GREAT PLATINUM BENEFITS

Great Eastern Life

Table of Contents

Group Hospital & Surgical

THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED

(Reg. No. 1908 00011G)

HEAD OFFICE:
1 Pickering Street #13-01, Great Eastern Centre, SINGAPORE 048659.

GREAT PLATINUM BENEFITS
GROUP HOSPITAL AND SURGICAL POLICY

Group Policy Number : G000XXXX

Policyholder : ABC COMPANY LTD

Policy Commencement Date : 01 Jun 2021

Whereas the Policyholder has requested The Great Eastern Life Assurance Company Limited (hereinafter called "the Company") to grant the benefits hereinafter referred to. The Company hereby agrees to pay to the Policyholder the benefits subject to all the terms, conditions and provisions of this Policy. This Policy is issued in consideration of payment of the necessary premiums and shall take effect on the Policy Commencement Date.

IN WITNESS WHEREOF, the Company has caused this Policy to be signed as of 1 June 2021 (issue date).

Koh Beng Seng
Chairman

Norman Ip
Director

GREAT PLATINUM BENEFITS
GROUP HOSPITAL AND SURGICAL POLICY

Table of Contents

GREAT PLATINUM BENEFITS
GROUP HOSPITAL AND SURGICAL POLICY

GREAT PLATINUM BENEFITS
GROUP HOSPITAL AND SURGICAL POLICY

SECTION I - GENERAL DEFINITIONS

In this Policy where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

(1) "**Accident**" means an unexpected, unintended, unforeseeable event causing injury to an Insured Member or Insured Dependant. The Accident must happen while the Insured Member or Insured Dependant is covered under this Policy.

(2) "Accidental Injury" means any bodily injury caused solely and directly by Accident, and independently of any other cause.

(3) "**Actively At Work**" means reporting for work at the place assigned by the Policyholder and performing, in the customary manner, all the regular duties of his employment with the Policyholder on full time basis or being on entitled annual leave for reasons other than on medical grounds.

(4) "**Any One Disability**" means all disabilities arising from the same cause, including any and all complications therefrom. Subsequent recurrence or relapse from the same cause shall be treated as a new disability if it is separatedby 14 calendar days following the latest discharge from the Hospital of the Insured Member or Insured Dependant

(5) "**Bodily Injury**" or "**Bodily Injuries**" means a bodily injury sustained by an Insured Member or Insured Dependant and is caused by an Accident.

(6) "**Class 1 Occupation classification**" means a professional, managerial, administrative, clerical, non-manual occupation or work of a supervisory nature which does not involve the use of tools and machinery or exposure to special hazards.

(7) "**Class 2 Occupational classification**" means a work involving substantial amount of traveling, or manual work not of a particularly hazardous nature but involving the use of tools and machinery.

(8) "**Class 3 Occupational classification**" means a work involving a fair amount of manual works for example, with machinery, chemicals or construction.

(9) "**Daily Room and Board**" means actual Standard Room accommodation charges (including room and board in a high dependency unit), meals and general nursing care incurred per day while the Insured Member or Insured Dependant is in Hospital Confinement.

(10) "**Effective Date**" means the date from which the insurance coverage of the Insured Member or Insured Dependant as specified under this Policy has become effective.

(11) "**Eligibility Date**" means the date agreed in writing between the Policyholder and the Company on which an Eligible Member is eligible to participate in the insurance coverage under this Policy.

(12) "**Eligible Dependant**" means:

(i) The legal spouse of a Eligible Member who is not divorced or separated, and who has not attained the age of 70 years at the Policy Commencement Date or the age of 75 years at Renewal Date; or
(ii) An unmarried and unemployed natural or step child(ren) from a legal marriage or legally adopted child(ren) of a Eligible Member who is between attained age of 15 days old (and discharged from hospital immediately after birth) and 25 years old (next birthday) at the Policy Commencement Date or Renewal Date;

who is a Singaporean or Singapore Permanent Resident or with a valid employment pass (EP holders, S Pass, or Work Permit holders)/ Dependant pass and is residing in Singapore.

(13) "**Eligible Expenses**" means expenses which are covered according to the provisions of this Policy.

(14) "**Eligible Member**" means members as specified in the Policy Schedule and whose eligibility to participate in the insurance plan under this Policy has been agreed in writing between the Policyholder and the Company.

(15) "**Evidence of Insurability**" means the health declaration form completed by the Eligible Member or Eligible

Dependant or any underwriting requirements advised by the Company.

(16) "**Foreign Based Employee**" means a permanent full time employee of the Policyholder who is residing, or is based, outside the Republic of Singapore for more than one year and engaged in a Class 1 or 2 Occupation.

(17) "**Foreign Based Employee's Dependant**" means a person who qualifies as a Dependant and he is not residing in the Republic of Singapore.

(18) "**GST**" means the goods and services tax payable under the Goods and Services Tax Act, Chapter 117A of Singapore.

(19) "**Government**" refers to the government of the Republic of Singapore.

(20) "Home Country" means the country of citizenship declared on the Personal Health Declaration/Proposal Form under the heading of "Nationality". In the event of dual nationality the Home Country will be taken to mean the country which the Insured Member has declared on the Personal Health Declaration/Proposal Form. Where dependants are included under the Policy, the Home Country for all dependants will be deemed to be the same Home Country as declared for that Insured Member in the Personal Health Declaration/Proposal Form.

(21) "**Hospital**" means an establishment constituted and registered as a hospital for the care and treatment of sick and injured persons as bed-paying patients and which

(a) has facilities for diagnosis and major surgery, provides 24 hours a day nursing services by registered graduate nurses and is under constant supervision of one or more Registered Medical Practitioners;
(b) is not a clinic, an alcoholic or drug rehabilitation centre, a nursing, rest or convalescent home, a spa or a hydroclinic or similar establishment;
(c) is not a community hospital unless:

(i) it is for continuity of medical treatments immediately following discharge from a Singapore Government Hospital,
(ii) it must be referred by a Registered Medical Practitioner from a Singapore Government Hospital,
(iii) it is not for respite care, and
(iv) it is essential for medical as distinct from domestic reasons

(22) "**Hospital Confinement**" means confinement of an Insured Member or Insured Dependant in a Hospital:

(a) for at least 6 consecutive hours and in which a room and board charge is made in connection with such confinement; or
(b) for any duration because of a surgical procedure without incurring any charge for Room and Board.

(23) "**Illness**" means a physical condition marked by a pathological deviation from normal healthy state.

(24) "**Insured Dependant**" means any Eligible Dependant, in respect of whom insurance under this Policy has been effected

(25) "**Insured Member**" means an Eligible Member, in respect of whom an insurance coverage under this Policy has been effected.

(26) **"Maximum Coverage Age"** means the maximum age of coverage as specified in the Policy Schedule attached hereto.

(27) "**Maximum Limit per Policy Period**" means the maximum amount of benefits payable under SECTION III - BENEFIT PROVISIONS.

(28) "**Medical Services**" means medically necessary services and medical examinations to be provided to an Insured Member or Insured Dependant on account of an Illness or Injury, other than the services excluded under SECTION IV – LIMITATIONS AND EXCLUSIONS of this Policy.

(29) "**Policy**" means this agreement, any rider or endorsement therein, any amendment signed by the Company, the application of the Policyholder, medical reports and any individual proposal form or any other form signed by the Insured Member or Insured Dependant or the Policyholder constituting the entire contract.

(30) "**Policy Commencement Date**" means the date from which the insurance coverage under this Policy becomes effective.

(31) "**Policy Period**" means a period of one calendar year or such other periods as may be agreed in writing between the Company and the Policyholder, starting from the Policy Commencement Date for the first Policy Period and from the respective Renewal Dates for subsequent Periods of Insurance.

(32) "**Pre-Existing Condition**" means any illnesses, diseases, injuries or impairments from which the Insured Member or Insured Dependant is suffering, whether known or unknown to the Insured Member or Insured Dependant as long as the cause or pathology of the conditions has already existed before the Effective Date in respect of the Insured Member or Insured Dependant under this Policy.

(33) "**Reasonable and Customary Charges**" means charges that do not exceed the general level of charges made by providers of medical services of similar standing in Singapore for similar or comparable treatment or services or supplies for similar Illness or Injury.

(34) "**Registered Medical Practitioner**" means a person qualified by degree in western medicine and legally licensed and authorised to practice medicine and surgery in the geographical area of his country, who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(35) "**Renewal Date**" means the date immediately following the last day of any Policy Period as stated in the endorsement to this Policy.

(36) "**Singapore Government Hospital**" or "**Singapore Government Restructured Hospital**" means any of the Hospitals classified as a Singapore Government Hospital or Singapore Government Restructured Hospital respectively by the Ministry of Health in Singapore.

(37) "**Specialist**" means a Registered Medical Practitioner, qualified by a degree in western medicine, possesses a specialist qualification recognized by the Singapore Medical Council or its equivalent in the geographical area of his country, accredited with the Specialist Accreditation Board under the Ministry of Health in Singapore or its equivalent and who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(38) "**Standard Room**" means the class of hospital ward, which is categorized as standard by the Hospital in which the Insured Member or Insured Dependant is confined as an inpatient and shall not include luxury suites or other special rooms that exist at the Hospital in addition to standard room.

(39) "**Surgery**" means any of the following surgical operations not otherwise excluded under this Policy in a Hospital or a legally licensed clinic (for day surgery) and performed by a duly qualified surgeon or Registered Medical Practitioner and involving local or general anaesthesia:

(a) incision, excision and suturing of wounds (excluding removal of suturing); or
(b) electrocautery and laser techniques; or
(c) reduction of a fracture and dislocation by manipulation; or
(d) the use of endoscopic procedures other than purely for routine examination purposes.

(40) **"Traditional Chinese Medicine (TCM)"** means the group of TCM practitioner which are registered in Singapore with the TCM Practitioners Board or its equivalent in the geographical area of his country to provide Medical Services to the Insured Member or Insured Dependant.

(41) "**Usual Country of Residence**" means the country in which the Insured Member declared on the Personal Health Declaration/Proposal Form. A permanent change in the Usual Country of Residence shall be deemed to mean the Insured Member 's living or intending to live in another country for a period in excess of 180 consecutive days

(42) "**Visit**" means a personal visit during which the Registered Medical Practitioner or Specialist or Traditional Chinese Medicine Practitioner actually see the Insured Member or Insured Dependant..

(43) "**We**" or "**our**" or "**us**" or "**the Company**" means The Great Eastern Life Assurance Company Limited.

(44) "**You**" or "**your**" or "**Policyholder**" means the person, persons or corporation named as the Policyholder in the Schedule of this Policy.

SECTION II - GENERAL PROVISIONS

1. Eligibility and Commencement of Insurance

   (a) All Eligible Members who are Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement Date shall be covered under this Policy on such date, unless otherwise agreed by the Company.

   (b) All Eligible Members who are not Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement Date shall not be covered under this Policy and shall only be covered on the date they are Actively At Work, unless otherwise agreed by the Company.

   (c) All new and existing employees of the Policyholder becoming eligible after the Policy Commencement Date will be covered on their respective Eligibility Dates provided that they are Actively At Work on their respective Eligibility Dates. Any Eligible Member who is on medical leave or in hospital on his respective Eligibility Date, will be covered on the date he returns to active service at work.

   (d) An Insured Member or Insured Dependant whose insurance coverage under this Policy was terminated due to any cause and who re-applies for insurance coverage shall be considered as a new member.

   Depending on the Company assessment of the evidence provided by the Eligible Member, the Company reserve the right to accept the Eligible Member's application of insurance at standard rates and terms, or impose extra loading, and/or additional terms and conditions to allow the Eligible Member who does not fulfil the above criteria to be eligible for insurance, or decline the application.

2. Eligible Dependant's Participation and Insurance

   (a) Section II Clause 2 of this Policy is valid only upon the application of the Eligible Dependant's coverage by the Policyholder and the Company's acceptance of the Eligible Dependant's application in writing.

   (b) Insurance on an Eligible Dependant will start on his Eligibility Date provided he is not hospitalised, or on medical leave and is in good health.

3. Termination

   (a) The coverage of any Insured Member shall automatically be terminated on the earliest of the following dates:

      (i) The date of termination of his active full-time employment with the Policyholder;

      (ii) The date on which this Policy is terminated;

      (iii) The date of expiration of the period for which the last premium payment is made in respect of his coverage;

      (iv) The end of the Policy Period during which the Insured Member reaches his Maximum Coverage Age;

      (v) When the Insured Member begins his temporary leave of absence, vacation without pay, sick or injured for more than 6 months. Written notice shall be given to the Company within 14 days after the end of the 6th month of such occurrence;

      (vi) The date the Insured Member dies;

      (vii) The date that this Policy is terminated in accordance with Section II Clause 3(c) and 3(d) of this Policy.

   (b) The coverage of any Insured Dependant shall automatically be terminated on the earliest of the following dates:

      (i) The date the insurance of the Insured Member to whom the Insured Dependant is a dependant is terminated;

      (ii) The date on which this Policy is terminated;

(iii) The date of expiration of the period for which the last premium payment is made in respect of his coverage;

(iv) The end of the Policy Period during which the Insured Dependant reaches his Maximum Coverage Age;

(v) The date the Insured Dependant no longer qualifies as an Eligible Dependant as defined in Section I Clause 12 of this Policy and his insurance will end on the last day of the Policy Period during which he no longer qualifies as an Eligible Dependant;

(vi) The date that this Policy is terminated in accordance with Section II Clause 3(c) and 3(d) of this Policy.

(c) This Policy shall be terminated on the date notified to the Policyholder by the Company to terminate the Policy by virtue of war (declared or undeclared) or act of war (whether or not there has been a declaration of war) where such date shall be at the discretion of the Company.

(d) This Policy may be terminated by either the Company or the Policyholder by giving thirty-one (31) days notice in writing. Termination of this Policy by the Policyholder or by the Company shall be without prejudiceto any claim arising prior to such termination. If the Policy is terminated by the Company, a prorata premiumwill be charged for the period the Policy was in force. If the Policyholder terminates the Policy the premium charged will be based on the following scale:

Period Of Cover	Premium Charged
Up to 1 Month	3 Months
More than 1 Month and Up to 2 Months	4 Months
More than 2 Months and Up to 3 Months	5 Months
More than 3 Months and Up to 4 Months	6 Months
More than 4 Months and Up to 5 Months	7 Months
More than 5 Months and Up to 6 Months	8 Months
More than 6 Months and Up to 8 Months	10 Months
More than 8 Months	12 Months

4. Premium

Premium is payable to the Company in advance on each premium due date, unless otherwise specified by the Company in writing. The payment of any premium shall not maintain the coverage under this Policy in force beyond the date when the next premium becomes payable, except as set forth in the provision below entitled ‘Grace Period’.

The Company reserves the right to change the rate at which the premiums are calculated on any Renewal Date or when the risks being insured under this Policy have substantially increased and provided further that the Company notifies the Policyholder at least thirty (30) days in advance.

5. Renewal Privilege

This Policy shall be renewed for a further term of one policy year on each Renewal Date subject to the consent of the Company.

6. Grace Period

It is a condition precedent to liability under this Policy that 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 Policy Commencement Date or Renewal Date of the Policy, or thirty (30) days from the date of the premium/tax invoice issued by the Company, whichever is the later, or

(b) Where the premium is payable other than on annual basis,

(i) Thirty (30) days from the Policy Commencement Date or Renewal Date of the Policy or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is the later, for the first instalment, and

(ii) on the agreed premium payment dates for subsequent instalments.

Where the Policyholder has confirmed its intention to renew the Policy but has not provided the Company with the complete data necessary for the renewal of the Policy by the renewal date, the Company shall issue a premium tax invoice for the estimated renewal premium. The premium tax invoice will be issued within thirty (30) days from the date of risk inception. The payment of the estimated premium under the premium tax invoice shall be subject to the Grace Period.

(c) In the event that any premium is not paid to the Company within the Grace Period, the Company reserves the right to terminate this Policy from the Renewal Date and the Company shall be discharged from all liability therefrom.

No claim incurred within the Grace Period shall be paid until premiums due under this Policy relating to the respective Policy Period is received in full by the Company.

7. Data Required

(a) The Policyholder shall furnish to the Company all such data, information and evidence as the Company may reasonably require upon or with regard to the happening of any event affecting or relating to the insurance coverage of any Insured Member or Insured Dependant under this Policy. Clerical errors in keeping the Policyholder's records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated. But upon discovery of such error, an equitable adjustment will be made.

(b) The Company shall be permitted to examine the Policyholder's records at all reasonable times, as far as they relate to the subject matter of this Policy.

(c) The Policyholder shall give immediate notice to the Company of any change in the nature of its business which increases the risks already being insured under this Policy and shall pay additional premium that may be required by the Company.

8. Assignment or Succession

If the business of the Policyholder shall be assigned to or succeeded by any person, persons or corporation, then subject to the consent of the Company, the payment of premiums under this Policy may at the option of such person, persons or corporation be continued in which case such person, persons or corporation shall as from the date of such assignment or succession take the place of and be treated for all purposes of this Policy (including this present condition) as being the Policyholder hereof.

9. Evidence of Age

Documentary evidence of age satisfactory to the Company shall be required before any benefit in respect of any coverage under this Policy shall be payable.

If the age has been under-stated, the amount payable shall be only such sum as the premium paid would purchase according to the premium rate at the true age. If the age is over-stated the excess of premium will be refunded.

10. Misstatement

Where a misstatement of age or other relevant facts has caused an Insured Member or Insured Dependant to be Insured hereunder when he is otherwise ineligible for insurance coverage, or where such statement has caused an Insured Member or Insured Dependant to remain insured when he would otherwise be disqualified for further insurance coverage in accordance with the terms and limitations of this Policy, his insurance coverage shall be void and there shall be a refund of premiums paid in respect of the Insured Member or Insured Dependant, provided always that where there is fraud on the part of the Policyholder or Insured Member or Insured Dependant, no premiums paid are to be refunded.

11. Contract

All statements relating to material facts made by the Policyholder or by an Insured Member or Insured Dependant shall, in the absence of fraud, be deemed representations and not warranties and no such statement shall avoid this Policy or be used in defence of a claim thereunder, unless it is in writing.

No agent or broker is authorised to make or to modify this contract, to extend the time for payment of premium, to

waive any lapse or forfeiture, to waive any of the Company's rights or requirements, or to bind the Company by making any promise or by accepting any representation or information in respect of this Policy.

This Policy cannot be varied unless approved in writing by the Company.

12. Alteration of Contract

The Company shall be entitled to amend the terms and conditions of this Policy by giving you thirty (30) days' prior written notice and such amendments shall be evidenced by endorsements issued and signed by the Company.

13. Arbitration

All differences arising out of the Policy or incidental thereto or to the insurance coverage hereby effected shall be referred to a single arbitrator to be appointed in writing by the parties, or if they cannot agree upon a single arbitrator, to two arbitrators, one to be appointed in writing by each party and such arbitrators shall before commencing their investigations elect an umpire. In all other respects the arbitration shall be subject to the statutory provisions for the time being in force relating to arbitration. Unless and until an award has been made, no action or other legal proceedings shall be commenced in respect of any claim or by virtue of this Policy. After the expiration of two years from the date of an event giving rise to a claim under this Policy, the Company shall not be liable in respect thereof unless the Company shall have admitted liability in respect of such claim or the claim shall in the meantime have been referred to arbitration.

14. Exclusion of Contracts (Rights Of Third Parties) Act Cap. 53B

This Policy is a contract between the Company and the Policyholder. A person who is not a party to this Policy shall have no right under the Contracts (Rights of Third Parties) Act Cap. 53B and any subsequent amendments to the Act, to enforce any of its terms. Insured Members or Insured Dependant are not parties to this Policy and shall have no rights whatsoever under this Policy.

15. Operation of Law

This Policy shall be construed according to and governed by the law of Singapore.

16. Data Use

The Policyholder hereby confirms and represents to the Company and its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives"), that each Insured Member or Insured Dependant has agreed and consented to the disclosure of his/her personal data to the Companies and their Representatives, the Companies' authorised service providers and relevant third parties (collectively, "Great Eastern Persons") for their collection, use and/or disclosure of the personal data for purposes reasonably required by the Companies to provide the insurance coverage under this Policy. In respect of the Insured Members or Insured Dependant who are subsequently enrolled into this Policy, the Policyholder further undertakes that it shall ensure and procure that each of such Insured Member or Insured Dependant has provided such agreement and consent in relation to his/her personal data for such purposes.

The above mentioned purposes are set out in the Company's Privacy Statement, which is accessible from Great Eastern Singapore's website and which the Policyholder hereby confirms that both the Policyholder and the Insured Members or Insured Dependant have read and understood.

The consents referred to herein are cumulative and additional to any rights which any of the Great Eastern Persons may have to collect, use, and/or disclose the insured Members' or Insured Dependants' personal data, with or without consent, to the extent permitted under applicable law.

17. Non-Participation

This Policy does not participate in the profits of the Company.

18. Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for the Policy is automatic and no further action is required from the Policyholder. For more information on the types of benefits that are covered under the scheme as well as the

limits of coverage, where applicable, please contact the Company or visit the Life Insurance Association (LIA) or SDIC websites (www.lia.org.sg or www.sdic.org.sg).

19. Geographical Limits

The coverage provided under this Policy is twenty-four (24) hours a day worldwide unless otherwise endorsed or amended.

20. Currency

Premiums and benefits payable under this Policy shall be in Singapore currency unless otherwise endorsed or amended.

SECTION III – BENEFIT PROVISIONS

1. Extent of Benefits

(a) Inpatient Benefits

(i) If an Insured Member or Insured Dependant is in Hospital Confinement or undergoes Surgery as a result of an Illness or Bodily Injury while he is insured under this Policy, we will pay the benefits as described below according to the Schedule of Benefits and subject to the terms, conditions, limitations, exclusions and provisions of this Policy.

(ii) All benefits under this Policy are applicable to the Insured Member or Insured Dependant for 24 hours a day without geographical limitation. However, we will only pay for Reasonable and Customary Charges incurred on charges made to an Insured Member or Insured Dependant on his medical treatment.

(iii) If an Insured member or Insured Dependant is in Hospital Confinement or undergoes Surgery as a result of an Illness or Bodily Injury while he is insured under this Policy, we will pay the benefits subjected to the Reasonable and Customary Charges, except Daily Room & Board benefit where the Company will assess according to his entitled ward type.

The Company's claims liability is limited to the charges with reference to the guidelines and published fee benchmarks provided by Ministry of Health in Singapore.Wherever such publications are not available, the Company reserves the rights to decide on the amount, that is claimable, subjected to the Policy terms.

The benefits under this Policy are applicable without geographical limitations.

2. Inpatient Benefits

(a) Daily Room and Board

(i) We will reimburse the actual Daily Room and Board charges incurred by an Insured Member or Insured Dependant during his Hospital Confinement, based on the Hospital's prevailing room and board charges for the class of ward which the Insured Member or Insured Dependant is entitled to, as specified in the Schedule of Benefits.

(ii) Daily Room and Board means actual room and board (including room and board in a high dependency unit), meals and general nursing care incurred per day while the Insured Member or Insured Dependant is in Hospital Confinement.

(b) Intensive Care Unit / High Dependency Unit

(i) If an Insured Member or Insured Dependant is warded in an intensive care unit/high dependency unit while in Hospital Confinement, we will reimburse the actual charges up to the maximum benefit limit as stated in the Schedule of Benefits.

(ii) The aggregate number of days for which the charges are payable in respect of Daily Room and Board

charges for intensive care unit/high dependency unit shall not exceed the overall maximum of days stay as stated in the Schedule of Benefit for the Intensive Care Unit/High Dependency Unit Benefit.

(c) Hospital Miscellaneous Services

If an Insured Member or Insured Dependant is warded in a Hospital, we will reimburse the actual amount charged by the Hospital for any of the following services rendered during such Hospital Confinement which are customarily supplied by the Hospital for the Insured Member or Insured Dependant's use:

(i) Drugs and Medicines consumed during his Hospital Confinement;

(ii) Dressings, Ordinary Splints and Plaster casts;

(iii) X-ray Examinations;

(iv) Electrocardiograms;

(v) Basal Metabolism Tests;

(vi) Laboratory Tests;

(vii) Intravenous Infusions;

(viii) Blood Transfusions;

(ix) Head/brain scan and ultrasound;

(x) Anaesthesia and oxygen and their administration (not exceeding 25% of the Surgical Benefits eligible);

(xi) An operating room; and

(xii) Ambulance fee subject to a maximum of S$150

(d) Surgery

(i) If an Insured Member or Insured Dependant undergoes a Surgery in a Hospital, we will reimburse the actual surgical fee charged for the Surgery.

(ii) If the surgery for a condition resulting from Illness or Bodily Injury is performed either through a single or multiple incisions in various stages over a period of time, all the surgical fees charged in the various stages for the said condition will be aggregated in computing the maximum amount payable as shown in the Schedule of Benefits.

(e) In-Hospital Attending Doctor’s Visit

(i) If an Insured Member or Insured Dependant is confined to a Hospital but no Surgery is performed, we will reimburse the fee charged by the attending Registered Medical Practitioner for Visits in the hospital regardless of number of Visits per day.

(ii) Where Surgery has been performed on the Insured Member or Insured Dependant, such consultation fees shall form part of the Surgery Benefit as specified in Section III Clause (d) above.

(f) Pre-Hospitalisation Specialist Consultation

If an Insured Member or Insured Dependant incurred charges for Specialist consultation (including medications) which are recommended by a Registered Medical Practitioner, we will reimburse these charges provided Hospital Confinement or Surgery is required within 120 days after the Specialist Consultation.

(g) Pre-Hospitalisation Diagnostic X-Ray and Laboratory Tests

If an Insured Member or Insured Dependant incurs charges for diagnostic X-ray and laboratory tests which are recommended by a Registered Medical Practitioner, we will reimburse these charges incurred provided

Hospital Confinement or Surgery is required within 120 days after the diagnostic X-ray and laboratory tests.

(h) Post Hospitalisation/Surgery Treatment

If an Insured Member or Insured Dependant incurs expenses for follow-up treatments for the same disability provided by the Registered Medical Practitioner treating him during his hospitalization, we will reimburse the expenses incurred for follow-up treatment within 120 days immediately following his discharge from the Hospital or clinic (in the case of day-surgery), including medication, diagnostic, laboratory tests, outpatient physiotherapy and in connection to this same disability.

(i) Emergency Outpatient Treatment Benefit (due to Accidents Only)

If an Insured Member or Insured Dependant sustains Bodily Injury as a result of an Accident and within 24 hours from the time of the Accident, was given emergency outpatient treatment in a hospital or at a Registered Medical Practitioner's clinic, we will reimburse the Reasonable and Customary Charges incurred for such treatment and any follow-up treatment up to 31 days from date of the Accident. The total amount payable must not exceed the maximum benefit limit as shown in the Schedule of Benefits for Emergency Outpatient Treatment Benefit (due to Accidents Only).

(j) Emergency Outpatient Dental Treatment Benefit (due to Accidents Only)

If an Insured Member or Insured Dependant sustains Bodily Injury as a result of an Accident and within 24 hours from the time of the Accident, was given emergency outpatient dental treatment provided by a dentist in a hospital clinic, we will reimburse the Reasonable and Customary Charges incurred for such treatment and any follow-up treatment up to 31 days from date of the Accident. The total amount payable must not exceed the maximum benefit limit as shown in the Schedule of Benefits for Emergency Outpatient Dental Treatment Benefit (due to Accidents Only).

