each subsequent increase of insurance respectively.

Section M – Policy Non-Participating

This Policy shall not participate in any surplus distribution by the Company.

Section N – Limitation of Coverage

This Policy shall not cover or provide for the payment of benefits to specific persons or entities as a result of any of the following:

The application of or compliance with certain laws and regulations which prohibit performance based on the identity, domicile, place of incorporation or nationality of the Policyholder, insured, claimant, insurer, or the parent company and ultimate controlling entity of the Policyholder, insured, claimant or insurer, or the country where the claim arises.

Should any person or entity be found to have been erroneously enrolled under this Policy, insurance coverage for such person or entity shall cease with immediate effect and any unearned premiums paid in respect of such person or entity shall be refunded by the Company to the Policyholder.

Should any claim for payment of any nature be found to have been made under this Policy by a person or entity excluded by this provision, no such payment will be made.

Section O – Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC).

Section P – Contracts (Rights of Third Parties) Act, Chapter 53B

Save and except where contrary to Singapore law governing any of the benefits granted under this Policy, or where expressly provided otherwise, a person who is not a party to this Policy has no right under the Contracts (Rights of Third Parties) Act, Chapter 53B, Singapore, to enforce any term of this Policy.

Notwithstanding anything in this Policy, the consent of any third party (including a Member) is not required for any variation (including any release or compromise of any liability) or termination of this Policy.

Section Q – Personal Data

The Policyholder represents and warrants that it has obtained the consent of all individual Members and Dependants (as the case may be), except to the extent such consent is not required under relevant laws, for the Company, its associated persons and organisations, agents, brokers and other intermediaries, business partners, third party service providers and representatives, whether within or outside Singapore (collectively "AIA Persons") to collect, use, store, retain and/or process (collectively "Use") all personal data and information ("Personal Data") provided to AIA Persons or which AIA Persons possess about the Members, in the manner and for the purposes described in the AIA Personal Data Policy ("PD Policy") as may be amended from time to time, and which is available on the Company's website. The Policyholder shall indemnify AIA Persons from and against all claims, actions, losses, penalties, damages, costs and expenses arising from its breach of the provisions of this Section P. AIA Persons shall have the right to enforce any benefit under this Section P under the Contracts (Rights of Third Parties) Act, Chapter 53B.

Section R – Subcontractors and Delegates

Notwithstanding any other agreement to the contrary, the Company may in its sole and absolute discretion subcontract or delegate any of its services in the administration of the Policy or the performance of its other obligations under this Policy to a third party appointed by the Company at its own cost and expense, subject that the Company will remain responsible and liable to the Policyholder for the work and activities of each subcontractor or delegated person for the Company's obligations under this Policy.

Group Critical Ilness

THIS SUPPLEMENTARY CONTRACT is issued by AIA Singapore Private Limited (hereinafter called the "Company") and shall form a part of the Group Life & TPD Policy (hereinafter called the "Basic Policy") to which it is attached.

The Company agrees, in consideration of the payment in advance to the Company of the additional premiums applicable to this Supplementary Contract and computed in accordance with the Additional Premium Rate stated in the Schedule hereto, to cover the insured as provided by and subject to the provisions herein contained.

SECTION 1 - BASIC POLICY PROVISIONS

This Supplementary Contract is subject to all the Provisions of the Basic Policy except as herein modified. Reference in such Provisions to the Basic Policy shall be deemed, unless the context otherwise requires, to include a reference to this Supplementary Contract.

SECTION 2 - BENEFITS

IF, WHILE THIS SUPPLEMENTARY CONTRACT IS IN FORCE, an insured is diagnosed to be suffering from a Critical Illness as hereinafter defined or actually undergoes a surgery for a Critical Illness covered herein while insured hereunder, the Company shall, subject to the provisions herein contained, pay in one lump sum the Principal Sum or portion thereof as specified in Section 9 (Schedule of Critical Illness) of this Supplementary Contract.

