EasyCover Critical Illness Plan
Policy Provisions

(Yearly/5-year/10-year/20-year renewable plan)

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

EasyCover Critical Illness Plan

Contents

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1. Definitions

Accident refers to an unforeseen, unexpected, violent, and involuntary external event or contiguous series of events of an accidental and visible nature which is the sole and direct cause of a bodily injury and independently of any other causes (including but not limited to illness or any naturally occurring condition or degenerative process) while this Policy is in force.

Activities of Daily Living refers to the following activities:

(i) 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.
(ii) Dressing - The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
(iii) Transferring - The ability to move from a bed to an upright chair or wheelchair and vice versa.
(iv) Mobility - The ability to move indoors from room to room on level surfaces.
(v) Toileting - The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
(vi) Feeding - The ability to feed oneself once food has been prepared and made available.

Age refers to the age of the Insured on his or her next birthday unless otherwise specified.

Anaesthetist, Medical Practitioner, Specialist or Surgeon refers to a person other than the Policy Owner, the Insured, an insurance agent, business partner(s), employee/employer or a relative of any of them (unless approved in advance by Us in writing) who is registered and licensed with the Health Bureau of Macau under the Decree-Law No. 84/90/M, amended by Decree-Law No. 20/98/M and Law No. 18/2020 of Macau or otherwise legally authorized and entitled to practice western medical and surgical services in any country in accordance with the laws of that country, and who is acceptable to Us. An Anaesthetist cannot be the attending Medical Practitioner or Surgeon operating on the Insured.

Big 3 Disease(s) refers to Cancer, Heart Attack and Stroke of the Crises.

Basic Plan refers to the plan EasyCover Critical Illness Plan as shown in the Policy Schedule.

Beneficiary refers to a person chosen by Policy Owner to receive the Death Benefit under this Policy at the death of the Insured.

Chinese Medicine Practitioner refers to a person other than the Policy Owner, the Insured, an insurance agent, business partner(s), employee/employer or a relative of any of them (unless approved in advance by Us in writing) who is registered with the Health Bureau of Macau under the Decree-Law 84/90/Mas as an herbalist or an acupuncturist, or registered with the local medical authorities at the place of treatment if the treatment is received outside Macau.

Clinical Surgery refers to a Medically Necessary Out-patient procedure, which is performed either in the office or clinic of a Medical Practitioner or in the outpatient department or emergency department of a Hospital.

Commencement Date refers to the date of premium commencing and the date used for determining the issue age of the Insured and is shown in the Policy Schedule.

Crisis refers to a Disease listed under “Crises covered in EasyCover Critical Illness Plan” in Appendix 1: List of Diseases Covered. Any diagnosis of a Crisis for the purpose of claiming the Crisis Benefit must fulfil the meaning together with the terms and conditions stated under the heading of that Crisis in Appendix 2: Definition of Crisis.

Current Sum Insured refers to the Initial Sum Insured less any benefits paid under Special Disease Benefit pursuant to Clause 4.2 and Critical Medical Care Benefit pursuant to Clause 4.3 of the Benefit Provisions of this

Policy. The Current Sum Insured is the amount on which calculation of the Crisis Benefit and Death Benefit is based, and shall be deemed to be zero once the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured.

Day Patient refers to an Insured receiving medical services or treatments given in medical clinic, day case procedure centre or Hospital where the Insured is not in Hospitalisation.

Disease(s) refers to the Disease(s) covered under this Policy as set out in Appendix 1: List of Diseases Covered. Each Disease is further defined in Appendix 2 or Appendix 3.

Eligible Expenses refers to reasonable and customary charges incurred for Medically Necessary treatment, services or supplies rendered with respect to the same Big 3 Disease for which the Crisis Benefit claim is paid or payable.

Reasonable and customary refers to a fee or expense which:
1. is actually charged for Medically Necessary treatment, supplies or medical services;
2. does not exceed the usual or reasonable average level of charges for similar treatment, supplies or medical services in the location where the expense is incurred;
3. does not include charges that would not have been made if no insurance existed.

We may adjust benefit(s) payable under this Policy for fees or expenses that We judge not to be reasonable and customary after comparing with fee schedules used by the government, relevant authorities or recognised medical associations in the location where the fee or expense is incurred.

Endorsement refers to an additional document attached to this Policy that outlines any adjustments that We make to this Policy.

Expiry Date refers to the Policy Anniversary immediately preceding the 100th birthday of the Insured.

First Confirmed Diagnosis refers to the first time that a diagnosis of a Disease is made by a Medical Practitioner and confirmed by histopathological and / or cytopathological patterns and / or radiological tests, blood tests and / or other laboratory tests results. Date of diagnosis of a Disease suffered by the Insured will be the day when tissue specimen, culture, blood specimen or any other laboratory investigation upon which the diagnosis is determined is first taken from the Insured. For Cancer and Carcinoma-in-situ or Early Stage Malignancy of Specific Organs, a diagnosis based on history, physical and radiological findings only will not meet the standards of diagnosis required by this Policy.

First Symptoms refer to any condition, Disease or any of its direct causes in respect of an Insured, where the Insured and / or the Policy Owner was aware or should reasonably have been aware of signs or symptoms of the condition, Disease, or where any laboratory test or investigation showed the likely presence of the condition or Disease.

Hospital refers to a medical facility that meets all of the following requirements:
1. is licensed as a hospital under the laws of the country where it operates;
2. is supervised by Medical Practitioners and provides twenty-four (24) -hour care by Qualified Nurses;
3. is operated mainly to diagnose and treat injuries or illnesses on an In-patient basis;
4. has diagnostics and major surgery facilities; and
5. is not primarily a clinic, nursing facility, nursing home, convalescence home, psychiatric facility, drug and alcohol rehabilitation facility, preventative medicine facility, homeopathic facility or hospice care.

Hospitalise and **Hospitalisation** refer to the period when the Insured stays in a Hospital as an In-patient for Medically Necessary treatment of an illness, Injury or a Big 3 Disease. The Hospital stay must be for at least six (6) continuous hours or, if this does not happen, the Hospital must charge for room and board. The Insured

cannot leave the Hospital before he or she is discharged. Hospitalisation ends when the Hospital issues its final accounts in preparation for the Insured to formally leave, or be discharged from, the Hospital.

Initial Sum Insured refers to the amount shown on the Policy Schedule or Endorsement as the "Sum Insured" when this Policy is issued, or as amended subsequently at the Policy Owner's request (to increase or decrease) in accordance with Our then applicable rules and regulations, which forms the basis for calculation of the Special Disease Benefit, Critical Medical Care Benefit, Additional 50% Coverage Benefit for Big 3 Diseases (if applicable) and Additional Medical Coverage for Big 3 Diseases (if applicable). For the avoidance of doubt, any payments made under this Policy will not affect the Initial Sum Insured.

Injury refers to bodily damage to the Insured caused solely and directly by an Accident that occurs while this Policy is in force.

In-patient refers to the Insured is admitted to a Hospital on the written recommendation of a Medical Practitioner or Specialist to receive Medically Necessary treatment for an illness, Injury or a Big 3 Disease that cannot be provided safely outside the Hospital premises.

Insured refers to the person insured by this Policy and is shown on the Policy Schedule or any Endorsement.

Intensive Care Unit refers to the unit in a Hospital that has one-to-one nursing care, where patients undergo specialised resuscitation, monitoring and treatment procedures. The unit must be staffed twenty-four (24) hours a day with highly trained nurses, technicians and Medical Practitioners, and be equipped with life-saving medical equipment to continuously assess vital body functions.

Invasive Life Support refers to a medical service, procedure or supply which is necessary and is:
- Extracorporeal Membrane Oxygenation (ECMO); or
- Left ventricular assist device (LVAD) or intra-aortic balloon pump; or
- Ventilatory support by invasive artificial airway (endotracheal tube or tracheostomy tube) for a minimum of three (3) days.

The following are not covered: Prolonged admission and ventilation in Intensive Care Unit or surgery done for organ donation; admission to Intensive Care Unit or surgery for cosmetic, weight reduction or gender transformation purposes; hospitalisation for psychiatric or mental illness; surgery to correct vision or refractory disorder; or hospitalisation to High Dependency Unit (HDU), or general hospital ward. However, ventilation by any non-invasive ventilator such as CPAP, BiPAP or Face mask, is specifically excluded.

Medically Necessary refers to a medical service, procedure or supply which is necessary and is:
1. consistent with the diagnosis and customary medical treatment for the Insured's Disease;
2. recommended by a Medical Practitioner for the care or treatment of the Insured's Disease involved and must be widely accepted professionally in Macau as effective, appropriate and essential based upon recognized standards of the health care specialty involved; and
3. not furnished primarily for the personal comfort or convenience of the Insured or any medical service provider. Experimental, screening and preventive services or supplies are not considered Medically Necessary.

Out-patient refers to when the Insured receives Medically Necessary western medical treatment for the Big 3 Disease in the office or clinic of a Medical Practitioner or in the outpatient department or emergency department of a Hospital.

Policy consists of this policy document, its Policy Schedule, application form, any Endorsement and / or any supplement.

Policy Anniversary refers to the same date each year as the Commencement Date while this Policy is in force.

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Policy Date refers to the date when coverage under this Policy becomes effective as shown in the Policy Schedule or the Reinstatement Date, whichever is later.

Policy Owner, **You or Your** refers to the person who owns this Policy as shown in the Policy Schedule or any Endorsement.

Policy Schedule refers to the document attached to this Policy. The Policy Schedule shows important information about this Policy, including the policy number, the premium payable, the benefits of this Policy and other particulars.

Policy Year refers to a period of twelve (12) consecutive calendar months from the Commencement Date and every succeeding twelve (12) consecutive calendar months period after that.

Prescribed Diagnostic Imaging Tests refers to computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.

Qualified Nurse(s) refers to a person other than the Policy Owner, the Insured, an insurance agent, business partner(s), employee/employer or a relative of any of them (unless approved in advance by Us in writing) who is legally recognised to perform services in the specialist area of their titled profession by the relevant government-recognised registration body in Macau, or in the region in which he or she practises.

Rehabilitation Centre refers to a registered institution (other than a Hospital) which provides physiotherapy, occupational therapy and other rehabilitative treatment for physical injury, dysfunction or disability.

Reinstatement Date refers to the date that We approve an application to reinstate this Policy.

Renewable Period refers to the initial renewable period as shown in the Policy Schedule or the number of year(s) from the date the Basic Plan is renewed to the Expiry Date, whichever is shorter.

Special Disease refers to a Disease listed under "Special Diseases covered in EasyCover Critical Illness Plan" in Appendix 1: List of Diseases Covered. Any diagnosis of a Special Disease for the purpose of claiming the Special Disease Benefit must fulfil the meaning together with the terms and conditions stated under the heading of that Special Disease in Appendix 3: Definition of Special Disease.

Standard Private Room refers to a standard single occupancy room with an adjoining bathroom for the Insured's use during his or her Hospitalisation, but does not include any Hospital room that has its own kitchen, dining or sitting room.

Standard Semi-private Room refers to a single or double occupancy room in a Hospital, with a shared bath or shower room.

Standard Ward Room refers to a room type in a Hospital that is of a quality below a Standard Semi-private Room.

Term Critical Illness Series means EasyCover Critical Illness Plan and other selected critical illness insurance term plan(s) as specified by Us from time to time.

Total Claims refer to the aggregate amount of the Special Disease Benefit, Crisis Benefit, Critical Medical Care Benefit and / or the Death Benefit payments.

We, **Us** or **Our** refers to FWD Life Insurance Company (Macau) Limited, the issuer of this Policy.

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2. General Provisions

2.1 The Policy

This Policy is governed by the laws of Macao Special Administrative Region of China (Macau) and is proof of an insurance contract between You and Us. Once this Policy has commenced, insurance is provided regardless of the Insured's occupation, or the countries that the Insured travels to or resides in.