(k) Miscarriage

We will reimburse the actual charges incurred by the Insured Member or Insured Dependant for non-elective miscarriage due to an Accident or medical reason or ectopic pregnancy which requires in-hospital or outpatient treatment by a Registered Medical Practitioner, up to the maximum benefit limit as stated in the Schedule of Benefit for Miscarriage Benefit, excluding charges incurred during prenatal treatments.

(l) Surgical Implants

Eligible charges for surgical implants which are medically necessary and recommended by the attending Registered Medical Practitioner in connection with a surgical operation, shall be payable up to the maximum limit as specified in the Schedule of Benefits.

(m) Funeral Expense

The Funeral Expense benefit will be payable upon satisfactory proof of death of the Insured Member or Insured Dependant due to any causes. The total amount payable must not exceed the maximum limit as shown in the Schedule of Benefits for Funeral Expense.

(n) Outpatient Kidney Dialysis

(i) If an Insured Member or Insured Dependant incurs expenses for outpatient kidney dialysis at a registered dialysis centre or unit, which are recommended by a Registered Medical Practitioner, the Company shall reimburse the Insured Member or Insured Dependant these fees and charges incurred provided such benefit is specifically provided for under the Schedule of Benefit of this Policy. All related eligible outpatient expenses incurred by the Insured Member or Insured Dependant in respect of Kidney Dialysis is payable subject to the c o-payment amount or co-Insurance (where applicable) and maximum benefit limit as stated in the Schedule of Benefits for Outpatient Kidney Dialysis Benefit.

(ii) Notwithstanding anything contrary to Section IV clause 2(a) this benefit shall not be payable if an Insured Member or Insured Dependant had been diagnosed or received medical treatment or has been prescribed treatment for kidney diseases or its related conditions prior to the Effective Date of the Insured Member's or Insured Dependant's cover for the Outpatient Kidney Dialysis a unless the Insured Member orInsured Dependant has already been continuously insured, without lapse in coverage for at least 12 months with a similar Group Hospital and Surgical Insurance Policy issued in Singapore and which provides similar

coverage for Outpatient Kidney Dialysis or under this Policy or with both.

(o) Outpatient Cancer Treatment

(i) If an Insured Member or Insured Dependant incurs expenses for cancer treatment at an outpatient department of a Hospital or a registered cancer treatment centre which are recommended by a Registered Medical Practitioner, we will reimburse these fees and charges incurred provided such benefit is specifically provided for under the Schedule of Benefit of this Policy. Eligible outpatient expenses incurred by the Insured Member or Insured Dependant are in respect of chemotherapy (including immunotherapy), radiotherapy, erythropoietin, and cyclosporin treatment. The total amount payable must not exceed the maximum benefit limit and co-payment or co-Insurance (where applicable) as stated in the Schedule of Benefits for Outpatient Cancer Treatment.

(ii) Notwithstanding anything contrary to Section IV clause 2(a), this benefit shall not be payable if an Insured Member or Insured Dependant had been diagnosed or received medical treatment or has been prescribed treatment for cancer or its related conditions prior to the Effective Date of the Insured Member or Insured Dependant's coverage for the Outpatient Cancer Treatment unless the Insured Member or Insured Dependant has already been continuously insured, without lapse in coverage for at least 12 months with a similar Group Hospital and Surgical Insurance Policy issued in Singapore and which provides similar coverage for Outpatient Cancer Treatment or under this Policy or with both.

(p) Dread Disease Recuperation Benefit

The Company shall pay the lump sum benefit as specified in the Schedule of Benefits if an Insured Member or Insured Dependant or Insured Dependant is diagnosed as suffering from any one of the four (4) Critical Illnesses: Major Cancer, Heart Attack of Specified Severity, Stroke with Permanent Neurological Deficit, Coronary Artery By-pass Surgery.

(i) Major Cancer

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 Major Cancer includes, but is not limited to, leukemia, lymphoma and sarcoma.

Major Cancer diagnosed on the basis of finding tumour cells and/or tumour-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence does not meet the above definition.

For the above definition, the following are excluded:

- Pre-malignant;
- Non-invasive;
- Carcinoma-in situ (Tis) or Ta;
- Having borderline malignancy;
- Having any degree of malignant potential;
- Having suspicious malignancy;
- Neoplasm of uncertain or unknown behavior; or All grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL) and intra epithelial neoplasia;
- Any non-melanoma skin carcinoma, skin confined primary cutaneous lymphoma and dermatofibrosarcoma protuberans 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 Neuroendocrine tumours 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 Stage I or IA according to the latest edition of the AJCC Cancer Staging Manual, or below;
- Chronic Lymphocytic Leukaemia less than RAI Stage 3; and

- All bone marrow malignancies which do not require recurrent blood transfusions, chemotherapy targeted cancer therapies, bone marrow transplant, haematopoietic stem cell transplant or other major interventionist treatment; and
- All tumours in the presence of HIV infection.

(ii) Heart Attack of Specified Severity

Death of heart muscle due to ischaemia, 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

(iii) Stroke with Permanent Neurological Deficit

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;
- Ischaemic disorders of the vestibular system; and
- Secondary haemorrhage within a pre-existing cerebral lesion.

(iv) 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.

The Company shall pay this dread disease recuperation Benefit provided that such Major Cancer, Heart Attack of Specified Severity, Stroke with Permanent Neurological Deficit, Coronary Artery By-pass Surgery takes place after 90 days following the date on which an Insured Member or Insured Dependant is first covered under this policy.

The Company shall pay the Benefit under SECTION III - BENEFIT PROVISIONS 2(p) Dread Disease Recuperation only for the first instance suffered by an Insured Member or Insured Dependant after the

commencement of this policy and only once during the lifetime of this policy in respect of each Insured Member or Insured Dependant.

(q) Mental Wellness

This Policy is extended to cover hospitalisation received by Insured Member or Insured Dependant for mental wellness condition. The treatment must be provided by a registered mental health practitioner

The mental health practitioner must be registered with the Singapore Association of Counselling, Singapore Psychological Society, Singapore Psychiatric Association or a registered medical practitioner who is recognised by the Singapore Medical Council or its equivalent in the geographical area of his practice.

The benefit includes follow-up treatments provided or recommended by the same registered mental health practitioner which are incurred within one hundred and twenty (120) days immediately following his discharge from the hospital.

The total benefit payable shall not exceed the maximum limit as stated in the Schedule of Benefits for Mental Wellness.

(r) Rehabilitation Benefit

If an Insured Member or Insured Dependant is recommended by the attending Registered Medical Practitioner to recuperate in a community/rehabilitation Hospital registered and approved by the Ministry of Health of Singapore, the Company shall pay for the actual charges incurred in such confinement subject to a maximum of 31 days after hospitalization or surgery, but not to exceed the maximum benefit limit of S$5,000 per Insured Member or Insured Dependant per Policy Period.

(s) Overseas Hospitalisation (due to Accident)

If an Insured Member or Insured Dependant sustains Bodily Injury from an Accident while travelling outside of Singapore and as a result of such Injury requires hospitalization overseas, the Company shall pay for the actual expenses incurred for such hospitalization, up to the maximum benefit limit as shown in the Schedule of Benefits. Coverage shall apply to travel within 180 days of departure from Singapore.

(t) Parental Accommodation

If an Insured Dependant child age below 12 (next birthday), upon the recommendation of a Registered Medical Practitioner, is admitted to a Hospital for which benefits are payable under this Policy, the Company shall reimburse the actual charges of the daily cost of an additional bed in the same room for either the parent or legal guardian staying with the Insured Dependant child, up to maximum of 60 days per Policy Period as shown in the Schedule of Benefits.

(u) Home Nursing

If an Insured Member or Insured Dependant has been admitted into a Hospital for which benefits are payable, and upon discharge from the Hospital, as deemed medically necessary by the attending Registered Medical Practitioner, requires the services of a medically qualified and licensed nurse in the Insured Member's or Insured Dependant’s home to provide nursing services, the Company shall pay the actual charges of the cost of such nursing services, up to the maximum of 182 days per Policy Period as shown in the Schedule of Benefits.

The plan and schedule of the nursing care must be established and prescribed in writing by the attending Registered Medical Practitioner for the continued treatment of the specific medical condition for which the Insured Member or Insured Dependant has been hospitalised for. No payment shall be made for services provided with respect to custodial care, meals preparation, general housekeeping services, companionship, rest cure, convalescence or personal comfort issues.

(v) Hospital Cash Benefit

When an Insured Member or Insured Dependant is warded in the following Class of Ward in a Singapore Restructured Hospital, the respective hospital cash benefit shall apply accordingly:

Class of Ward	Hospital Cash Benefit per day of Hospital Confinement
B1	S$150
B2/B2+	S$250
C	S$300

The above shall be subjected to the following conditions:-

(i) Hospital Cash Benefit is only applicable for Hospital Confinement (excluding Day Surgery); and
(ii) The entire length of Hospital Confinement must be in the same class of ward; and
(iii) The Hospital Cash Benefit is payable for a maximum 90 days per Any One Disability.

The above Hospital Cash Benefits are not applicable to Foreign Workers (Employment Pass, Work Permit and S-Pass Holders).

(w) Emergency Medical Evacuation

This benefit applies while an Insured Member or Insured Dependant are traveling:

(i) Outside the Home Country or Usual Country of Residence on holiday or business not exceeding 90 consecutive days per trip, and

(ii) Within the Home Country or Usual Country of Residence

but excluding war zones and countries where the prevailing conditions render evacuation impracticable.

The Company and its medical advisers reserve the absolute right to decide if the Insured Member or Insured Dependant's medical condition is sufficiently serious to warrant Emergency Medical and/or Repatriation. The Company or its medical advisers shall also decide the place to which the Insured Member or Insured Dependant shall be evacuated and the means by which the evacuation should be carried out, having regard to all the assessed facts and circumstances of which the Company is aware at the relevant time.

The Company will only pay for evacuation or repatriation arrangements if it is prior approved and authorized by Our 24-hour Emergency Assistance Centre.

The Company will pay in full for the Insured Member or Insured Dependant's reasonable transportation costs to be evacuated for inpatient treatment if the treatment required is covered under the Policy and is recommended by a Registered Medical Practitioner for medical reasons and is not available locally. This must be approved in advance by the 24-hour Emergency Assistance Centre. The Insured Member or Insured Dependant must provide the Company with any information or proof that the Company may reasonably ask to support the request.

The Company will only pay for the evacuation of the Insured Member or Insured Dependant requiring the treatment to the nearest place where the treatment is available. This could be another part of the country which he or she is in if this is appropriate. Please note that the nearest country may not be the Insured Member or Insured Dependant's Home Country.

(x) Repatriation of Mortal Remains

(i) In the event of an Insured Member or Insured Dependant's death while travelling outside his country of residence, the Company through its appointed service provider ("Appointed Service Provider") or an authorized representative of the Appointed Service Provider shall organize and arrange for the return of the mortal remains of the deceased Insured Member or Insured Dependant to his country of residence or country of origin. The service shall be organised and managed by the Appointed Service Provider subject to the prior authorisation and request from the Company to provide so.

(ii) The costs and expenses incurred from the organizing of the repatriation of mortal remains shall include, but are not limited to:-

- transportation of the deceased Insured Member's or Insured Dependant’s body from the place of death to the nearest airport to his place of residence or country of origin; and/or
- actual expenses incurred for the services and supplies provided by a mortician or undertaker, including but not limited to the cost of a casket and embalming and cremation if so elected; and/or
- relevant documents such as death certificate, embalming certificate, death autopsy report or other

associated certificates, paper documents or necessary government authorisations; and/or

(iii) The maximum amount payable for this benefit shall be the actual expenses incurred but shall not exceed a maximum amount of S$75,000. The said maximum amount is inclusive of the corresponding benefit payable under Group Term Life and Group Hospitalisation and Surgical, where applicable.

(iv) Exclusions:

No benefit shall be payable under any of the following circumstances:

- The total length of stay when he/she travels outside his country of residence or country of regular employment or country of origin exceed 90 consecutive days per trip.
- Services rendered without the authorization and/or intervention of the Appointed Service Provider.
- Services rendered by any other party apart from the Appointed Service Provider for which no charge is usually made.
- Medical treatment administered by the Insured Member's or Insured Dependant's immediate family members or relatives, whether being a qualified medical practitioner or not.
- Where the Insured Member or Insured Dependant has already been undergoing medical treatment at the time before the Insured Member or Insured Dependant commences his journey and the costs and expenses concerned relates to that treatment, or if the said journey was undertaken against the order or advice of a medical practitioner.
- The Insured Member or Insured Dependant was traveling with the intention of obtaining medical treatment overseas.

SECTION IV – LIMITATIONS AND EXCLUSIONS

1. Limitations

When an Insured Member or Insured Dependant is entitled to benefits payable under the Work Injury Compensation Act or similar legislation, government or public programme of medical benefits, other group or individual insurance, the benefits payable under this Policy shall be the lower of:

(a) the balance of charges not covered by benefits payable under such law, legislation, programme or other insurances; or

(b) the amount calculated from the Schedule of Benefits of this Policy.

2. Exclusions

An Insured Member or Insured Dependant shall not be eligible for any benefits in respect of any fees or charges incurred for any of the following services provided to the Insured Member or Insured Dependant unless specifically provided for in the Schedule of Benefits of this Policy:

(a) Any Pre-Existing Condition of the Insured Member or Insured Dependant which originated before the Effective Date of his insurance unless he has already been continuously insured, without lapse in coverage for at least 12 months under this Policy or unless otherwise agreed by us except for Dread Disease Recuperation Benefit whereby any pre-existing condition is permanently excluded.

(b) All treatments relating to congenital anomalies and congenital sickness or anomalies or genetic defects present at or existing from the time of his birth regardless of the time of discovery of such anomalies or defects and the time of such treatment or surgical procedure for the same.

(c) Self-inflicted injuries, or injuries sustained as a result of a criminal act or attempted suicide (while sane or insane); nervous and mental conditions (Save for Section III clause 2(q) benefits); alcoholism or drug addiction.

(d) All treatments pertaining to sterilisation, infertility (including procedures done at fertility clinic, reproductive assistance clinic or reproductive medicines clinics or centres), sexual dysfunction, sex-reassignment operation or procedure, impotency and use of birth control methods; sex and growth hormone replacement therapies.

(e) All treatments occasioned by or resulting from pregnancy, childbirth (including diagnostic tests for pregnancy), miscarriage, abortion and all complications arising from any of the same except for non-elective miscarriage due to medical reason and ectopic pregnancy.

(f) Any dental work or treatment, oral surgery, orthodontics and orthognathic surgery; temporo-mandibular joint disorder; eye examination and vision care, surgical procedure for correction of eye refraction, Laser treatment of eye, procurement or use of contact lenses or eye glasses; speech therapy.

(g) All health screening related examinations, including multiphasic health screening, laboratory tests and X-rays, and screening mammograms; services (irrespective of whether there is hospital confinement) for the primary purpose of diagnosis, medical check-up, genetic screening; immunisation/vaccinations, outpatient physiotherapy, procedures not generally recognised as standard medical practice such as hydrotherapy, traditional Chinese medicine, acupuncture, osteopathic, podiatric, chiropractic, foot reflexology, experimental treatment and procedure under investigation.

(h) All treatments for xanthelasma, scar, keloid, syringoma, acne, alopecia, cosmetic skin surgeries, inguinal hernia (except if Insured Member or Insured Dependant is more than 5 years old), hydrocele and all complication; Circumcision (except where it is medically necessary) or treatment relating to the same; vitamins and health supplement; house-call or office calls by Registered Medical Practitioner

(i) All treatments for cosmetic and plastic surgery for the purposes of beautification and any complication arising thereof except for cosmetic and plastic surgery which are medically necessary arising from injury sustained as a result of an Accident occurring while the Insured Member or Insured Dependant is insured under this Policy.

(j) All treatments for sleep apnea including sleep study, obesity, weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition or whether treatment is medically necessary.

(k) All treatments for any type of sexually-transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) and all illnesses or diseases caused by or related to the Human Immunodeficiency Virus (HIV).

(l) Outpatient treatment for chemotherapy, radiotherapy, immunotherapy, kidney dialysis, unless provided in the Schedule of Benefits of this Policy.

(m) Rest cares, sanatoria care or special nursing care; treatment or services that are not medically necessary or reasonably required for the illness or bodily injury caused by an Accident; treatments, services and supplies not recommended, approved and performed by a Registered Medical Practitioner or which are not medically necessary for the treatment of an Illness or Bodily Injury; administrative or other charges of a non-medical nature e.g. telephone calls, referral fees or medical report fees.

(n) Procurement of hearing aids, wheel-chairs, all forms of home aids, dialysis machine and any other hospital-type equipment; stem cell support therapy, treatment following brain death, Interferon and other biological response modifiers.

(o) Injuries or sickness arising directly or indirectly from insurrection, war or act of war (whether declared or undeclared), direct participation in strikes, riots or civil commotion, or full-time service in any of the armed forces including National Service under Section 10 of the Enlistment Act, Cap. 93 of the Republic of Singapore except National Service reservist duty or training under Section 14 of the Enlistment Act, Cap. 93 of the Republic of Singapore.

(p) Hospital Confinement or treatments occurring and received by the Insured Member or Insured Dependant after the Insured Member or Insured Dependant ceases to be insured under this Policy.

SECTION V – COVERAGE FOR INSURED MEMBER OR INSURED DEPENDANT ABOVE AGE 70 NEXT BIRTHDAY

1. Insured Member or Insured Dependant who are accepted and insured under this Policy before attaining their seventieth (70) birthdays, shall be eligible for continuation of coverage beyond age seventieth (70) years next birthday at the Renewal Date, subject to the following conditions:

   (a) Participation shall be on compulsory basis

(b) The premium payable shall be based on age-related premium.

(c) The maximum benefit payable shall be as per the limits provided under the Schedule of Benefits.

SECTION VI – COVERAGE FOR FOREIGN BASED EMPLOYEE OR FOREIGN BASED EMPLOYEE'S DEPENDANT

1. This Policy will not insure any person who is residing or based outside Singapore unless:

   (a) the total number of Foreign Based Employees or Foreign Based Employee's Dependant are not more than 10% of the total group size; and

   (b) the person is a Foreign Based Employee or Foreign Based Employee's Dependant as defined under Section I of this Policy; and

   (c) the Policyholder has declared to the Company the name of the Foreign Based Employee or Foreign Based Employee's Dependant and the country in which he is residing or based in; and

   (d) the Company has advised the Policyholder in writing of the terms of acceptance of insurance on that Foreign Based Employee or Foreign Based Employee's Dependant. Insurance coverage on the Foreign Based Employee or Foreign Based Employee's Dependant will not start until the Company has accepted such cover in writing.

2. The Company reserves the right to decline insurance on any Foreign Based Employee or Foreign Based Employee's Dependant who is based or residing in a country where the risk is not acceptable to the Company.

3. If a Foreign Based Employee's or Foreign Based Employee's Dependant's name has not been declared to the Company, the Company reserves the right to decline any claim for benefit under this Policy or adjust the benefit amount payable in respect of that Foreign Based Employee or Foreign Based Employee's Dependant.

4. Upon any Renewal Date of this Policy, the continuation of coverage for any Foreign Based Employee or Foreign Based Employee's Dependant on or after the Renewal Date will be subject to acceptance by the Company in writing, and on such terms and conditions which the Company may choose to impose.

SECTION VII – CLAIMS

1. Notice & Proof of Claim

   (a) The Insured Member or Insured Dependant or his legal representative must notify us in writing within 30 days after the happening of any event likely to give rise to a claim under this Policy. However, the claim will not be invalidated if it can be shown that it was not reasonably possible for him to notify us within this period.

   (b) Written notice of death of any Insured Member or Insured Dependant must be given within 30 days after the death of the Insured Member or Insured Dependant. Satisfactory proof of death must be given to the Company within 90 days after the death of the Insured Member or Insured Dependant. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

   (c) If an Insured Member or Insured Dependant is permanently disabled, written notice must be given within 30 days after the commencement of the Hospital Confinement permanent disability of the Insured Member or Insured Dependant. Satisfactory proof of disability must be given to the Company within 90 days after the commencement of the permanent disability of the Insured Member or Insured Dependant. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

   (d) Written notice given by or on behalf of the Insured Member or Insured Dependant to the Company with particulars sufficient to identify the Insured Member or Insured Dependant 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 shall be shown not to have been reasonably possible to give such notice and that such notice was given as soon as was reasonably possible.

(e) All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Insured Member or Insured Dependant or the Insured Member's or Insured Dependant'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 Member or Insured Dependant 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.

(f) If the Insured Member or Insured Dependant is residing in a country outside Singapore, the Company may at its discretion require the Insured Member or Insured Dependant to come to Singapore for medical examination by a Registered Medical Practitioner in Singapore.

(g) The Company may also require the Policyholder to furnish at his expense evidence to establish the continuing health condition of the Insured Member or Insured Dependant and to show that the Insured Member or Insured Dependant is not engaged in any form of employment.

(h) Proof of the date of birth of the Insured Member or Insured Dependant 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 Member or Insured Dependant 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.

(i) In case of death, the Company has the right to investigate the circumstances of death, to have a post-mortem examination either before or after burial. In the event of an accidental death, a police report and post-mortem report must be submitted to the Company.

2. Payment of Benefit

(a) All benefits shall be paid only when the claim shall have been proven to the satisfaction of the Company and the total amount of compensation shall have been ascertained and agreed upon by the Company and Policyholder.

(b) Any amount payable under this Policy will be paid to the order of the Policyholder, unless the Policyholder otherwise notifies in writing. Any payment so made shall effectively discharge the Company from any further liability in respect thereof.

(c) If the medical or hospital bills submitted for reimbursement of benefits under this Policy are not expressed in Singapore currency, we will convert the amount of the bills into Singapore currency at the rate of exchange as determined by the Company.

3. Fraudulent Claims

If any claim under this Policy is in any respect, fraudulent or if any fraudulent means or devices shall be used by the Policyholder or an Insured Member or Insured Dependant or any one acting on behalf of the said parties to obtain a benefit under this Policy, the Company shall be under no liability in respect of such claims and shall be entitled to recover any payment made prior to the discovery of fraud.

SECTION VIII – COMPANY NOT LIABLE

The Company shall not be held responsible or be liable as a party in any way whatsoever to any legal proceeding for damages or otherwise, which may be instituted by any Insured Member or Insured Dependant against any provider of Medical Services for reasons of neglect, malpractice or other causes arising from acts or omissions in the treatment or examination of the Insured Member or Insured Dependant by any provider of Medical Services as provided in this Policy.

In providing a service to an Insured Member or Insured Dependant, the Company and its authorised providers may supply information including medical information pertaining to the treatment of the Insured Member or Insured Dependant to the Policyholder.

Neither the Company nor its employees nor its authorised providers shall be liable for any loss or damage suffered by the Policyholders, Insured Member or Insured Dependant due to any error or omission in the information supplied however caused if the supply of information had been made in good faith by the Company or its authorised providers.

GREAT PLATINUM BENEFITS
GROUP HOSPITAL AND SURGICAL POLICY

SECTION IX – PREMIUM TABLE

Plan Type	Plan 1	Plan 2	Plan 3
Age Band (next birthday)	Annual Premium per Insured Member or Insured Dependant (S$) (inclusive of GST)		
30 and below	1,052.00	1,014.00	930.00
31 - 35	1,243.00	1,199.00	1,099.00
36 - 40	1,266.00	1,221.00	1,118.00
41 - 45	1,513.00	1,460.00	1,338.00
46 - 50	1,765.00	1,702.00	1,560.00
51 - 55	2,364.00	2,281.00	2,090.00
56 - 60	2,951.00	2,848.00	2,609.00
61 - 65	4,267.00	4,115.00	3,772.00
66 - 70	6,148.00	5,931.00	5,436.00
71 - 75*	8,861.00	8,549.00	7,833.00

*Renewal only

The above premium rates are subject to the prevailing rate of GST (where applicable). The prevailing rate of GST is subject to change.

GREAT PLATINUM BENEFITS
GROUP HOSPITAL AND SURGICAL POLICY

SCHEDULE OF BENEFITS

Schedule of Benefits		**Plan 1**	**Plan 2**	**Plan 3**
(Maximum Limit per Policy Period)		**S$**	**S$**	**S$**
a)	Daily Room & Board (per day up to maximum 120 days inclusive of ICU)	**1 Bed Private Standard**	**1 Bed Private Standard**	**1 Bed Private Standard**
b)	Intensive Care Unit (ICU)	As Charged	As Charged	As Charged
c)	Hospital Miscellaneous Services	As Charged	As Charged	As Charged
d)	Surgery (Waiver of Surgical Schedule)	As Charged	As Charged	As Charged
e)	In-Hospital Doctor's Visits (per day up to maximum of 120 days)	As Charged	As Charged	As Charged
f)	Pre-Hospitalisation Diagnostic X-Ray & Lab. Tests (Within 120 days prior to hospitalisation)	As Charged	As Charged	As Charged
g)	Pre-Hospitalisation Specialist Consultation (Within 120 days prior to hospitalisation)	As Charged	As Charged	As Charged
h)	Post-Hospitalisation/Surgery Treatment (Up to 120 days upon discharge from hospital)	As Charged	As Charged	As Charged
i)	Emergency Outpatient Treatment (due to accident only)	As Charged	As Charged	As Charged
j)	Emergency Outpatient Dental Treatment (due to accident only)	As Charged	As Charged	As Charged
k)	Miscarriage (including ectopic pregnancy)	As Charged	As Charged	As Charged
l)	Surgical Implants	10,000	10,000	5,000
m)	Funeral Expense	10,000	10,000	10,000
n)	Outpatient Kidney Dialysis (maximum per Policy Period)	75,000	75,000	50,000
o)	Outpatient Cancer Treatment (maximum per Policy Period)	75,000	75,000	50,000
p)	Dread Disease Recuperation Benefit (Major Cancer, Heart Attack of Specified Severity, Stroke with Permanent Neurological Deficit, Coronary Artery By-pass Surgery)^	10,000	10,000	5,000
q)	Mental Wellness (maximum per Policy Period)	10,000	10,000	5,000
r)	Rehabilitation Benefit (up to maximum 31 days)	5,000	5,000	5,000
s)	Overseas Hospitalisation due to Accident	As Charged	As Charged	As Charged
t)	Parental Accommodation (For child age below 12, up to maximum 60 days per Policy Period)	As Charged	As Charged	As Charged
u)	Home Nursing (up to maximum 182 days per Policy Period)	As Charged	As Charged	As Charged
v))	Hospital Cash Benefit (up to 90 days of confinement in Government Restructured Hospital) - B1 Ward - B2/B2+ Ward - C Ward	 150 250 300	 150 250 300	 150 250 300
w)	Emergency Medical Evacuation*	75,000	75,000	50,000
x)	Repatriation of Mortal Remains*	75,000	75,000	50,000
	Overall Maximum Limit per Policy Period (applicable to all benefits except items marked with *)	**500,000**	**300,000**	**150,000**

Note:

^ These covered Dread Disease fall under the Life Insurance Association Singapore (LIA)'s standard definitions for 37 severe-stage Critical Illness (Version 2019). You may refer to www.lia.org.sg for the standard definitions (Version 2019). Pre-existing conditions are permanently excluded for this benefit.

THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED

(Reg. No. 1908 00011G)

HEAD OFFICE:
1 Pickering Street #13-01,
Great Eastern Centre,
SINGAPORE 048659.