Any payment made hereunder shall be an advance payment and shall reduce the amount of the Insurance Amount applicable to the insured.

Any payment made under this Supplementary Contract shall reduce the insured's Insurance Amount under the Basic Policy to which this Supplementary Contract is attached, to the extent of the amount paid under this Supplementary Contract.

SECTION 3 - DEFINITIONS

"**Critical Illnesses**" - shall mean illnesses or surgical procedures as herein specified of which the date of diagnosis of the illnesses or the date of diagnosis of conditions leading to performance of these surgical procedures was made more than 30 days following the later of:

(a) the effective date of this Supplementary Contract; or
(b) the effective date of coverage of the insured; or
(c) the date of reinstatement of the Policy or this Supplementary Contract.

The Company, however, shall not pay any benefits for Heart Attack of Specified Severity, Major Cancers, Coronary Artery By-pass Surgery, Angioplasty & Other Invasive Treatment For Coronary Artery or Other Serious Coronary Artery Disease if the date of diagnosis of the Heart Attack, Major Cancers or the date of diagnosis of any conditions leading to performance of Coronary Artery By-pass Surgery or Angioplasty & Other Invasive Treatment for Coronary Artery to the insured was made within 90 days from the later of:-

(a) the effective date of this Supplementary Contract; or
(b) the effective date of coverage of the insured; or
(c) the date of reinstatement of the Policy or this Supplementary Contract.

SECTION 4 - NO-EVIDENCE LIMIT

Principal Sum in excess of the No-Evidence Limit as stated in the Schedule of this Supplementary Contract may be accepted subject to evidence of insurability satisfactory to the Company, the Principal Sum shall be limited to the No-Evidence Limit and the premium charge shall be based on this amount. The No-Evidence Limit is re-determined at each Policy Anniversary and the Company reserves the right to require evidence of insurability for any increase in Principal Sum which is in excess of the new No-Evidence Limit.

SECTION 5 - EXCLUSIONS

1. No benefit is payable if any Critical Illness was diagnosed due, directly or indirectly to a congenital defect or disease which has manifested or was diagnosed before the insured attains 17 years of age.

2. No benefit is payable for Coronary Artery Surgery and/or Other Serious Coronary Artery Disease if the Insured Member had a diagnosis of “myocardial infarction” prior to the effective date of his coverage.

3. No benefit is payable for any Critical Illness which, as it can be established, was diagnosed prior to the effective date of coverage of the respective insured (and in the case of renewed coverage, "effective date of coverage" includes the effective date of coverage of all previous periods of coverage before the renewed term of the Supplementary Contract).

4. No benefit is payable for any Critical Illness if it can be established that the insured sought advice or treatment for symptoms which, in the opinion of the Company, had contributed directly or indirectly to the Critical Illness prior to the effective date of coverage of the respective insured.

SECTION 6 - FILING PROOF OF CRITICAL ILLNESS

Claims must be submitted to the Company within ninety (90) days of the date of death or the diagnosis of Critical Illness.

SECTION 7 - EXAMINATION

The Company shall have the right and opportunity to examine the insured when and so often as it may reasonably require during the pendency of claim hereunder, and also the right and opportunity to call for an autopsy in case of death where it is not forbidden by law.

The Company reserves the right to require the insured to undergo a blood test including a test for HIV as a condition precedent to the liability of the Company to make any payment.

SECTION 8 - TERMINATION OF COVERAGE

The coverage hereunder of any insured shall automatically cease on the earlier of the following dates:

(a) at the end of the Policy Period during which the insured attains the age of seventy (70) years;
(b) after the Principal Sum as insured hereunder has been fully paid;
(c) when coverage under the Basic Policy ceases.

SECTION 9 - SCHEDULE OF CRITICAL ILLNESS

1. Major Cancers

A malignant tumour positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells with invasion and destruction of normal tissue.

The term malignant tumour includes leukemia, lymphoma and sarcoma.