The Policy Owner and the Insured are required to provide truthful and accurate information during the application of this Policy. We have issued this Policy after taking into account the information provided by You and the Insured (if they are different people) during application process and payment of the premium as shown in the Policy Schedule. This information provided is considered representations and not warranties.

2.2 Cooling-off Period

If Policy Owner is not completely satisfied with this Policy, and Policy Owner has not made a claim, Policy Owner can cancel it by giving a written notice to Us. Such notice must be signed by the Policy Owner and received directly by Us together with this Policy (if received) within twenty one (21) calendar days immediately following:

(1) the day We deliver this Policy to the Policy Owner or Policy Owner's nominated representative; or
(2) the day We deliver a cooling-off notice (separate from the policy) to the Policy Owner or Policy Owner's nominated representative informing Policy Owner about this Policy and the right to cancel within the stated 21 calendar day period;

whichever is earlier.

This twenty-one (21) calendar day period is called the cooling-off period. Policy Owner can cancel this Policy and receive premiums without interest back. We follow the cooling-off period principles set out by Monetary Authority of Macao to protect customers.

2.3 Alterations and Company Notices

No alterations in the terms and conditions and provisions of this Policy will be valid unless made in an Endorsement and / or any supplement to this Policy and issued by Us. No agent or other persons have the authority to change or waive any provision of this Policy.

If We need to send You any notices, We will send them to Your latest correspondence address recorded in Our records, and such notice will be deemed to have been received by the Policy Owner forty-eight (48) hours after posting.

2.4 Policy Owner

Under this policy document, the words You, Your or Policy Owner refer to the person who owns this Policy as shown on the Policy Schedule or any Endorsement.

As the Policy Owner, You are the only person who can request changes to, and exercise the rights and privileges related to this Policy while this Policy is in effect.

If You hold this Policy on trust for a beneficiary by virtue of an express trust, We will consider any rights or options exercised by You in relation to this Policy as being made with the consent of, and for the sole benefit of, the beneficiary(ies) of that trust. We will not contact that beneficiary to confirm their consent.

You are entitled to any proceeds of this Policy that do not result from the death of the Insured. If You die, the proceeds will be payable to the appointed executors or administrators for and on behalf of Your estate, unless You are also the Insured, in which case the proceeds will be paid to the Beneficiary.

2.5 Beneficiary

Beneficiary refers to a person nominated by You to receive any proceeds of this Policy if the Insured dies. Your nominated Beneficiary is entitled to any benefits of this Policy if the Insured dies.

If a Beneficiary dies before the Insured, his or her share of the policy benefits will be redistributed to any surviving Beneficiaries in proportion to their nominated share (or equally if no nomination has been made).

If both the Insured and a Beneficiary die in the same incident and the official time of death is recorded as being the same time, We will determine the distribution of the proceeds of this Policy as if the elder of the two people had died first.

If You have not nominated any Beneficiaries, or if all of the Beneficiaries die before the Insured, We will pay the proceeds to You, or the appointed executors or administrators for and on behalf of Your estate (if You die).

During the Insured's lifetime, the Beneficiary has no right to and cannot request any changes to, claim benefits from, or exercise any rights and privileges in relation to this Policy.

2.6 Changes of Policy Owner and Beneficiary

While this Policy is in effect, the Policy Owner and the Beneficiary may be changed if You (as the current Policy Owner) submit a written request to Us. After assessing that We have all of the relevant information, We will process and register this change in Our records and such change will be effective from the date We approve the request (irrespective of whether the Policy Owner and/or the Insured is/are alive on that date).

2.7 Assignment

You can assign this Policy as collateral for a loan, however unless You inform Us in writing of the assignment, and We make a record of this assignment, We will not be bound by this assignment. You are responsible for the validity of the assignment and instructing Us any benefits under this Policy are paid to the assignees. Any payment We make before We record the assignment will not be affected by the assignment. Any money owed to Us under this Policy will take priority over any rights of any assignee(s).

2.8 Increase in Initial Sum Insured

While this Policy is in effect and the Insured is alive, provided that no claims have been made, You can request in writing to increase the Initial Sum Insured before the first Policy Anniversary subject to Our

applicable rules and procedures (including but not limited to the relevant underwriting requirements). We will review the request and may request further information before accepting or declining the request. If We approve the request, We will register this change in Our records and such change will be effective from the Policy Date. We will send an Endorsement to Your latest correspondence address in Our records.

2.9 Reduction in Initial Sum Insured

While this Policy is in effect and the Insured is alive and subject to the minimum Initial Sum Insured determined by Us in Our sole discretion, provided that no benefit has been claimed, You can request in writing to reduce the Initial Sum Insured subject to Our applicable rules and procedures. We will review the request and may request further information before accepting or declining the request. If We approve the request, We will register this change in Our records and such change will be effective from the date We approve the request. We will send an Endorsement to Your latest correspondence address in Our records.

2.10 Surrender

While this Policy is in effect and the Insured is alive, You can request to surrender this Policy by sending Us a completed surrender form or by any other means acceptable by Us, and subject to Our applicable rules and procedures. This Policy has no cash values and no benefits will be payable upon surrender. This Policy will be terminated on the date We approve the request.

2.11 Misstatement or Non-disclosure

We have used the information, including but not limited to Age, gender and other material facts, provided by You and the Insured (if they are different people) during the application process to determine whether to offer this Policy.

If the Insured's Age or gender shown in the Policy Schedule is incorrect, We will calculate any amount paid or payable or benefit accruing according to how much the premiums paid would have purchased at the time of the application on the basis of the correct Age and/or sex. However, any recalculated amount will not be more than the original benefit which is specified in the Policy Schedule or any Endorsement.

We may cancel this Policy and treat it as having never existed if (i) any information provided by You and the Insured during the application process is incorrect and if, based on the correct information, We would not have offered this Policy; or (ii) any material facts were not disclosed during the application process which may affect Our risk assessment. In this situation, We will refund any premium(s) paid without interest after deducting any benefits that We have paid. We will send written notification of the cancellation to Your correspondence address in Our records.

2.12 Incontestability

Except in instances of fraud or non-payment of premium, We waive Our rights to cancel this Policy and treat it as having never existed after it has been in effect for one (1) year (meaning the Insured has been alive) from the Policy Date, or the Reinstatement Date (if this Policy is reinstated).

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2.13 Payment Currency

All amounts that We or You are required to pay in relation to this Policy will be paid in the currency shown in the Policy Schedule provided that We have the absolute discretion to accept payment in another currency.

2.14 Third Party Contractual Right

Any person who is not a party to this Policy has no rights to enforce any of its terms.

2.15 General Interpretation and Application

Where the context requires, words importing one gender shall include the other gender, and singular terms shall include the plural and vice versa. Headings are for convenience only and shall not affect the interpretation of this Policy. References to sections, clauses, provisions and schedules are to sections, clauses, provisions and schedules to this Policy. Should any conflict arise in respect of the interpretation of any provision in this Policy and any other material otherwise produced by Us, then the provisions of this Policy shall prevail.

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3. Premiums and Reinstatement Provisions

3.1 Payment of Premiums

The first premium is due on the Commencement Date. If this is not paid within thirty (30) calendar days of the Policy Date, this Policy shall be deemed null and void. In this situation, We will not be legally obliged to pay any benefits under this Policy.

Subsequent premiums must be paid during the term of this Policy. Premiums must be paid at a frequency We agree with You.

We provide a thirty (30)-day grace period from the due date of any premium(s). If We still do not receive this premium after the thirty (30)-day grace period, We will terminate this Policy effective from the date the unpaid premium was due.

The premium of this Policy is not guaranteed. We reserve the right from time to time to review, vary and significantly increase all or any of the premium stated in the Policy Schedule or any Endorsement attached to this Policy due to factors including but not limited to claims experience and policy persistency, provided any premium review shall be applied to all other policies of the same kind.

In addition, if Additional Medical Coverage for Big 3 Diseases is selected, the premium of Additional Medical Coverage for Big 3 Diseases is not guaranteed and will be determined annually at Our sole discretion based on the Age of the Insured at the Policy Anniversary, and the premium of the Policy will change every year.

3.2 Renewal

While this Policy is in effect and the Insured is alive, the Basic Plan of this Policy can be renewed for another Renewal Period at the end of each Renewable Period without the requirement of evidence of insurability. Unless You tell Us in writing before the next renewal that You do not want to renew, the Basic Plan of this Policy will be automatically renewed at the end of each Renewable Period until the Expiry Date based on the terms and conditions of this Policy, provided that premiums under this Policy are paid when due. The premium within the Renewable Period is not guaranteed but will not be increased solely based on the Age of the Insured (except for Additional Medical Coverage for Big 3 Diseases). The premium rates upon renewal are not guaranteed and will be determined at Our sole discretion based on factors including but not limited to the Age of the Insured at the time of renewal, claims experience and policy persistency from all policies under this product.

We reserve the right to revise, amend or modify this Policy at each Policy Anniversary, and We will notify You in writing at least thirty (30) calendar days before the Policy Anniversary after which the revisions will take effect. If You refuse to accept the revisions, We can terminate this Policy when You have not paid the premium for thirty (30) calendar days from when it was due.

3.3 No re-underwriting except in limited circumstances

While this Policy is in force, We will not have the right to re-underwrite this Policy irrespective of any change in health conditions of the Insured after the date of Endorsement, Commencement Date or the Policy Date, whichever is the earlier.

We shall not have the right to re-underwrite this Policy irrespective of any change. This restriction applies to any change including but not limited to where there is any upgrade or downgrade of any benefits, or any addition or removal of any benefits, as permitted under this Policy, regardless of where they are set out in this Policy.

Notwithstanding the second paragraph of this clause, We will have the right to re-underwrite this Policy only under the following circumstances –

1. Where the Policy Owner requests Us to re-underwrite this Policy at the time of renewal for reduction in premium loading or removal of case-based exclusion(s) according to the Company's underwriting practices. For the avoidance of doubt, We will not have the right to terminate or not to renew this Policy if any of the aforesaid requests is rejected by Us or the re-underwriting result is not accepted by the Policy Owner;
2. At any time where the Policy Owner requests to subscribe additional benefits (if any) or switch to another insurance plan which provides upgrade or addition of benefits (in which cases the re-underwriting shall be limited to such upgrade or additional benefits).
   (i) However, at any time where the Policy Owner requests to unsubscribe the additional benefits (if any) in this Policy, or switch to another insurance plan which provides downgrade or reduction of benefits, We will not have the right to re-underwrite this Policy but shall have the discretion to accept or reject the request according to its prevailing practices in handling similar requests; and
   (ii) We will not have the right to terminate or not to renew this Policy if any of the aforesaid requests is rejected by Us or the re-underwriting result is not accepted by the Policy Owner;

We and Policy Owner acknowledge that –

3. if under the terms of this clause, We have the right, or is required, to re-underwrite this Policy based on certain factors including but not limited to health conditions, smoking status, occupations, residency and financial conditions at renewal, We will, in accordance with the terms of this clause and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and
4. as a result of re-underwriting, this Policy may be terminated, new premium loading may be applied, existing premium loading may be adjusted upwards or downwards, new case-based exclusion(s) may be applied, and existing case-based exclusion(s) may be revised or removed.

3.4 Deduction of Outstanding or Unpaid Premium

If there are any outstanding or unpaid premium(s) under this Policy, We will deduct these amounts from any benefits or proceeds payable under this Policy.

Upon the payment of Death Benefit or Crisis Benefit, if You are paying the premium(s) at a frequency other than annually (for example, monthly), We will deduct from the benefit(s) the amount of unpaid premiums (if any) for the Policy Year in which the Insured died or the Crisis Benefit is paid (as the case may be).