GREAT PLATINUM BENEFITS
GROUP CLINICAL CONTRACT RIDER

This Contract Rider shall be attached to and form part of the Group Hospital and Surgical Policy (hereinafter called "the Policy") No. G000XXXX with effect from 01 June 2021, and is valid only if the Policy is in full force. The provisions of the Policy shall apply to this Contract Rider to the extent that the same are not inconsistent with the terms and conditions, exclusions and limitations hereof.

SECTION I – GENERAL DEFINITIONS

In this Contract Rider where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

(1) **"Accident"** means an unexpected, unintended, unforeseeable event causing injury to an Insured Member or Insured Dependant. The Accident must happen while the Insured Member or Insured Dependant is covered under this Contract Rider.

(2) "**Bodily Injury**" or "**Bodily Injuries**" means a bodily injury sustained by an Insured Member or Insured Dependant and is caused by an Accident.

(3) "**Co-payment**" means the amount of Eligible Expenses payable per visit under the Schedule of Benefits that has to be borne by the Insured Member or Insured Dependant.

(4) "**Effective Date**" means the date from which the insurance coverage of the Insured Member or Insured Dependant as specified under this Contract Rider has become effective.

(5) "**Eligibility Date**" means the date agreed in writing between the Policyholder and the Company on which an Eligible Member is eligible to participate in the insurance coverage under this Contract Rider.

(6) "**Eligible Dependant**" means:

a) The legal spouse of a Eligible Member who is not divorced or separated, and who has not attained the age of 70 years at the Policy Commencement Date or 75 years at Renewal Date; or
b) An unmarried and unemployed natural or step child(ren) from a legal marriage or legally adopted child(ren) of a Eligible Member who is between attained age of 15 days old (and discharged from hospital immediately after birth) and 25 years old (next birthday) at the Policy Commencement Date or Renewal Date;

who is a Singaporean or Singapore Permanent Resident or with a valid employment pass (EP holders, S Pass, or Work Permit holders)/ Dependant pass and is residing in Singapore.

(7) "**Eligible Expenses**" means expenses which are covered according to the provisions of this Contract Rider.

(8) "**Eligible Member**" means members as specified in the Policy Schedule and whose eligibility to participate in the insurance plan under this Policy has been agreed in writing between the Policyholder and the Company.

(9) "**General Practitioner**" means a Registered Medical Practitioner, qualified by a degree in western medicine, who is registered with the Singapore Medical Council or its equivalent in the geographical area of his country, and conducts Medical Services in an Outpatient Clinic setting and not at a specialist level, and who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(10) "**GST**" means the goods and services tax payable under the Goods and Services Tax Act, Chapter 117A of Singapore.

(11) "**Government**" refers to the government of the Republic of Singapore.

(12) "**Hospital**" means an establishment constituted and registered as a hospital for the care and treatment of sick and injured persons as bed-paying patients and which

(a) has facilities for diagnosis and major surgery, provides 24 hours a day nursing services by registered graduate nurses and is under constant supervision of one or more Registered Medical Practitioners;
(b) is not a clinic, an alcoholic or drug rehabilitation centre, a nursing, rest or convalescent home, a spa or a hydroclinic or similar establishment;
(c) is not a community hospital unless:

(i) it is for continuity of medical treatments immediately following discharge from a Singapore Government Hospital,
(ii) it must be referred by a Registered Medical Practitioner from a Singapore Government Hospital,
(iii) it is not for respite care, and
(iv) it is essential for medical as distinct from domestic reasons

(13) "**Hospital Confinement**" means confinement of an Insured Member or Insured Dependant in a Hospital:

(a) for at least 6 consecutive hours and in which a room and board charge is made in connection with such confinement; or
(b) for any duration because of a surgical procedure without incurring any charge for Room and Board.

(14) "**Illness**" means a physical condition marked by a pathological deviation from normal healthy state.

(15) "**Insured Dependant**" means any Eligible Dependant, in respect of whom insurance under this Policy has been effected

(16) "**Insured Member**" means an Eligible Member, in respect of whom an insurance coverage under this Policy has been effected.

(17) "**Medical Services**" means medically necessary services and medical examinations provided to an Insured Member or Insured Dependant on account of an Illness or Injury, other than the services excluded under SECTION III – LIMITATIONS and SECTION IV – EXCLUSIONS

(18) "**Member Card**" means an identification card issued by the Company to an Insured Member or Insured Dependant.

(19) "**Non-Panel Clinic**" means a General Practitioner clinic in Singapore who is not on the Company's approved panel of Registered Medical Practitioners.

(20) "**Outpatient Clinic**" means either:

(a) A General Practitioner Clinic which is registered and licensed by Ministry of Health in Singapore; or
(b) A Government Polyclinic in Singapore; or
(c) An Accident & Emergency (A&E) Department of any Hospital in Singapore; or
(d) A General Practitioner clinic outside Singapore which is registered and licensed to practice western medicine in the geographical area of his country, and shall not include, any Hospital, or any alternative treatment clinic or centre (where alternative treatment includes, but is not limited to, chiropractic treatment, acupuncture, homeopathy, physiotherapy and reflexology).

(21) "**Panel Clinic**" means the group of General Practitioner clinic in Singapore designated and approved by the Company to provide Medical Services to the Insured Member or Insured Dependant.

(22) "**Panel Radiological and Laboratory Facilities**" means the group of radiological and laboratory facilities in Singapore designated and approved by the Company to provide diagnostic x-ray and laboratory tests to the Insured Member or Insured Dependant.

(23) "**Policy**" means this agreement, any rider or endorsement therein, any amendment signed by the Company, the application of the Policyholder, medical reports and any individual proposal form or any other form signed by the Insured Member or Insured Dependant or the Policyholder constituting the entire contract.

(24) "**Policy Commencement Date**" means the date from which the insurance coverage under this Contract Rider becomes effective.

(25) "**Policy Period**" means a period of one calendar year or such other periods as may be agreed in writing between the Company and the Policyholder, starting from the Policy Commencement Date for the first Policy Period and from the respective Renewal Dates for subsequent Periods of Insurance.

(26) "**Reasonable and Customary Charges**" means charges that do not exceed the general level of charges made by providers of medical services of similar standing in Singapore for similar or comparable treatment or services or supplies for similar Illness or Injury.

(27) "**Registered Medical Practitioner**" means a person qualified by degree in western medicine and legally licensed and authorised to practice medicine and surgery in the geographical area of his country, who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(28) "**Renewal Date**" means the date immediately following the last day of any Policy Period as stated in the endorsement to this Contract Rider.

(29) "**Second Opinion**" means the consulting of a second Specialist for the same medical condition for which the Insured Member or Insured Dependant elects to consult on his own regardless if a referral has been given by a Panel Clinic or any Registered Medical Practitioner.

(30) "**Singapore Government Hospital**" or "**Singapore Government Restructured Hospital**" means any of the Hospitals classified as a Singapore Government Hospital or Singapore Government Restructured Hospital respectively by the Ministry of Health in Singapore.

(31) "**Standard Diagnostic X-ray and Laboratory Tests**" means the following diagnostic procedures including but not limited to x-ray, ultrasound, mammography, echocardiogram, spirometry, tonometry, treadmill stress test, diabetes retinal screening and laboratory tests.

(32) "**Traditional Chinese Medicine (TCM)**" means the group of TCM practitioner which are registered in Singapore with the Ministry of Health to provide Medical Services to the Insured Member or Insured Dependant.

(33) "**Traditional Chinese Medicine Practitioner**" shall means a person who is legally authorised and registered by the Ministry of Health of Singapore or in the geographical area of his practice, to practice Traditional Chinese Medicine, and who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(34) "**Visit**" means a personal visit during which the General Practitioner or Specialist actually see the Insured Member or Insured Dependant.

(35) "**We**" **or** "**our**" **or** "**us**" **or** "**the Company**" means The Great Eastern Life Assurance Company Limited.

(36) "**You**" **or** "**your**" **or** "**Policyholder**" means the person, persons or corporation named as the Policyholder in the Schedule of this Contract Rider.

SECTION II – BENEFIT PROVISIONS

The Company will pay the benefits described below for the charges which are made to an Insured Member or Insured Dependant in connection to his Medical Services,

(1) which results directly from an Illness or Bodily Injury of the Insured Member or Insured Dependant; and

(2) which are incurred while he is insured under this Contract Rider; and

(3) subject to the terms, conditions, limitations, exclusions and provision of this Contract Rider and General Provisions of the Policy.

(a) Medical Services at Panel Clinic

(i) If an Insured Member or Insured Dependant presents his valid Medical Card when visiting a Panel Clinic, the Panel Clinic will provide Medical Services, to the Insured Member or Insured Dependant, without requiring any payment from the Insured Member or Insured Dependant, except if this Contract Rider has a Co-payment provision.

(ii) If this Contract Rider has a Co-payment provision, then the Insured Member or Insured Dependant must pay the Panel Clinic the Co-payment amount per Visit as stated in the Schedule of Benefits of this Contract Rider.

(iii) If an Insured Member or Insured Dependant did not present his valid Member Card to the Panel Clinic without valid reason, he must pay the fees and charges for the Medical Services to the Panel Clinic and we may refuse reimbursement of charges incurred without assigning any reason.

(b) Medical Services at a Government Polyclinic in Singapore

If an Insured Member or Insured Dependant Visits a Government polyclinic in Singapore and pays the fees and charges for the Medical Services, the Company shall reimburse the Insured Member or Insured Dependant these fees and charges incurred on an as charged basis, subject to the Co-payment or co-insurance amount (where applicable) and maximum limit as stated in the Schedule of Benefits of this Contract Rider.

(c) Medical Services at an Accident & Emergency Department of any Hospital in Singapore

If an Insured Member or Insured Dependant visits an Accident & Emergency Department of any Hospital in Singapore and incurs the fees and charges for the Medical Services, the Company shall reimburse the Insured Member or Insured Dependant these fees and charges incurred, subject to the Co-payment amount (where applicable) and benefit limit as stated in the Schedule of Benefits.

For any benefits payable under this clause, the Company will make payment to the Panel Clinic and Hospitals with which it has a payment arrangement. Otherwise, the Company will make payment directly to the Policyholder and/orthe Insured Members or Insured Dependant.

(d) Medical Services at Panel Radiological and Laboratory Facilities

If an Insured Member or Insured Dependant Visits a Panel Radiological or Laboratory Facilities for Standard Diagnostic X-ray and Laboratory Tests upon a written referral by a Panel Clinic in connection to an Illness or Bodily Injury, the Panel Radiological or Laboratory Facilities will provide the laboratory or radiological services to the Insured Member or Insured Dependant, without requiring any payment from the Insured Member or Insured Dependant.

(e) Medical Services at Non-Panel Clinic in Singapore

If an Insured Member or Insured Dependant visits an Outpatient Clinic which is not a Panel Clinic, and pays the fees and charges for the Medical Services including Standard Diagnostic X-ray and Laboratory Tests, the Company shall reimburse the fees and charges incurred by Insured Member or Insured Dependant provided such benefit is specifically provided for under the Schedule of Benefits. The amount payable is subject to the Co-payment amount (where applicable) and benefit limit as stated in the Schedule of Benefits.

(f) Medical Services at Outpatient Clinic Outside Singapore

If an Insured Member or Insured Dependant visits an Outpatient Clinic outside Singapore and pays the fees and charges for the Medical Services, the Company shall reimburse the Insured Member or Insured Dependant these fees and charges incurred provided such benefit is specifically provided for under the Schedule of Benefits. The amount payable is subject to the Co-payment amount (where applicable) and benefit limit as stated in the Schedule of Benefits.

(g) Medical Services at Traditional Chinese Medicine (TCM)

If an Insured Member or Insured Dependant visits a Traditional Chinese Medicine Practitioner on an outpatient basis in connection to an illness or Bodily Injury, the Company shall pay or reimburse the Insured Member or Insured Dependant these fees and charges incurred provided such benefit is specifically provided for under the Schedule of Benefit of this Policy. The amount payable is subject to the Co-payment amount (where applicable) and the maximum benefit limit as stated in the Schedule of Benefits of this Policy.

(h) Flu Vaccination

The Company shall reimburse the charges for flu vaccination that are incurred by the Insured Member or Insured Dependant, to the maximum limit per Policy Period as stated in the Schedule of Benefits.

SECTION III – LIMITATIONS

1. When an Insured Member or Insured Dependant is entitled to benefits payable under the Work Injury Compensation Act or similar legislation, government or public programme of medical benefits, other group or individual insurance, the benefits payable under this Contract Rider shall be the lower of the balance of charges not covered by benefits payable under such law, legislation, programme or other insurances; or the amount calculated from the Schedule of Benefits of this Contract Rider.

2. The Company shall reimburse the fees and charges incurred by an Insured Member or Insured Dependant for only one Visit on any given day to an Outpatient Clinic (whether an Accident & Emergency Department of any Hospital in Singapore, an Outpatient Clinic outside Singapore, or a Government Polyclinic in Singapore) other than a Panel General Practitioner. Should an Insured Member or Insured Dependant make two or more such Visit per day, the Company shall only reimburse fees and charges up to the highest benefit limit per Visit the Insured Member or Insured Dependant is eligible for on that day.

SECTION IV – EXCLUSIONS

1. An Insured Member or Insured Dependant shall not be eligible for any benefits in respect of any fees or charges incurred for any of the following services provided to the Insured Member or Insured Dependant:

   (a) Any specialist medical treatment or service;

   (b) Any hospital services, except treatment in an Accident & Emergency (A&E) Department in any Hospital in Singapore;

   (c) All health screening related examinations, including multiphasic health screening, laboratory tests and X-rays and screening mammograms;

   (d) Neonatal services (neonates defined as infants aged 1 – 14 days) and hospitalisation beginning in the first 14 days of life; and neonatal intensive care for babies of all ages;

   (e) Treatment relating to birth control, infertility and impotency; treatment occasioned by or resulting from pregnancy, childbirth (including diagnostic tests for pregnancy), miscarriage, abortion and all complications arising from any of the same;

   (f) Any dental work or treatment, oral surgery, orthodontics and orthonathic surgery; temporo-mandibular joint disorder;

   (g) Eye examination, surgical procedure for correction of eye refraction, Laser treatment of eye, procurement or use of contact lenses or eye glasses; speech therapy; cosmetic or plastic surgery;

   (h) Services (irrespective of whether there is Hospital Confinement) for the primary purpose of diagnosis, medical check-up, genetic or health screening; immunisation, procedures not generally recognised as standard medical practice such as hydrotherapy, acupuncture, chiropractic, foot reflexology, experimental

treatment and procedure under investigation;

(i) Chemotherapy, immunotherapy, radiotherapy and renal treatment;

(j) All treatment including and relating to kidney dialysis and/or organ transplants;

(k) Rest cares, sanatoria care or special nursing care; treatment or services that are not medically necessary or reasonably required for the Illness or bodily injury caused by an Accident;

(l) Circumcision (except where it is medically necessary) or treatment relating to the same;

(m) All prophylactic treatment and anti-viral therapy;

(n) Sex hormones and growth hormone replacement therapies;

(o) Vitamins and health supplement, unless medically required and in the presence of vitamin deficiency;

(p) CT scan, ultrasound, radioisotope scan, barium studies, MRI services;

(q) Physiotherapy;

(r) Treadmill ECG;

(s) Second Opinion;

(t) Implants (homograft, heterograft, artificial) and prostheses; procurement of hearing aids, wheel-chairs, all forms of home aids, dialysis machine and any other hospital-type equipment;

(u) Laboratory investigation related to cancer markers, sex and growth hormones;

(v) Stem cell support therapy, treatment following brain death, Interferon and other biological response modifiers;

(w) Cases treated and claimable under the basic Group Hospital & Surgical Policy;

(x) House-calls or office calls performed by a General Practitioner outside of the site of any Panel General Practitioner.

(y) Self-inflicted injuries, or injuries sustained as a result of a criminal act of the Insured Member or Insured Dependant or attempted suicide (while sane or insane); nervous and mental conditions, alcoholism or drug addiction;

(z) Congenital anomalies or genetic defects of the Insured Member or Insured Dependant present at or existing from the time of his birth regardless of the time of discovery of such anomalies or defects and the time of such treatment or surgical procedure for the same;

(aa) Treatment for xanthelasma, syringoma, acne, alopecia, cosmetic skin surgeries, inguinal hernia, hydrocele and all complications arising from any of the same;

(bb) Treatment for sleep apnea, obesity, weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition;

(cc) Venereal disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complexes and all illnesses or diseases associated with the Human Immuno Deficiency Virus (HIV);

(dd) Injuries or sickness arising directly or indirectly from insurrection, war or act of war (whether declared or undeclared), direct participation in strikes, riots or civil commotion, or full-time service in any of the armed forces including National Service under Section 10 of the Enlistment Act, Cap. 93 of the Republic of Singapore except National Service reservist duty or training under Section 14 of the Enlistment Act, Cap. 93 of the Republic of Singapore.

(ee) The Insured Member or Insured Dependant shall not be entitled to any reimbursement for any expenses administrative or other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services, e.g. telephone calls or referral fees.

SECTION V – DUTIES OF THE COMPANY AND THE POLICYHOLDER

1. Duties of the Company

The Company will provide each Insured Member or Insured Dependant with a valid Member Card to facilitate identification and the utilization of Medical Services offered under the Panel General Practitioner, upon acceptance of his coverage under this Contract Rider. This Member Card is issued on the condition that if the Insured Member or Insured Dependant uses the Member Card to obtain Medical Services from a Panel General Practitioner, he will be deemed to have agreed to the terms and conditions as stipulated under both the Member Card and this Contract Rider governing the use of this Member Card.

2. Duties of the Policyholder

(a) The Policyholder will notify the Company of any person who becomes an Eligible Member or Eligible Dependant within 14 days of the person's Eligibility Date. The Company shall deem that insurance on the Eligible Member or Eligible Dependant became effective on the earliest date that such an Eligible Member or Eligible Dependant could have been eligible and charge the Policyholder a premium for insurance from that date until the expiry of this Contract Rider, on a pro-rated basis (as applicable, if the Eligibility Date of that Eligible Member or Eligible Dependant is effective after the Contract Rider Commencement Date or any subsequent Policy Renewal Date).

(b) The Policyholder must retrieve the Member Card of any Insured Member or Insured Dependant who ceases to be eligible to be insured under this Contract Rider and return the Member Card to the Company. Until the Company receives the Member Card, the Company shall deem that Insured Member or Insured Dependant to be still insured. Upon receipt of the Member Card, the Company will refund premium to the Policyholder for the insurance cancelled from the date of the termination of the insurance, on a pro-rated basis subject to there being no claims incurred or reported during this period. In the event of claims which are not notified to the Company at the time of termination of the insurance, the Company reserves the right to recover any benefits paid for such claims from the Policyholder.

SECTION VI – CLAIMS

1. Notice & Proof of Claim

(a) The Insured Member or Insured Dependant or his legal representative must notify us in writing within 30 days after the happening of any event likely to give rise to a claim under this Contract Rider. However, the claim will not be invalidated if it can be shown that it was not reasonably possible for him to notify us within this period.

(b) Satisfactory proof of claim must be given to the Company within 30 days after the happening of any event likely to give rise to a claim under the Policy. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

(c) Written notice given by or on behalf of the Insured Member or Insured Dependant to the Company with particulars sufficient to identify the Insured Member or Insured Dependant, shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in this Contract Rider shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that such notice was given as soon as was reasonably possible.

(d) All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Insured Member or Insured Dependant or the Insured Member's or Insured Dependant'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 Member or Insured Dependant as and when and as often as it may reasonably be required pending any claim or the payment of any claims made under this Contract Rider.

(e) Proof of the date of birth of the Insured Member or Insured Dependant 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 Member or Insured Dependant notified to the Company is incorrect, the Company shall not be liable to pay more than the amount which would be payable under this Contract Rider if the date of birth and/or age had been correctly stated.

2. Payment of Benefit

(a) All benefits shall be paid only when the claim shall have been proven to the satisfaction of the Company and the total amount of compensation shall have been ascertained and agreed upon by the Company and Policyholder.

(b) Any amount payable under this Contract Rider will be paid to the order of the Policyholder, unless the Policyholder otherwise notifies in writing. Any payment so made shall effectively discharge the Company from any further liability in respect thereof.

(c) If the medical or hospital bills submitted for reimbursement of benefits under this Contract Rider are not expressed in Singapore currency, we will convert the amount of the bills into Singapore currency at the rate of exchange as determined by the Company.

3. Fraudulent Claims

If any claim under this Contract Rider is in any respect, fraudulent or if any fraudulent means or devices shall be used by the Policyholder or an Insured Member or Insured Dependant or any one acting on behalf of the said parties to obtain a benefit under this Contract Rider, the Company shall be under no liability in respect of such claims and shall be entitled to recover any payment made prior to the discovery of fraud.

SECTION VII – COMPANY NOT LIABLE

The Company shall not be held responsible or be liable as a party in any way whatsoever to any legal proceeding for damages or otherwise, which may be instituted by any Insured Member or Insured Dependant against any provider of Medical Services for reasons of neglect, malpractice or other causes arising from acts or omissions in the treatment or examination of the Insured Member or Insured Dependant by any provider of Medical Services as provided in this Contract Rider.

In providing a service to an Insured Member or Insured Dependant, the Company and its authorised providers may supply information including medical information pertaining to the treatment of the Insured Member or Insured Dependant to the Policyholder.

Neither the Company nor its employees nor its authorised providers shall be liable for any loss or damage suffered by the Policyholders, Insured Member or Insured Dependant due to any error or omission in the information supplied however caused if the supply of information had been made in good faith by the Company or its authorised providers.

GREAT PLATINUM BENEFITS
GROUP CLINICAL CONTRACT RIDER

SECTION VIII – PREMIUM TABLE

OUTPATIENT CLINICAL

Plan Type	Plan 1
Age Band (next birthday)	Annual Premium per Insured Member or Insured Dependant (S$) (inclusive of GST)
50 and below	326.00
51 - 60	538.00
61 - 70	600.00
71 -75*	600.00

*Renewal only

The above premium rates are subject to the prevailing rate of GST (where applicable). The prevailing rate of GST is subject to change.

GREAT PLATINUM BENEFITS
GROUP CLINICAL CONTRACT RIDER

SCHEDULE OF BENEFITS

In respect of Fees and Charges for Medical Services provided

	Schedule of Benefits	**Plan 1 (S$)**
a)	**Medical Services at Panel Clinic (including Telemedicine)** (Cashless Basis)	As Charged
b)	**Medical Services at Government Polyclinic in Singapore** (Reimbursement Basis)	As Charged
c)	**Medical Services at an Accident & Emergency Department of any Hospital in Singapore** Private Hospitals (Reimbursement Basis) Singapore Government/Restructured Hospitals (Cashless Basis)*	 150 per visit As Charged
d)	**Medical Services at Panel Radiological and Laboratory Facilities** (With Referral from Panel Clinic Only)	As Charged
e)	**Medical Services at Non-Panel Clinic in Singapore** (Reimbursement Basis)	40 per visit
f)	**Medical Services at an Outpatient Clinic Outside Singapore** (Reimbursement Basis)	100 per visit
g)	**Medical Services at Traditional Chinese Medicine (TCM)** (Reimbursement Basis)	30 per visit (max 10 visits per policy period)
h)	**Flu Vaccination (only available at designated clinics)** (Cashless Basis)	As Charged (max 1 visit per policy period)

Note:
*Consultation at A&E Department in the following Singapore Government/Restructured Hospitals (GRH) are on cashless facilities:

a) Singapore General Hospital
b) KK Women's and Children's Hospital
c) Tan Tock Seng Hospital
d) Khoo Teck Puat Hospital
e) National University Hospital
f) Admiralty Medical Centre
g) Singapore National Eye Centre
h) National Heart Centre Singapore
i) National Neuroscience Institute
j) Changi General Hospital
k) Sengkang General Hospital

THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED
(Reg. No. 1908 00011G)

HEAD OFFICE:
1 Pickering Street #13-01,
Great Eastern Centre,
SINGAPORE 048659.

GREAT PLATINUM BENEFITS
GROUP OUTPATIENT CONTRACT RIDER

This Contract Rider shall be attached to and form part of the Group Hospital and Surgical Policy (hereinafter called "the Policy") No. G000XXXX with effect from 01 June 2021, and is valid only if the Policy is in full force. The provisions of the Policy shall apply to this Contract Rider to the extent that the same are not inconsistent with the terms and conditions, exclusions and limitations hereof.

SECTION I – GENERAL DEFINITIONS

In this Policy where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

(1) **"Accident"** means an unexpected, unintended, unforeseeable event causing injury to an Insured Member or Insured Dependant. The Accident must happen while the Insured Member or Insured Dependant is covered under this Policy.

(2) "**Bodily Injury or Bodily Injuries**" means a bodily injury sustained by an Insured Member or Insured Dependant and is caused by an Accident.

(3) "**Co-payment**" means the amount of Eligible Expenses payable per visit under the Endorsement Schedule that has to be borne by the Insured Member or Insured Dependant.

(4) "**Effective Date**" means the date from which the insurance coverage of the Insured Member or Insured Dependant as specified under this Contract Rider has become effective.

(5) "**Eligibility Date**" means the date agreed in writing between the Policyholder and the Company on which an Eligible Member is eligible to participate in the insurance coverage under this Policy.

(6) "**Eligible Dependant**" means:

a) The legal spouse of a Eligible Member who is not divorced or separated, and who has not attained the age of 70 years at the Policy Commencement Date or 75 years at Renewal Date; or
b) An unmarried and unemployed natural or step child(ren) from a legal marriage or legally adopted child(ren) of a Eligible Member who is between attained age of 15 days old (and discharged from hospital immediately after birth) and 25 years old (next birthday) at the Policy Commencement Date or Renewal Date;

who is a Singaporean or Singapore Permanent Resident or with a valid employment pass (EP holders, S Pass, or Work Permit holders)/ Dependant pass and is residing in Singapore.

(7) "**Eligible Expenses**" means expenses which are covered according to the provisions of this Policy.

(8) "**Eligible Member**" means members as specified in the Policy Schedule and whose eligibility to participate in the insurance plan under this Policy has been agreed in writing between the Policyholder and the Company.

(9) "**General Practitioner**" means a Registered Medical Practitioner, qualified by a degree in western medicine, who is registered with the Singapore Medical Council or its equivalent in the geographical area of his country, and conducts Medical Services in an Outpatient Clinic setting and not at a specialist level, and who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(10) "**GST**" means the goods and services tax payable under the Goods and Services Tax Act, Chapter 117A of Singapore.

(11) "**Government**" refers to the government of the Republic of Singapore.

(12) "**Hospital**" means an establishment constituted and registered as a hospital for the care and treatment of sick and injured persons as bed-paying patients and which

(a) has facilities for diagnosis and major surgery, provides 24 hours a day nursing services by registered graduate nurses and is under constant supervision of one or more Registered Medical Practitioners;
(b) is not a clinic, an alcoholic or drug rehabilitation centre, a nursing, rest or convalescent home, a spa or a hydroclinic or similar establishment;
(c) is not a community hospital unless:

(i) it is for continuity of medical treatments immediately following discharge from a Singapore Government Hospital,
(ii) it must be referred by a Registered Medical Practitioner from a Singapore Government Hospital,
(iii) it is not for respite care, and
(iv) it is essential for medical as distinct from domestic reasons

(13) "**Hospital Confinement**" means confinement of an Insured Member or Insured Dependant in a Hospital:

(a) for at least 6 consecutive hours and in which a room and board charge is made in connection with such confinement; or
(b) for any duration because of a surgical procedure without incurring any charge for Room and Board.

(14) "**Illness**" means a physical condition marked by a pathological deviation from normal healthy state.