For the above definition, the following are excluded:

- All tumours which are histologically classified as any of the following:
  Pre-malignant;
  Non-invasive;
  Carcinoma-in-situ;
  Having borderline malignancy;
  Having any degree of malignant potential;
  Having suspicious malignancy;
  Neoplasm of uncertain or unknown behavior; or
  Cervical Dysplasia CIN-1, CIN-2 and CIN-3;
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All Prostate cancers histologically described as T1N0M0 (TNM Classification) or below; or Prostate cancers of another equivalent or lesser classification;
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- All tumours of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification) or below;
- All Gastro-Intestinal Stromal tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- Chronic Lymphocytic Leukaemia less than RAI Stage 3; and
- All tumours in the presence of HIV infection.

2. Heart Attack of Specified Severity

Death of heart muscle due to obstruction of blood flow, that is evident by at least three of the following criteria proving the occurrence of a new heart attack:

- History of typical chest pain;
- New characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block;
- Elevation of the cardiac biomarkers, inclusive of CKMB above the generally accepted normal laboratory levels or Cardiac Troponin T or I at 0.5ng/ml and above;
- Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. The imaging must be done by Cardiologist specified by the Company.

For the above definition, the following are excluded:

- Angina;
- Heart attack of indeterminate age; and
- A rise in cardiac biomarkers or Troponin T or I following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Explanatory note: 0.5ng/ml = 0.5ug/L = 500pg/ml

3. Stroke

A cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and cerebral thrombosis resulting in permanent neurological deficit with persisting clinical symptoms. This diagnosis must be supported by all of the following conditions:

- Evidence of permanent clinical neurological deficit confirmed by a neurologist at least 6 weeks after the event; and
- Findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke.

The following are excluded:

- Transient Ischaemic Attacks;
- Brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease;
- Vascular disease affecting the eye or optic nerve; and
- Ischaemic disorders of the vestibular system.

Permanent means expected to last throughout the lifetime of the Life Assured.

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

4. Coronary Artery By-pass Surgery

The actual undergoing of open-chest surgery or Minimally Invasive Direct Coronary Artery Bypass surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. This diagnosis must be supported by angiographic evidence of significant coronary artery obstruction and the procedure must be considered medically necessary by a consultant cardiologist.

Angioplasty and all other intra arterial, catheter based techniques, 'keyhole' or laser procedures are excluded.

5. Kidney Failure

Chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.

6. Aplastic Anaemia

Chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- Blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The diagnosis must be confirmed by a haematologist.

7. End Stage Lung Disease

End stage lung disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following:

- FEV_1 test results which are consistently less than 1 litre;
- Permanent supplementary oxygen therapy for hypoxemia;
- Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO_2 \leq 55mmHg$); and
- Dyspnea at rest.

The diagnosis must be confirmed by a respiratory Specialist.

8. End Stage Liver Failure

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

- Permanent jaundice;
- Ascites; and
- Hepatic encephalopathy.

Liver disease secondary to alcohol or drug abuse is excluded.

9. Coma

A coma that persists for at least 96 hours. This diagnosis must be supported by evidence of all of the following:

- No response to external stimuli for at least 96 hours;
- Life support measures are necessary to sustain life; and
- Brain damage resulting in permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

Coma resulting directly from alcohol or drug abuse is excluded.

10. Deafness (Loss of Hearing)

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by audiometric and sound-threshold tests provided and certified by an Ear, Nose, Throat (ENT) specialist.

Total means "the loss of at least 80 decibels in all frequencies of hearing".

11. Heart Valve Surgery

The actual undergoing of open-heart surgery to replace or repair heart valve abnormalities. The diagnosis of heart valve abnormality must be supported by cardiac catheterization or echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist.

12. Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

All psychiatric related causes are excluded.

13. Major Burns

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Life Assured's body.

14. Major Organ / Bone Marrow Transplantation

The receipt of a transplant of:

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

Other stem cell transplants are excluded.