3.5 Reinstatement

If this Policy was terminated because of unpaid premiums, We may agree to reinstate this Policy, subject to the terms and conditions of this Policy and the applicable rules and procedures at that time, if You:

1. apply to Us in writing within one (1) year from the date of a default in payment of premium pursuant to which this Policy was terminated;
2. provide Us with satisfactory evidence that the Insured still qualifies for this Policy based on the same factors that We used when assessing the initial application; and
3. repay all unpaid premiums (with interest at an interest rate that We set).

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We may refuse the application for reinstatement or may adjust the terms of this Policy. This Policy will only take effect again from the Reinstatement Date.

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4. Benefit Provisions

While the coverage of this Policy is in effect and subject to the terms, conditions, exclusions, limitations and restriction contained in this Policy (including any attached endorsements), We will, upon receipt of due proof and Our approval, pay the benefit(s) in accordance with the Benefit Provisions.

We will pay the Crisis Benefit, Special Disease Benefit and Critical Medical Care Benefit only where the First Symptoms appear, the condition occurs and the diagnosis or surgery relating to the relevant Disease, illness or Injury occurs after the first ninety (90) calendar days from the Policy Date. This first ninety (90) calendar days limitation does not apply if any Disease, illness or Injury is solely and directly caused by an Accident and independently of any cause.

4.1 Crisis Benefit

While this Policy is in force, if the Insured has the First Confirmed Diagnosis of a Crisis, We will pay to the Policy Owner the Crisis Benefit equivalent to one hundred percent (100%) of the Current Sum Insured.

This Crisis Benefit will only be paid once until the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured.

If Additional Medical Coverage for Big 3 Diseases is not selected when Crisis Benefit is payable for Big 3 Diseases, upon payment of the Crisis Benefit for Big 3 Diseases, Our liability (if any) under this Policy shall be limited to the Life Enrichment Program, subject to Clause 4.8 below.

4.2 Special Disease Benefit

While this Policy is in force, if the Insured has the First Confirmed Diagnosis of a Special Disease, We will pay to the Policy Owner a benefit of thirty-five percent (35%) of the Initial Sum Insured in respect of that Special Disease (except Carcinoma-in-situ or Early Stage Malignancy of Specific Organs, Angioplasty of Coronary Artery and Special Diseases for Juvenile).

The benefit payable for each of (i) Carcinoma-in-situ or Early Stage Malignancy of Specific Organs, (ii) Angioplasty of Coronary Artery and (iii) Special Diseases for Juvenile is equal to the lesser of:

(i) Thirty-five percent (35%) of the Initial Sum Insured; or
(ii) HK$400,000 / US$50,000 (in the case of Hong Kong dollar and United States dollar denominated Policies respectively) per life of each claim under all policies of Term Critical Illness Series.

Each Special Disease can be claimed once only under this Policy, except the following:

(a) *Carcinoma-in-situ or Early Stage Malignancy of Specific Organs*

More than one (1) claim for Special Disease Benefit can be made in respect of Carcinoma-in-situ or Early Stage Malignancy of Specific Organs under the Policy. To be eligible for the second and subsequent claim, the claim must be in relation to a covered organ of a Carcinoma-in-situ or Early Stage Malignancy (as defined and classified under the "Appendix 3: Definition of Special Disease") that is different from the organ(s) which was/were covered under the previous claim for the Special Disease Benefit (for which benefit has been paid). If the relevant covered organ has both a left and a right component (such as, but not limited to, the lungs or breasts), the left side and right side of the organ shall be considered one and the same organ ("Paired Organ").

(b) *Angioplasty of Coronary Artery*

A maximum of two (2) claims for Special Disease Benefit can be made in respect of Angioplasty of Coronary Artery under this Policy, provided that the second claim for Special Disease Benefit has fulfilled the relevant additional condition(s) and / or requirement(s) as set out in the respective definitions of Angioplasty of Coronary Artery under the "Appendix 3: Definition of Special Disease".

If more than one (1) conditions are diagnosed as arising from the same Disease, though they may exist in different stages, conditions or forms, We will only pay one benefit for the condition for which the highest benefit amount under Clause 4.1, Clause 4.2 and Clause 4.3 is payable.

If more than one (1) conditions are diagnosed in any component of a Paired Organ, though they may exist in different stages, conditions or forms, We will only pay one benefit for the condition for which the highest benefit amount under Clause 4.1, Clause 4.2 and Clause 4.3 is payable.

This benefit will be payable until the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured. Upon the payment of claims under this Special Disease Benefit, the Current Sum Insured of this Policy will be reduced accordingly. Death Benefit, Crisis Benefit and future premium will be reduced accordingly. The benefit payable under each claim of Special Disease Benefit will in no event be higher than the Current Sum Insured.

4.3 Critical Medical Care Benefit

While this Policy is in force, if it becomes Medically Necessary for the Insured to be Hospitalised in an Intensive Care Unit for three (3) or more consecutive days with the use of Invasive Life Support, We will pay to the Policy Owner the Critical Medical Care Benefit which is equal to the lesser of the following:

(i) Twenty percent (20%) of the Initial Sum Insured; or
(ii) HK$400,000 / US$50,000 (in the case of Hong Kong dollar and United States dollar denominated Policies respectively) per life of each claim under all policies of Term Critical Illness Series.

If one or more than one illness or Injury (including their complications and Hospitalisation in Intensive Care Unit) arising from a single and same incident are diagnosed, though they may exist in different stages, conditions or forms, We will only pay one benefit for the illness or Injury (including their complications and Confinement in Intensive Care Unit) for which the highest benefit amount under Clause 4.1, Clause 4.2 and Clause 4.3 is payable.

This benefit will be payable until the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured. Upon the payment of claims under this Critical Medical Care Benefit, the Current Sum Insured of this Policy will be reduced accordingly. Death Benefit, Crisis Benefit and future premium will be reduced accordingly. The payment under Critical Medical Care Benefit will in no event be higher than the Current Sum Insured.

This benefit will be payable only once under this Policy.

4.4 Waiver of Premium upon Crisis Benefit Claims paid/payable for Big 3 Diseases

While the Policy is still in force, if Additional Medical Coverage for Big 3 Diseases is selected when the Crisis Benefit is payable for Big 3 Diseases, We will waive the balance of premiums payable under this Policy. Without prejudice to Clause 3.4, The first premium to be waived will be the one falling due immediately after the date of the First Confirmed Diagnosis of the Big 3 Disease which is the subject of

the Crisis Benefit claim, except any premium falling due shall continue to be paid pending Our approval of a claim for this benefit. Following such approval, We will refund any premiums paid to this Policy which are later waived.

Regardless of the mode of payment of premiums selected under this Policy, any waiver of premiums shall be effected as if the Policy were on a monthly premium mode. However, there will be no waiver of any premium the due date of which is more than one (1) year before the day of receipt by Us of written notice of the Crisis Benefit claim for Big 3 Diseases.

4.5 Additional 50% Coverage Benefit for Big 3 Diseases

Subject to Our applicable rules and procedures at that time, You may select the Additional 50% Coverage Benefit for Big 3 Diseases when You apply for Your Policy or at the end of each Renewable Period, and You can change Your selection at the end of each Renewable Period. If You select this benefit, it will be set out in Policy Schedule or Endorsement.

Once the Crisis Benefit has been paid/or is payable for Big 3 Diseases and while the Policy is still in force, We will pay to the Policy Owner the Additional 50% Coverage Benefit for Big 3 Diseases equivalent to fifty percent (50%) of the Initial Sum Insured.

This benefit is in addition to other benefits payable under this Policy and is payable when the Crisis Benefit is payable for Big 3 Diseases under the Policy.

This benefit will be payable once under this Policy, and this benefit amount paid shall not be deducted from the Current Sum Insured of this Policy.

4.6 Additional Medical Coverage for Big 3 Diseases

Subject to Our applicable rules and procedures at that time, You may select the Additional Medical Coverage for Big 3 Diseases when You apply for Your Policy or at the end of each Renewable Period, and You can change Your selection at the end of each Renewable Period. If You select this benefit, it will be set out in Policy Schedule or Endorsement.

Once the Crisis Benefit has been paid and/ or is payable for Big 3 Diseases and while the Policy is still in force, if the Eligible Expenses incurred in respect of the same Big 3 Disease for which the Crisis Benefit claim are paid or payable have reached the lower of the total Initial Sum Insured under all policies of the Term Critical Illness Series with Additional Medical Coverage for Big 3 Diseases or HK$500,000 / US$62,500 (in the case of Hong Kong dollar and United States dollar denominated Policies respectively), We will reimburse Eligible Expenses incurred in respect of that Big 3 Disease in excess of the aforesaid threshold under Hospitalisation Benefits, Surgical Benefits and Other Benefits in accordance with Clause 4.6.1 and Clause 4.6.2, up to the lesser of:

(1) one hundred percent (100%) of the total Initial Sum Insured under all policies of the Term Critical Illness Series with Additional Medical Coverage for Big 3 Diseases; or
(2) HK$1,000,000 / US$125,000 (in the case of Hong Kong dollar and United States dollar denominated Policies respectively) per life under all policies of the Term Critical Illness Series with Additional Medical Coverage for Big 3 Diseases,

provided that the Eligible Expenses for that Big 3 Disease are incurred within two (2) years from the date of the First Confirmed Diagnosis of such Big 3 Disease.

If You can obtain a refund of any expenses otherwise recoverable under this benefit from any other sources, We will only pay the portion of these expenses in excess of the refund obtained from other sources up to the above limit. You must tell Us if the Insured can obtain a refund of all or part of the Eligible Expenses otherwise recoverable under this benefit from any other sources. If We have paid a benefit which is recoverable from another source, You must refund this amount to Us.

The Policy will be terminated once the above maximum limit for the Eligible Expenses is reached or upon expiry of this benefit, which is two (2) years after the date of the First Confirmed Diagnosis of such Big 3 Disease (whichever is earlier).

4.6.1 Hospitalisation Benefits, Surgical Benefits and Other Benefits under Additional Medical Coverage for Big 3 Diseases

Hospitalisation Benefits

We will reimburse the Eligible Expenses described below (subject to any other maximum limits as set out in this Policy or any Endorsement) if the Insured is Hospitalised in a Standard Semi-private Room or a room of lower level for the treatment of the same Big 3 Disease for which the Crisis Benefit claim is paid or payable:

1. Room and Board

We will reimburse one hundred percent (100%) of the Eligible Expenses for room and board (Standard Semi-private Room level or below) when the Insured is Hospitalised.

2. Intensive Care Unit Charges

We will reimburse one hundred percent (100%) of the Eligible Expenses if the Insured is Hospitalised in an Intensive Care Unit on the written recommendation of the Insured's attending Medical Practitioner.

If We make the reimbursement for Intensive Care Unit charges, We will not pay the benefit under Room and Board under item 1 in Clause 4.6.1.

3. Medical Practitioner's Hospital Visit and Specialist's Fee

While the Insured is Hospitalised, We will reimburse one hundred percent (100%) of the Eligible Expenses charged:

- by the Insured's attending Medical Practitioner to visit the Insured; and
- for Specialist treatment recommended in writing by the Insured's attending Medical Practitioner.

4. Miscellaneous Hospital Medical Charges

We will reimburse one hundred percent (100%) of the Eligible Expenses charged by the Hospital or Clinical Surgery for the following items:

- Drugs and medicines required by the Insured;
- Dressing, ordinary splints and plaster casts but excluding special braces, artificial limbs, appliances and equipment;
- Laboratory examinations;
- Electrocardiograms;
- Physiotherapy;
- Basal metabolism tests;

- X-ray examinations;
- Medical report charges as a result of tests and examinations;
- Administration of blood and blood plasma but excluding costs of blood or blood plasma;
- Local ambulance service to or from where the Insured is Hospitalised; and
- Use of post-operative recovery room.