(15) "**Insured Dependant**" means any Eligible Dependant, in respect of whom insurance under this Policy has been effected

(16) "**Insured Member**" means an Eligible Member, in respect of whom an insurance coverage under this Policy has been effected.

(17) "**Medical Services**" means medically necessary services and medical examinations to be provided to an Insured Member or Insured Dependant on account of an Illness or Injury, other than the services excluded under SECTION III – LIMITATIONS and SECTION IV – EXCLUSIONS.

(18) "**Member Card**" means an identification card issued by the Company to an Insured Member or Insured Dependant.

(19) "**Non-Panel Clinic**" means a General Practitioner clinic in Singapore who is not on the Company's approved panel of Registered Medical Practitioners.

(20) "**Non-Panel Specialist Clinic**" means a Specialist clinic who is not on the Company's approved panel of Specialists.

(21) "**Outpatient Clinic**" means either:

(a) A General Practitioner Clinic which is registered and licensed by Ministry of Health in Singapore; or
(b) A Government Polyclinic in Singapore; or
(c) An Accident & Emergency (A&E) Department of any Hospital in Singapore; or
(d) A General Practitioner clinic outside Singapore whose General Practitioner is registered and licensed to practice western medicine in the geographical area of his country, and shall not include, any Hospital, or any alternative treatment clinic or centre (where alternative treatment includes, but is not limited to, chiropractic treatment, acupuncture, homeopathy, physiotherapy and reflexology).

(22) "**Panel Clinic**" means the group of General Practitioner clinic in Singapore designated and approved by the Company to provide Medical Services to the Insured Member or Insured Dependant.

(23) "**Panel Radiological and Laboratory Facilities**" means the group of radiological and laboratory facilities in Singapore designated and approved by the Company to provide diagnostic x-ray and laboratory tests to the Insured Member or Insured Dependant.

(24) "**Panel Specialist Clinic**" means the group of private Specialist clinics in Singapore designated and approved by the Company to provide Medical Services to the Insured Member or Insured Dependant and extend to include the Specialist Outpatient Clinic of all Singapore Government Restructured Hospitals.

(25) "**Policy**" means this agreement, any rider or endorsement therein, any amendment signed by the Company, the application of the Policyholder, medical reports and any individual proposal form or any other form signed by the Insured Member or Insured Dependant. or the Policyholder constituting the entire contract.

(26) "**Policy Commencement Date**" means the date from which the insurance coverage under this Policy becomes effective.

(27) "**Policy Period**" means a period of one calendar year or such other periods as may be agreed in writing between the Company and the Policyholder, starting from the Policy Commencement Date for the first Policy Period and from the respective Renewal Dates for subsequent Periods of Insurance.

(28) "**Reasonable and Customary Charges**" means charges that do not exceed the general level of charges made by providers of medical services of similar standing in Singapore for similar or comparable treatment or services or supplies for similar Illness or Injury.

(29) "**Registered Medical Practitioner**" means a person qualified by degree in western medicine and legally licensed and authorised to practice medicine and surgery in the geographical area of his country, who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(30) "**Renewal Date**" means the date immediately following the last day of any Policy Period as stated in the endorsement to this Policy.

(31) "**Second Opinion**" means the consulting of a second Specialist for the same medical condition for which the Insured Member or Insured Dependant elects to consult on his own regardless if a referral has been given by a Panel Clinic or any Registered Medical Practitioner.

(32) "**Singapore Government Hospital**" or "**Singapore Government Restructured Hospital**" means any of the Hospitals classified as a Singapore Government Hospital or Singapore Government Restructured Hospital respectively by the Ministry of Health in Singapore.

(33) "**Specialist**" means a Registered Medical Practitioner, qualified by a degree in western medicine, possesses a specialist qualification recognized by the Singapore Medical Council or its equivalent in the geographical area of his country, accredited with the Specialist Accreditation Board under the Ministry of Health in Singapore or its equivalent and who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(34) "**Standard Diagnostic X-ray and Laboratory Tests**" means the following diagnostic procedures including but not limited to x-ray, ultrasound, mammography, echocardiogram, spirometry, tonometry, treadmill stress test, diabetes retinal screening and laboratory tests.

(35) "**Traditional Chinese Medicine (TCM)**" means the group of TCM practitioner which are registered in Singapore with the Ministry of Health to provide Medical Services to the Insured Member or Insured Dependant.

(36) "**Traditional Chinese Medicine Practitioner**" shall means a person who is legally authorised and registered by the Ministry of Health of Singapore or in the geographical area of his practice, to practice Traditional Chinese Medicine, and who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(37) "**Visit**" means a personal visit during which the Registered Medical Practitioner or Specialist or Traditional Chinese Medicine Practitioner actually see the Insured Member or Insured Dependant..

(38) "**We" or "our" or "us" or "the Company**" means The Great Eastern Life Assurance Company Limited.

(39) "**You" or "your" or "Policyholder**" means the person, persons or corporation named as the Policyholder in the Schedule of this Policy.

SECTION II – BENEFIT PROVISIONS

The Company will pay the benefits described below for the charges which are made to an Insured Member or Insured

Dependant in connection to his Medical Services,

(1) which results directly from an Illness or Bodily Injury of the Insured Member or Insured Dependant; and

(2) which are incurred while he is insured under this Contract Rider; and

(3) subject to the terms, conditions, limitations, exclusions and provision of this Contract Rider and General Provisions of the Policy.

(a) Medical Services at Panel Clinic

(i) If an Insured Member or Insured Dependant presents his valid Medical Card when visiting a Panel Clinic, the Panel Clinic will provide Medical Services, to the Insured Member or Insured Dependant, without requiring any payment from the Insured Member or Insured Dependant, except if this Contract Rider has a Co-payment provision.

(ii) If this Contract Rider has a Co-payment provision, then the Insured Member or Insured Dependant must pay the Panel Clinic the Co-payment amount per Visit as stated in the Schedule of Benefits of this Contract Rider.

(iii) If an Insured Member or Insured Dependant did not present his valid Member Card to the Panel Clinic without valid reason, he must pay the fees and charges for the Medical Services to the Panel Clinic and we may refuse reimbursement of charges incurred without assigning any reason.

(b) Medical Services at a Government Polyclinic in Singapore

If an Insured Member or Insured Dependant Visits a Government polyclinic in Singapore and pays the fees and charges for the Medical Services, the Company shall reimburse the Insured Member or Insured Dependant these fees and charges incurred on an as charged basis, subject to the Co-payment or co-insurance amount (where applicable) and maximum limit as stated in the Schedule of Benefits of this Contract Rider.

(c) Medical Services at an Accident & Emergency Department of any Hospital in Singapore

If an Insured Member or Insured Dependant visits an Accident & Emergency Department of any Hospital in Singapore and incurs the fees and charges for the Medical Services, the Company shall reimburse the Insured Member or Insured Dependant these fees and charges incurred, subject to the Co-payment amount (where applicable) and benefit limit as stated in the Schedule of Benefits.

For any benefits payable under this clause, the Company will make payment to the Panel Clinic and Hospitals with which it has a payment arrangement. Otherwise, the Company will make payment directly to the Policyholder and/or the Insured Members or Insured Dependant.

(d) Medical Services at Panel Radiological and Laboratory Facilities

If an Insured Member or Insured Dependant Visits a Panel Radiological or Laboratory Facilities for Standard Diagnostic X-ray and Laboratory Tests upon a written referral by a Panel Clinic in connection to an Illness or Bodily Injury, the Panel Radiological or Laboratory Facilities will provide the laboratory or radiological services to the Insured Member or Insured Dependant, without requiring any payment from the Insured Member or Insured Dependant.

(e) Medical Services at Non-Panel Clinic in Singapore

If an Insured Member or Insured Dependant visits an Outpatient Clinic which is not a Panel Clinic, and pays the fees and charges for the Medical Services including Standard Diagnostic X-ray and Laboratory Tests, the Company shall reimburse the fees and charges incurred by Insured Member or Insured Dependant provided such benefit is specifically provided for under the Schedule of Benefits. The amount payable is subject to the Co-payment amount (where applicable) and benefit limit as stated in the Schedule of Benefits.

(f) Medical Services at Outpatient Clinic Outside Singapore

If an Insured Member or Insured Dependant visits an Outpatient Clinic outside Singapore and pays the fees and charges for the Medical Services, the Company shall reimburse the Insured Member or Insured Dependant these fees and charges incurred provided such benefit is specifically provided for under the Schedule of Benefits. The amount payable is subject to the Co-payment amount (where applicable) and benefit limit as stated in the Schedule

of Benefits.

(g) Medical Services at Traditional Chinese Medicine (TCM)

If an Insured Member or Insured Dependant Visits a Traditional Chinese Medicine Practitioner on an outpatient basis in connection to an illness or Bodily Injury, the Company shall pay or reimburse the Insured Member or Insured Dependant these fees and charges incurred provided such benefit is specifically provided for under the Schedule of Benefit of this Policy. The amount payable is subject to the Co-payment amount (where applicable) and the maximum benefit limit as stated in the Schedule of Benefits of this Policy.

(h) Flu Vaccination

Each Insured Member or Insured Dependant is entitled to one flu vaccination per Policy Period. Insured Member or Insured Dependant has to go any of the clinics designated and approved by the Company to receive the vaccination.

(i) Medical Services at Panel Specialist Clinic

(i) If an Insured Member or Insured Dependant Visits a Panel Specialist Clinic upon a written referral by a Panel Clinic and incurs fees and charges for the Medical Services, the Panel Specialist Clinic will provide Medical Services, to the Insured Member or Insured Dependant, without requiring any payment from the Insured Member or Insured Dependant, subject to the Co-payment (where applicable) as stated in the schedule of benefits of this Contract Rider.

(ii) If an Insured Member or Insured Dependant, upon a written referral by a Panel Clinic, visits a Panel Specialist Clinic at the Singapore Government Restructured Hospitals and incurs fees and charges for the medical services, the Company shall reimburse the Insured Member or Insured Dependant on these fees and charges incurred in full.

(iii) For any benefits payable under this clause, the Company will make payment to the Panel Specialist Clinic and Hospitals with which it has a payment arrangement. Otherwise, the Company will make payment directly to the Policyholder and/or the Insured Members or Insured Dependant.

(iv) If this Contract Rider has a Co-payment provision, then the Insured Member or Insured Dependant must pay the Panel Specialist Clinic the Co-payment amount per Visit as stated in the Schedule of Benefits of this Contract Rider.

(j) Medical Services at Non-Panel Specialist Clinic

If an Insured Member or Insured Dependant Visits a Non-Panel Specialist Clinic which is recommended by a Registered Medical Practitioner and incur charges for the Medical Services including laboratory investigations and/or radiological services, the Company shall reimburse the charges incurred by the Insured Member or Insured Dependant subject to the Co-Payment (where applicable) and maximum limit as stated in the Schedule of Benefits of this Contract Rider.

(k) Direct Access to Paediatrician

For Insured Dependant (child) aged 7 years and below, no referral letter by a Registered Medical Practiitoner is required for visits to paediatricians. The Company shall reimburse the charges incurred by the Insured Member or Insured Dependant subject to the Co-payment amount or co-Insurance (where applicable) and benefit limit per Policy Period as stated in the Schedule of Benefits.

(l) Other Diagnostic Scans

If an Insured Member or Insured Dependant Visits a radiological facility upon a written referral by a Panel Clinic or a Registered Medical Practitioner and incurs fees and charges for other than standard radiological scan [such as high-end and high field radiological scan like Magnetic Resonance Imaging (MRI), Computer Tomography (CT) or Positron Emission Tomography (PET) Scans] in connection to an Illness or Bodily Injury, the Company shall pay or reimburse the Insured Member or Insured Dependant these fees and charges incurred, subject to the Co-Payment (where applicable) and maximum limit as stated in the Schedule of Benefits of this Contract Rider

(m) Outpatient Physiotherapy and Chiropractic Treatment

(i) If an Insured Member or Insured Dependant incurs expenses for physiotherapy treatment on an outpatient

basis upon a written referral by a Panel Clinic or a Registered Medical Practitioner in connection to an Illness or Bodily Injury, the Company shall pay or reimburse the Insured Member or Insured Dependant these fees and charges incurred provided such benefit is specifically provided for under the Schedule of Benefits of this Contract Rider. The amount payable is subject to the Co-Payment (where applicable) and benefit limit per Policy Period as stated in the Schedule of Benefits of this Contract Rider.

(ii) Chiropractic Treatment

Treatment expenses incurred during a visit to a trained and qualified chiropractor as referred by a Panel Clinic or Registered Medical Practitioner attending to the Insured Member or Insured Dependant, shall be payable up to maximum limit as stated in the Schedule of Benefits of this Contract Rider.

(n) Mental Wellness

Reimbursement of charges incurred for counselling through video consultation with a trained and legally qualified psychologists or counsellors that are designated and approved by the Company. Each Insured Member or Insured Dependant is entitled to a maximum number of sessions as specified in the Schedule of Benefits for Mental Wellness. Medication, however is not covered.

The mental health practitioner must be registered with the Singapore Association of Counselling, Singapore Psychological Society, Singapore Psychiatric Association or a registered medical practitioner who is recognized by the Singapore Medical Council.

SECTION III – LIMITATIONS

1. When an Insured Member or Insured Dependant is entitled to benefits payable under the Work Injury Compensation Act or similar legislation, government or public programme of medical benefits, other group or individual insurance, the benefits payable under this Policy shall be the lower of the balance of charges not covered by benefits payable under such law, legislation, programme or other insurances; or the amount calculated from the schedule of benefits of this Contract Rider.

2. The Company shall reimburse the fees and charges incurred by an Insured Member or Insured Dependant for only one Visit on any given day to an Outpatient Clinic (whether an Accident & Emergency Department of any Hospital in Singapore, an Outpatient Clinic outside Singapore, or a Government Polyclinic in Singapore) other than a Panel Clinic. Should an Insured Member or Insured Dependant make two or more such Visit per day, the Company shall only reimburse fees and charges up to the highest benefit limit per Visit the Insured Member or or Insured Dependant is eligible for on that day.

SECTION IV – EXCLUSIONS

1. An Insured Member or Insured Dependant shall not be eligible for any benefits in respect of any fees or charges incurred for any of the following services provided to the Insured Member or Insured Dependant:

(a) Any hospital services, except treatment in an Accident & Emergency (A&E) Department in any Hospital in Singapore;

(b) All health screening related examinations, including multiphasic health screening, laboratory tests and X-rays and screening mammograms;

(c) Neonatal services (neonates defined as infants aged 1 – 14 days) and hospitalisation beginning in the first 14 days of life; and neonatal intensive care for babies of all ages;

(d) Treatment relating to birth control, infertility and impotency; treatment occasioned by or resulting from pregnancy, childbirth (including diagnostic tests for pregnancy), miscarriage, abortion and all complications arising from any of the same;

(e) Any dental work or treatment, oral surgery, orthodontics and orthonathic surgery; temporo-mandibular joint disorder;

(f) Eye examination, consultation, diagnostic and treatment of eye refraction and its complication thereof (such as myopia, amblyopia, strabismus etc.), Laser treatment of eye, procurement or use of contact lenses or eye glasses; speech therapy; cosmetic or plastic surgery;

(g) Services (irrespective of whether there is hospital confinement) for the primary purpose of diagnosis, medical check-up, genetic or health screening; immunisation, procedures not generally recognised as standard medical practice such as hydrotherapy, acupuncture, foot reflexology, experimental treatment and procedure under investigation;

(h) Chemotherapy, immunotherapy, radiotherapy and renal treatment;

(i) All treatment including and relating to kidney dialysis and/or organ transplants;

(j) Rest cares, sanatoria care or special nursing care; treatment or services that are not medically necessary or reasonably required for the illness or bodily injury caused by an Accident;

(k) Circumcision (except where it is medically necessary) or treatment relating to the same;

(l) All prophylactic treatment and anti-viral therapy (except flu vaccination);

(m) Sex hormones and growth hormone replacement therapies;

(n) Vitamins and health supplement, unless medically required and in the presence of vitamin deficiency;

(o) CT scan, ultrasound, radioisotope scan, barium studies, MRI services, unless specified in the Schedule of Benefits of this Contract Rider;

(p) Physiotherapy unless specified in the Schedule of Benefits of this Contract Rider;

(q) Second Opinion;

(r) Implants (homograft, heterograft, artificial) and prostheses; procurement of hearing aids, wheel-chairs, all forms of home aids, dialysis machine and any other hospital-type equipment;

(s) Laboratory investigation related to cancer markers, sex and growth hormones;

(t) Stem cell support therapy, treatment following brain death, Interferon and other biological response modifiers;

(u) Cases treated and claimable under the Group Hospital and Surgical Policy;

(v) House-calls or office calls performed by a General Practitioner outside of the site of any Panel Clinic;

(w) Telemedicine except it is approved by the Company to provide Medical Services to the Insured Member or Insured Dependant.

(x) Treatment by Specialist without a referral from a registered General Practitioner; unless otherwise specified in the Schedule of Benefits of this Contract Rider;

(y) Self-inflicted injuries, or injuries sustained as a result of a criminal act of the Insured Member or Insured Dependant or attempted suicide (while sane or insane); nervous and mental conditions (save for Section II clause 2(n) benefits) alcoholism or drug addiction;

(z) Congenital anomalies or genetic defects of the Insured Member or Insured Dependant present at or existing from the time of his birth regardless of the time of discovery of such anomalies or defects and the time of such treatment or surgical procedure for the same;

(aa) Treatment for xanthelasma, syringoma, acne, alopecia, cosmetic skin surgeries, inguinal hernia, hydrocele and all complications arising from any of the same;

(bb) Treatment for sleep apnea, obesity, weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition;

(cc) Venereal disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complexes and all illnesses or diseases associated with the Human Immuno Deficiency Virus (HIV);

(dd) Injuries or sickness arising directly or indirectly from insurrection, war or act of war (whether declared or

undeclared), direct participation in strikes, riots or civil commotion, or full-time service in any of the armed forces including National Service under Section 10 of the Enlistment Act, Cap. 93 of the Republic of Singapore except National Service reservist duty or training under Section 14 of the Enlistment Act, Cap. 93 of the Republic of Singapore.

2. The Insured Member or Insured Dependant shall not be entitled to any reimbursement for any expenses administrative or other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services, e.g. telephone calls or referral fees, delivery charges for despatching medication under telemedicine services.

SECTION V – DUTIES OF THE COMPANY AND THE POLICYHOLDER

1. Duties of the Company

The Company will provide each Insured Member or Insured Dependant with a valid Member Card to facilitate identification and the utilization of Medical Services offered under the Panel, upon acceptance of his coverage under this Contract Rider. This Member Card is issued on the condition that if the Insured Member or Insured Dependant uses the Member Card to obtain Medical Services from a Panel Clinic, he will be deemed to have agreed to the terms and conditions as stipulated under both the Member Card and this Contract Rider governing the use of this Member Card.

2. Duties of the Policyholder

(a) The Policyholder will notify the Company of any person who becomes an Eligible Member or Eligible Dependant within 14 days of the person's Eligibility Date. The Company shall deem that insurance on the Eligible Member or Eligible Dependant became effective on the earliest date that such an Eligible Member or Eligible Dependant could have been eligible and charge the Policyholder a premium for insurance from that date until the expiry of this Contract Rider, on a pro-rated basis (as applicable, if the Eligibility Date of that Eligible Member or Eligible Dependant is effective after the Contract Rider Commencement Date or any subsequent Policy Renewal Date).

SECTION VI – CLAIMS

1. Notice & Proof of Claim

(a) The Insured Member or Insured Dependant or his legal representative must notify us in writing within 30 days after the happening of any event likely to give rise to a claim under this Policy. However, the claim will not be invalidated if it can be shown that it was not reasonably possible for him to notify us within this period.

(b) Written notice and satisfactory proofs of any claim of any Insured Member or Insured Dependant must be given within 30 days after the happening of any event likely to give rise to a claim under this Policy. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

(c) Written notice given by or on behalf of the Insured Member or Insured Dependant to the Company with particulars sufficient to identify the Insured Member or Insured Dependant, 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 shall be shown not to have been reasonably possible to give such notice and that such notice was given as soon as was reasonably possible.

(d) All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Insured Member or Insured Dependant or the Insured Member's or Insured Dependant'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 Member or Insured Dependant 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.

(e) Proof of the date of birth of the Insured Member or Insured Dependant 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 Member or Insured Dependant 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.

2. Payment of Benefit

(a) All benefits shall be paid only when the claim shall have been proven to the satisfaction of the Company and the total amount of compensation shall have been ascertained and agreed upon by the Company and Policyholder.

(b) Any amount payable under this Policy will be paid to the order of the Policyholder, unless the Policyholder otherwise notifies in writing. Any payment so made shall effectively discharge the Company from any further liability in respect thereof.

(c) If the medical or hospital bills submitted for reimbursement of benefits under this Policy are not expressed in Singapore currency, we will convert the amount of the bills into Singapore currency at the rate of exchange as determined by the Company.

3. Fraudulent Claims

If any claim under this Policy is in any respect, fraudulent or if any fraudulent means or devices shall be used by the Policyholder or an Insured Member or Insured Dependant or any one acting on behalf of the said parties to obtain a benefit under this Policy, the Company shall be under no liability in respect of such claims and shall be entitled to recover any payment made prior to the discovery of fraud.

SECTION VII – COMPANY NOT LIABLE

The Company shall not be held responsible or be liable as a party in any way whatsoever to any legal proceeding for damages or otherwise, which may be instituted by any Insured Member or Insured Dependant against any provider of Medical Services for reasons of neglect, malpractice or other causes arising from acts or omissions in the treatment or examination of the Insured Member or Insured Dependant by any provider of Medical Services as provided in this Policy.

In providing a service to an Insured Member or Insured Dependant, the Company and its authorised providers may supply information including medical information pertaining to the treatment of the Insured Member or Insured Dependant to the Policyholder.

Neither the Company nor its employees nor its authorised providers shall be liable for any loss or damage suffered by the Policyholders, Insured Member or Insured Dependant due to any error or omission in the information supplied however caused if the supply of information had been made in good faith by the Company or its authorised providers.

GREAT PLATINUM BENEFITS
GROUP OUTPATIENT CONTRACT RIDER

SECTION VIII – PREMIUM TABLE

OUTPATIENT CLINICAL

Plan Type	Plan 1
Age Band (next birthday)	Annual Premium per Insured Member or Insured Dependant (S$) (inclusive of GST)
50 and below	326.00
51 - 60	538.00
61 - 70	600.00
71 -75*	600.00

*Renewal only

OUTPATIENT SPECIALIST AND DIAGNOSTIC X-RAY AND LABORATORY TESTS

Plan Type	Plan 1	Plan 2
Age Band (next birthday)	Annual Premium per Insured Member or Insured Dependant (S$) (inclusive of GST)	
50 and below	425.00	377.00
51 - 60	546.00	484.00
61 - 70	862.00	765.00
71 -75*	862.00	765.00

*Renewal only

The above premium rates are subject to the prevailing rate of GST (where applicable). The prevailing rate of GST is subject to change.

GREAT PLATINUM BENEFITS
GROUP OUTPATIENT CONTRACT RIDER

SCHEDULE OF BENEFITS

In respect of Fees and Charges for Medical Services provided

	Schedule of Benefits	**Plan 1 (S$)**
a)	**Medical Services at Panel Clinic (including Telemedicine)** (Cashless Basis)	As Charged
b)	**Medical Services at Government Polyclinic in Singapore** (Reimbursement Basis)	As Charged
c)	**Medical Services at an Accident & Emergency Department of any Hospital in Singapore** Private Hospitals (Reimbursement Basis) Singapore Government/Restructured Hospitals (Cashless Basis)*	 150 per visit As Charged
d)	**Medical Services at Panel Radiological and Laboratory Facilities** (With Referral from Panel Clinic Only)	As Charged
e)	**Medical Services at Non-Panel Clinic in Singapore** (Reimbursement Basis)	40 per visit
f)	**Medical Services at an Outpatient Clinic Outside Singapore** (Reimbursement Basis)	100 per visit
g)	**Medical Services at Traditional Chinese Medicine (TCM)** (Reimbursement Basis)	30 per visit (max 10 visits per policy period)
h)	**Flu Vaccination (only available at designated clinics)** (Cashless Basis)	As Charged (max 1 visit per policy period)

Note:
*Consultation at A&E Department in the following Singapore Government/Restructured Hospitals (GRH) are on cashless facilities:

a) Singapore General Hospital
b) KK Women's and Children's Hospital
c) Tan Tock Seng Hospital
d) Khoo Teck Puat Hospital
e) National University Hospital
f) Admiralty Medical Centre
g) Singapore National Eye Centre
h) National Heart Centre Singapore
i) National Neuroscience Institute
j) Changi General Hospital
k) Sengkang General Hospital

GREAT PLATINUM BENEFITS
GROUP OUTPATIENT CONTRACT RIDER

OUTPATIENT SPECIALIST AND DIAGNOSTIC X-RAY AND LABORATORY TESTS

Schedule of Benefits		Plan 1 (S$)	Plan 2 (S$)
a)	**Medical Services at Specialist Outpatient Clinics in Singapore Government/Restructured Hospitals** (Cashless Basis) (With Referral from Panel General Practitioner Only) (includes Standard Diagnostic X-Ray and Laboratory Tests referred by Panel Specialist Clinic)	As Charged	As Charged
b)	**Medical Services at Panel and Non-Panel Private Specialist** (With Referral from a Registered Medical Practitioner) - Panel Private Specialist Clinics (Cashless Basis) - Non-Panel Private Specialist Clinics (Reimbursement Basis) (includes Standard Diagnostic X-Ray and Laboratory Tests referred by Non-Panel Specialist Clinic)	3,000 per policy period (item b & c)	2,000 per policy period (item b & c)
c)	**Direct Access to Paediatrician** (Reimbursement Basis) (Waiver of Referral Letter for Insured Dependants below 7 years old) Limit per visit: $100 per visit		
d)	**Other Diagnostic Scans** (Reimbursement Basis) (includes MRI/CT/PET or Any High Field Scans) (With Referral from a Registered Medical Practitioner)	3,000 per policy period (item d & e)	2,000 per policy period (item d & e)
e)	**Outpatient Physiotherapy and Chiropractic Treatment** (Reimbursement Basis) (With Referral from a Registered Medical Practitioner)		
f)	**Mental Wellness (Teleconsultation only)** (Cashless Basis) (Waiver of Referral Letter)	3 sessions per policy period	2 sessions per policy period

Note:

1. Eligible Dependant cover must be of the same plan as Eligible Member.

THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED

(Reg. No. 1908 00011G)

Group Dental

HEAD OFFICE:
1 Pickering Street #13-01,
Great Eastern Centre,
SINGAPORE 048659.

GREAT PLATINUM BENEFITS
GROUP DENTAL CONTRACT RIDER

This Contract Rider shall be attached to and form part of the Group Hospital and Surgical Policy (hereinafter called "the Policy") No. G000XXXX with effect from dd mm yyyy (Commencement Date), and is valid only if the Policy is in full force. The provisions of the Policy shall apply to this Contract Rider to the extent that the same are not inconsistent with the terms and conditions, exclusions and limitations hereof.

SECTION I – GENERAL DEFINITIONS

In this Contract Rider where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

(1) "**Panel Dentist**" means a person qualified by degree in western medicine, who is a member of the Singapore Dental Association and legally licensed and duly qualified to practice as a dentist or dental surgeon in the, who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(2) "**Panel Dental Clinic**" means the group of dental clinic in Singapore designated and approved by the Company to provide Medical Services to the Insured Member or Insured Dependant.