15. Multiple Sclerosis

The definite occurrence of Multiple Sclerosis. The diagnosis must be supported by all of the following:

- Investigations which unequivocally confirm the diagnosis to be Multiple Sclerosis;
- Multiple neurological deficits which occurred over a continuous period of at least 6 months; and
- Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

Other causes of neurological damage such as SLE and HIV are excluded.

16. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist. The condition must result in the inability of the Life Assured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months:

Activities of Daily Living:

(a) Washing- the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
(b) Dressing- the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
(c) Transferring- the ability to move from a bed to an upright chair or wheelchair and vice versa;
(d) Mobility- the ability to move indoors from room to room on level surfaces;
(e) Toileting- the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
(f) Feeding- the ability to feed oneself once food has been prepared and made available.

For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

17. Parkinson's Disease

The unequivocal diagnosis of idiopathic Parkinson's Disease by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

- The disease cannot be controlled with medication;
- Signs of progressive impairment; and
- Inability of the Life Assured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months:

Activities of Daily Living:

(a) Washing- the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
(b) Dressing- the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
(c) Transferring- the ability to move from a bed to an upright chair or wheelchair and vice versa;
(d) Mobility- the ability to move indoors from room to room on level surfaces;
(e) Toileting- the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
(f) Feeding- the ability to feed oneself once food has been prepared and made available.

Drug-induced or toxic causes of Parkinsonism or all other causes of Parkinson's Disease are excluded.

For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

18. Surgery to Aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

Surgery performed using only minimally invasive or intra arterial techniques are excluded.

19. Alzheimer's Disease / Severe Dementia

Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the life assured. This diagnosis must be supported by the clinical confirmation of an appropriate consultant and supported by the Company's appointed doctor.

The following are excluded:

- Non-organic diseases such as neurosis and psychiatric illnesses; and
- Alcohol related brain damage.

20. Fulminant Hepatitis

A submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

- Rapid decreasing of liver size as confirmed by abdominal ultrasound;
- Necrosis involving entire lobules, leaving only a collapsed reticular framework;
- Rapid deterioration of liver function tests;
- Deepening jaundice; and
- Hepatic encephalopathy.

21. Motor Neurone Disease

Motor neurone disease characterised by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis. This diagnosis must be confirmed by a neurologist as progressive and resulting in permanent neurological deficit.

22. Primary Pulmonary Hypertension

Primary Pulmonary Hypertension with substantial right ventricular enlargement confirmed by investigations including cardiac catheterisation, resulting in permanent physical impairment of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

The NYHA Classification of Cardiac Impairment:

Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain.

Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

23. HIV Due to Blood Transfusion and Occupationally Acquired HIV

A) Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:
   - The blood transfusion was medically necessary or given as part of a medical treatment;
   - The blood transfusion was received in Singapore after the Issue Date, Date of endorsement or Date of reinstatement of this Supplementary Contract, whichever is the later;
   - The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
   - The insured does not suffer from Thalassaemia Major or Haemophilia.

B) Infection with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the Issue Date, date of endorsement or date of reinstatement of this Supplementary Contract, whichever is the later whilst the Insured was carrying out the normal professional duties of his or her occupation in Singapore, provided that all of the following are proven to the Company's satisfaction:
   - Proof of the accident giving rise to the infection must be reported to the Company within 30 day of the accident taking place;
   - Proof that the accident involved a definite source of the HIV infected fluids;
   - Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented accident. This proof must include a negative HIV antibody test conducted within 5 days of the accident; and
   - HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

This benefit is only payable when the occupation of the insured is a medical practitioner, housemen, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic (in Singapore).

This benefit will not apply under either section A or B where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.

24. Benign Brain Tumor

Benign brain tumour means a non-malignant tumour located in the cranial vault and limited to the brain, meninges or cranial nerves where all of the following conditions are met:

- It is life threatening;
- It has caused damage to the brain;
- It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit; and
- Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques.