For clarity, We will not cover:

a) non-medical miscellaneous charges, such as guest meals, personal wi-fi, telephone, photocopying, taxis and personal items;
b) items that have not been recommended in writing by the Insured's attending Medical Practitioner;
c) narcotics used by the Insured (unless taken as prescribed by a Medical Practitioner); or
d) any genetic testing, medical services, procedures or supplies which are not Medically Necessary.

We have the right to determine whether a particular service or charge will be reimbursed under this benefit.

5. Hospital Companion Bed

We will reimburse one hundred percent (100%) of the expenses charged by the Hospital in which the Insured is Hospitalised on the charge for an extra bed for one (1) person who accompanies the Insured in Hospital during his / her Hospitalisation.

6. Private Nursing Care's Fee

We will reimburse one hundred percent (100%) of the Eligible Expenses for private nursing services provided by a Qualified Nurse if the services have been recommended in writing by the Insured's attending Medical Practitioner following the Insured's surgery or after the transfer from an Intensive Care Unit to another ward within the Hospital.

We will only pay for charges for one Qualified Nurse who provides the services at any one time.

Surgical Benefits

We will reimburse one hundred percent (100%) of the Eligible Expenses (subject to any other maximum limits as set out in this Policy or any Endorsement) charged to the Insured during his or her Hospitalisation or Clinical Surgery for treatment of the same Big 3 Disease for which the Crisis Benefit claim is paid or payable, including the charges for consultation, medication, the Surgeon's fee, Anaesthetist's fee, operating theatre fee and other Eligible Expenses for items and equipment used during the procedures.

Other Benefits

1. Post-hospitalisation Out-patient

If the Insured's attending Medical Practitioner recommends the Insured to undergo follow-up Out-patient consultations after the Hospitalisation or Clinical Surgery for the same Big 3 Diseases for which the Crisis Benefit claim is paid or payable, We will reimburse one hundred

percent (100%) of the Eligible Expenses for the consultations following the Insured's discharge or the Clinical Surgery.

We will only pay for one (1) consultation per day.

We will also reimburse one hundred percent (100%) of the Eligible Expenses for any prescribed medication given and diagnostic tests taken which relate to the Hospitalisation or Clinical Surgery.

We will only pay this benefit if the Insured's attending Medical Practitioner has made the recommendation in writing, and We will not pay any Post-hospitalisation Out-patient Benefit for any treatment from a Chinese Medicine Practitioner, chiropractor treatment, podiatry consultation or physiotherapy, regardless of whether such consultation relates to the follow-up Out-patient consultations.

We will only pay this benefit if We have paid a benefit under Hospitalisation Benefits or Surgical Benefits under Clause 4.6.1, and is subject to any other maximum limits as set out in this Policy or any Endorsement.

2. Post-hospitalisation Home Nursing

If the Insured's attending Medical Practitioner believes that it is Medically Necessary to have nursing support after Hospitalisation and/or surgical treatment for the same Big 3 Diseases for which the Crisis Benefit claim is paid or payable, we will reimburse one hundred percent (100%) of the Eligible Expenses for a Qualified Nurse to attend the Insured's home within the thirty one (31) calendar days immediately after the Insured's discharge following surgery or Intensive Care Unit admission.

We will only pay this benefit if we have paid a benefit under Hospitalisation Benefits or Surgical Benefits and the Insured's attending Medical Practitioner has made a recommendation in writing, and the services relate directly to the same Big 3 Diseases for which the Crisis Benefit claim is paid or payable. This benefit is restricted to nursing services provided by one (1) Qualified Nurse at any time, and is subject to any other maximum limits as set out in the Policy or any Endorsement, even if the Insured is Hospitalised more than once.

3. Non-surgical Cancer Treatment

If the Crisis Benefit is payable for a Cancer and the Insured's attending Medical Practitioner or Specialist considers non-surgical cancer treatment (including chemotherapy, radiotherapy, immunotherapy, targeted therapy and cancer hormonal therapy) is Medically Necessary for that Cancer, We will reimburse one hundred percent (100%) of the Eligible Expenses of this treatment, including oncology drugs. We will reimburse the costs of both In-patient and Out-patient treatment, subject to any other maximum limits as set out in this Policy or any Endorsement.

4. Prescribed Diagnostic Imaging Tests

We will reimburse one hundred percent (100%) of the Eligible Expenses on Prescribed Diagnostic Imaging Tests performed in a setting for providing medical services to a Day Patient recommended in writing by the Insured's attending Medical Practitioner for the investigation or treatment of the same Big 3 Diseases for which the Crisis Benefit claim is paid or payable, subject to any other maximum limits as set out in this Policy or any Endorsement.

5. Rehabilitation Treatment

If We have paid Hospitalisation Benefits or Surgical Benefits, We will reimburse one hundred percent (100%) of the Eligible Expenses the Insured incurred in a Rehabilitation Centre for rehabilitation treatment recommended in writing by the Insured's attending Medical Practitioner, provided that for each occasion of rehabilitation treatment the Insured's stay at the Rehabilitation Centre is for at least six (6) continuous hours, and subject to any other maximum limits as set out in this Policy or any Endorsement.

4.6.2 Limitation on Additional Medical Coverage for Big 3 Diseases

Without prejudice to the maximum limit of the Additional Medical Coverage for Big 3 Diseases, if on any day of Hospitalisation, the Insured is Hospitalised in a room of a higher level than a Standard Semi-private Room at his own choice, the amount of Eligible Expenses reimbursable pursuant to Clause 4.6 shall be reduced by multiplying the following percentage:-

Actual room type	**Standard Ward Room**	**Standard Semi-private Room**	**Standard Private Room**	**Level above the Standard Private Room**
Percentage applied to the Eligible Expenses	100%	100%	50%	25%

The above adjustment shall not be applied if the Hospitalisation in room of a higher level than a Standard Semi-private Room is necessitated by the following reasons:

1. unavailability of accommodation at the specified ward class due to ward or room shortage for emergency treatment;
2. isolation purposes that require a specific class of accommodation; or
3. other reasons not involving personal preference of the Policy Owner and/or the Insured which We regard as valid at Our discretion.

4.6.3 Claimable Amount Estimate

Before the Insured receives Medically Necessary services for a Big 3 Diseases, the Policy Owner may request Us to provide an estimate on the amount that may be claimed under Benefit Provisions. The Policy Owner shall provide Us with the estimated fees to be incurred as furnished by the Hospital and/or attending Medical Practitioner as required by the laws and regulations regulating the private healthcare facilities in Macau at the time of request. Upon receiving the request, We will inform the Policy Owner of the claimable amount estimate under Benefit Provisions based on the estimation furnished by the Hospital and/or attending Medical Practitioner. Our estimate is for reference only, and the actual amount claimable by the Policy Owner shall be subject to the final expenses as evidenced required by Us.

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4.7 Death Benefit

If the Insured dies while this Policy is in force, and before the Expiry Date, We will pay to the Beneficiary(ies) one hundred percent (100%) of the Current Sum Insured under the Policy as Death Benefit.

No benefit will be payable under this Death Benefit if the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured at the time of the death of the Insured.

4.8 Life Enrichment Program

While this Policy is in force and the Insured is still alive, when Crisis Benefit is payable for Big 3 Diseases, We will provide a Life Enrichment Program to the Insured and the fee will be waived. The Life Enrichment Program is available once per Insured.

The Life Enrichment Program is a rehabilitation program which will start within six (6) calendar months from the payment date of the Crisis Benefit claim for Big 3 Diseases.

Details of the Life Enrichment Program will be determined at Our sole discretion at the time the services are provided, and the services may be provided by third party service providers as We may designate. We will not be responsible for any act or failure to act on the part of the service providers and their healthcare network teams (if any). We reserve the right to revise the Life Enrichment Program at any time without prior notice.

4.9 Non-participating

This Policy is non-participating and will not share in the divisible surplus of Our life insurance funds.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

5. Medical Check-up Coupon

While this Policy is in force and the Insured is still alive, a Medical Check-up Coupon will be offered to the Insured by third party service providers, designated by Us, on each of the 2nd, 4th, 6th, 8th and 10th Policy Anniversaries, subject to the following:

1. The Policy was issued at the Insured's Age of eighteen (18) or above;
2. The Policy has been in effect for at least two (2) Policy Years; and
3. All premiums due have been paid.

If the Policy was issued at the Insured's Age of seventeen (17) or below, this Medical Check-up Coupon will be available biennially to the Insured starting from the Policy Anniversary of the Insured's Age of twenty (20) if the Policy is still in force.

The Insured is entitled to a maximum of five (5) medical check-ups coupon per life under all policies of Term Critical Illness Series. The terms and conditions of the check-up service will be determined at the sole discretion of Us at the time the services are provided.

We reserve the right to amend any of the above benefits without prior notice to the Policy Owner and / or the Insured.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

6. Option to Convert to A New Whole Life Critical Illness Protection Plan

Subject to the then applicable rules and procedures, Policy Owner can choose to convert the entire amount or any portion of the Initial Sum Insured under this Policy to a new whole life critical illness protection plan with limited premium payment term ("New Policy") that We then offer without providing further evidence of insurability of the Insured within thirty-one (31) calendar days immediately before or after any Policy Anniversary, provided that all of the following conditions are fulfilled:

(i) This Policy has been in effect for at least two (2) Policy Years;
(ii) This Policy is issued without loading premium and / or additional individual exclusions;
(iii) This Policy remains in force till the respective Policy Anniversary when the option under Clause 6 is exercised;
(iv) The issuance of the New Policy is subject to its availability when this option is exercised;
(v) No benefit under section 4 has been paid, or is payable under this Policy;
(vi) All premiums that are due under this Policy have been paid;
(vii) The Insured's Age is or below fifty-five (55) when the New Policy is issued;
(viii) The term and conditions of the New Policy (including but not limited to the benefits payable, exclusions applied and diseases covered) will be subject to the then applicable policy provisions of the New Policy, and may be different from this Policy;
(ix) The application and successful issuance of the New Policy will be subject to the terms and conditions as determined by Us from time to time and at Our sole discretion at the time of application, including but not limited to Our prevailing rules and regulations (including minimum/maximum issue age and minimum sum insured) and any maximum aggregated limit prescribed by Us on the sums insured per Insured under specified critical illness protection plans;
(x) If only a portion of the Initial Sum Insured is converted, the Policy may be continued for the remaining years and the premiums shall be reduced accordingly provided always that the Policy meets Our rules then in effect, including but not limited to the minimum Initial Sum Insured and premiums then in effect;
(xi) The New Policy will become effective on or after the respective Policy Anniversary of this Policy if your application is accepted and this Policy will be terminated on the date of the New Policy is in effect;
(xii) This option can be exercised once only and once exercised is irrevocable; and
(xiii) The premium of the New Policy shall be determined in accordance with the Insured's Age and Our prevailing premium rates when this option is exercised.

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7. Exclusions

This following applies only to Crisis Benefit, Special Disease Benefit, Critical Medical Care Benefit and Additional Medical Coverage for Big 3 Diseases (if applicable).

This Policy shall not cover any loss / claim directly or indirectly caused by or resulting from any of the following:

1. Intentional self-inflicted Injury or attempted suicide, while sane or insane and while intoxicated or not.
2. The participation in any criminal event.
3. Any condition arising out of consumption of poisoning drugs, psychiatric drug, drug abuse, alcohol abuse, abuse of solvents and other substances unless prescribed by a Medical Practitioner for treatment.
4. Human Immunodeficiency Virus (HIV) related illness, including Acquired Immunization Deficiency Syndrome (AIDS) and / or any mutations, derivations or variations thereof, which is derived from an HIV infection (Except "HIV due to Blood Transfusion" and "Occupationally Acquired HIV" as defined under Appendix 2: Definition of Crisis).

Please refer to item 1 under Other Benefits in Clause 4.6.1 for exclusions for Post-hospitalisation Out-patient and item 4 under Hospitalisation Benefits in Clause 4.6.1 for exclusions for Miscellaneous Hospital Medical Charges (if applicable).