(3) "**We**" or "**our**" or "**us**" or "**the Company**" means The Great Eastern Life Assurance Company Limited.

SECTION II - BENEFIT PROVISIONS

The Company will reimburse the charges incurred by an Insured Member or Insured Dependant for dental treatment provided in a Panel Dental Clinic as stated in the Schedule of Benefits. .

SECTION III - LIMITATIONS

When an Insured Member or Insured Dependant is entitled to benefits payable under the Work Injury Compensation Act or similar legislation, government or public programme of medical benefits, other group or individual insurance, the benefits payable under this Contract Rider shall be the lower of the balance of charges not covered by benefits payable under such law, legislation, programme or other insurances, or the amount calculated from the Schedule of Compensation of this Contract Rider.

SECTION IV - EXCLUSIONS

An Insured Member or Insured Dependant shall not be eligible for any benefits in respect of any fees or charges incurred for any of the following services provided to the Insured Member or Insured Dependant:

(a) Treatment which is cosmetic in nature;

(b) Treatment or services not stated in the Schedule of Benefits;

(c) Treatment or services incurred outside of our Panel Dental Clinic

(d) Extra charges made for consultation outside the normal operating clinic hours.

SECTION V - CLAIMS

1. Notice and Proof of Claim

   (a) Written proof must be given to the Company within 30 days from the date of treatment by the Panel Dental Clinic where applicable.

SECTION VI - GENERAL PROVISIONS

1. All other definitions, terms, conditions and provisions under the Policy shall also apply.

GREAT EMPLOYEE BENEFITS GROUP DENTAL CONTRACT RIDER

SECTION VII - PREMIUM TABLE

Plan Type	Plan 1
Age Band (next birthday)	Annual Premium per Insured Member or Insured Dependant (S$) (inclusive of GST)
70 and below	398.00
71 -75*	398.00

*Renewal only

The above premium rates are subject to the prevailing rate of GST (where applicable). The prevailing rate of GST is subject to change.

GREAT PLATINUM BENEFITS
GROUP DENTAL CONTRACT RIDER

SCHEDULE OF BENEFITS

In respect of Fees and Charges for Medical Services provided

Schedule of Benefits		**Plan 1 (S$)**
1	**General Consultation, Scaling/Polishing, Fillings** Consultation & Examination Scaling & Polishing Tooth Colour / Composite - For Anterior / Buccal teeth only, 2 surfaces - For Posterior teeth only, 2 surfaces Amalgam Fillings - For Anterior / Buccal teeth only, 2 surfaces - For Posterior teeth only, 2 surfaces	As Charged, Cashless at Panel Dental Clinics
2	**Dental X-Rays** Intraoral - Occlusal / Periapical / Bitewing Extraoral - Panoramic / OGP / Cephalogram / Tomograms	
3	**Extractions & Consumables** Non-surgical / simple / routine extraction Surgical / complex extraction Surgical, Impacted Wisdom tooth extraction Fluoride treatment Dental treatment consumables, hygiene products, infection control etc	
4	**Drugs** Analgesic (Oral) - In relation to a dental procedure/surgery Antibiotics (Oral) - In relation to a dental procedure/surgery	
5	**Root Canal Treatment** Pulpotomy Pulp Cap First Root Canal - Anterior Tooth First Root Canal - Premolar Tooth First Root Canal - Molar Tooth Subsequent Canals	
6	**Alveoplasty** Per Quadrant, in connections with extractions Per Quadrant, not in connection with extractions For complete Alveoplasty involving more than one quadrant	
7	**Others** Biopsy & examination of tissue Excision of tumour	

THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED

(Reg. No. 1908 00011G)

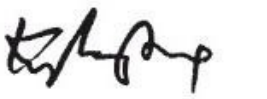
HEAD OFFICE:
1 Pickering Street #13-01,
Great Eastern Centre,
SINGAPORE 048659.

GREAT PLATINUM BENEFITS
GROUP PERSONAL ACCIDENT POLICY

Group Policy Number	:	G000XXXX
Policyholder	:	ABC COMPANY LTD
Policy Commencement Date	:	01 June 2021

Whereas the Policyholder has requested The Great Eastern Life Assurance Company Limited (hereinafter called "the Company") to grant the benefits hereinafter referred to. The Company hereby agrees to pay to the Policyholder the benefits subject to all the terms, conditions and provisions of this Policy. This Policy is issued in consideration of payment of the necessary premiums and shall take effect on the Policy Commencement Date.

IN WITNESS WHEREOF, the Company has caused this Policy to be signed as of 1 June 2021.



Koh Beng Seng
Chairman

Norman Ip
Director

GREAT PLATINUM BENEFITS
GROUP PERSONAL ACCIDENT POLICY

Table of Contents

GREAT PLATINUM BENEFITS
GROUP PERSONAL ACCIDENT POLICY

SECTION I - GENERAL DEFINITIONS

In this Policy where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

(a) "**Accident**" means an unexpected, unintended and unforeseeable event causing injury to an Insured Member or Insured Dependant. The Accident must happen while the Insured Member or Insured Dependant is covered under this Policy.

(b) "**Accidental Injury**" means any bodily injury caused solely and directly by Accident, and independently of any other cause, and such injury shall result in the death or disability of the Insured Member or Insured Dependant within 365 days from the date of the Accident

(c) "**Actively At Work**" means reporting for work at the place assigned by the Policyholder and performing, in the customary manner, all the regular duties of his employment with the Policyholder on full time basis or being on entitled annual leave for reasons other than on medical grounds.

(d) "**Class 1 Occupation classification**" means a professional, managerial, administrative, clerical, non-manual occupation or work of a supervisory nature which does not involve the use of tools and machinery or exposure to special hazards.

(e) "**Class 2 Occupational classification**" means a work involving substantial amount of traveling, or manual work not of a particularly hazardous nature but involving the use of tools and machinery.

(f) "**Class 3 Occupational classification**" means a work involving a fair amount of manual works for example, with machinery, chemicals or construction.

(g) "**Eligibility Date**" means the date agreed in writing between the Policyholder and the Company on which an Eligible Member is eligible to participate in the assurance under this Policy.

(h) "**Eligible Dependant**" means:

i) The legal spouse of a Eligible Member who is not divorced or separated, and who has not attained the age of 70 years at the Policy Commencement Date or the age of 75 years at Renewal Date; or
ii) An unmarried and unemployed natural or step child(ren) from a legal marriage or legally adopted child(ren) of a Eligible Member who is between attained age of 12 months and 25 years old (next birthday) at the Policy Commencement Date or Renewal Date;

who is a Singaporean or Singapore Permanent Resident or with a valid employment pass (EP holders, S Pass, or Work Permit holders)/ Dependant pass and is residing in Singapore.

(i) "**Eligible Member**" means members as specified in the Policy Schedule and whose eligibility to participate in the insurance plan under this Policy has been agreed in writing between the Policyholder and the Company.

(j) **"Foreign Based Employee"** means a permanent full time employee of the Policyholder who is residing, or is based, outside the Republic of Singapore for more than one year and engaged in a Class 1 or 2 Occupation.

(k) **"Foreign Based Employee's Dependant"** means a person who qualifies as a Dependant and he is not residing in the Republic of Singapore for more than one year and is engaged in a Class 1 or 2 Occupation

(l) "**Insured Dependant**" means any Eligible Dependant, in respect of whom insurance under this Policy has been effected.

(m) "**Insured Member**" means an Eligible Member, in respect of whom an insurance under this Policy has been effected.

(n) "**Limb**" means a hand at or above the wrist or a foot at or above the ankle.

(o) "**Loss**" means total, permanent and irrecoverable loss of use or loss by physical severance.

(p) "**Loss Event**" means any of the loss events set out in the Schedule of Compensation.

(q) "**Maximum Coverage Age**" means the maximum age of coverage as specified in the Policy Schedule attached hereto.

(r) "**Policy**" means this agreement, any rider or endorsement therein, any amendment signed by the Company, the application of the Policyholder, medical reports and any individual proposal form or any other form signed by the Insured Member or Insured Dependant or the Policyholder constituting the entire contract.

(s) "**Policy Commencement Date**" means the date from which the insurance coverage under this Policy becomes effective.

(t) "**Policy Period**" means a period of one calendar year or such other periods as may be agreed in writing between the Company and the Policyholder, starting from the Policy Commencement Date for the first Policy Period and from the respective Renewal Dates for subsequent Periods of Insurance.

(u) "**Registered Medical Practitioner**" means a person qualified by degree in western medicine and legally licensed and authorised to practice medicine and surgery in the geographical area of his country, who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(v) "**Renewal Date**" means the date immediately following the last day of any Policy Period as stated in the endorsement to this Policy.

(w) "**Sum Assured**" means the amount of insurance coverage effected under this Policy in respect of the Insured Member or Insured Dependant.

(x) "**Third Degree Burns**" means major burns which result in full thickness skin destruction as determined by a Registered Medical Practitioner.

(y) "**Total and Permanent Disability**" means 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 Member or Insured Dependant 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 loss by severance or loss of permanent use of both hands at or above the wrists or both feet at or above the ankles; or The loss by severance or loss of permanent use of one hand at or above the wrist and one foot at or above the ankle; or The loss by severance or loss of permanent use of one limb at or above the wrist or ankle and loss of sight of one eye shall be considered as Total and Permanent Disability

SECTION II - GENERAL PROVISIONS

1. Eligibility and Commencement of Insurance

   (a) All Eligible Members who are Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement Date shall be covered under this Policy on such date, unless otherwise agreed by the Company.

   (b) All Eligible Members who are not Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement Date shall not be covered under this Policy and shall only be covered on the date they are Actively At Work, unless otherwise agreed by the Company.

   (c) All new and existing employee of the Policyholder becoming eligible after the Policy Commencement Date will be covered on their respective Eligibility Date provided he is Actively At Work on his respective Eligibility Date. Any Eligible Member who is on medical leave or in hospital on his respective Eligibility Date, will be covered on the date he returns to active service at work.

   (d) An Eligible Member shall be covered automatically for his Sum Assured on his Eligibility Date except that

if he is not Actively At Work on that date, his Sum Assured shall be effective on the date after he is Actively At Work, subject to the condition that the Policyholder shall notify the Company within 90 days after the Eligible Member is eligible to be covered under this Policy.

(e) Any Insured Member or Insured Dependant's Sum Assured which has been changed (in accordance to the basis of coverage as endorsed in the Policy) shall be covered automatically for the aggregate Sum Assured on the date of change.

(f) An Insured Member or Insured Dependant whose insurance coverage under this Policy was terminated due to any cause and who re-applies for insurance coverage shall be considered as a new member.

2. Dependant's Participation and Insurance

(a) Section II Clause 2 of this Policy is valid only upon the application of the Eligible Dependant's coverage by the Policyholder and the Company's acceptance of the Eligible Dependant's application in writing.

(b) Insurance of an Eligible Dependant will start on his Eligibility Date provided he is not hospitalized, or on medical leave and is in good health.

3. Termination

(a) The coverage of any Insured Member shall automatically be terminated on the earliest of the following dates:

(i) The date of termination of his active full-time employment with the Policyholder;

(ii) The date on which this Policy is terminated;

(iii) The date of expiration of the period for which the last premium payment is made in respect of his coverage;

(iv) The end of the Policy Period during which the Insured Member reaches his Maximum Coverage Age

(v) When the Insured Member begins his temporary leave of absence, vacation without pay, sick or injured for more than 6 months. Written notice shall be given to the Company within 14 days after the end of the 6th month of such occurrence;

(vi) The date the Insured Member dies; or

(vii) The date that this Policy is terminated in accordance with Section II Clause 3(c) and 3(d) of this Policy.

(b) The coverage of any Insured Dependant shall automatically be terminated on the earliest of the following dates:

(i) The date the insurance of the Insured Member to whom the Insured Dependant is a dependant is terminated;

(ii) The date on which this Policy is terminated;

(iii) The date of expiration of the period for which the last premium payment is made in respect of his coverage;

(iv) The end of the Policy Period during which the Insured Dependant reaches the Maximum Coverage Age;

(v) The date the Insured Dependant no longer qualifies as an Eligible Dependant as defined in Section I Clause (i) of this Policy and his insurance will end on the last day of the Policy Period during which he no longer qualifies as an Eligible Dependant;

(vi) The date that this Policy is terminated in accordance with Section II Clause 3(c) and 3(d) of this Policy.

(c) This Policy shall be terminated on the date notified to the Policyholder by the Company to terminate the Policy by virtue of war (declared or undeclared) or act of war (whether or not there has been a declaration of war) where such date shall be at the discretion of the Company.

(d) This Policy may be terminated by either the Company or the Policyholder by giving thirty-one (31) days notice in writing. Termination of this Policy by the Policyholder or by the Company shall be without prejudice to any claim arising prior to such termination. If the Policy is terminated by the Company, a prorata premium will be charged for the period the Policy was in force. If the Policyholder terminates the Policy the premium charged will be based on the following scale:

Period Of Cover	Premium Charged
Up to 1 Month	3 Months
More than 1 Month and Up to 2 Months	4 Months
More than 2 Months and Up to 3 Months	5 Months
More than 3 Months and Up to 4 Months	6 Months
More than 4 Months and Up to 5 Months	7 Months
More than 5 Months and Up to 6 Months	8 Months
More than 6 Months and Up to 8 Months	10 Months
More than 8 Months	12 Months

4. Premium

Premium is payable to the Company in advance on each premium due date, unless otherwise specified by the Company in writing. The payment of any premium shall not maintain the coverage under this Policy in force beyond the date when the next premium becomes payable, except as set forth in the provision below entitled 'Grace Period'.

The Company reserves the right to change the rate at which the premiums are calculated on any Renewal Date or when the risks being insured under this Policy have substantially increased and provided further that the Company notifies the Policyholder at least thirty (30) days in advance.

5. Renewal Privilege

This Policy shall be renewed for a further term of one policy year on each Renewal Date subject to the consent of the Company.

6. Grace Period

It is a condition precedent to liability under this Policy that 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 Policy Commencement Date or Renewal Date of the Policy, or thirty (30) days from the date of the premium/tax invoice issued by the Company, whichever is the later, or

(b) Where the premium is payable other than on annual basis,

(i) Thirty (30) days from the Policy Commencement Date or Renewal Date of the Policy or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is the later, for the first instalment, and

(ii) on the agreed premium payment dates for subsequent instalments.

Where the Policyholder has confirmed its intention to renew the Policy but has not provided the Company with the complete data necessary for the renewal of the Policy by the Renewal Date, the Company shall issue a premium tax invoice for the estimated renewal premium. The premium tax invoice will be issued within thirty (30) days from the date of risk inception. The payment of the estimated premium under the premium tax invoice shall be subject to the Grace Period.

(c) In the event that any premium is not paid to the Company within the Grace Period, the Company reserves the right to terminate this Policy from the Renewal Date and the Company shall be discharged from all liability therefrom.

No claim incurred within the Grace Period shall be paid until premiums due under this Policy relating to the respective Policy Period is received in full by the Company.

7. Data Required

(a) The Policyholder shall furnish to the Company all such data, information and evidence as the Company may reasonably require upon or with regard to the happening of any event affecting or relating to the assurance of any Insured Member or Insured Dependant under this Policy. Clerical errors in keeping the Policyholder's records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated. But upon discovery of such error, an equitable adjustment will be made.

(b) The Company shall be permitted to examine the Policyholder's records at all reasonable times, as far as they relate to the subject matter of this Policy.

(c) The Policyholder shall give immediate notice to the Company of any change in the nature of its business which increases the risks already being insured under this Policy and shall pay any additional premium that may be required by the Company.

8. Assignment or Succession

If the business of the Policyholder shall be assigned to or succeeded by any person, persons or corporation, then subject to the consent of the Company, the payment of premiums under this Policy may at the option of such person, persons or corporation be continued in which case such person, persons or corporation shall as from the date of such assignment or succession take the place of and be treated for all purposes of this Policy (including this present condition) as being the Policyholder hereof.

9. Evidence of Age

Documentary evidence of age satisfactory to the Company shall be required before any benefit in respect of any coverage under this Policy shall be payable.

If the age has been under-stated, the amount payable shall be only such sum as the premium paid would purchase according to the premium rate at the true age. If the age is over-stated the excess of premium will be refunded.

10. Misstatement

Where a misstatement of age or other relevant facts has caused an Insured Member or Insured Dependant to be Insured hereunder when he is otherwise ineligible for assurance, or where such statement has caused an Insured Member or Insured Dependant to remain insured when he would otherwise be disqualified for further assurance in accordance with the terms and limitations of this Policy, his insurance coverage shall be void and there shall be a refund of premiums paid in respect of the Insured Member or Insured Dependant, provided always that where there is fraud on the part of the Policyholder or Insured Member or Insured Dependant, no premiums paid are to be refunded.

11. Contract

All statements relating to material facts made by the Policyholder or by an Insured Member or Insured Dependant shall, in the absence of fraud, be deemed representations and not warranties and no such statement shall avoid this Policy or be used in defence of a claim thereunder, unless it is in writing.

No agent or broker is authorised to make or to modify this contract, to extend the time for payment of premium, to waive any lapse or forfeiture, to waive any of the Company's rights or requirements, or to bind the Company by making any promise or by accepting any representation or information in respect of this Policy.

This Policy cannot be varied unless approved in writing by the Company.

12. Alteration of Contract

This Policy may at any time be amended and changed by written agreement between the Company and the Policyholder. Any amendments to this contract shall be binding on all Insured Members whether insured under this Policy prior to or on or after the effective date of the amendment.

13. Arbitration

All differences arising out of the Policy or incidental thereto or to the insurance coverage hereby effected shall be referred to a single arbitrator to be appointed in writing by the parties, or if they cannot agree upon a single arbitrator, to two arbitrators, one to be appointed in writing by each party and such arbitrators shall before commencing their investigations elect an umpire. In all other respects the arbitration shall be subject to the statutory provisions for the time being in force relating to arbitration. Unless and until an award has been made, no action or other legal proceedings shall be commenced in respect of any claim or by virtue of this Policy. After the expiration of two years from the date of an event giving rise to a claim under this Policy, the Company shall not be liable in respect thereof unless the Company shall have admitted liability in respect of such claim or the claim shall in the meantime have been referred to arbitration.

14. Exclusion of Contracts (Rights Of Third Parties) Act Cap. 53B

This Policy is a contract between the Company and the Policyholder. A person who is not a party to this Policy shall have no right under the Contracts (Rights of Third Parties) Act Cap. 53B and any subsequent amendments to the Act, to enforce any of its terms. Insured Members or Insured Dependant are not parties to this Policy and shall have no rights whatsoever under this Policy.

15. Operation of Law

This Policy shall be construed according to and governed by the law of Singapore.

16. Data Use

The Policyholder hereby confirms and represents to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") that each Insured Member or Insured Dependant has agreed and consented to the disclosure of his personal data to the Companies and their Representatives, and further, that for the Companies and their Representatives' collection, use and/or disclosure of the personal data of the Insured Members or Insured Dependant, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonable required by the Companies to provide the insurance coverage under this Policy. In respect of the Insured Members or Insured Dependant who are subsequently enrolled into this Policy, the Policyholder further undertakes that it shall ensure and procure that each of such Insured Members or Insured Dependant has provided such agreement and consentin relation to his/her personal data for such purposes.

The abovementioned purposes are set out in the Company's Privacy Statement, which is accessible from Great Eastern Singapore’s website and which the Policyholder hereby confirms that both the Policyholder and the Insured Members or Insured Dependant have read and understood.

The consents referred to herein are cumulative and additional to any rights which any of the Great Eastern Persons may have to collect, use, and/or disclose the Insured Member or Insured Dependants’ personal data, withor without consent, to the extent permitted under applicable law.

17. Non-Participation

This Policy does not participate in the profits of the Company.

18. Policy Owners’ Protection Scheme

This Policy is protected under the Policy Owners’ Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for the Policy is automatic and no further action is required

from the Policyholder. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact the Company or visit the Life Insurance Association (LIA) or SDIC websites (www.lia.org.sg or www.sdic.org.sg).

19. Geographical Limits

The coverage provided under this Policy is twenty-four (24hours) a day worldwide unless otherwise endorsed or amended.

20. Currency

Premiums and benefits payable under this Policy shall be in Singapore currency unless otherwise endorsed or amended.

SECTION III - BENEFIT PROVISIONS

1. Always subject to all the terms, conditions, exclusions and provisions of this Policy, upon receipt of proof of age and adequate documentary proof that the Insured Member sustains an Accidental Injury resulting in a Loss Event while covered under this Policy and occurring within 365 days from the date of the Accident, the Company will pay to the Policyholder the benefits which shall not exceed the amount obtained by multiplying the appropriate percentages shown for that Loss Event under the Schedule of Compensation by the Sum Assured specified in thePolicy Schedule but the Insured Member or Insured Dependant shall not be entitled to compensation under more than one of the Sections in the Schedule of Compensation in respect of any one accident.

2. Total and Permanent Disability Benefit

(a) In the event an Insured Member suffers from Total and Permanent Disability as defined under Section I or Section III Clause 2(b) of this Policy prior to his seventieth (70) birthday and this disability shall have lasted for not less than six (6) months duration, the Company upon receipt of satisfactory proof of such Total and Permanent Disability, shall pay the Sum Assured in one lump sum.

(b) An Insured Member shall be regarded as being totally and permanently disabled if that Insured Member due to injury or sickness or disease, is certified as unable to perform at least 3 out of 6 activities of daily living as defined below, even with the aid of special equipment, and will always to require the physical assistance of another person throughout the entire activity.

For actively working Insured Member or Insured Dependant between age 16 to 70 next birthday

"Total and Permanent Disability" means 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 Member or Insured Dependant can ever sufficiently do or follow to earn or obtain any wages, compensation or profit.

For Insured Member or Insured Dependant with no gainful occupation between age 16 to 70 next birthday

"Total and Permanent Disability" means the inability of the Insured Member or Insured Dependant to perform at least 3 out of 6 activities of daily living as defined below, even with the aid of special equipment, and will always to require the physical assistance of another person throughout the entire activity.

The activities of daily living are:

1) Washing

The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.

2) Dressing

The ability to put on, takes off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or other surgical or medical appliances.

3) Feeding

The ability to feed oneself food after it has been prepared and made available.

4) Mobility

The ability to move indoors from room to room on level surfaces.

5) Toileting

The ability to do all of the following: to get to and from the lavatory, to get on and off the lavatory, to maintain an adequate level of personal hygiene.

6) Transferring

The ability to move from a bed to an upright chair or wheelchair and vice versa.

Constant Care definition of Total and Permanent Disability - For Insured Dependant age up to 15 next birthday

An Insured Dependant shall be regarded as being totally and permanently disabled under a Constant Care definition of disability, only if that Insured Dependant, due to accident or sickness, has been disabled to such an extent that he / she is required to be confined at home, to a hospital or other institution in order to receive constant care and medical attention.

The Total and Permanent Disability shall have lasted for not less than six (6) months duration and upon receipt of satisfactory proof of such Total and Permanent Disability, the Sum Assured shall become payable to the Policyholder or to the order of Policyholder.

1. For the avoidance of doubt, this Policy shall cover, notwithstanding Section VI – Exclusion but otherwise subject to the terms and conditions of this policy, the following benefits:

   (a) Compassionate Death Allowance Benefit

   In the event of an accidental death of the Insured Member, the Company shall pay a compassionate death allowance of S$5,000 in addition to any death benefit paid for the Insured Member under this Policy.

   (b) Child Education Fund Benefit

   If an accidental death of the Insured Member who, at the date of the accident, had any Dependant Child, the Company shall pay a one lump sum of S$5,000.

   "Dependent Child" means any unmarried child less than twenty-five (25) years of age if enrolled as a full time student in a recognised institution of higher learning, and who is dependent upon the Insured Member for his or her maintenance and support provided that any Dependent Child engaged in full-time National Service will not be covered.

   (c) Accidental Death due to Common Carrier Benefit

   If during the period of insurance, an Insured Member suffers Bodily Injury whilst boarding, alighting or travelling in a duly licensed commercial aircraft as a fare-paying passenger, which directly and independently of all other causes, results in the death of the Insured Member within twelve (12) months from the date of the Accident, the Company shall pay 10% of the Principal Sum or maximum of S$10,000,

whichever is lesser, in addition to any death benefit paid for the Insured Member under this Policy.

(d) Comatose State due to Common Carrier Benefit

If during the period of insurance, an Insured Member suffers a Bodily Injury whilst boarding, alighting or travelling in a duly licensed commercial aircraft as a fare-paying passenger, which directly and independently of all other causes, results in the Insured Member being in a Hospital and in a Comatose State, within thirty (30) days of the Accident, the company shall pay twenty percent (20%) of the Principal Sum, or maximum of S$50,000, whichever is lesser.

"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. Coma resulting directly from alcohol or drug abuse is excluded.

(2) Maximum Sum Assured

(a) The maximum Sum Assured for any Insured Member under this Policy issued by the Company shall not exceed S$1,000,000.

(b) The maximum Sum Assured for any Insured Dependant under this Policy issued by the Company shall not exceed S$250,000.

SECTION IV – COVERAGE FOR FOREIGN BASED EMPLOYEE OR FOREIGN BASED EMPLOYEE'S DEPENDANTS

1. This Policy will not insure any person who is residing or based outside Singapore unless:

(a) the total number of Foreign Based Employees or Foreign Based Employee's Dependants are not more than 10% of the total group size; and

(b) the person is a Foreign Based Employee or Foreign Based Employee's Dependant as defined under Section I of this Policy; and

(c) the Policyholder has declared to the Company the name of the Foreign Based Employee or Foreign Based Employee's Dependant and the country in which he is residing or based in; and

(d) the Company has advised the Policyholder in writing of the terms of acceptance of insurance on that Foreign Based Employee or Foreign Based Employee's Dependant. Insurance coverage on the Foreign Based Employee or Foreign Based Employee's Dependant will not start until the Company has accepted such cover in writing.

2. The Company reserves the right to decline insurance on any Foreign Based Employee or Foreign Based Employee's Dependant who is based or residing in a country where the risk is not acceptable to the Company.

3. If a Foreign Based Employee or Foreign Based Employee's Dependant's name has not been declared to the Company, the Company reserves the right to decline any claim for benefit under this Policy or adjust the benefit amount payable in respect of that Foreign Based Employee or Foreign Based Employee's Dependant.

4. Upon any Renewal Date of this Policy, the continuation of coverage for any Foreign Based Employee or Foreign Based Employee's Dependant on or after the Renewal Date will be subject to acceptance by the Company in writing, and on such terms and conditions which the Company may choose to impose.

SECTION V – LIMITATIONS

1. The total amount of benefits payable in respect of an Insured Member or Insured Dependant in any one Policy Period shall not exceed, in aggregate, 100% of the Sum Assured, except as provided in Section IV Clause 4 of this Policy.

2. No benefit shall be payable for any injury or disability which forms part of another injury or disability for which a greater amount of benefit is payable.

3. If an Insured Member or Insured Dependant sustains an Accidental Injury during the Policy Period resulting in a Loss Event, the Company shall pay for that specific Loss Event in accordance with the Schedule of Compensation without reference to or taking into account any previous Loss Event suffered by the Insured Member or Insured Dependant due to the same Accident whether prior to or during the Policy Period.

4. When an Insured Member or Insured Dependant suffers from the Loss Events described in items 1, 2, 3, 4, 5, 6 and 7 under part (B) of the Schedule Of Compensation, the benefit payable by the Company shall exceed 100% of the Sum Assured, as specified in the said Schedule Of Compensation, and during any one Policy Period, the Company shall pay for only one of the aforementioned Loss Events suffered by the Insured Member or Insured Dependant.