The following are excluded:

- Cysts;
- Granulomas;
- Vascular Malformations;
- Haematomas; and
- Tumours of the pituitary gland or spinal cord.

25. Viral Encephalitis

Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

Encephalitis caused by HIV infection is excluded.

26. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

- The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
- A consultant neurologist.

Bacterial Meningitis in the presence of HIV infection is excluded.

27. Angioplasty & Other Invasive Treatment For Coronary Artery

The actual undergoing of balloon angioplasty or similar intra arterial catheter procedure to correct a narrowing of minimum 60% stenosis, of one or more major coronary arteries as shown by angiographic evidence. The revascularisation must be considered medically necessary by a consultant cardiologist.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Payment under this condition is limited to 10% of the Principal Sum under this Supplementary Contract subject to a S$25,000 maximum sum payable. This benefit is payable once only and shall be deducted from the amount of this Supplementary Contract, thereby reducing the amount of the Principal Sum which may be payable herein. Such payment will also reduce the Sum Insured under the Basic Policy to the extent of the payment made.

Diagnostic angiography is excluded.

28. Blindness (Loss of Sight)

Permanent and irreversible loss of sight in both eyes as a result of illness or accident to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in both eyes using a Snellen eye chart or equivalent test, or visual field of 20 degrees or less in both eyes. The blindness must be confirmed by an ophthalmologist.

29. Major Head Trauma

Accidental head injury resulting in permanent neurological deficit with persisting clinical symptoms to be assessed no sooner than 6 weeks from the date of the accident. This diagnosis must be confirmed by a consultant neurologist and supported by unequivocal findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques. "Accident" means an event of violent, unexpected, external, involuntary and visible nature which is independent of any other cause and is the sole cause of the head Injury.

The following are excluded:

- Spinal cord injury; and
- Head injury due to any other causes.

Permanent means expected to last throughout the lifetime of the Life Assured.

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

30. Paralysis (Loss of Use of Limbs)

Total and irreversible loss of use of at least 2 entire limbs due to injury or disease persisting for a period of at least 6 weeks and with no foreseeable possibility of recovery. This condition must be confirmed by a consultant neurologist.

Self-inflicted injuries are excluded.

31. Terminal Illness

The conclusive diagnosis of an illness that is expected to result in the death of the Life Assured within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed doctor.

Terminal illness in the presence of HIV infection is excluded.

32. Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following are excluded:

- Localised scleroderma (linear scleroderma or morphea);
- Eosinophilic fascitis; and
- CREST syndrome.

33. Apallic Syndrome

Universal necrosis of the brain cortex with the brainstem intact. This diagnosis must be definitely confirmed by a consultant neurologist holding such an appointment at an approved hospital. This condition has to be medically documented for at least one month.

34. Systemic Lupus Erythematosus With Lupus Nephritis

A multi-system, multifactorial, autoimmune disorder characterised by the development of auto-antibodies directed against various self-antigens. In respect of this contract, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

The WHO Classification of Lupus Nephritis:

Class I	Minimal Change Lupus Glomerulonephritis
Class II	Messangial Lupus Glomerulonephritis
Class III	Focal Segmental Proliferative Lupus Glomerulonephritis
Class IV	Diffuse Proliferative Lupus Glomerulonephritis
Class V	Membranous Lupus Glomerulonephritis

35. Other Serious Coronary Artery Disease

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

36. Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

- Poliovirus is identified as the cause,
- Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

37. Loss of Independent Existence

A condition as a result of a disease, illness or injury whereby the Life Assured is unable to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living", for a continuous period of 6 months.

Activities of Daily Living:

(a) Washing - the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
(b) Dressing - the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
(c) Transferring - the ability to move from a bed to an upright chair or wheelchair and vice versa;
(d) Mobility - the ability to move indoors from room to room on level surfaces;
(e) Toileting - the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
(f) Feeding - the ability to feed oneself once food has been prepared and made available.