7.1 Waiting Period

We will not pay the Crisis Benefit, Special Disease Benefit, Critical Medical Care Benefit, Additional 50% Coverage Benefit for Big 3 Diseases (if applicable) and Additional Medical Coverage for Big 3 Diseases (if applicable) where the First Symptoms appear, the condition occurs and the diagnosis or surgery relating to the relevant Disease, illness or Injury occurs within the first ninety (90) calendar days from (i) the Policy Date; and (ii) if Additional 50% Coverage Benefit for Big 3 Diseases and/or Additional Medical Coverage for Big 3 Diseases is/are selected, the date of Endorsement. This first ninety (90) calendar days limitation does not apply if any Disease, illness or Injury is solely and directly caused by an Accident and independently of any cause.

For the avoidance of doubt, ninety (90) calendar days waiting period limitation applies to the respective Additional 50% Coverage Benefit for Big 3 Diseases and Additional Medical Coverage for Big 3 Diseases only if such Benefit is not selected in the Renewable Period immediately preceding the concerned Renewable Period.

7.2 Suicide

If the Insured commits suicide within twelve (12) calendar months from the Policy Date (or the Reinstatement Date, whichever is later), Our legal responsibility will be limited to the total premium amount paid to Us without interest, after deducting any policy benefits that We have paid and any outstanding amounts owed to Us. This applies regardless of whether the Insured was sane or insane when committing suicide.

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8. Claim Provisions

8.1 Notice of Claim

Written notice of any claim for Death Benefit, Crisis Benefit, Special Disease Benefit, Critical Medical Care Benefit and Additional Medical Coverage for Big 3 Diseases (if applicable) must be given to Us within thirty (30) calendar days (and in any case no later than six (6) calendar months) from the date of death of the Insured, the date of the relevant medical treatment or First Confirmed Diagnosis of such respective Crisis or Special Disease (as applicable). Any claims for Death Benefit, Crisis Benefit, Special Disease Benefit, Critical Medical Care Benefit and Additional Medical Coverage for Big 3 Diseases (if applicable) received after the said six (6)-month period shall not be accepted, unless We in Our sole discretion decide otherwise.

8.2 Proof of Loss

Upon receipt of a notice of claim, We will provide the claimant with such forms as it requires for the filing of proof of loss.

Written proof of loss satisfactory to Us must be given to Us within ninety (90) calendar days after the time the proof is required or as soon thereafter as is reasonably possible, and in no event, except in the absence of legal capacity, later than six (6) calendar months from the time the proof is required.

All certificates, information and evidence required by Us shall be furnished at the expense of the claimant.

The Insured shall, at Our request and expense, submit to a medical examination by a designated Medical Practitioner in Macau, when and so often as We may reasonably require.

8.3 Proof of Occurrence

Proof of occurrence of any insured event must be supported by:

1. a Medical Practitioner;
2. confirmatory investigations including but not limited to clinical, radiological, histological and laboratory evidence; and
3. if the Insured event requires a surgical procedure to be performed the procedure must be the usual treatment for the condition and be Medically Necessary.

We must be satisfied with the proof of the occurrence of any insured event. We reserve the right to require the Insured to undergo an examination or other reasonable tests to confirm the occurrence of an insured event.

All certificates, information and evidence required by Us will be furnished at the expense of the claimant.

The Insured shall, at Our request and expense, submit to a medical examination by a designated Medical Practitioner in Macau, when and so often as We may reasonably require.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

8.4 Abandoned Claims

If We decline any claim under this Policy and the Policy Owner does not initiate any legal action in respect of such claim within twelve (12) calendar months from the date of such decline, the claim for all purposes shall be deemed abandoned and shall not thereafter be recoverable.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

9. Termination Provisions

This Policy will automatically end on the earliest of the following:

1. The death of the Insured;
2. The Expiry Date of this Policy;
3. The date of Policy surrender. Such date is determined in accordance with Our applicable rules and regulations in relation to Policy surrender;
4. On the premium due date, if the Policy Owner has not paid the premium within the thirty (30)-day grace period;
5. The Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured (except if Additional Medical Coverage for Big 3 Diseases is selected, and when Crisis Benefit is payable for Big 3 Diseases, this Policy will be terminated when Additional Medical Coverage for Big 3 Diseases has been paid or terminated in accordance with Clause 4.6). All riders (if any) will also be terminated once the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured; and
6. When the entire amount of the Initial Sum Insured under this Policy is converted to a whole life critical illness protection plan with limited premium payment term in accordance with clause 6 subject to Our relevant rules at the time of conversion.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

10. Obligation to Provide Information

The Policy Owner acknowledges that We and/or Our affiliates are obliged to comply with legal and/or regulatory requirements in various jurisdictions as promulgated and amended from time to time, such as the United States Foreign Account Tax Compliance Act, and the automatic exchange of information regime ("AEOI") followed by the Financial Services Bureau (the "Applicable Requirements"). These obligations include providing information of clients and related parties (including personal information) to relevant local and international authorities and/or to verify the identity of the clients and related parties. In addition, Our obligations under the AEOI are to:

1. identify accounts as non-excluded "financial accounts" ("NEFAs");
2. identify the jurisdiction(s) in which NEFA-holding individuals and NEFA-holding entities reside for tax purposes;
3. determine the status of NEFA-holding entities as "passive non-financial entities (NFEs)" and identify the jurisdiction(s) in which their controlling persons reside for tax purposes;
4. collect information on NEFAs ("Required Information") which is required by various authorities; and
5. furnish Required Information to the Financial Services Bureau.

The Policy Owner agrees that from time to time We shall have the right to request from the Policy Owner, and disclose to relevant authority(ies), various information about the Policy Owner, the Beneficiary and this Policy as required under Applicable Requirements for the following purposes:

1. for Us to issue this Policy to the Policy Owner;
2. for Us to provide benefits available to the Policy Owner and / or the Beneficiary under the terms of this Policy; and / or
3. for this Policy to remain in force in accordance with its terms.

In addition, the Policy Owner agrees to notify Us in writing within thirty (30) days if there is any change to any of the information previously provided to Us that relates to Our legal obligations under this clause (whether at time of application or at any other time).

If the Policy Owner does not provide such information within the time period as reasonably requested by Us, notwithstanding any other provisions of this Policy, We shall be entitled to, to the extent permitted by Applicable Requirements:

1. report this Policy and/or information about the Policy Owner and/or the Beneficiary to relevant authority(ies);
2. terminate this Policy and refund any premium, after deducting any benefits We have paid, and any amounts owed to Us; or
3. take any such other action as may be reasonably required including but not limited to making adjustments to the values, balances, benefits or entitlements under this Policy.

Prior to the expiry of such time period and notwithstanding any other provisions of this Policy, We shall have the sole discretion to suspend or defer any transaction or provision of any services to the Policy Owner under this Policy, including the payment of any benefit, if any information reasonably requested by Us under Applicable Requirements remains outstanding.

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Appendix 1: List of Diseases Covered

Crises covered in EasyCover Critical Illness Plan	
Group 1: Cancer - Cancer	
Group 2: Diseases related to Organ Failure - Aplastic Anaemia - Chronic Liver Disease - Chronic Lung Disease - End Stage Lung Disease (including Chronic Obstructive Lung Disease, Severe Bronchiectasis and Severe Emphysema) - Fulminant Hepatitis - HIV Due to Blood Transfusion	- Major Organ Transplantation (lung, pancreas, liver, bone marrow) - Medullary Cystic Disease - Occupationally Acquired HIV - Severe Pulmonary Fibrosis - Severe Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis - Surgical Removal of One Lung
Group 3: Diseases related to Circulatory System - Cardiomyopathy - Coronary Artery Disease Surgery - Eisenmenger's Syndrome - Heart Attack - Heart Valve Surgery - Infective Endocarditis - Kidney Failure	- Major Organ Transplantation (kidney, heart) - Other Serious Coronary Artery Disease - Primary Pulmonary Arterial Hypertension - Stroke - Surgery to Aorta
Group 4: Diseases related to Nervous System - Alzheimer's Disease - Apallic Syndrome - Bacterial Meningitis - Benign Brain Tumour - Blindness - Creutzfeld-Jacob Disease - Encephalitis - Loss of Hearing - Major Head Trauma - Motor Neurone Disease	- Multiple Sclerosis - Muscular Dystrophy - Paralysis - Parkinson's Disease - Poliomyelitis - Progressive Bulbar Palsy - Progressive Muscular Atrophy - Progressive Supranuclear Palsy - Severe Myasthenia Gravis
Group 5: Other Diseases - Amputation of Feet due to Complication from Diabetes Mellitus - Chronic Adrenal Insufficiency - Chronic Relapsing Pancreatitis - Coma - Crohn's Disease - Ebola - Elephantiasis - Loss of Independent Existence - Loss of Limbs - Loss of Speech	- Major Burns - Necrotizing Fasciitis - Pheochromocytoma - Severe Osteoporosis - Severe Rheumatoid Arthritis - Systemic Sclerosis - Terminal Illness - Ulcerative Colitis

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Special Diseases covered in EasyCover Critical Illness Plan	
Group 1: Cancer - Carcinoma-in-situ of Specific Organs (all organs except skin, including but not limited to the organs listed below) a) Breast b) Cervix Uteri c) Colon and Rectum d) Fallopian Tube e) Liver f) Lung g) Nasopharynx h) Ovary i) Pancreas j) Penis k) Stomach and Esophagus l) Testis m) Urinary Tract (for the purpose of in-situ cancers of the bladder, stage Ta of papillary carcinoma is included) n) Uterus o) Vagina	- Early Stage Malignancy of Specific Organs a) Chronic Lymphocytic Leukaemia b) Prostate c) Thyroid d) Non Melanoma Skin Cancer
Group 2: Diseases related to Organ Failure - Acute Aplastic Anaemia - Biliary Tract Reconstruction Surgery - Liver Surgery - Miliary Tuberculosis - Moderately Severe Chronic Lung Disease	- Moderately Severe Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis - Skin Transplantation - Surgical Removal of One Kidney
Group 3: Diseases related to Circulatory System - Angioplasty for Carotid Arteries - Angioplasty of Coronary Artery - Cardiac pacemaker / defibrillator insertion - Carotid Artery Surgery - Early Cardiomyopathy - Early Renal Failure - Insertion of a Vena-Cava Filter	- Keyhole Coronary Bypass Surgery - Minimally Invasive Surgery to Aorta - Percutaneous Valve Surgery - Pericardiectomy - Secondary Pulmonary Hypertension
Group 4: Diseases related to Nervous System - Cochlear Implant Surgery - Cerebral Aneurysm Requiring Surgery - Early Amyotrophic Lateral Sclerosis - Early Multiple Sclerosis - Early Progressive Bulbar Palsy - Early Progressive Muscular Atrophy - Less Severe Encephalitis - Loss of Sight in One Eye - Moderately Severe Alzheimer's Disease - Moderately Severe Bacterial Meningitis	- Moderately Severe Brain Damage - Moderately Severe Muscular Dystrophy - Moderately Severe Paralysis - Moderately Severe Parkinson’s Disease - Moderately Severe Poliomyelitis - Severe Psychiatric Illness - Surgery for Subdural Haematoma - Surgical Removal of Pituitary Tumour

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Group 5: Other Diseases - Acute Necrohemorrhagic Pancreatitis - Adrenalectomy for Adrenal Adenoma - Amputation of One Foot due to Complication from Diabetes Mellitus - Coma for 48 hours - Crohn's Disease (Regional Enteritis) - Diabetic Retinopathy	- Early Elephantiasis - Loss of Speech due to Vocal Cord Paralysis - Moderately Severe Burns - Moderately Severe Rheumatoid Arthritis - Osteoporosis with Fractures - Severance of One Limb - Severe Central or Mixed Sleep Apnea
Special Diseases for Juvenile (age next birthday 1 (15 days) – 18) covered in EasyCover Critical Illness Plan	
- Autism - Dengue Haemorrhagic Fever - Juvenile Huntington Disease - Kawasaki Disease - Marble Bone Disease (Osteogenesis) - Osteogenesis Imperfecta	- Rheumatic Fever with Valvular Impairment - Severe Asthma - Still's Disease - Type 1 Diabetes Mellitus - Type I Juvenile Spinal Amyotrophy - Type II Juvenile Spinal Amyotrophy

Appendix 2: Definition of Crisis

Group 1: Cancer

1.1-Cancer

(a) Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue; or

(b) Any occurrence of histologically confirmed leukemia, lymphoma or sarcoma.