SECTION VI – EXCLUSIONS

The insurance under this Policy shall not cover any Loss Event caused directly, or indirectly, wholly or partly, by:

1. Suicide or any attempted suicide or self-inflicted injury or illness, whether the Insured Member or Insured Dependant is sane or insane;

2. War (declared or undeclared), hostilities, civil war or any warlike operations; military or naval or air-force service while under orders for warlike operations.

3. Participation in riot or commission of an assault or act of crime;

4. Participation in competitive racing of any kind other than on foot;

SECTION VII – CLAIMS

1. Notice and Proof of Claim

(a) The Insured Member or Insured Dependant or his legal representative must notify the Company in writing within 30 days after the happening of any event likely to give rise to a claim under this Policy. However, the claim will not be invalidated if it can be shown that it was not reasonably possible for him to notify the Company within this period.

(b) Written notice of death of any Insured Member or Insured Dependant must be given within 30 days after the death of the Insured Member or Insured Dependant. Satisfactory proof of death must be given to the Company within 90 days after the death of the Insured Member or Insured Dependant. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

(c) If an Insured Member or Insured Dependant is permanently disabled, written notice must be given within 30 days after the commencement of the permanent disability of the Insured Member or Insured Dependant. Satisfactory proof of disability must be given to the Company within 90 days after the commencement of the permanent disability of the Insured Member or Insured Dependant. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

(d) Written notice given by or on behalf of the Insured Member or Insured Dependant to the Company with particulars sufficient to identify the Insured Member or Insured Dependant, 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 shall be shown not to have been reasonably possible to give such notice and that such notice was given as soon as was reasonably possible.

(e) All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Insured Member or Insured Dependant or the Insured Member or Insured Dependant'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 Member or Insured Dependant 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.

(f) If the Insured Member or Insured Dependant is residing in a country outside Singapore, the Company may at its discretion require the Insured Member or Insured Dependant to come to Singapore for medical examination by a Registered Medical Practitioner in Singapore.

(g) The Company may also require the Policyholder to furnish at his expense evidence to establish the continuing health condition of the Insured Member or Insured Dependant and to show that the Insured Member or Insured Dependant is not engaged in any form of employment.

(h) Proof of the date of birth of the Insured Member or Insured Dependant 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 Member or Insured Dependant 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.

(i) In case of death, the Company has the right to investigate the circumstances of death, to have a post-mortem examination either before or after burial. In the event of an accidental death, a police report and post-mortem report must be submitted to the Company.

2. Payment of Benefit

(a) All benefits shall be paid only when the claim shall have been proven to the satisfaction of the Company and the total amount of compensation shall have been ascertained and agreed upon by the Company and Policyholder.

(b) Any amount payable under this Policy will be paid by cheque to the order of the Policyholder, unless the Policyholder otherwise notifies in writing. Any payment so made shall effectively discharge the Company from any further liability under this Policy.

3. Fraudulent Claims

If any claim under this Policy is in any respect, fraudulent or if any fraudulent means or devices shall be used by the Policyholder or an Insured Member or Insured Dependant or any one acting on behalf of the said parties to obtain a benefit under this Policy, the Company shall be under no liability in respect of such claims and shall be entitled to recover any payment prior to the discovery of fraud.

SECTION VIII – COMPANY NOT LIABLE

The Company shall not be held responsible or be liable as a party in any way whatsoever to any legal proceeding for damages or otherwise, which may be instituted by any Insured Member or Insured Dependant against any provider of Medical Services for reasons of neglect, malpractice or other causes arising from acts or omissions in the treatment or examination of the Insured Member or Insured Dependant by any provider of Medical Services as provided in this Policy.

In providing a service to an Insured Member or Insured Dependant, the Company and its authorised providers may supply information including medical information pertaining to the treatment of the Insured Member or Insured Dependant to the Policyholder.

Neither the Company nor its employees nor its authorised providers shall be liable for any loss or damage suffered by the Policyholders, Insured Member or Insured Dependant due to any error or omission in the information supplied however caused if the supply of information had been made in good faith by the Company or its authorised providers.

GREAT PLATINUM BENEFITS
GROUP PERSONAL ACCIDENT POLICY

SECTION IX – PREMIUM TABLE

Plan Type	Plan 1	Plan 2	Plan 3	Plan 4
Sum Assured (S$)	1,000,000	750,000	500,000	250,000
Occupation Class^	Annual Premium per Insured Member or Insured Dependant (S$) (inclusive of GST)			
1	428.00	321.00	214.00	107.00
2	556.40	417.30	278.20	139.10
3	770.40	577.80	385.20	192.60

GREAT PLATINUM BENEFITS
GROUP PERSONAL ACCIDENT POLICY

SCHEDULE OF COMPENSATION

	Loss Events	Compensation Payable % of Capital Sum Assured
A	DEATH	100%
	Burial Expenses	S$2,000
B	PERMANENT DISABILITY	
	(unless "Total and Permanent Loss" is a defined term in the Policy)	
	1. Permanent total disability	150%
	2. Total paralysis of all limbs	150%
	3. Loss of both hands or both feet	150%
	4. Loss of one hand or one foot	125%
	5. Loss of entire sight of both eyes	150%
	6. Loss of or the permanent total loss of one limb and loss of sight of one eye	150%
	7. Total and permanent loss of speech and hearing	150%
	8. Permanent and incurable insanity	100%
	9. Total and permanent loss of hearing in	
	a. Both ears	75%
	b. One ear	25%
	10. Total and permanent loss of speech	50%
	11. Total and permanent loss of the lens of one eye	50%
	12. Loss of sight of one eye	100%
	13. Loss of one thumb	
	a. Both phalanges	30%
	b. One phalanx	15%
	14. Loss of four fingers and thumbs(all phalanges)	70%
	15. Loss of four fingers(all phalanges)	40%
	16. Loss of any one finger	
	a. Three phalanges	10%
	b. Two phalanges	8%
	c. One phalanx	5%
	17. Loss of toes	
	a. All	15%
	b. Great, both phalanges	5%
	c. Great, one phalanx	3%
	d. Other than great, if more than one toe, each	1%
	18. Fractured leg or patella with establish non-union	10%
	19. Shortening of leg by at least 5 cm	7.5%
	20. Third Degree Burns	
	Area Damage as a percentage of total body surface area	
	*Head equal to or greater than 2% but less than 5%	50%
	equal to or greater than 5% but less than 8%	75%
	equal to or greater than 8%	100%
	*Body equal to or greater than 10% but less than 15%	50%
	equal to or greater than 15% but less than 20%	75%
	equal to or greater than 20%	100%
	21. Other permanent disablement not specified the Company will adopt a percentage that is consistent with the above scale without reference to the Insured Member or Insured Dependant's occupation.	

Where any other permanent disablement loss is not specified above (other than loss of sense of taste or smell), the Company reserves the right to adopt a percentage of permanent Disablement after consulting its appointed Registered Medical Practitioners which in the opinion of the Company is not inconsistent with the provisions as specified above without taking into account the employment or occupation of the Insured Member or Insured Dependant.

The aggregate of all percentages payable under any or all of (A) and (B) in respect of any one accident shall not exceed 150%.

THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED

(Reg. No. 1908 00011G)

HEAD OFFICE:
1 Pickering Street #13-01,
Great Eastern Centre,
SINGAPORE 048659.

GREAT PLATINUM BENEFITS
GROUP TERM LIFE POLICY

Group Policy Number :

Policyholder :

Policy Commencement Date :

Whereas the Policyholder has requested The Great Eastern Life Assurance Company Limited (hereinafter called "the Company") to grant the benefits hereinafter referred to. The Company hereby agrees to pay to the Policyholderthe benefits subject to all the terms, conditions and provisions of this Policy. This Policy is issued in consideration of payment of the necessary premiums and shall take effect on the Policy Commencement Date.

The terms, conditions and provisions in this and the subsequent pages, including all schedules, riders, amendments or endorsements included at issue or added thereafter, shall be deemed to form part of this Policy.

IN WITNESS WHEREOF, the Company has caused this Policy to be signed as of DD MM YY.

Koh Beng Seng
Chairman

Norman Ip
Director

Table of Contents

SECTION I - GENERAL DEFINITIONS

In this Policy where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

(a) **"Actively At Work"** means reporting for work at the place assigned by the Policyholder and performing, in the customary manner, all the regular duties of his employment with the Policyholder on full time basis or being on entitled annual leave for reasons other than on medical grounds.

(b) "**Class 1 Occupation classification**" means a professional, managerial, administrative, clerical, non-manual occupation or work of a supervisory nature which does not involve the use of tools and machinery or exposure to special hazards.

(c) "**Class 2 Occupational classification**" means a work involving substantial amount of traveling, or manual work not of a particularly hazardous nature but involving the use of tools and machinery.

(d) "**Class 3 Occupational classification**" means a work involving a fair amount of manual works for example, with machinery, chemicals or construction.

(e) "**Effective Date**" means the date from which the insurance coverage of the Insured Member or Insured Dependant as specified under this Policy has become effective.

(f) **"Eligibility Date"** means the date agreed in writing between the Policyholder and the Company on which an Eligible Member or Eligible Dependant is eligible to participate in the insurance coverage under this Policy.

(g) "**Eligible Dependant**" means:

(i) The legal spouse of an Eligible Member who is not divorced or separated, and who has not attained the age of 70 years at the Policy Commencement Date or 75 years at Renewal Date; or

(i) An unmarried and unemployed natural or step child(ren) from a legal marriage or legally adopted child(ren) of an Eligible Member who is between attained age of 12 months and 25 years old (next birthday) at the Policy Commencement Date or Renewal Date;

who is a Singaporean or Singapore Permanent Resident or with a valid employment pass (EP holders, S Pass, or Work Permit holders)/ Dependant pass and is residing in Singapore.

(h) **"Eligible Member"** means members as specified in the Policy Schedule and whose eligibility to participate in the insurance plan under this Policy has been agreed in writing between the Policyholder and the Company.

(i) "**Evidence of Insurability**" means the health declaration form completed by the Eligible Member or Eligible Dependant or any underwriting requirements as advised by the Company.

(j) **"Foreign Based Employee"** means a permanent full time employee of the Policyholder who is residing, or is based, outside the Republic of Singapore for more than one year and engaged in a Class 1 or 2 Occupation.

(k) **"Foreign Based Employee's Dependant"** means a person who qualifies as a Dependant and he is not residing in the Republic of Singapore.

(l) "**Insured Dependant**" means any Eligible Dependant, in respect of whom insurance under this Policy has been effected.

(m) "**Insured Member**" means an Eligible Member, in respect of whom an insurance coverage under this Policy has been effected.

(n) "**Maximum Coverage Age**" means the maximum age of coverage as specified in the Policy Schedule attached hereto.

(o) **"Non-Medical Limit"** means the amount of insurance in respect of each Insured Member or Insured Dependant which the Company will accept without requiring evidence of insurability. The Non-Medical Limit for this Policy is S$250,000 and up to age 65 next birthday.

(p) **"Policy"** means this agreement, any rider or endorsement therein, any amendment signed by the Company, the application of the Policyholder, medical reports and any individual proposal form or any other form signed by the Insured Member or Insured Dependant or the Policyholder constituting the entire contract.

(q) **"Policy Commencement Date"** means the date from which the insurance coverage under this Policy becomes effective.

(r) **"Policy Period"** means a period of one calendar year or such other periods as may be agreed in writing between the Company and the Policyholder, starting from the Policy Commencement Date for the first PolicyPeriod and from the respective Renewal Dates for subsequent Periods of Insurance.

(s) "**Pre-Existing Condition**" means any illnesses, diseases, injuries, impairments from which the Insured Member or Insured Dependant is suffering, whether known or unknown to the Insured Member or Insured Dependant as long as the cause or pathology of the conditions has already existed before the Effective Date in respect of the Insured Member or Insured Dependant under this Policy.

(t) **"Registered Medical Practitioner"** means a person qualified by degree in western medicine and legally licensed and authorised to practice medicine and surgery in the geographical area of his country, who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(u) **"Renewal Date"** means the date immediately following the last day of any Policy Period as stated in the endorsement to this Policy.

(v) **"Sum Assured"** shall mean the amount of assurance effected under this Policy in respect of the Insured Member or Insured Dependant.

(w) **"Terminal Illness"** means the conclusive diagnosis of an illness that is expected to result in the death of the Insured Member or Insured Dependant within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed doctor.

(x) "**Total and Permanent Disability**" means 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 Member or Insured Dependant 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 loss by severance or loss of permanent use of both hands at or above the wrists or both feet at or above the ankles; or the loss by severance or loss of permanent use of one hand at or above the wrist and one foot at or above the ankle; or The loss by severance or loss of permanent use of one limb at or above the wrist or ankle and loss of sight of one eye shall be considered as Total and Permanent Disability

SECTION II - GENERAL PROVISIONS

1. Eligibility and Commencement of Insurance

   (a) All Eligible Members who are Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement Date shall be covered under this Policy on such date, unless otherwise agreed by the Company.

   (b) All Eligible Members who are not Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement Date shall not be covered under this Policy and shall only be covered on the date they are Actively At Work, unless otherwise agreed by the Company.

(c) All new and existing employees of the Policyholder becoming eligible after the Policy Commencement Date will be covered on their respective Eligibility Dates provided that they are Actively At Work on their respective Eligibility Dates. Any Eligible Member who is on medical leave or in hospital on his respective Eligibility Date, will be covered on the date he returns to active service at work.

(d) An Eligible Member shall be covered automatically for his Sum Assured not exceeding the Non- Medical Limit, if any, on his Eligibility Date except that if he is not Actively At Work on that date, his Sum Assured within the Non-Medical Limit shall be effective on the date after he is Actively At Work, subject to the condition that the Policyholder shall notify the Company within 90 days after the EligibleMember is eligible to be covered under this Policy. The amount of his insurance coverage in excess of the Non-Medical Limit may be accepted subject to Evidence of Insurability satisfactory to the Company.

(e) Any Insured Member or Insured Dependant's Sum Assured which has been changed (in accordance to the basis of coverage as endorsed in the Policy) shall be covered automatically for the aggregate Sum Assured not exceeding the Non-Medical Limit on the date of change.

(f) The aggregate Sum Assured in excess of the Non-Medical Limit of any Insured Member or Insured Dependant may be accepted subject to Evidence of Insurability satisfactory to the Company. In the absence of written acceptance by the Company, the Sum Assured of the Insured Member or Insured Dependant shall be limited to the amount of Non-Medical Limit or to the last Sum Assured already accepted by the Company in writing.

(g) An Insured Member or Insured Dependant whose insurance coverage under this Policy was terminated due to any cause and who re-applies for insurance coverage shall be considered as a new member.

(h) Any proposed cover above the Non-Medical Limit shall be subjected to underwriting by the Company prior to effective date and on each Renewal Date and the Company reserves the right to impose term and conditions or reject such proposal.

2. Dependant's Participation and Insurance

(a) Section II Clause 2 of this Policy is valid only upon the application of the Eligible Dependant's coverage by the Policyholder and the Company's acceptance of the Eligible Dependant's application in writing.

(b) Insurance of an Eligible Dependant will start on his Eligibility Date provided he is not hospitalized, or on medical leave and is in good health.

3. Termination

(a) The coverage of any Insured Member shall automatically be terminated on the earliest of the following dates:

(i) The date of termination of his active full-time employment with the Policyholder;

(ii) The date on which this Policy is terminated;

(iii) The date of expiration of the period for which the last premium payment is made in respect of his coverage;

(iv) The end of the Policy Period during which the Insured Member reaches his Maximum Coverage Age

(v) When the Insured Member is on his temporary leave of absence, vacation without pay, sick or injured for more than 6 months. Written notice shall be given to the Company within 14 days after the end of the 6th month of such occurrence

(vi) The date the Insured Member dies;

(vii) The date that this Policy is terminated in accordance with Section II Clause 2(b) and 2(c) of this Policy.

(b) The coverage of any Insured Dependant shall automatically be terminated on the earliest of the following dates:

(i) The date the insurance of the Insured Member to whom the Insured Dependant is a dependant is terminated;

(ii) The date on which this Policy is terminated;

(iii) The date of expiration of the period for which the last premium payment is made in respect of his coverage;

(iv) The end of the Policy Period during which the Insured Dependant reaches his Maximum Coverage Age;

(v) The date the Insured Dependant no longer qualifies as an Eligible Dependant as defined in Section I Clause (g) of this Policy and his insurance will end on the last day of the Policy Period during which he no longer qualifies as an Eligible Dependant;

(vi) The date that this Policy is terminated in accordance with Section II Clause 3(c) and 3(d) of this Policy.

(c) This Policy shall be terminated on the date notified to the Policyholder by the Company to terminate the Policy by virtue of war (declared or undeclared) or act of war (whether or not there has been a declaration of war) where such date shall be at the discretion of the Company.

(d) This Policy may be terminated by either the Company or the Policyholder by giving thirty-one (31) days' notice in writing. Termination of this Policy by the Policyholder or by the Company shall be without prejudice to any claim arising prior to such termination. If the Policy is terminated by the Company, a prorata premium will be charged for the period the Policy was in force. If the Policyholder terminates the Policy the premium charged will be based on the following scale:

Period Of Cover	Premium Charged
Up to 1 Month	3 Months
More than 1 Month and Up to 2 Months	4 Months
More than 2 Months and Up to 3 Months	5 Months
More than 3 Months and Up to 4 Months	6 Months
More than 4 Months and Up to 5 Months	7 Months
More than 5 Months and Up to 6 Months	8 Months
More than 6 Months and Up to 8 Months	10 Months
More than 8 Months	12 Months

4. Premium

Premium is payable to the Company in advance on each premium due date, unless otherwise specified by the Company in writing. The payment of any premium shall not maintain the coverage under this Policy in force beyond the date when the next premium becomes payable, except as set forth in the provision below entitled 'Grace Period'.

The Company reserves the right to change the rate at which the premiums are calculated on any RenewalDate or when the risks being insured under this Policy have substantially increased and provided further that the Company notifies the Policyholder at least thirty (30) days in advance.

5. Renewal Privilege

This Policy shall be renewed for a further term of one policy year on each Renewal Date subject to the consent of the Company.

6. Grace Period

It is a condition precedent to liability under this Policy that 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 Policy Commencement Date or Renewal Date of the Policy, or thirty (30) days from the date of the premium/tax invoice issued by the Company, whichever is the later, or

(b) Where the premium is payable other than on annual basis,

(i) Thirty (30) days from the Policy Commencement Date or Renewal Date of the Policy or thirty (30) days from the date of the premium tax invoice issued by the Company, whichever is the later, for the first instalment, and

(ii) on the agreed premium payment dates for subsequent instalments.

Where the Policyholder has confirmed its intention to renew the Policy but has not provided the Company with the complete data necessary for the renewal of the Policy by the Renewal Date, the Company shall issue a premium tax invoice for the estimated renewal premium. The premium tax invoice will be issued within thirty (30) days from the date of risk inception. The payment of the estimated premium under the premium tax invoice shall be subject to the Grace Period.

(c) In the event that any premium is not paid to the Company within the Grace Period, the Company reserves the right to terminate this Policy from the Renewal Date and the Company shall be discharged from all liability therefrom.

No claim incurred within the Grace Period shall be paid until premiums due under this Policy relating to the respective Policy Period is received in full by the Company.

7. Data Required

(a) The Policyholder shall furnish to the Company all such data, information and evidence as the Company may reasonably require upon or with regard to the happening of any event affecting or relating to the insurance coverage of any Insured Member or Insured Dependant under this Policy. Clerical errorsin keeping the Policyholder's records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated. But upon discovery of such error, an equitable adjustment will be made.

(b) The Company shall be permitted to examine the Policyholder's records at all reasonable times, as far as they relate to the subject matter of this Policy.

(c) The Policyholder shall give immediate notice to the Company of any change in the nature of its business which increases the risks already being insured under this Policy and shall pay additional premium that may be required by the Company.

8. Assignment or Succession

If the business of the Policyholder shall be assigned to or succeeded by any person, persons or corporation, then subject to the consent of the Company, the payment of premiums under this Policy may at the option of such person, persons or corporation be continued in which case such person, persons or corporation shall as from the date of such assignment or succession take the place of and be treated for all purposes of this Policy (including this present condition) as being the Policyholder hereof.

9. Evidence of Age

Documentary evidence of age satisfactory to the Company shall be required before any benefit in respect of any insurance coverage under this Policy shall be payable.

If the age has been under stated, the amount payable shall be only such sum as the premium paid would purchase according to the premium rate at the true age. If the age is over-stated the excess of premium will be refunded.

10. Misstatement

Where a misstatement of age or other relevant facts has caused an Insured Member or Insured Dependant to be Insured hereunder when he is otherwise ineligible for insurance coverage, or where such statement has caused an Insured Member or Insured Dependant to remain insured when he would otherwise be disqualified for further insurance coverage in accordance with the terms and limitations of this Policy, his insurance coverage shall be void and there shall be a refund of premiums paid in respect of the Insured Memberor Insured Dependant, provided always that where there is fraud on the part of the Policyholder or Insured Member or Insured Dependant, no premiums paid are to be refunded.

11. Contract

All statements relating to material facts made by the Policyholder or by an Insured Member or Insured Dependant shall, in the absence of fraud, be deemed representations and not warranties and no such statement shall avoid this Policy or be used in defence of a claim thereunder, unless it is in writing.

No agent or broker is authorised to make or to modify this contract, to extend the time for payment of premium, to waive any lapse or forfeiture, to waive any of the Company's rights or requirements, or to bind the Company by making any promise or by accepting any representation or information in respect of this Policy.

This Policy cannot be varied unless approved in writing by the Company.

12. Alteration of Contract

This Policy may at any time be amended and changed by written agreement between the Company and the Policyholder. Any amendments to this contract shall be binding on all Insured Member or Insured Dependant whether insured under this Policy prior to or on or after the effective date of the amendment.

13. Arbitration

All differences arising out of the Policy or incidental thereto or to the insurance coverage hereby effectedshall be referred to a single arbitrator to be appointed in writing by the parties, or if they cannot agree upon a single arbitrator, to two arbitrators, one to be appointed in writing by each party and such arbitrators shall before commencing their investigations elect an umpire. In all other respects the arbitration shall be subjectto the statutory provisions for the time being in force relating to arbitration. Unless and until an award has been made, no action or other legal proceedings shall be commenced in respect of any claim or by virtue of this Policy. After the expiration of two years from the date of an event giving rise to a claim under this Policy, the Company shall not be liable in respect thereof unless the Company shall have admitted liability in respect of such claim or the claim shall in the meantime have been referred to arbitration.

14. Exclusion of Contracts (Rights Of Third Parties) Act Cap. 53B

This Policy is a contract between the Company and the Policyholder. A person who is not a party to this Policy shall have no right under the Contracts (Rights of Third Parties) Act Cap. 53B and any subsequent

amendments to the Act, to enforce any of its terms. Insured Members or Insured Dependant are not parties to this Policy and shall have no rights whatsoever under this Policy.

15. Operation of Law

This Policy shall be construed according to and governed by the law of Singapore.

16. Data Use

The Policyholder hereby confirms and represents to the Company and its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives"), that each Insured Member or Insured Dependant has agreed and consented to the disclosure of his/her personal data to the Companies and their Representatives, the Companies' authorised service providers and relevant third parties (collectively, "Great Eastern Persons") for their collection, use and/or disclosure of the personal data for purposes reasonably required by the Companies to provide the insurance coverage under this Policy. In respect of the Insured Members or Insured Dependant who are subsequently enrolled into this Policy, the Policyholder further undertakes that it shall ensure and procure that each of such Insured Member or Insured Dependant has provided such agreement and consent in relation to his/her personal data for such purposes.

The abovementioned purposes are set out in the Company's Privacy Statement, which is accessible from Great Eastern Singapore's website and which the Policyholder hereby confirms that both the Policyholder and the Insured Members or Insured Dependant have read and understood.

The consents referred to herein are cumulative and additional to any rights which any of the Great Eastern Persons may have to collect, use, and/or disclose the Insured Members' or Insured Dependant personal data, with or without consent, to the extent permitted under applicable law.

17. Non-Participation

This Policy does not participate in the profits of the Company.

18. Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for the Policy is automatic and no further action is required from the Policyholder. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact the Company or visit the Life Insurance Association (LIA) or SDIC websites (www.lia.org.sg or www.sdic.org.sg).

19. Geographical Limits

The coverage provided under this Policy is twenty-four (24) hours a day worldwide unless otherwise endorsed or amended.

20. Currency

Premiums and benefits payable under this Policy shall be in Singapore currency unless otherwise endorsed or amended.

SECTION III - BENEFIT PROVISIONS

While this Policy is in force and subject always to all the terms, conditions and provisions of this Policy, we will provide the following benefits:

1. Death Benefit

Upon receipt of proof of age and adequate documentary proof that the Insured Member or Insured Dependant died while insured under this Policy, the Sum Assured shall become payable in a lump sum to the Policyholder. No Death Benefit will be further payable if the Sum Assured has been fully paid under Section III Clause 4 of this Policy.

After the Total and Permanent Disability benefit is payable, no more Death benefit is payable.

2. Total and Permanent Disability Benefit

(a) In the event an Insured Member or Insured Dependant suffers from Total and Permanent Disability as defined under Section I or Section III Clause 2(a)of this Policy prior to his seventieth (70) birthday and this disability shall have lasted for not less than six (6) months duration, the Company upon receipt of satisfactory proof of such Total and Permanent Disability, shall pay the Sum Assured in one lump sum.

(i) For actively working Insured Member or Insured Dependant between age 16 to 70 next birthday

"Total and Permanent Disability" means 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 Member or Insured Dependant can ever sufficiently do or follow to earn or obtain any wages, compensation or profit.

(i) For Insured Member or Insured Dependant with no gainful occupation between age 16 to 70 next birthday

"Total and Permanent Disability" means the inability of the Insured Member or Insured Dependant to perform at least 3 out of 6 activities of daily living as defined below, even with the aid of special equipment, and will always to require the physical assistance of another person throughout the entire activity.

The activities of daily living are:

1) Washing

The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.

2) Dressing

The ability to put on, takes off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or other surgical or medical appliances.

3) Feeding

The ability to feed oneself food after it has been prepared and made available.

4) Mobility

The ability to move indoors from room to room on level surfaces.

5) Toileting

The ability to do all of the following: to get to and from the lavatory, to get on and off the lavatory, to maintain an adequate level of personal hygiene.

6) Transferring

The ability to move from a bed to an upright chair or wheelchair and vice versa.

(ii) Constant Care definition of Total and Permanent Disability - For Insured Dependant age up to 15 next birthday

An Insured Dependant shall be regarded as being totally and permanently disabled under a Constant Care definition of disability, only if that Insured Dependant, due to accident or sickness, has been disabled to such an extent that he / she is required to be confined at home, to a hospital or other institution in order to receive constant care and medical attention.

The Total and Permanent Disability shall have lasted for not less than six (6) months duration and upon receipt of satisfactory proof of such Total and Permanent Disability, the Sum Assured shall become payable to the Policyholder or to the order of Policyholder.