This condition must be confirmed by the company's approved doctor.

Non-organic diseases such as neurosis and psychiatric illnesses are excluded.

For the purpose of this definition, “aided” shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

Group Accidental Death & Dismemberment

THIS SUPPLEMENTARY CONTRACT is issued by AIA Singapore Private Limited (hereinafter called the "Company") and shall form a part of the Group Life & TPD Policy (hereinafter called the "Basic Policy") to which it is attached.

The Company agrees, in consideration of the payment in advance to the Company of the additional premiums applicable to this Supplementary Contract and computed in accordance with the Additional Premium Rate stated in the Schedule of this Supplementary Contract, to cover the insured as provided by and subject to the provisions herein contained.

SECTION 1 - BASIC POLICY PROVISIONS

This Supplementary Contract is subject to all the Provisions of the Basic Policy except as herein modified. Reference in such Provisions to the Basic Policy shall be deemed, unless the context otherwise requires, to include a reference to this Supplementary Contract. Capitalized terms not otherwise defined in this Supplementary Contract shall have the meanings ascribed to them in the Basic Policy.

SECTION 2 - DEFINITIONS

In this Supplementary Contract unless stated otherwise:

1. "**Accident**" shall mean an unforeseen event, which is caused solely and directly by external, violent, sudden and accidental means.

2. **"Injury"** shall mean bodily injury which

   (a) is sustained by an insured during the period of this Supplementary Contract, and
   (b) is caused solely and directly by Accident, and
   (c) solely and independently of any other cause, except sickness or surgical treatment directly resulting from or rendered necessary by such injury,

that occasions the death or disablement of the insured within twelve (12) calendar months of the date of Accident.

3. **"Permanent"** shall mean lasting twelve (12) calendar months and at the expiry of that period beyond hope of improvement.

4. **"Loss of use"** shall mean loss in terms of physical incapacity or disability and not in terms of professional or occupational incapacity or disability.

SECTION 3 - EXPOSURE AND DISAPPEARANCE

When by reason of an Injury covered by this Supplementary Contract, an insured is exposed to the elements and as the result of such exposure suffers an event for which Compensation is otherwise payable hereunder, such event shall be covered under the terms of this Supplementary Contract.

If the body of an insured has not been found within one (1) year after the date of the disappearance, sinking or wrecking of the conveyance in which he was traveling at the time of the Injury and under such circumstances as would otherwise be covered hereunder, it shall be presumed that he suffered loss of life resulting from Injury at the time of such disappearance, sinking or wrecking.

SECTION 4 - NO EVIDENCE LIMIT

Amount of insurance in excess of the No-Evidence Limit as stated in the Policy Schedule may be accepted subject to evidence of insurability satisfactory to the Company. In the absence of written acceptance by the Company, the amount of insurance shall be limited to the No-Evidence Limit and premium charged shall be based on this amount. The No-Evidence Limit is re-determined at each Policy Anniversary and the Company reserves the right to require evidence of insurability for any increase in amount of insurance that is in excess of the new No-Evidence Limit.

SECTION 5 - BENEFITS

1. Accidental Death & Disablement Benefit

If as a result of Injury the insured suffers any Event of Loss described in the following Schedule of Indemnities, the Company, upon receipt and approval of proof, shall, subject to the provisions, conditions and limitations contained herein or which may be endorsed hereon, pay an indemnity according to the said Schedule.

2. Permanent Total Disability Benefit

If as a result of Injury and commencing within twelve (12) months from the date thereof the insured is totally and permanently disabled and prevented from engaging in any gainful occupation or employment for the remainder of his lifetime, the Company shall pay, provided such disability has continued for a period of twelve (12) consecutive months, the Principal Sum as stated in the Policy Schedule less any other amount paid or payable under this Supplementary Contract as the result of the same Injury.