The following tumours are excluded:

(i) Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as pre-malignant;

(ii) All skin cancers, unless there is evidence of metastases or the tumour is a malignant melanoma of greater than 1.5mm maximum thickness as determined by histological examination using the Breslow method;

(iii) Prostate cancers which are histologically described as TNM Classification T1(a) or T1(b), or are of another equivalent or lesser classification;

(iv) Papillary micro-carcinoma of the thyroid;

(v) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification; and

(vi) Chronic lymphocytic leukaemia less than RAI Stage I or Binet Stage A-I.

Group 2: Diseases related to Organ Failure

2.1-Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one (1) of the following:

(a) blood product transfusion;
(b) marrow stimulating agents;
(c) immunosuppressive agents; or
(d) bone marrow transplantation.

2.2-Chronic Liver Disease

End stage liver failure with increasing jaundice that in general medical opinion will not improve in future and resulting in either ascites or encephalopathy.

Liver disease secondary to alcohol or drug abuse is excluded.

2.3-Chronic Lung Disease

The Diagnosis of interstitial fibrosis requiring at least intermittent oxygen therapy and showing consistent reduction in FEV1 of one (1) litre or less under appropriate medication. Diagnosis, severity and test results must be confirmed by a Medical Practitioner.

2.4-End Stage Lung Disease (including Chronic Obstructive Lung Disease, Severe Bronchiectasis and Severe Emphysema)

The final or end stage of lung disease, causing chronic respiratory failure, as demonstrated by all of the following:

(a) FEV1 test results consistently less than one (1) litre;
(b) Requiring permanent supplementary oxygen therapy for hypoxemia;
(c) Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO2 \leq 55mmHg$); and
(d) Dyspnea at rest.

The diagnoses must be confirmed by a pulmonologist.

2.5-Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by a Hepatitis virus, leading precipitously to liver failure. The diagnosis in respect of this illness must be based on the meeting of all of the following criteria:

(a) A rapidly decreasing liver size;
(b) Necrosis involving entire lobules, leaving only a collapsed reticular framework; and
(c) Rapid deterioration of liver function tests.

Evidence of the following must be produced:

(a) Liver function test to show massive parenchymal liver disease; and
(b) Objective signs of portasystemic encephalopathy.

2.6-HIV Due to Blood Transfusion

The Insured being infected by HIV provided that:

(a) The infection is due to a blood transfusion received after commencement of the policy; and
(b) The institution which provided the transfusion admits liability or there is a final court verdict that cannot be appealed indicating such liability; and
(c) The infected Insured is not a haemophiliac.

This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS.

Infection in any other manner, including infection as a result of sexual activity or intravenous drug use is excluded. The insurer must have open access to all blood samples and be able to obtain independent testing of such blood samples.

2.7-Major Organ Transplantation (lung, pancreas, liver, bone marrow)

The actual undergoing of a transplant of the lung, pancreas, liver or bone marrow as a recipient. Inclusion on an official organ transplant waiting list, for any of the above organs, also qualifies for benefits. The transplant must be Medically Necessary and based on objective confirmation of organ failure.

2.8-Medullary Cystic Disease

A hereditary kidney disorder characterised by gradual and progressive loss of kidney function because of cysts in the kidney medulla.

Diagnosis must be supported by imaging evidence of multiple medullary cysts with cortical atrophy.

2.9-Occupationally Acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) where the virus is acquired as the result of:

(a) An injury occurring during the course of the Insured's normal occupation; or
(b) Occupational handling of blood or other body fluids.

The following conditions must be fulfilled for a valid claim:

(a) The infection must have incurred while the Insured worked in his/her profession;
(b) The Insured must provide the negative result of a test for HIV-virus or antibodies to HIV virus that was made within five (5) days after the reported incident; and
(c) HIV virus or HIV antibodies must be proven within twelve (12) months after the incident.

2.10-Severe Pulmonary Fibrosis

Severe and diffuse type of pulmonary fibrosis requiring extensive and permanent oxygen therapy at least eight (8) hours per day.

The diagnosis must be confirmed with lung biopsy and by a Specialist in respiratory medicine.

2.11-Severe Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis

Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis means an autoimmune illness in which tissues and cells are damaged by deposition of pathogenic autoantibodies and immune complexes.

The diagnosis of S.L.E. with Lupus Nephritis will be based on the following conditions:

(1) Clinically there must be at least four (4) out of the following presentations suggested by The American College of Rheumatology:

1.1 Malar rash;
1.2 Discoid rash;
1.3 Photosensitivity;

1.4 Oral ulcers;
1.5 Arthritis;
1.6 Serositis;
1.7 Renal disorder;
1.8 Leukopenia (<4,000/μL), or Lymphopenia (< 1,500/μL), or Haemolytic anaemia, or Thrombocytopenia (< 100,000/μL); or
1.9 Neurological disorder;

AND

(2) Two (2) or more of the following tests being positive:
2.1 Anti-nuclear Antibodies;
2.2 L.E. cells;
2.3 Anti-DNA; or
2.4 Anti-Sm (Smith IgG Autoantibodies);

AND

(3) There is lupus nephritis causing impaired renal function with a creatinine clearance rate of thirty (30) ml per minute or less.

We reserve the right to change this definition from time to time to reflect the changes in qualitative or quantitative medical categorization of this illness so as to give effect to the original intent of this definition.

2.12-Surgical Removal of One Lung

Complete surgical removal of the entire right or entire left lung necessitated by an illness or accident of the Insured. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a pulmonologist or thoracic surgeon.

Group 3: Diseases related to Circulatory System

3.1-Cardiomyopathy

Impaired ventricular function of variable aetiology, resulting in permanent and irreversible physical impairments to the degree of at least Functional Class 4 of the New York Heart Association Functional Classification of Cardiac Impairment. The diagnosis must be confirmed by a consultant cardiologist and supported by the appropriate test results including echocardiography.

Cardiomyopathy caused by alcohol or drug abuse is specifically excluded.

Class 4 of the New York Heart Association Classification of cardiac impairment means that the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination & laboratory studies.

3.2-Coronary Artery Disease Surgery

The actual undergoing of open-chest surgery to correct or treat coronary artery disease (CAD) by way of coronary artery by-pass grafting.

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

3.3-Eisenmenger's Syndrome

Eisenmenger's Syndrome shall mean the occurrence of a reversed or bidirectional shunt as a result of pulmonary hypertension, caused by a heart disorder.

All of the following criteria must be met:

(a) Presence of permanent physical impairment classified as NYHA IV; and
(b) The diagnosis of Eisenmenger's Syndrome and the level of physical impairment must be confirmed by a Medical Practitioner who is a cardiologist.

3.4-Heart Attack

The death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The diagnosis must be supported by all of the following:

(a) a history of typical chest pain;
(b) new electrocardiogram (ECG) changes indicating acute myocardial infarction; and
(c) elevation of cardiac enzymes CK-MB or cardiac troponin T/I > 0.5 ng/ml.

Provided other criteria are met but cardiac enzymes are not available, echocardiographic proof of death of a portion of the heart muscle with the evidence of reduction in left ventricular ejection fraction of less than fifty percent (50%) or significant hypokinesia, akinesia, or wall motion abnormalities consistent with a heart attack having occurred will be considered.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes including but not limited to angina are excluded.

3.5-Heart Valve Surgery

Open heart valve surgery requiring median sternotomy, performed to replace or repair one (1) or more heart valves, as a consequence of defects that cannot be repaired by intra arterial catheter procedures alone. The surgery must be performed after a recommendation by a consultant cardiologist.

3.6-Infective Endocarditis

Infective Endocarditis shall mean inflammation of the inner lining of the heart caused by infectious organisms.

All of the following criteria must be met:

(a) Positive result of the blood culture proving presence of the infectious organism;
(b) Presence of at least moderate valve incompetence (means regurgitant fraction of twenty percent (20%) or above) or moderate valve stenosis (means valve area of thirty percent (30%) or less of normal value) attributable to Infective Endocarditis; and
(c) The diagnosis of Infective Endocarditis and the severity of valvular impairment must be confirmed by a Medical Practitioner who is a cardiologist.

3.7-Kidney Failure

End stage renal failure presenting chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated, or renal transplant is carried out.

3.8-Major Organ Transplantation (kidney, heart)

The actual undergoing of a transplant of the heart or kidney as a recipient. Inclusion on an official organ transplant waiting list, for any of the above organs, also qualifies for benefits. The transplant must be Medically Necessary and based on objective confirmation of organ failure.

3.9-Other Serious Coronary Artery Disease

Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded).

For purposes of this definition, "major coronary artery" refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

3.10-Primary Pulmonary Arterial Hypertension

Primary Pulmonary Hypertension is the pathological increase of pulmonary pressure due to structural, functional or circulatory disturbances of the lung leading to right ventricular enlargement. The disease must result in permanent irreversible physical impairment to the degree of at least Class 4 of the New York Heart Association Classification of cardiac impairment.

Class 4 of the New York Heart Association Classification of cardiac impairment means that the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination & laboratory studies.

3.11-Stroke

Any cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by all of the following conditions:

(a) evidence of permanent neurological damage confirmed by a consultant neurologist at least four (4) weeks after the event; and
(b) findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke.

The following are excluded:

(a) Transient Ischaemic Attacks;
(b) vascular disease affecting the eye or optic nerve; and
(c) ischaemic disorders of the vestibular system.

3.12-Surgery to Aorta

Means the actual undergoing of surgery via thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta, a coarctation of the aorta or a traumatic rupture of the aorta. 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.

Group 4: Diseases related to Nervous System

4.1-Alzheimer's Disease

Progressive deterioration or loss of intellectual capacity or abnormal behavior as evidenced by the clinical state and accepted standardized questionnaires or tests arising from Alzheimer's Disease or irreversible organic degenerative brain disorders, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in significant reduction in mental and social functioning requiring the continuous care and supervision of the Insured. The diagnosis must be clinically confirmed by an appropriate consultant.

4.2-Apallic Syndrome

Universal necrosis of the brain cortex, with the brainstem remaining intact. Diagnosis must be confirmed by a neurologist and condition must be documented for at least one (1) month.

4.3-Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit. Confirmation of bacterial infection in cerebrospinal fluid by lumbar puncture is required. Permanent functional neurological impairment lasting for a minimum period of thirty (30) days has to be confirmed by a consultant neurologist.

4.4-Benign Brain Tumour

A non-cancerous tumour in the brain or meninges within the cranium, giving rise to characteristic signs of increased intra-cranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.

The following are excluded:
(a) cysts;

(b) granulomas;
(c) malformations in, or of, the arteries or veins of the brain;
(d) haematomas;
(e) tumours in the pituitary gland or spine; and
(f) tumours of the acoustic nerve.

4.5-Blindness

Total and irreversible loss of sight in both eyes as a result of illness or injury. The blindness must be confirmed by a Medical Practitioner who is an ophthalmologist.

4.6-Creutzfeld-Jacob Disease (CJD)

The occurrence of Creutzfeld-Jacob Disease or Variant Creutzfeld-Jacob Disease which is characterised by rapidly progressive dementia and directly in the Insured's permanent inability to perform at least two (2) of the ADLs.