3. Extended Death and Total and Permanent Disability

In the event an Insured Member's employment with the Policyholder is terminated due to his medical condition, his coverage under this Policy shall be extended from the date he leaves their employment for a period equivalent to the length of time he was continuously insured under this Policy subject to a maximum period of 12 months and provided that:

(a) the Insured Member has not attained his seventieth (70) birthday; and

(b) such Insured Member remains continuously unemployed from the date he leaves their employment; and

(c) the Insured Member resides in Singapore during extended period of the benefit; and

(d) no claim has been made under Section III Clause 2 of this Policy; and

(e) the coverage for this Insured Member under this Policy has not been accepted by the Company as a sub-standard risk or on special terms and conditions or both; and

(f) written notice of such termination of employment is given by the Policyholder to the Company within 14 days from the date of termination of employment, failing which no extension of cover shall be granted; and

(g) this Policy continues to be in force during this extended period of the benefit, This Extended Benefit will cease if this Policy is terminated or expired; and

(h) the coverage for the Insured Member shall be based on the amount he was last accepted prior to his termination of employment.

(i) Premiums will be charged during this extended period of the benefit.

The coverage in respect of benefits under all other supplementary contracts attached to this Policy shall be terminated once this extended benefit is effected.

4. Terminal Illness Benefit

If an Insured Member or Insured Dependant suffers a medical condition which is expected to lead to death within next 12 months, this diagnosis must be supported by a specialist consultant and confirmed by a Registered Medical Practitioner appointed by the Company. The Company will pay the Sum Assured for the Insured Member or Insured Dependant's condition in one lump sum upon receipt of satisfactory proof of the Terminal Illness.

5. Repatriation Benefit

(a) In the event of an Insured Member or Insured Dependant's death while travelling outside his country of residence or country of regular employment, the Company through its appointed service provider

("Appointed Service Provider") or an authorized representative of the Appointed Service Provider shall organize and arrange for the return of the mortal remains of the deceased Insured Member or Insured Dependant's to his country of residence or country of regular employment or country of origin. The service shall be organised and managed by the Appointed Service Provider subject to the prior authorisation and request from the Company to provide so.

(b) The costs and expenses incurred from the organizing of the repatriation of mortal remains shall include, but are not limited to:-

(i) transportation of the deceased Insured Member or Insured Dependant's body from the place of death to his place of residence or country of regular employment or country of origin; and/or

(ii) actual expenses incurred for the services and supplies provided by a mortician or undertaker, including but not limited to the cost of a casket and embalming and cremation if so elected; and/or

(iii) relevant documents such as death certificate, embalming certificate, death autopsy report or other associated certificates, paper documents or necessary government authorisations; and/or

(c) The maximum amount payable for this Repatriation benefit shall be the actual expenses incurred but shall not exceed a maximum amount of $75,000. The said maximum amount is inclusive of the corresponding benefit payable under Group Term Life and Group Hospitalisation and Surgical, where applicable.

(d) Exclusions:

No benefit shall be payable under any of the following circumstances:

(i) Services rendered without the authorization and/or intervention of the Appointed Service Provider.

(ii) Services rendered by any other party apart from the Appointed Service Provider for which no charge is usually made.

(iii) Medical treatment administered by the Insured Member or Insured Dependant's immediate family members or relatives, whether being a qualified medical practitioner or not.

(iv) Where the Insured Member or Insured Dependant has already been undergoing medical treatment at the time before the Insured Member or Insured Dependant commences his journey and the costs and expenses concerned relates to that treatment, or if the said journey was undertaken against the order or advice of a medical practitioner.

(v) The Insured Member or Insured Dependant was traveling with the intention of obtaining medical treatment overseas.

6. Maximum Sum Assured

(a) The maximum Sum Assured for any Insured Member under this Policy issued by the Company shall not exceed S$1,000,000.

(b) The maximum Sum Assured for any Insured Dependant under this Policy issued by the Company shall not exceed S$250,000.

SECTION IV – COVERAGE FOR INSURED MEMBER OR INSURED DEPENDANT ABOVE AGE 70 YEARS OLD

1. Insured Members or Insured Dependant who are accepted and insured under this Policy before attaining their seventieth (70) birthdays, shall be eligible for continuation of coverage beyond age seventieth (70) years next birthday at the Renewal Date, subject to the following conditions:

(a) Participation shall be on compulsory basis;

(b) Insured Member or Insured Dependant shall be covered for Death benefit, Terminal Illness and Repatriation benefit only.

SECTION V – COVERAGE FOR FOREIGN BASED EMPLOYEE OR FOREIGN BASED EMPLOYEE'S DEPENDANT

1. This Policy will not insure any person who is residing or based outside Singapore unless:
   (a) the total number of Foreign Based Employees or Foreign Based Employee's Dependant are not more than 10% of the total group size; and

   (b) the person is a Foreign Based Employee or Foreign Based Employee's Dependant as defined under Section I of this Policy; and

   (c) the Policyholder has declared to the Company the name of the Foreign Based Employee or Foreign Based Employee's Dependant and the country in which he is residing or based in; and

   (d) the Company has advised the Policyholder in writing of the terms of acceptance of insurance on that Foreign Based Employee or Foreign Based Employee's Dependant. Insurance coverage on the Foreign Based Employee or Foreign Based Employee's Dependant will not start until the Company has accepted such cover in writing.

2. The Company reserves the right to decline insurance on any Foreign Based Employee or Foreign Based Employee's Dependant who is based or residing in a country where the risk is not acceptable to the Company.

3. If a Foreign Based Employee's or Foreign Based Employee's Dependant name has not been declared to the Company, the Company reserves the right to decline any claim for benefit under this Policy or adjust the benefit amount payable in respect of that Foreign Based Employee or Foreign Based Employee's Dependant.

Upon any Renewal Date of this Policy, the continuation of coverage for any Foreign Based Employee or Foreign Based Employee's Dependant on or after the Renewal Date will be subject to acceptance by the Company in writing, and on such terms and conditions which the Company may choose to impose.

SECTION VI – EXCLUSIONS

The following exclusions shall apply to all Insured Members or Insured Dependant under this Policy:

1. Pre-Existing Conditions of an Insured Member or Insured Dependant are excluded during the first 12 months from the Effective Date of an Insured Member or Insured Dependant unless declared and accepted by the Company.

2. Suicide is excluded during the first 12 months from the Effective Date of an Insured Member or Insured Dependant.

SECTION VII – CLAIMS

1. Notice and Proof of Claim

   (a) The Insured Member or Insured Dependant or his legal representative must notify the Company in writing within 30 days after the happening of any event likely to give rise to a claim under this Policy. However, the claim will not be invalidated if it can be shown that it was not reasonably possible for himto notify the Company within this period.

   (b) Written notice of death of any Insured Member or Insured Dependant must be given within 30 days after the death of the Insured Member or Insured Dependant. Satisfactory proof of death must be given to the Company within 90 days after the death of the Insured Member or Insured Dependant. If an extension is

required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

(c) If an Insured Member or Insured Dependant is totally and permanently disabled, written notice must be given within 30 days after the commencement of the total and permanent disability of the Insured Member or Insured Dependant. Satisfactory proof of disability must be given to the Company within 90 days after the commencement of the total and permanent disability of the Insured Member or Insured Dependant. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

(d) Written notice given by or on behalf of the Insured Member or Insured Dependant to the Company with particulars sufficient to identify the Insured Member or Insured Dependant, 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 shall be shown not to have been reasonably possible to give such notice and that such notice was given as soon as was reasonably possible.

(e) All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Insured Member or Insured Dependant or the Insured Member or Insured Dependant'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 Member or Insured Depdendant 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.

(f) If the Insured Member or Insured Dependant is residing in a country outside Singapore, the Company may at its discretion require the Insured Member or Insured Dependant to come to Singapore for medical examination by a Registered Medical Practitioner in Singapore.

(g) The Company may also require the Policyholder to furnish at his expense evidence to establish the continuing health condition of the Insured Member or Insured Dependant and to show that the Insured Member or Insured Dependant is not engaged in any form of employment.

(h) Proof of the date of birth of the Insured Member or Insured Dependant 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 Member or Insured Dependant 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.

(i) In case of death, the Company has the right to investigate the circumstances of death, to have a post-mortem examination either before or after burial. In the event of an accidental death, a policereport and post-mortem report must be submitted to the Company.

2. Payment of Benefit

(a) All benefits shall be paid only when the claim shall have been proven to the satisfaction of the Company and the total amount of compensation shall have been ascertained and agreed upon by the Company and Policyholder.

(b) Any amount payable under this Policy will be paid by cheque to the order of the Policyholder, unless the Policyholder otherwise notifies in writing. Any payment so made shall effectively discharge the Company from any further liability under this Policy.

3. Fraudulent Claims

If any claim under this Policy is in any respect, fraudulent or if any fraudulent means or devices shall be used by the Policyholder or an Insured Member or Insured Dependant or any one acting on behalf of the said parties to obtain a benefit under this Policy, the Company shall be under no liability in respect of such claims and shall be entitled to recover any payment prior to the discovery of fraud.

SECTION VIII – COMPANY NOT LIABLE

The Company shall not be held responsible or be liable as a party in any way whatsoever to any legal proceeding for damages or otherwise, which may be instituted by any Insured Member or Insured Dependant against any provider of Medical Services for reasons of neglect, malpractice or other causes arising from acts or omissionsin the treatment or examination of the Insured Member or Insured Dependant by any provider of Medical Services as provided in this Policy.

In providing a service to an Insured Member or Insured Dependant, the Company and its authorised providers may supply information including medical information pertaining to the treatment of the Insured Member or Insured Dependant to the Policyholder.

Neither the Company nor its employees nor its authorised providers shall be liable for any loss or damage suffered by the Policyholders, Insured Member or Insured Dependant due to any error or omission in the information supplied however caused if the supply of information had been made in good faith by the Company or its authorised providers.

SECTION IX- PREMIUM TABLE

Plan Type	Plan 1	Plan 2	Plan 3	Plan 4
Sum Assured (S$)	1,000,000	750,000	500,000	250,000
Age Band (next birthday)	Annual Premium per Insured Member or Insured Dependant(S$) (GST exempted)			
30 and below	800.00	600.00	400.00	200.00
31 - 35	800.00	600.00	400.00	200.00
36 - 40	1,000.00	750.00	500.00	250.00
41 - 45	1,520.00	1,140.00	760.00	380.00
46 - 50	2,160.00	1,620.00	1,080.00	540.00
51 - 55	3,960.00	2,970.00	1,980.00	990.00
56 - 60	7,560.00	5,670.00	3,780.00	1,890.00
61 - 65	12,420.00	9,315.00	6,210.00	3,105.00
66 - 70	21,560.00	16,170.00	10,780.00	5,390.00
71 - 75*	41,000.00	30,750.00	20,500.00	10,250.00

*Renewal only

THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED

(Reg. No. 1908 00011G)

HEAD OFFICE:
1 Pickering Street #13-01,
Great Eastern Centre,
SINGAPORE 048659.

GREAT PLATINUM BENEFITS
GROUP LIVING ASSURANCE CONTRACT RIDER (ACCELERATED)

This Contract Rider shall be attached to and form part of the Group Term Life Policy No. <GXXXXXXX> with effect from <dd mmm 2021> (the "Policy), and is valid only if the Policy is in full force. The provisions of the Policy shall apply to this Contract Rider to the extent that the same are not inconsistent with the terms and conditions, exclusions and limitations hereof.

SECTION I - GENERAL DEFINITIONS

In this Contract Rider where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

(a) "**Accident**" means an unexpected, unintended, unforeseeable event causing injury to an Insured Member. The Accident must happen while the Insured Member is covered under this Contract Rider.

(b) **Activities of Daily Living (ADLs)** means:

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;

Dressing - the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

Transferring - the ability to move from a bed to an upright chair or wheelchair and vice versa;

Mobility - the ability to move indoors from room to room on level surfaces;

Toileting - the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

Feeding - the ability to feed oneself once food has been prepared and made available.

(c) "**Effective Date**" means the date from which the assurance of the Insured Member or Insured Dependant as specified under this Contract Rider has become effective.

(d) "**Eligible Dependant**" means:

i. The legal spouse of an Eligible Member who is not divorced or separated, and who has not attained the age of 70 years at the Policy Commencement Date or 70 year at Renewal Date; or

ii. An unmarried and unemployed natural or step child(ren) from a legal marriage or legally adopted child(ren) of an Eligible Member who is between attained age of 12 months and 25 years old (next birthday) at the Policy Commencement Date or Renewal Date;

who is a Singaporean or Singapore Permanent Resident or with a valid employment pass (EP holders, S Pass, or Work Permit holders)/ Dependant pass and is residing in Singapore.

(e) "**Eligible Member**" means members as specified in the Policy Schedule and whose eligibility to participate in

the insurance plan under this Policy has been agreed in writing between the Policyholder and the Company.

(f) "**Evidence of Insurability**" means the health declaration form completed by the Eligible Member or Eligible Dependant or any underwriting requirements as advised by the Company.

(g) "**Insured Dependant**" means any Eligible Dependant, in respect of whom insurance under this Contract Rider has been effected.

(h) "**Insured Member**" means an Eligible Member, in respect of whom an assurance under the Contract Rider has been effected

(i) "**Limited Advance Payment benefit**" refers to an amount equal to 10% of the Sum Assured subject to a maximum of S$25,000.

(j) "**Major Illness**" means any of the major illnesses specified and defined in Section III of this Contract Rider.

(k) "**Major Illness Benefit**" means the amount of insurance coverage effected under this Contract Rider in respect of an Insured Member or Insured Dependant.

(l) "**Maximum Coverage Age**" means the maximum age of coverage as specified in the Policy Schedule attached hereto.

(m) "**Non Medical Limit**" means the amount of insurance in respect of each Insured Member or Insured Dependant which the Company will accept without requiring evidence of insurability. The Non Medical Limit for this Contract Rider is S$200,000 and up to age 65 next birthday.

(n) "Permanent Neurological Deficit"
Permanent means expected to last throughout the lifetime of the Insured Member.

Permanent neurological deficit means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Insured Member. 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.

(o) "**Pre-existing Condition**" means any illnesses, diseases, injuries or impairments from which the Insured Member or Insured Dependant is suffering, whether known or unknown to the Insured Member or Insured Dependant as long as the cause or pathology of the conditions has already existed before the Effective Date in respect of the Insured Member or Insured Dependant under this Contract Rider.

(p) "**Policy Period**" means a period of one calendar year or such other periods as may be agreed in writing between the Company and the Policyholder, starting from the Policy Commencement Date for the first Policy Period and from the respective Renewal Dates for subsequent Periods of Insurance.

(q) "**Registered Medical Practitioner**" means a person qualified by degree in western medicine and legally licensed and authorised to practice medicine and surgery in the geographical area of his country, who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(r) "**Renewal Date**" means the date immediately following the last day of any Policy Period as stated in the endorsement to this Contract Rider.

(s) "**Sum Assured**" means the amount of insurance coverage effected under this Contract Rider in respect of the Insured Member or Insured Dependant.

SECTION II - GENERAL PROVISIONS

1. Eligibility and Commencement of Insurance

   (a) Subject to Clause 1(c), 1(d) and 1 (g), all Eligible Members who are Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement Date or at the Renewal Date (where applicable) shall be covered under the Policy on such date, unless otherwise agreed by the Company.

   (b) All Eligible Members who are not Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement or at Renewal Date (where applicable) shall not be covered under the Policy and shall only be covered on the date they are Actively At Work, unless otherwise agreed by the Company.

   (c) For any Eligible Member who is applying for a Sum Assured which exceeds the Non Medical Limit provided under this Contract Rider he is required to provide the Company with satisfactory Evidence of Insurability.

   Depending on the Company assessment of the Evidence of Insurability provided by the Eligible Member, the Company reserves the right to accept the Eligible Member's application of insurance at standard rates and terms, or impose extra loading, and/or additional terms and conditions to allow the Eligible Member who does not fulfil the above criteria to be eligible for insurance, or decline the insurance.

   (d) All new and existing employee of the Policyholder becoming eligible after the Policy Commencement Date will be covered on his respective Eligibility Date provided he is Actively At Work on his respective Eligibility Date. Any Eligible Member who is on medical leave or in hospital on his respective Eligibility Date, will be covered on the date he returns to active service at work.

   (e) An Eligible Member shall be covered automatically for his Sum Assured not exceeding the Non Medical Limit, if any, on his Eligibility Date except that if he is not Actively At Work on that date, his Sum Assured within the Non Medical Limit shall be effective on the date after he is Actively At Work, subject to the condition that the Policyholder shall notify the Company within 90 days after the Eligible Member is eligible to be covered under the Contract Rider. The amount of his insurance coverage in excess of the Non Medical Limit may be accepted subject to satisfactory Evidence of Insurability.

   (f) Any Insured Member or Insured Dependant's Sum Assured which has been changed (in accordance to the basis of coverage as endorsed in the Contract Rider) shall be covered automatically for the aggregate Sum Assured not exceeding the Non Medical Limit on the date of change.

   (g) The aggregate Sum Assured in excess of the Non Medical Limit of any Insured Member or Insured Dependant may be accepted subject to Evidence of Insurability satisfactory to the Company. In the absence of written acceptance by the Company, the Sum Assured of the Insured Member or Insured Dependant shall be limited to the amount of Non Medical Limit or to the last Sum Assured already accepted by the Company in writing.

   (h) An Insured Member or Insured Dependant whose insurance coverage under the Contract Rider was terminated due to any cause and who re-applies for insurance coverage shall be considered as a new member.

   (i) Any proposed cover above the Non-Medical Limit shall be subjected to underwriting by the Company prior to effective date and on each Renewal Date and the Company reserves the right to impose term and conditions or reject such proposal.

2. Dependant's Participation and Insurance

   (a) Section II Clause 2 of this Contract Rider is valid only upon the application of the Eligible Dependant's coverage by the Policyholder and the Company's acceptance of the Eligible Dependant's application in writing.

(b) Insurance of an Eligible Dependant will start on his Eligibility Date provided he is not hospitalized, or on medical leave and is in good health.

SECTION III - DEFINITIONS OF MAJOR ILLNESSES

1. Heart Attack of Specified Severity

Death of heart muscle due to ischaemia, 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

2. Stroke with Permanent Neurological Deficit

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;
- Ischaemic disorders of the vestibular system; and
- Secondary haemorrhage within a pre-existing cerebral lesion.

3. 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.

4. Major Cancer

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 Major Cancer includes, but is not limited to, leukemia, lymphoma and sarcoma.

Major Cancer diagnosed on the basis of finding tumour cells and/or tumour-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence does not meet the above definition.

For the above definition, the following are excluded:

- Pre-malignant;
- Non-invasive;
- Carcinoma-in situ (Tis) or Ta;
- Having borderline malignancy;
- Having any degree of malignant potential;
- Having suspicious malignancy;
- Neoplasm of uncertain or unknown behavior; or All grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL) and intra epithelial neoplasia;
- Any non-melanoma skin carcinoma, skin confined primary cutaneous lymphoma and dermatofibrosarcoma protuberans 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 Neuroendocrine tumours 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 Stage I or IA according to the latest edition of the AJCC Cancer Staging Manual, or below;
- Chronic Lymphocytic Leukaemia less than RAI Stage 3; and
- All bone marrow malignancies which do not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, haematopoietic stem cell transplant or other major interventionist treatment; and
- All tumours in the presence of HIV infection.

5. End Stage Kidney Failure

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

6. 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.

7. 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.

8. Paralysis (Irreversible 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.

9. Multiple Sclerosis

The definite diagnosis 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.

10. 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.

11. HIV Due to Blood Transfusion and Occupationally Acquired HIV

(A) Infection of the Insured Member or Insured Dependant 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 Effective Date of the Insured Member or Insured Dependant;
- 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 Member or Insured Dependant does not suffer from Thalassaemia Major or Haemophilia.

(B) Infection of the Insured Member or Insured Dependant with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the Effective Date of the Insured Member or Insured Dependant, whilst the Insured Member or Insured Dependant 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 Member or Insured Dependant 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.

12. Alzheimer's Disease / Severe Dementia

Deterioration or loss of cognitive function 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 Insured Member or Insured Dependant. 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.

13. Blindness (Irreversible 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.

The blindness must not be correctable by surgical procedures, implants or any other means.

14. 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.

For the above definition, medically induced coma and Coma resulting directly from alcohol or drug abuse is excluded.

15. Deafness (Irreversible 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".

Irreversible means "cannot be reasonably restored to at least 40 decibels by medical treatment, hearing aid and/or surgical procedures consistent with the current standard of the medical services available in Singapore after a

period of 6 months from the date of intervention."

16. Open Chest 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.

17. Irreversible Loss of Speech

Total and irreversible 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.

18. Major Burns

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Member or Insured Dependant's body.

19. Open Chest 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.

20. Terminal Illness

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

21. Muscular Dystrophy

The unequivocal diagnosis of muscular dystrophy must be made by a consultant neurologist. The condition must result in the inability of the Insured Member or Insured Dependant 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:

22. End Stage Lung Disease

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

- FEV1 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 ($PaO2 \leq 55mmHg$); and
- Dyspnea at rest.

The diagnosis must be confirmed by a respiratory physician.

23. 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.

24. 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.

25. Idiopathic 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 Insured Member or Insured Dependant 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:

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.

26. Irreversible Aplastic Anaemia

Chronic persistent and irreversible bone marrow failure 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 or haematopoietic stem cell transplantation.

The diagnosis must be confirmed by a haematologist.

27. Benign Brain Tumor

A benign tumour in the brain where all of the following conditions are met:

- 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;
- Abscess;
- Angioma;

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

28. 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 neurologistand supported by relevant 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.

29. Severe 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.

30. 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 Sum Assured under this Contract Rider subject to a S$25,000 maximum sum payable. This benefit is payable once only and shall be deducted from the amount of this Contract Rider, thereby reducing the amount of the Sum Assured which may be payable herein.

Diagnostic angiography is excluded.

31. Severe Encephalitis

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

Encephalitis caused by 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 confirmed by a consultant rheumatologist and supported by biopsy or equivalent confirmatory test, 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. Persistent Vegetative State (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

The unequivocal diagnosis of Systemic Lupus Erythematosus (SLE) based on recognised diagnostic criteria and supported with clinical and laboratory evidence. In respect of this Contract Rider, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class VI Lupus Nephritis, established by renal biopsy, and in accordance with the RPS/ISN classification system). The final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

The RPS/ISN classification of lupus nephritis:
Class I Minimal mesangial lupus nephritis
Class II Mesangial proliferative lupus nephritis
Class III Focal lupus nephritis (active and chronic; proliferative and sclerosing)
Class IV Diffuse lupus nephritis (active and chronic; proliferative and sclerosing; segmental and global)
Class V Membranous lupus nephritis
Class VI Advanced sclerosis lupus nephritis

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 invasive coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed.

Diagnosis by Imaging or non-invasive diagnostic procedures such as CT scan or MRI does not meet the confirmatory status required by the definition.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery. The branches of the above coronary arteries are excluded.

36. Poliomyelitis

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

The diagnosis must be confirmed by a consultant neurologist or specialist in the relevant medical field.

37. Loss of Independent Existence

A condition as a result of a disease, illness or injury whereby the Insured Member or Insured Dependant 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.

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.

SECTION IV - BENEFIT PROVISIONS

Subject always to all the terms, conditions and provisions of the Policy and this Contract Rider, upon receipt of proof of age and adequate documentary proof that the Insured Member or Insured Dependant is diagnosed as suffering from a Major Illness while insured under this Rider, the Major Illness Benefit shall become payable in one lump sum provided that no claim has been admitted under the Policy.

Subject always to all the terms, conditions and provisions of the Policy and this Contract Rider, upon receipt of proof of age and adequate documentary proof that the Insured Member or Insured Dependant died while insured under this Rider, a lump sum amount of S$3,000 (in addition to the Sum Assured under the Policy) shall become payable.

The Sum Assured covered under the Policy shall automatically be reduced by the amount of Major Illness Benefit payment and may not be increased at any time thereafter unless the Company agrees in writing. The coverage of this Insured Member or Insured Dependant under this Contract Rider shall be automatically terminated upon payment of a valid claim for a Major Illness Benefit.

SECTION V - LIMITATIONS

1. Maximum Sum Assured

   (a) The maximum Sum Assured for any Insured Member under this Contract Rider and any other group policy or rider issued by the Company for Major Illness benefits shall not exceed S$500,000.

   (b) The maximum Sum Assured for any Insured Dependant under this Contract Rider and any other group policy or rider issued by the Company for Major Illness benefits shall not exceed S$200,000.

   (c) The Sum Assured for any Insured Member or Insured Dependant under this Contract Rider must be lower than the Sum Assured of any Insured Member or Insured Dependant under the Policy.

2. Waiting Period For Major Illnesses

   A Major Illness benefit shall not be payable if the Major Illness as diagnosed on an Insured Member or Insured Dependant falls within the following periods of time from the date on which his insurance becomes effective:

   (a) 90 days for Heart Attack of Specified Severity, Coronary Artery By-Pass Surgery and Major Cancer; Angioplasty & Other Invasive Treatment for Coronary Artery; Other Serious Coronary Artery Disease; or

   (b) 30 days for any other remaining Major Illness.

   For any increase in insurance coverage for Major Illness Benefit, the Company shall only pay benefit amount prior to such increase as follows:

(i) If the Major Illness or its symptoms occur within 90 days for Heart Attack of Specified Severity, Coronary Artery By-Pass Surgery and Major Cancer; Angioplasty & Other Invasive Treatment for Coronary Artery; Other Serious Coronary Artery Disease; or
(ii) If any other remaining Major Illness or its symptoms occur within 30 days;

from the date of increase in insurance coverage for Major Illness Benefit.

The limitation does not apply to subsequent renewal of Sum Assured already accepted in writing by the Company.

3. Single Pay-Out Of Major Illness Benefits

A Major Illness Benefit shall be payable only once even if multiple Major Illnesses are diagnosed on an Insured Member or Insured Dependant at the same time. In no case shall a Major Illness Benefit be payable more than once to an Insured Member or Insured Dependant.

However, if an Insured Member or Insured Dependant undergoes Angioplasty or any Other Intensive Treatment for Coronary Artery, and the Policyholder is entitled to receive the Limited Advanced Payment benefit, the Major Illness Benefit of the Insured Member or Insured Dependant will be reduced by the amount of the Limited Advanced Payment benefit, and may not be increased at any time thereafter unless the Company agrees in writing.

4. Termination

The coverage of any Insured Member or Insured Dependant shall automatically be terminated at the end of the Policy Period during which the Insured Member or Insured Dependant reaches his Maximum Coverage Age.

SECTION VI - EXCLUSIONS

The following exclusions shall apply to all Insured Members or Insured Dependant under this Contract Rider regardless of whether he is accepted within the Non Medical Limit or under other terms of acceptance in writing:

1. If the Insured Member or Insured Dependant has had or is diagnosed as having suffered from any Major Illness as defined under Section II of this Contract Rider prior to the Effective Date of the Insured Member or Insured Dependant, that such Major Illness(es) shall be permanently excluded.

2. A Major Illness Benefit shall not be payable for Coronary Artery By-Pass Surgery if the Insured Member or Insured Dependant is diagnosed as having suffered a Heart Attack of Specified Severity prior to the Effective Date of the Insured Member or Insured Dependant.

3. A Major Illness Benefit shall not be payable for a Heart Attack of Specified Severity if the Insured Member or Insured Dependant had undergone Coronary Artery By-Pass Surgery prior to the Effective Date of the Insured Member or Insured Dependant.