(a) Mobility Aid Extension Benefit – If as a result of his becoming totally and permanently disabled, the insured needs and can operate:

i. a self-powered, climbing wheelchair; and/or
ii. his/her motor vehicle with the controls suitably adjusted; and/or
iii. a life, necessary ramps, railings and holds to usual place of residence,

the Company will reimburse ninety-five percent (95%) of the costs of such equipment and the installation thereof, up to a maximum of S$1,000.

If the insured becomes entitled to a refund of all or part of such expenses from any other source, the Company will only be liable for the excess of the amount recoverable from such other source.

3. Major Burns Benefit

If as a result of Injury the insured suffers Third Degree Burns (full thickness skin destruction) covering at least twenty-five percent (25%) of the body surface, the Company shall pay the Principal Sum less any other amount paid or payable under this Supplementary Contract as the result of the same Injury.

4. Compassionate Death Allowance Benefit

If as a result of Injury the insured dies, the Company will pay a compassionate death allowance of S$2,000, in addition to any death benefit paid or payable under this Supplementary Contract.

5. Children Education Fund Benefit

If as a result of Injury the insured dies and leaves behind any Dependant Child, the Company shall pay a one time lump sum of S$5,000.

Dependant Child shall mean any unmarried child less than twenty-five (25) years of age and unemployed.

6. Accidental Death Due To Common Carrier Benefit

If during the period of insurance, as a result of Injury whilst boarding, alighting or traveling in a duly licensed commercial aircraft as a fare-paying passenger, which directly and independently of all other causes, the insured dies within twelve (12) months of the date of the Accident, the Company will pay 10% of the Principal Sum up to a maximum of S$10,000, in addition to any death benefit payable for the insured under this Supplementary Contract.

7. Comatose State Due To Common Carrier Benefit

If during the period of insurance, as a result of Injury whilst boarding, alighting or traveling in a duly licensed commercial aircraft as a fare-paying passenger, which directly and independently of all other causes, the insured is hospitalized and in a Comatose State, within thirty (30) days of the date of the Accident, the Company will pay twenty percent (20%) of the Principal Sum as stated in the Policy Schedule, up to a maximum of S$20,000.

Comatose State means a state of unconsciousness with no reaction or response to external stimuli or internal needs, persisting continuously with the use of life support systems, for a continuous period of at least ninety-six (96) hours. Permanent neurological deficit, as certified by a consultant neurologist, must be present.

SECTION 6 - RISKS EXCLUDED

The insurance under this Supplementary Contract shall not cover any loss or disability caused directly or indirectly, wholly or partly, by any one of the following occurrences:

i. self-destruction or any attempt thereat, while sane or insane;
ii. war, declared or undeclared, revolution or any warlike operations;
iii. participation in a riot, violation or attempted violation of the law or resistance to arrest;
iv. Traveling or flying in, ascending or descending from any aerial device or aircraft, unless the insured is traveling as a fare-paying passenger in a duly licensed commercial aircraft and the said aircraft was not engaged in any rescue, instructional or training purposes during such flight;
v. racing on horse or wheels.

SECTION 7 - FILING PROOF OF LOSS

Written notice of death of any insured must be given to the Company within ninety (90) days after the death of such insured.

1. In the event an insured is afflicted with Total and Permanent Disability, full particulars together with the address and whereabouts of the insured must be given in writing to the Company as soon as reasonably possible and satisfactory proof of such disability must be furnished to the Company within ninety (90) days after the commencement of the disability.

2. Written notice given by or on behalf of the insured to the Company with particulars sufficient to identify the insured, shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in this Policy shall not invalidate any claim if it is proved by or on behalf of the claimant that it was not reasonably possible to give such notice within the prescribed period, and that such notice was given as soon as it was reasonably possible to do so.

   All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Policyholder or the Policyholder's legal representative and shall be in such form and of such nature as the Company may prescribe. The Company shall have the right and opportunity to examine the insured as and when and as often as it may reasonably be required pending any claim or the payment of any claims made under this Policy. The Company may also require the insured to furnish, at his expense, evidence to establish the continuing health condition of the insured, including the submission of documents and information, where applicable, to prove that the insured has not been engaged in any form of employment for the period relevant to the claim and continues to remain unemployed.