The diagnosis must be made by Specialist with appropriate testing such as electroencephalogram (EEG) with result of a specific type of abnormality in CJD and magnetic resonance imaging (MRI) showing specificity of brain degeneration.

Other common causes of dementia should be ruled out by a spinal tap. Disease caused by human growth hormone treatment is excluded.

4.7-Encephalitis

Severe inflammation of brain substance which results in significant and permanent neurological deficit lasting at least thirty (30) days as certified by a Medical Practitioner specialising in neurology.

4.8-Loss of Hearing

Means irrecoverable loss of hearing in both ears, with an auditory threshold of more than eighty (80) decibels in all frequencies, as a result of sickness or injury.

Only Insured aged three (3) (age next birthday) or above on first diagnosis is eligible to receive a benefit under this illness.

4.9-Major Head Trauma

Accidental head injury causing significant and permanent functional impairment which has lasted for a minimum period of three (3) months from the date of the trauma or injury. The resultant significant permanent functional impairment must be confirmed by a neurologist.

4.10-Motor Neurone Disease

Motor neurone disease supported by definitive evidence of appropriate and relevant neurological signs that has persisted for at least ninety (90) days. The diagnosis must be made by a Medical Practitioner as progressive and supported by appropriate investigations.

4.11-Multiple Sclerosis

A disease due to demyelination of neurological brain tissue. A consultant neurologist must make a diagnosis of Clinically Definite Multiple Sclerosis. The diagnosis must be supported by all of the following:

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

4.12-Muscular Dystrophy

The diagnosis of muscular dystrophy confirmed by a consulting neurologist, and based on a combination of all of the following:

(a) Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
(b) Characteristic electromyogram; and
(c) Clinical suspicion confirmed by muscle biopsy.

4.13-Paralysis

The total loss of function of two or more limbs due to injury or disease of the spinal cord or brain, where such functional loss is considered to be permanent by a neurologist.

4.14-Parkinson's Disease

Unequivocal diagnosis of Parkinson's Disease by a consulting neurologist where the condition:

(a) cannot be controlled with medication;
(b) shows signs of progressive impairment; and
(c) must result in the permanent inability to perform, without assistance, at least three (3) of the six (6) Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinsonism are excluded.

4.15-Poliomyelitis

Infection with the polio virus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness that has persisted for at least ninety (90) days.

Poliomyelitis not involving paralysis is excluded. Other causes of paralysis are specifically excluded.

4.16-Progressive Bulbar Palsy

Neurological disorder with paralysis in the head region, difficulties in chewing and swallowing, problems in speaking, persistent signs of involvement of the spinal nerves and the motor centres in the brain and spastic weakness and atrophy of the muscles of the extremities. The disease must be unequivocally diagnosed by a consultant neurologist. These conditions have to be medically documented for at least three (3) months.

4.17-Progressive Muscular Atrophy

Confirmation of definitive diagnosis of Fried-Emery, Kugelberg-Welander, Aran-Duchenne or Vulpian-Bernhardt Muscular Atrophy by a consultant neurologist. The diagnosis must be supported by muscle biopsy and CPK estimates. These conditions have to be medically documented for at least three (3) months.

4.18-Progressive Supranuclear Palsy

Progressive Supranuclear Palsy shall mean a degenerative neurological disease characterised by supranuclear gaze paresis, pseudobulbar palsy, axial rigidity and dementia.

The diagnosis of Progressive Supranuclear Palsy must be confirmed by a Medical Practitioner who is a neurologist.

4.19-Severe Myasthenia Gravis

Severe Myasthenia Gravis shall mean an acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatiguability.

All of the following criteria must be met:

(a) Presence of muscle weakness categorized as Class III, IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
(b) The diagnosis of Myasthenia Gravis and categorization must be confirmed by a Medical Practitioner who is a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere
Class II: Eye muscle weakness of any severity, mild weakness of other muscles
Class III: Eye muscle weakness of any severity, moderate weakness of other muscles
Class IV: Eye muscle weakness of any severity, severe weakness of other muscles

Class V: Intubation needed to maintain airway

Group 5: Other Diseases

5.1-Amputation of Feet due to Complication from Diabetes Mellitus

Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Specialist in diabetology as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation shall not be covered.

5.2-Chronic Adrenal Insufficiency

Chronic Adrenal Insufficiency shall mean a chronic disorder of the adrenal glands resulting in insufficient secretion of steroid hormones.

All of the following criteria must be met:

(a) Continuous hormone replacement therapy has been instituted and the therapy is expected to last for the whole life of the Insured; and
(b) The diagnosis of Chronic Adrenal Insufficiency must be confirmed by a Medical Practitioner who is an endocrinologist.

5.3-Chronic Relapsing Pancreatitis

More than three (3) attacks of pancreatitis resulting in pancreatic dysfunction causing malabsorption needing enzyme replacement therapy.

The diagnosis must be made by a gastroenterologist and confirmed by Endoscopic Retrograde Cholangio Pancreatography (ERCP).

Chronic Relapsing Pancreatitis caused by alcohol use is excluded.

5.4-Coma

A state of unconsciousness with no reaction to external stimuli or internal needs which:

(a) Requires the use of life support systems for a continuous period of at least ninety-six (96) hours; and
(b) Results in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following is not covered:

(a) Coma secondary to alcohol or drug abuse.

5.5-Crohn's Disease

Crohn's Disease is a chronic granulomatous inflammatory disease of the intestine. The diagnosis must be confirmed by characteristic histopathological features.

The disease must have resulted in at least one (1) of the following intestinal complications:

(a) Fistula Formation (Excluding Fistula-in-ano);
(b) Obstruction; or
(c) Perforation (not caused by an intervention).

5.6-Ebola

Infection with the Ebola virus where the following conditions are met:

(a) presence of the Ebola virus has been confirmed by laboratory testing;
(b) there are ongoing complications of the infection persisting beyond thirty (30) days from the onset of symptoms; and
(c) the infection does not result in death.

5.7-Elephantiasis

The result and complication of filariasis, characterised by massive swelling in the tissues of the body as a result of obstructed circulation in lymphatic vessels. Unequivocal diagnosis of elephantiasis must be clinically confirmed by an appropriate Specialist, including laboratory confirmation of microfilariae, and must be supported by Our medical adviser.

The benefit does not cover Lymphoedema caused by infection with a sexually transmitted disease, trauma, postoperative scarring, congestive heart failure, or congenital lymphatic system abnormalities.

5.8-Loss of Independent Existence

Inability to perform at least three (3) of the Activities of Daily Living as defined in the Policy (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months and leading to a permanent inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Medical Practitioner.

For Insured aged five (5) (age next birthday) or below at first diagnosis, the benefit is payable if the inability to perform two (2) out of six (6) ADLs persist till five (5) years old (age next birthday).

All psychiatric related causes are excluded.

5.9-Loss of Limbs

Complete severance of two (2) or more limbs above the wrist or ankle as a result of accident or disease.

5.10-Loss of Speech

Total and irrecoverable loss of the ability to speak due to physical damage to the vocal cords which must be established for a continuous period of three (3) months. Medical evidence is to be supplied by an appropriate Specialist and to confirm injury or disease to the vocal cords.

5.11-Major Burns

Means tissue injury causing third degree or full thickness burns to at least twenty percent (20%) of the body surface area.

5.12-Necrotizing Fasciitis

Necrotizing Fasciitis shall mean a quickly progressing infection of soft-tissue that starts in the subcutaneous tissue spreading along the fascial planes.

All of the following criteria must be met:

(a) Aggressive surgical debridement has been carried out to remove all the necrotic tissue; and
(b) The diagnosis of Necrotizing Fasciitis must be confirmed by a Medical Practitioner.

5.13-Pheochromocytoma

Pheochromocytoma shall mean a neuroendocrine tumor of the adrenal or extra-adrenal chromaffin tissue resulting in excessive secretion of catecholamines.

All of the following criteria must be met:

(a) Surgical removal of the tumor must have been performed; and
(b) The diagnosis of Pheochromocytoma must be confirmed by a Medical Practitioner who is an endocrinologist.

5.14-Severe Osteoporosis

Osteoporosis is a degenerative bone disease that results in loss of bone. The diagnosis must be supported by a bone density reading which satisfies the World Health Organization (WHO) definition of osteoporosis with a bone density reading T-score of less than –2.5. There must also be a history of three (3) or more osteoporotic fractures involving femur, wrist or vertebrae. These fractures must directly cause the Insured's permanent inability to perform at least three (3) of the ADLs.

Coverage for Severe Osteoporosis will automatically cease at age seventy (70) (age next birthday) of the Insured.

5.15-Severe Rheumatoid Arthritis

Widespread joint destruction as a result of severe Rheumatoid Arthritis with major clinical deformity of three (3) or more of the following joint areas:

(a) hands;
(b) wrists;
(c) elbows;
(d) cervical spine;
(e) knees; or
(f) ankles;

The diagnosis must be supported by all the following:

(a) Morning stiffness;
(b) Symmetric arthritis;
(c) Presence of rheumatoid nodules;
(d) Elevated titres of rheumatoid factors; and
(e) Radiographic evidence of severe involvement.

The severity of the disease shall be such that there will be at least two (2) of the Activities of Daily Living which the insured will, for a continuous period of at least six (6) months, have been unable to perform without the assistance of another person.

5.16-Systemic Sclerosis

Systemic Sclerosis shall mean a chronic systemic autoimmune disease characterised by tissue fibrosis, small blood vessel vasculopathy and the development of auto-antibodies.

All of the following criteria must be met:

(a) Evidence must be provided that at least one (1) of the following organs is involved:
    (i) esophagus;
    (ii) lung;
    (iii) heart; or
    (iv) kidney;

AND

(b) The diagnosis of Systemic Sclerosis and the organ involvement must be confirmed by a Medical Practitioner who is a Rheumatologist and Immunologist.

5.17 -Terminal Illness

The conclusive diagnosis of an illness that is expected to result in the death of the Insured within twelve (12) months. This diagnosis must be supported by a Specialist and confirmed by Our appointed doctor.

5.18-Ulcerative Colitis

Ulcerative Colitis shall mean acute Fulminant Ulcerative Colitis with life threatening electrolyte disturbances usually associated with intestinal distention and a risk of intestinal rupture, involving the entire colon with severe bloody diarrhoea and systemic signs and symptoms and for which the treatment is frequently total colectomy and ileostomy. Diagnosis must be based on histopathological features and surgery in the form of colectomy and/ or ileostomy should form part of the treatment.

Appendix 3: Definition of Special Disease

Part 1: For all Insured

Group 1: Cancer

1.1-Carcinoma-in-situ of Specific Organs

Carcinoma-in-situ shall mean a histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma in all organs except skin, including but not limited to any one of the following covered organ groups, and subject to any classification stated:

(a) Breast, where the tumour is classified as TIS according to the TNM Staging method;
(b) Colon and rectum;
(c) Liver;
(d) Lung;
(e) Nasopharynx;
(f) Ovary and/or fallopian tube, where the tumour is classified as TIS according to the TNM Staging method or FIGO* Stage 0;
(g) Pancreas;
(h) Penis;
(i) Stomach and esophagus;
(j) Testis;
(k) Urinary tract, for the purpose of in-situ cancers of the bladder, stage Ta of papillary carcinoma is included;
(l) Uterus, where the tumour is classified as TIS according to the TNM Staging method; or cervix uteri, classified as cervical intraepithelial neoplasia grade III (CIN III) or carcinoma in situ (CIS); or
(m) Vagina or vulva, where the tumour is classified as TIS according to the TNM Staging method or FIGO* Stage 0.

For purposes of this Policy, Carcinoma-in-situ must be confirmed by a biopsy.

* FIGO refers to the staging method of the Federation Internationale de Gynecologie et d'Obstetrique.