4. A Major Illness Benefit shall not be payable if the Major Illness is directly or indirectly, wholly or partly caused by or resulting from:

(a) Suicide or any attempted suicide or self-inflicted injury or illness, whether the Insured Member or Insured Dependant is sane or insane;
(b) Pre-existing Condition;
(c) Sexually transmitted diseases or viruses, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complexes and all illnesses or diseases associated with the Human Immunodeficiency Virus (HIV); except HIV infection due to Blood Transfusion and Occupationally Acquired HIV as defined in Section II of this Contract Rider;
(d) Wilful misuse of any drugs;
(e) Over-indulgence in alcohol;

(f) War (declared or undeclared), hostilities, civil war or any warlike operations; military or naval or air-force service while under orders for warlike operations and/or terrorism;
(g) Participation in riot or commission of an assault or act of crime;

SECTION VII – CLAIMS

1. Notice and Proof of Claim

(a) The Insured Member or Insured Dependant or his legal representative must notify the Company in writing within 30 days after the happening of any event likely to give rise to a claim under this Contract Rider. However, the claim will not be invalidated if it can be shown that it was not reasonably possible for him to notify the Company within this period.

(b) Written notice and satisfactory proofs of any claim of any Insured Member or Insured Dependant must be given within 30 days after the happening of any event likely to give rise to a claim under this Policy. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing

(c) Written notice given by or on behalf of the Insured Member or Insured Dependant to the Company with particulars sufficient to identify the Insured Member or Insured Dependant, shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in this Contract Rider shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and thatsuch notice was given as soon as was reasonably possible.

(d) All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Insured Member or Insured Dependant or the Insured Member or Insured Dependant'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 Member or Insured Dependant as and when and as often as it may reasonably be required pending any claim or the payment of any claims made under this Contract Rider.

(e) If the Insured Member or Insured Dependant is residing in a country outside Singapore, the Company may at its discretion require the Insured Member or Insured Dependant to come to Singapore for medical examination by a Registered Medical Practitioner in Singapore.

(f) The Company may also require the Policyholder to furnish at his expense evidence to establish the continuing health condition of the Insured Member or Insured Dependant and to show that the Insured Member or Insured Dependant is not engaged in any form of employment.

(g) Proof of the date of birth of the Insured Member or Insured Dependant 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 Member or Insured Dependant notified to the Company is incorrect, the Company shall not be liable to pay more than the amount which would be payable under this Contract Rider if the date of birth and/or age had been correctly stated.

(h) In case of death, the Company has the right to investigate the circumstances of death, to have a post-mortem examination either before or after burial. In the event of an accidental death, a police report and post-mortem report must be submitted to the Company.

2. Payment of Benefit

(a) All benefits shall be paid only when the claim shall have been proven to the satisfaction of the Company and the total amount of compensation shall have been ascertained and agreed upon by the Company and Policyholder.

(b) Any payment of the Major Illness Benefit under this Contract Rider will be made by cheque to the order of the Policyholder or its legal representative unless the Policyholder otherwise notifies in writing. Any payment so made shall effectively discharge the Company from any further liability under this Contract

Rider.

3. Fraudulent Claims

If any claim under this Contract Rider is in any respect, fraudulent or if any fraudulent means or devices shall be used by the Policyholder or an Insured Member or Insured Dependant or any one acting on behalf of the said parties to obtain a benefit under this Contract Rider, the Company shall be under no liability in respect of such claims and shall be entitled to recover any payment prior to the discovery of fraud.

SECTION VIII – COMPANY NOT LIABLE

The Company shall not be held responsible or be liable as a party in any way whatsoever to any legal proceeding for damages or otherwise, which may be instituted by any Insured Member or Insured Dependant against any provider of Medical Services for reasons of neglect, malpractice or other causes arising from acts or omissions in the treatment or examination of the Insured Member or Insured Dependant by any provider of Medical Services as provided in this Contract Rider.

In providing a service to an Insured Member or Insured Dependant, the Company and its authorised providers may supply information including medical information pertaining to the treatment of the Insured Member or Insured Dependant to the Policyholder.

Neither the Company nor its employees nor its authorised providers shall be liable for any loss or damage suffered by the Policyholders, Insured Member or Insured Dependant due to any error or omission in the information supplied however caused if the supply of information had been made in good faith by the Company or its authorised providers.

SECTION IX – PREMIUM TABLE

Plan Type	Plan 1	Plan 2	Plan 3	Plan 4
Sum Assured (S$)	500,000	400,000	300,000	200,000

Acceleration Basis				
Plan Type	Plan 1	Plan 2	Plan 3	Plan 4
Age Band (next birthday)	Annual Premium per Insured Member or Insured Dependant (S$) (GST exempted)			
30 and below	445.00	356.00	267.00	178.00
31 - 35	500.00	400.00	300.00	200.00
36 - 40	750.00	600.00	450.00	300.00
41 - 45	1,250.00	1,000.00	750.00	500.00
46 - 50	2,150.00	1,720.00	1,290.00	860.00
51 - 55	3,300.00	2,640.00	1,980.00	1,320.00
56 - 60	5,525.00	4,420.00	3,315.00	2,210.00
61 - 65	8,510.00	6,808.00	5,106.00	3,404.00
66 - 70	14,200.00	11,360.00	8,520.00	5,680.00

THE GREAT EASTERN LIFE ASSURANCE COMPANY LIMITED

(Reg. No. 1908 00011G)

HEAD OFFICE:
1 Pickering Street #13-01,
Great Eastern Centre,
SINGAPORE 048659.

GREAT PLATINUM BENEFITS
GROUP LIVING ASSURANCE CONTRACT RIDER (ADDITIONAL)

This Contract Rider shall be attached to and form part of the Group Term Life Policy No. <GXXXXXXX> with effect from <dd mmm 2021> (the "Policy"), and is valid only if the Policy is in full force. The provisions of the Policy shall apply to this Contract Rider to the extent that the same are not inconsistent with the terms and conditions, exclusions and limitations hereof.

SECTION I - GENERAL DEFINITIONS

In this Contract Rider where the context so admits the masculine gender shall be deemed to include the feminine, and likewise, the singular word shall be deemed to include the plural and vice versa, and the following words and expressions shall be deemed to have the following meanings:

(a) "**Accident**" means an unexpected, unintended, unforeseeable event causing injury to an Insured Member. The Accident must happen while the Insured Member is covered under this Contract Rider.

(b) **Activities of Daily Living (ADLs)** means:

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;

Dressing - the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

Transferring - the ability to move from a bed to an upright chair or wheelchair and vice versa;

Mobility - the ability to move indoors from room to room on level surfaces;

Toileting - the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

Feeding - the ability to feed oneself once food has been prepared and made available.

(c) "**Effective Date**" means the date from which the assurance of the Insured Member or Insured Dependant as specified under this Contract Rider has become effective.

(d) "**Eligible Dependant**" means:

i. The legal spouse of an Eligible Member who is not divorced or separated, and who has not attained the age of 70 years at the Policy Commencement Date or 70 year at Renewal Date; or

ii. An unmarried and unemployed natural or step child(ren) from a legal marriage or legally adopted child(ren) of an Eligible Member who is between attained age of 12 months and 25 years old (next birthday) at the Policy Commencement Date or Renewal Date;

who is a Singaporean or Singapore Permanent Resident or with a valid employment pass (EP holders, S Pass, or Work Permit holders)/ Dependant pass and is residing in Singapore.

(e) "**Eligible Member**" means members as specified in the Policy Schedule and whose eligibility to participate in

the insurance plan under this Policy has been agreed in writing between the Policyholder and the Company.

(f) "**Evidence of Insurability**" means the health declaration form completed by the Eligible Member or Eligible Dependant or any underwriting requirements as advised by the Company.

(g) "**Insured Dependant**" means any Eligible Dependant, in respect of whom insurance under this Contract Rider has been effected.

(h) "**Insured Member**" means an Eligible Member, in respect of whom an assurance under the Contract Rider has been effected

(i) "**Limited Advance Payment benefit**" refers to an amount equal to 10% of the Sum Assured subject to a maximum of S$25,000.

(j) "**Major Illness**" means any of the major illnesses specified and defined in Section III of this Contract Rider.

(k) "**Major Illness Benefit**" means the amount of insurance coverage effected under this Contract Rider in respect of an Insured Member or Insured Dependant.

(l) "**Maximum Coverage Age**" means the maximum age of coverage as specified in the Policy Schedule attached hereto.

(m) "**Non Medical Limit**" means the amount of insurance in respect of each Insured Member or Insured Dependant which the Company will accept without requiring evidence of insurability. The Non Medical Limit for this Contract Rider is S$200,000 and up to age 65 next birthday.

(n) "Permanent Neurological Deficit"
Permanent means expected to last throughout the lifetime of the Insured Member.

Permanent neurological deficit means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Insured Member. 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.

(o) "**Pre-existing Condition**" means any illnesses, diseases, injuries or impairments from which the Insured Member or Insured Dependant is suffering, whether known or unknown to the Insured Member or Insured Dependant as long as the cause or pathology of the conditions has already existed before the Effective Date in respect of the Insured Member or Insured Dependant under this Contract Rider.

(p) "**Policy Period**" means a period of one calendar year or such other periods as may be agreed in writing between the Company and the Policyholder, starting from the Policy Commencement Date for the first Policy Period and from the respective Renewal Dates for subsequent Periods of Insurance.

(q) "**Registered Medical Practitioner**" means a person qualified by degree in western medicine and legally licensed and authorised to practice medicine and surgery in the geographical area of his country, who is neither an Insured Member or Insured Dependant himself, nor a relative, sibling, spouse, child or parent.

(r) "**Renewal Date**" means the date immediately following the last day of any Policy Period as stated in the endorsement to this Contract Rider.

(s) "**Sum Assured**" means the amount of insurance coverage effected under this Contract Rider in respect of the Insured Member or Insured Dependant.

SECTION II - GENERAL PROVISIONS

1. Eligibility and Commencement of Insurance

(a) Subject to Clause 1(c), 1(d) and 1 (g), all Eligible Members who are Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement Date or at the Renewal Date (where applicable) shall be covered under the Policy on such date, unless otherwise agreed by the Company.

(b) All Eligible Members who are not Actively At Work under Class 1, 2, 3 Occupation Classification on the Policy Commencement or at Renewal Date (where applicable) shall not be covered under the Policy and shall only be covered on the date they are Actively At Work, unless otherwise agreed by the Company.

(c) For any Eligible Member who is applying for a Sum Assured which exceeds the Non Medical Limit provided under this Contract Rider or he is more than 70 years next birthday (subject to change by the Company on each Renewal Date), he is required to provide the Company with satisfactory Evidence of Insurability.

Depending on the Company assessment of the Evidence of Insurability provided by the Eligible Member, the Company reserves the right to accept the Eligible Member's application of insurance at standard rates and terms, or impose extra loading, and/or additional terms and conditions to allow the Eligible Member who does not fulfil the above criteria to be eligible for insurance, or decline the insurance.

(d) All new and existing employee of the Policyholder becoming eligible after the Policy Commencement Date will be covered on his respective Eligibility Date provided he is Actively At Work on his respective Eligibility Date. Any Eligible Member who is on medical leave or in hospital on his respective Eligibility Date, will be covered on the date he returns to active service at work.

(e) An Eligible Member shall be covered automatically for his Sum Assured not exceeding the Non Medical Limit, if any, on his Eligibility Date except that if he is not Actively At Work on that date, his Sum Assured within the Non Medical Limit shall be effective on the date after he is Actively At Work, subject to the condition that the Policyholder shall notify the Company within 90 days after the Eligible Member is eligible to be covered under the Contract Rider. The amount of his insurance coverage in excess of the Non Medical Limit may be accepted subject to satisfactory Evidence of Insurability.

(f) Any Insured Member or Insured Dependant's Sum Assured which has been changed (in accordance to the basis of coverage as endorsed in the Contract Rider) shall be covered automatically for the aggregate Sum Assured not exceeding the Non Medical Limit on the date of change.

(g) The aggregate Sum Assured in excess of the Non Medical Limit of any Insured Member or Insured Dependant may be accepted subject to Evidence of Insurability satisfactory to the Company. In the absence of written acceptance by the Company, the Sum Assured of the Insured Member or Insured Dependant shall be limited to the amount of Non Medical Limit or to the last Sum Assured already accepted by the Company in writing.

(h) An Insured Member or Insured Dependant whose insurance coverage under the Contract Rider was terminated due to any cause and who re-applies for insurance coverage shall be considered as a new member.

(i) Any proposed cover above the Non-Medical Limit shall be subjected to underwriting by the Company prior to effective date and on each Renewal Date and the Company reserves the right to impose term and conditions or reject such proposal.

2. Dependant's Participation and Insurance

(a) Section II Clause 2 of this Contract Rider is valid only upon the application of the Eligible Dependant's coverage by the Policyholder and the Company's acceptance of the Eligible Dependant's application in writing.

(b) Insurance of an Eligible Dependant will start on his Eligibility Date provided he is not hospitalized, or on

medical leave and is in good health.

SECTION III - DEFINITIONS OF MAJOR ILLNESSES

1. Heart Attack of Specified Severity

Death of heart muscle due to ischaemia, 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

2. Stroke with Permanent Neurological Deficit

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;
- Ischaemic disorders of the vestibular system; and
- Secondary haemorrhage within a pre-existing cerebral lesion.

3. 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.

4. Major Cancer

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 Major Cancer includes, but is not limited to, leukemia, lymphoma and sarcoma.

Major Cancer diagnosed on the basis of finding tumour cells and/or tumour-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence does not meet the above definition.

For the above definition, the following are excluded:

- Pre-malignant;
- Non-invasive;
- Carcinoma-in situ (Tis) or Ta;
- Having borderline malignancy;
- Having any degree of malignant potential;
- Having suspicious malignancy;
- Neoplasm of uncertain or unknown behavior; or All grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL) and intra epithelial neoplasia;
- Any non-melanoma skin carcinoma, skin confined primary cutaneous lymphoma and dermatofibrosarcoma protuberans 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 Neuroendocrine tumours 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 Stage I or IA according to the latest edition of the AJCC Cancer Staging Manual, or below;
- Chronic Lymphocytic Leukaemia less than RAI Stage 3; and
- All bone marrow malignancies which do not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, haematopoietic stem cell transplant or other major interventionist treatment; and
- All tumours in the presence of HIV infection.

5. End Stage Kidney Failure

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

6. 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.

7. 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.

8. Paralysis (Irreversible 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.

9. Multiple Sclerosis

The definite diagnosis 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.

10. 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.

11. HIV Due to Blood Transfusion and Occupationally Acquired HIV

(A) Infection of the Insured Member or Insured Dependant 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 Effective Date of the Insured Member or Insured Dependant;
- 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 Member or Insured Dependant does not suffer from Thalassaemia Major or Haemophilia.

(B) Infection of the Insured Member or Insured Dependant with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the Effective Date of the Insured Member or Insured Dependant, whilst the Insured Member or Insured Dependant 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 Member or Insured Dependant 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.

12. Alzheimer's Disease / Severe Dementia

Deterioration or loss of cognitive function 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 Insured Member or Insured Dependant. 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.

13. Blindness (Irreversible 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.

The blindness must not be correctable by surgical procedures, implants or any other means.

14. 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.

For the above definition, medically induced coma and Coma resulting directly from alcohol or drug abuse is excluded.

15. Deafness (Irreversible 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".

Irreversible means "cannot be reasonably restored to at least 40 decibels by medical treatment, hearing aid and/or surgical procedures consistent with the current standard of the medical services available in Singapore after a

period of 6 months from the date of intervention."

16. Open Chest 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.

17. Irreversible Loss of Speech

Total and irreversible 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.

18. Major Burns

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Member or Insured Dependant's body.

19. Open Chest 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.

20. Terminal Illness

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

21. Muscular Dystrophy

The unequivocal diagnosis of muscular dystrophy must be made by a consultant neurologist. The condition must result in the inability of the Insured Member or Insured Dependant 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:

22. End Stage Lung Disease

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

- FEV1 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 ($PaO2 \leq 55mmHg$); and
- Dyspnea at rest.

The diagnosis must be confirmed by a respiratory physician.

23. 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.

24. 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.

25. Idiopathic 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 Insured Member or Insured Dependant 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:

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.

26. Irreversible Aplastic Anaemia

Chronic persistent and irreversible bone marrow failure 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 or haematopoietic stem cell transplantation.

The diagnosis must be confirmed by a haematologist.

27. Benign Brain Tumor

A benign tumour in the brain where all of the following conditions are met:

- 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;
- Abscess;
- Angioma;

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

28. 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 neurologistand supported by relevant 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.

29. Severe 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.

30. 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 Sum Assured under this Contract Rider subject to a S$25,000 maximum sum payable. This benefit is payable once only and shall be deducted from the amount of this Contract Rider, thereby reducing the amount of the Sum Assured which may be payable herein.

Diagnostic angiography is excluded.

31. Severe Encephalitis

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

Encephalitis caused by 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 confirmed by a consultant rheumatologist and supported by biopsy or equivalent confirmatory test, 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. Persistent Vegetative State (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

The unequivocal diagnosis of Systemic Lupus Erythematosus (SLE) based on recognised diagnostic criteria and supported with clinical and laboratory evidence. In respect of thisContract Rider, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class VI Lupus Nephritis, established by renal biopsy, and in accordance with the RPS/ISN classification system). The final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

The RPS/ISN classification of lupus nephritis:
Class I Minimal mesangial lupus nephritis
Class II Mesangial proliferative lupus nephritis
Class III Focal lupus nephritis (active and chronic; proliferative and sclerosing)
Class IV Diffuse lupus nephritis (active and chronic; proliferative and sclerosing; segmental and global)
Class V Membranous lupus nephritis
Class VI Advanced sclerosis lupus nephritis

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 invasive coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed.

Diagnosis by Imaging or non-invasive diagnostic procedures such as CT scan or MRI does not meet the confirmatory status required by the definition.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery. The branches of the above coronary arteries are excluded.

36. Poliomyelitis

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

The diagnosis must be confirmed by a consultant neurologist or specialist in the relevant medical field.

37. Loss of Independent Existence

A condition as a result of a disease, illness or injury whereby the Insured Member or Insured Dependant 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.

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.

SECTION IV - BENEFIT PROVISIONS

Subject always to all the terms, conditions and provisions of the Policy and this Contract Rider, upon receipt of proof of age and adequate documentary proof that the Insured Member or Insured Dependant is diagnosed as suffering from a Major Illness while insured under this Rider, the Major Illness Benefit shall become payable in one lump sum provided that no claim has been admitted under the Policy

Subject always to all the terms, conditions and provisions of the Policy and this Contract Rider, upon receipt of proof of age and adequate documentary proof that the Insured Member or Insured Dependant died while insured under this Rider, a lump sum amount of S$3,000 (in addition to the Sum Assured under the Policy) shall become payable.

The coverage of the Insured Member under this Contract Rider shall automatically be terminated upon payment of a valid claim for a Major Illness Benefit. The Sum Assured for the Insured Member under the Policy shall remain unchanged and he will not be eligible for any increase in Sum Assured in the Policy.

SECTION V - LIMITATIONS

1. Maximum Sum Assured

(a) The maximum Sum Assured for any Insured Member under this Contract Rider and any other group policy or rider issued by the Company for Major Illness benefits shall not exceed S$500,000.

(b) The maximum Sum Assured for any Insured Dependant under this Contract Rider and any other group policy or rider issued by the Company for Major Illness benefits shall not exceed S$200,000.

(c) The Sum Assured for any Insured Member or Insured Dependant under this Contract Rider must be lower than the Sum Assured of any Insured Member or Insured Dependant under the Policy.

2. Waiting Period For Major Illnesses

A Major Illness benefit shall not be payable if the Major Illness as diagnosed on an Insured Member or Insured Dependant falls within the following periods of time from the date on which his insurance becomes effective:

(a) Waiting period of 90 days for Heart Attack of Specified Severity, Coronary Artery By-Pass Surgery and Major Cancer; Angioplasty & Other Invasive Treatment for Coronary Artery; Other Serious Coronary Artery Disease; or

(b) Waiting period of 30 days for any other remaining Major Illness.

For any increase in insurance coverage for Major Illness Benefit, the Company shall only pay benefit amount prior to such increase as follows:

(i) If the Major Illness or its symptoms occur within 90 days for Heart Attack of Specified Severity, Coronary Artery By-Pass Surgery and Major Cancer; Angioplasty & Other Invasive Treatment for Coronary Artery; Other Serious Coronary Artery Disease; or

(ii) If any other remaining Major Illness or its symptoms occur within 30 days;

from the date of increase in insurance coverage for Major Illness Benefit.

The limitation does not apply to subsequent renewal of Sum Assured already accepted in writing by the Company.

3. Single Pay-Out Of Major Illness Benefits

A Major Illness Benefit shall be payable only once even if multiple Major Illnesses are diagnosed on an Insured Member or Insured Dependant at the same time. In no case shall a Major Illness Benefit be payable more than once to an Insured Member or Insured Dependant.

However, if an Insured Member or Insured Dependant undergoes Angioplasty or any Other Intensive Treatment for Coronary Artery, and the Policyholder is entitled to receive the Limited Advanced Payment benefit, the Major Illness Benefit of the Insured Member or Insured Dependant will be reduced by the amount of the Limited Advanced Payment benefit, and may not be increased at any time thereafter unless the Company agrees in writing.

4. Termination

The coverage of any Insured Member or Insured Dependant shall automatically be terminated at the end of the Policy Period during which the Insured Member or Insured Dependant reaches his Maximum Coverage Age.

SECTION VI - EXCLUSIONS

The following exclusions shall apply to all Insured Members or Insured Dependant under this Contract Rider regardless of whether he is accepted within the Non Medical Limit or under other terms of acceptance in writing:

1. If the Insured Member or Insured Dependant has had or is diagnosed as having suffered from any Major Illness as defined under Section II of this Contract Rider prior to the Effective Date of the Insured Member or Insured Dependant, that such Major Illness(es) shall be permanently excluded.

2. A Major Illness Benefit shall not be payable for Coronary Artery By-Pass Surgery if the Insured Member or Insured Dependant is diagnosed as having suffered a Heart Attack of Specified Severity prior to the Effective Date of the Insured Member or Insured Dependant.

3. A Major Illness Benefit shall not be payable for a Heart Attack of Specified Severity if the Insured Member or Insured Dependant had undergone Coronary Artery By-Pass Surgery prior to the Effective Date of the Insured Member or Insured Dependant.

4. A Major Illness Benefit shall not be payable if the Major Illness is directly or indirectly, wholly or partly caused by or resulting from:

   (a) Suicide or any attempted suicide or self-inflicted injury or illness, whether the Insured Member or Insured Dependant is sane or insane;
   (b) Pre-existing Condition;
   (c) Sexually transmitted diseases or viruses, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complexes and all illnesses or diseases associated with the Human Immunodeficiency Virus (HIV); except HIV infection due to Blood Transfusion and Occupationally Acquired HIV as defined in Section II of this Contract Rider;
   (d) Wilful misuse of any drugs;
   (e) Over-indulgence in alcohol;
   (f) War (declared or undeclared), hostilities, civil war or any warlike operations; military or naval or air-force service while under orders for warlike operations and/or terrorism;
   (g) Participation in riot or commission of an assault or act of crime;

SECTION VII – CLAIMS

1. Notice and Proof of Claim

   (a) The Insured Member or Insured Dependant or his legal representative must notify the Company in writing within 30 days after the happening of any event likely to give rise to a claim under this Contract Rider. However, the claim will not be invalidated if it can be shown that it was not reasonably possible for him to notify the Company within this period.

   (b) Written notice and satisfactory proofs of any claim of any Insured Member or Insured Dependant must be given within 30 days after the happening of any event likely to give rise to a claim under this Policy. If an extension is required, written request must be given before the end of the above period and any such extension is subject to the Company's approval in writing.

   (c) Written notice given by or on behalf of the Insured Member or Insured Dependant to the Company with particulars sufficient to identify the Insured Member or Insured Dependant, shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in this Contract Rider shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and thatsuch notice was given as soon as was reasonably possible.

   (d) All certificates, medical reports, information and evidence required by the Company shall be furnished at the expense of the Insured Member or Insured Dependant or the Insured Member or Insured Dependant'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 Member or Insured Dependant as and when and as often as it may reasonably be required pending any claim or the payment of any claims made under this Contract Rider.

   (e) If the Insured Member or Insured Dependant is residing in a country outside Singapore, the Company may at its discretion require the Insured Member or Insured Dependant to come to Singapore for medical examination by a Registered Medical Practitioner in Singapore.

   (f) The Company may also require the Policyholder to furnish at his expense evidence to establish the continuing health condition of the Insured Member or Insured Dependant and to show that the Insured Member or Insured Dependant is not engaged in any form of employment.

   (g) Proof of the date of birth of the Insured Member or Insured Dependant 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 Member or Insured Dependant notified to the Company is incorrect, the Company shall not be liable to pay more than the amount which would be payable under this Contract Rider if the date of birth and/or age had been correctly stated.

   (h) In case of death, the Company has the right to investigate the circumstances of death, to have a post-mortem examination either before or after burial. In the event of an accidental death, a police report and post-mortem report must be submitted to the Company.

2. Payment of Benefit

   (a) All benefits shall be paid only when the claim shall have been proven to the satisfaction of the Company and the total amount of compensation shall have been ascertained and agreed upon by the Company and Policyholder.

   (b) Any payment of the Major Illness Benefit under this Contract Rider will be made by cheque to the order of the Policyholder or its legal representative unless the Policyholder otherwise notifies in writing. Any payment so made shall effectively discharge the Company from any further liability under this Contract Rider.

3. Fraudulent Claims

   If any claim under this Contract Rider is in any respect, fraudulent or if any fraudulent means or devices shall be used by the Policyholder or an Insured Member or Insured Dependant or any one acting on behalf of the said parties to obtain a benefit under this Contract Rider, the Company shall be under no liability in respect of such claims and shall be entitled to recover any payment prior to the discovery of fraud.

SECTION VIII – COMPANY NOT LIABLE

The Company shall not be held responsible or be liable as a party in any way whatsoever to any legal proceeding for damages or otherwise, which may be instituted by any Insured Member or Insured Dependant against any provider of Medical Services for reasons of neglect, malpractice or other causes arising from acts or omissions in the treatment or examination of the Insured Member or Insured Dependant by any provider of Medical Services as provided in this Contract Rider.

In providing a service to an Insured Member or Insured Dependant, the Company and its authorised providers may supply information including medical information pertaining to the treatment of the Insured Member or Insured Dependant to the Policyholder.

Neither the Company nor its employees nor its authorised providers shall be liable for any loss or damage suffered by the Policyholders, Insured Member or Insured Dependant due to any error or omission in the information supplied however caused if the supply of information had been made in good faith by the Company or its authorised providers.

SECTION IX – PREMIUM TABLE

Plan Type	Plan 1	Plan 2	Plan 3	Plan 4
Sum Assured (S$)	500,000	400,000	300,000	200,000

Additional Basis				
Plan Type	Plan 1	Plan 2	Plan 3	Plan 4
Age Band (next birthday)	Annual Premium per Insured Member or Insured Dependant (S$) (GST exempted)			
30 and below	600.00	480.00	360.00	240.00
31 - 35	600.00	480.00	360.00	240.00
36 - 40	1,075.00	860.00	645.00	430.00
41 - 45	1,665.00	1,332.00	999.00	666.00
46 - 50	2,530.00	2,024.00	1,518.00	1,012.00
51 - 55	3,970.00	3,176.00	2,382.00	1,588.00
56 - 60	7,185.00	5,748.00	4,311.00	2,874.00
61 - 65	11,065.00	8,852.00	6,639.00	4,426.00
66 - 70	18,460.00	14,768.00	11,076.00	7,384.00