3. Any medical adviser of the Company or Registered Medical Practitioner acceptable to the Company shall be allowed to examine the insured at the insured's expense in such manner and at the times such medical adviser, Registered Medical Practitioner or the Company may require. If the insured is residing in a country outside Singapore, the Company may at its discretion require the insured to come to Singapore for medical examinations by a Registered Medical Practitioner in Singapore.

4. Proof of the date of birth of the insured must be furnished to the Company before any claim will be admitted or payable. If the date of birth and/or age of any insured notified to the Company is incorrect, the Company shall not be liable to pay more than the amount which would be payable under this Policy if the date of birth and/or age had been correctly stated.

SECTION 8 - PAYMENT OF INDEMNITIES

Unless stated to the contrary in the Policy to which this Supplementary Contract is attached, and if applicable, the following shall apply:

i. Indemnity for loss of life of the insured is payable to the Policyholder.
ii. All other indemnities under this Supplementary Contract are payable to the Insured Member.

SECTION 9 - PRIOR LOSSES

If an insured hereunder has sustained prior to his Entry Date, or shall thereafter sustain any of the loss described in the following Schedule of Indemnities, the insurance hereunder on such insured shall be issued or continued for the full amount in accordance with the Schedule of Indemnities hereunder, provided, however, that for any subsequent loss of which payment is to be made hereunder, payment shall be made in accordance with the above Schedule of Indemnities for the specific loss resulting from such subsequent accident without reference to any previous loss.

SCHEDULE OF INDEMNITIES

Event of Loss	% of Principal Sum
1. Loss of Life	100.0%
2. Permanent Total disablement	150.0%
3. Loss of or the permanent total loss of use of two limbs	150.0%
4. Loss of or the permanent total loss of use of one limb	125.0%
5. Permanent total loss of sight of both eyes	150.0%
6. Permanent total loss of sight of one eye	100.0%
7. Loss of or the permanent total loss of use of	
- one limb and loss of sight of one eye	150.0%
8. Loss of speech and hearing	150.0%
9. Permanent and incurable insanity	100.0%
10. Permanent total loss of hearing in	
- both ears	75.0%
- one ear	25.0%
11. Loss of speech	50.0%
12. Permanent total loss of the lens of one eye	50.0%
13. Loss of or the permanent total loss of use of four fingers and thumb of	
- right hand	70.0%
- left hand	50.0%
14. Total loss of or the permanent total loss of use of four fingers of	
- right hand	40.0%
- left hand	30.0%
15. Loss of or the permanent total loss of use of one thumb	
- both right phalanges	30.0%
- one right phalanx	15.0%
- both left phalanges	20.0%
- one left phalanx	10.0%
16. Loss of or the permanent total loss of use of fingers	
--three right phalanges	10.0%
- two right phalanges	7.5%
- one right phalanx	5.0%
- three left phalanges	7.5%
- two left phalanges	5.0%
- one left phalanx	2.0%
17. Loss of or the permanent total loss of use of toes	
- all-one foot	15.0%
- Great toe-two phalanges	5.0%
- Great toe-one phalanx	3.0%
- Other than great toe, each toe	1.0%
18. Fractured leg or patella, with established non-union	10.0%
19. Shortening of leg by at least 5 cm	7.5%

COMPENSATION: -

a. The total compensation payable for any disabilities due to the same Injury is arrived at by adding together the various percentages but shall not exceed 150% of the Principal Sum and there shall be no further liability under the Policy in respect of the same insured for Injury sustained thereafter;

b. The Company shall in its absolute discretion determine the percentage payable for any Permanent Disablement not otherwise provided for under Events 2 to 19 inclusive:

c. If the insured is left-handed, the percentage for the various disabilities of right hand and left hand will be transposed.