1.2-Early Stage Malignancy of Specific Organs

Early Stage Malignancy shall mean the presence of one (1) of the following malignant conditions:

(a) Papillary micro-carcinoma of the thyroid;
(b) Tumour of the prostate histologically classified as T1a or T1b according to the TNM classification system;
(c) Chronic lymphocytic leukaemia classified as RAI Stage I or Binet Stage A-1; or
(d) Non melanoma skin cancer of maximum thickness of 1.5mm or less as determined by histological examination using the Breslow method.

The Diagnosis must be based on histopathological features and confirmed by a Medical Practitioner.

Pre-malignant lesions and conditions, unless listed above, are excluded.

Group 2: Diseases related to Organ Failure

2.1-Acute Aplastic Anaemia

Acute reversible bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with any one (1) of the following:

(a) Marrow stimulating agents;
(b) Immunosuppressive agents; or
(c) Bone marrow transplantation

The diagnosis must be confirmed by a Medical Practitioner who is a hematologist or oncologist.

2.2-Biliary Tract Reconstruction Surgery

The undergoing of biliary tract reconstruction surgery involving choledochoenterostomy, necessitated diseases or trauma of the biliary tract. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a hepatologist or abdominal surgeon.

Biliary atresia is excluded.

2.3-Liver Surgery

Partial hepatectomy of at least one (1) entire left or entire right lobe of the liver necessitated by an illness or accident of the Insured. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a hepatologist or abdominal surgeon.

Liver surgery required due to a disorder caused by alcohol or drug abuse or required for purposes of organ donation are excluded.

2.4-Miliary Tuberculosis

Tuberculosis with wide dissemination into the whole body in which minute tubercles are formed in one (1) or more organs of the body as a result of infection with tubercle bacilli.

Miliary Tuberculosis caused by HIV infection is excluded.

2.5-Moderately Severe Chronic Lung Disease

The Diagnosis of interstitial fibrosis requiring at least intermittent oxygen therapy and showing consistent reduction in FEV 1 of one point two (1.2) litres or less under appropriate medication. Diagnosis, severity and test results must be confirmed by a Medical Practitioner.

2.6-Moderately Severe Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis

Moderately Severe Systemic Lupus Erythematosus (S.L.E) with Lupus Nephritis means an autoimmune illness in which tissues and cells are damaged by deposition of pathogenic autoantibodies and immune complexes and damage of the kidney function.

The diagnosis of S.L.E. with Lupus Nephritis will be based on the following conditions:

(1) Clinically there must be at least four (4) out of the following presentations suggested by The American College of Rheumatology.

1.1 Malar rash;
1.2 Discoid rash;
1.3 Photosensitivity;
1.4 Oral ulcers;
1.5 Arthritis;
1.6 Serositis;
1.7 Renal disorder;
1.8 Leukopenia (<4,000/μL), or Lymphopenia (< 1,500/μL), or Haemolytic anaemia, or Thrombocytopenia (< 100,000/μL); or
1.9 Neurological disorder;

AND

(2) Two (2) or more of the following tests being positive:

2.1 Anti-nuclear Antibodies;
2.2 L.E. cells;
2.3 Anti-DNA; or
2.4 Anti-Sm (Smith IgG Autoantibodies);

AND

(3) There is lupus nephritis causing impaired renal function with a creatinine clearance rate of 50 ml per minute or less.

2.7-Skin Transplantation

The actual undergoing of a transplant of skin as a recipient. Skin transplantation for the treatment of loss of skin following a disease or an injury. The skin grafting should cover at least ten percent (10%) of the body surface area as measured by The Rule of Nines or the Lund and Browder Body Surface Chart. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a Specialist of dermatology or plastic surgeon.

2.8-Surgical Removal of One Kidney

The complete surgical removal of one (1) kidney necessitated by disease or accident of the Insured. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a nephrologist or surgeon.

Removal of the kidney for purposes of organ donation is excluded.

Group 3: Disesases related to Circulatory System

3.1-Angioplasty for Carotid Arteries

Angioplasty shall mean the treatment of stenosis of fifty percent (50%) or above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

(a) Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and
(b) The Diagnosis and medical necessity of the treatment must be confirmed by a Medical Practitioner who is a Specialist in the relevant field.

3.2-Angioplasty of Coronary Artery

Treatment for narrowing or obstruction in one (1) or more major coronary arteries, by a balloon angioplasty, Percutaneous Transluminal Coronary Angioplasty (PTCA), atherectomy or similar intra-arterial catheter procedure. The angioplasty must be considered Medically Necessary by a consultant cardiologist, and there must be angiographic evidence of at least fifty percent (50%) stenosis in the affected coronary artery.

To be eligible for a second claim under Coronary Angioplasty, in addition to the abovementioned criteria, the treatment must also be performed on a location of stenosis or obstruction in a major coronary artery where no stenosis greater than sixty percent (60%) was identified in the coronary angiogram relating to the first claim of this illness, for which benefit has been paid.

For purposes of this definition, “major coronary artery” refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

3.3-Cardiac Pacemaker / Defibrillator Insertion

Insertion of a permanent cardiac defibrillator that is required as a result of serious cardiac arrhythmia which cannot be treated via any other method. The surgical procedure must be certified to be Medically Necessary by a registered Specialist in the relevant field.

Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be Medically Necessary by a registered Specialist in the relevant field. This benefit includes pacemakers deployed for cardiac resynchronisation therapy.

3.4-Carotid Artery Surgery

The undergoing of endarterectomy of the carotid artery which has been necessitated as a result of:

(a) at least fifty percent (50%) narrowing of the inner surface of the common or internal carotid artery as evidenced by an angiogram or any appropriate imaging studies such as computerised tomography (CT) scan or magnetic resonance imaging (MRI) or other appropriate diagnostic test(s); and
(b) experience of a Transient Ischaemic Attack (TIA).

The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a neurologist or vascular surgeon.

Endarterectomy of blood vessels other than the carotid artery are specifically excluded.

3.5-Early Cardiomyopathy

Condition of impaired ventricular function resulting in significant physical impairment of at least Class three (3) of the New York Heart Association (NYHA) classification of cardiac impairment. Cardiomyopathy includes dilated, hypertrophic and restrictive cardiomyopathy. The diagnosis and severity must be certified by a Medical Practitioner who is a cardiologist and supported by the appropriate test results including echocardiography.

Class 3 of the New York Heart Association Functional Classification of cardiac impairment means that the patient is symptomatic with marked limitation of physical activity. Comfortable at rest, but less-than-ordinary activity causes fatigue, palpitation, or dyspnea.

Cardiomyopathy caused by alcohol or drug abuse is specifically excluded.

3.6-Early Renal Failure

Chronic kidney disease with impaired renal function persisting for a period of six (6) consecutive months or more. There must be laboratory evidence (at least two (2) tests taken with an interval of two (2) months) that shows that renal function is severely decreased with a glomerular filtration rate (GFR) of less than 15 ml/min/1.73m^2 body surface area. The diagnosis and severity must be confirmed by a Medical Practitioner who is a nephrologist.

3.7-Insertion of a Vena-Cava Filter

The insertion of a vena-cava filter after there has been documented proof of recurrent pulmonary emboli and failure of anticoagulation therapy. The need for the insertion of a vena-cava filter must be certified to be Medically Necessary by a Medical Practitioner who is a cardiologist or pulmonologist.

3.8-Keyhole Coronary Bypass Surgery

The first time undergoing of bypass graft surgery via “keyhole” access for the correction of the narrowing or blockage of one (1) or more coronary arteries. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a consultant cardiologist.

Angioplasty and all other intra-arterial, catheter based techniques, or laser procedures stent insertion are excluded.

3.9-Minimally Invasive Surgery to Aorta

The undergoing of surgery via minimally invasive or intra arterial techniques to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta, as evidenced by a cardiac computerised tomography (CT) scan or magnetic resonance imaging (MRI) or other appropriate diagnostic test(s). For the purpose of this definition, aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a cardiologist or vascular surgeon.

3.10-Percutaneous Valve Surgery

Percutaneous valve surgery refers to percutaneous valvuloplasty, percutaneous valvotomy and percutaneous valve replacement, where the procedure is performed entirely via intravascular catheter based techniques. These surgical procedures must be certified to be Medically Necessary by a Medical Practitioner who is a cardiologist.

3.11-Pericardiectomy

The undergoing of a pericardiectomy or undergoing of a surgical procedure requiring keyhole cardiac surgery to treat pericardial disease. These surgical procedures must be certified to be Medically Necessary by a Medical Practitioner who is a cardiologist.

3.12-Secondary Pulmonary Hypertension

Secondary pulmonary hypertension with established right ventricular hypertrophy leading to the presence of permanent physical impairment of at least Class 3 of the New York Heart Association Classification of cardiac impairment. The diagnosis must be confirmed by a Medical Practitioner who is a cardiologist and supported by data provided through cardiac catheterization.

Class 3 of the New York Heart Association Functional Classification of cardiac impairment means that the patient is symptomatic with marked limitation of physical activity. Comfortable at rest, but less-than-ordinary activity causes fatigue, palpitation, or dyspnea.

All primary idiopathic pulmonary hypertension are specifically excluded. Pulmonary hypertension caused directly or indirectly by congenital heart disease are excluded.

Group 4: Diseases related to Nervous System

4.1-Cochlear Implant Surgery

The undergoing of a surgical cochlear implant is required due to permanent damage to the cochlea or auditory nerve, where all the following criteria are met:

(a) The Insured suffered from severe to profound sensorineural hearing impairment in both ears for over three (3) consecutive months; and

(b) There is limited benefit with the appropriate fitted hearing aid.

The surgical procedure as well as the insertion of the implant must be certified to be Medically Necessary by a Medical Practitioner who is an ear, nose and throat (ENT) Specialist.

Only Insured aged three (3) (age next birthday) or above on first diagnosis is eligible to receive a benefit under this illness.

4.2-Cerebral Aneurysm Requiring Surgery

The actual undergoing by the Insured of intracranial surgery via a craniotomy to clip, repair or remove an aneurysm of one (1) or more of the cerebral arteries. Catheter and intravascular technique are specially excluded from this condition.

4.3-Early Amyotrophic Lateral Sclerosis

Characterised by muscular weakness and atrophy, evidence of anterior horn cell dysfunction, visible muscle fasciculations, spasticity, hyperactive deep tendon reflexes and exterior plantar reflexes, evidence of corticospinal tract involvement, dysarthric and dysphagia. The diagnosis must be made by a Specialist with appropriate neuromuscular testing such as Electromyogram (EMG). The disease must result in significant physical impairment (as evidenced by the Insured's permanent inability to perform at least two (2) of the ADLs).

4.4-Early Multiple Sclerosis

A disease due to demyelination of neurological brain tissue. The diagnosis of Clinically Definite Multiple Sclerosis must be confirmed by a Medical Practitioner who is a neurologist and supported by all of the following:

(a) Investigations which unequivocally confirm the diagnosis to be Multiple Sclerosis;
(b) Multiple neurological deficits which occurred over a continuous period of at least thirty (30) days; and
(c) Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

4.5-Early Progressive Bulbar Palsy

Neurological disorder with paralysis in the head region, difficulties in chewing and swallowing, problems in speaking, persistent signs of involvement of the spinal nerves and the motor centres in the brain and spastic weakness and atrophy of the muscles of the extremities. The disease must be confirmed by a Medical Practitioner who is a neurologist. The condition must result in the permanent inability to perform, without assistance, at least two (2) of the six (6) Activities of Daily Living. These conditions have to be medically documented for at least thirty (30) days.

4.6-Early Progressive Muscular Atrophy

Confirmation of definite diagnosis of Fried-Emery, Kugelberg-Welander, Aran-Ducheme or Vulpian-Bernhardt Muscular Atrophy by a consultant neurologist. The diagnosis must be supported by muscle biopsy and CPK estimates. The condition must result in the permanent inability to perform, without assistance, at least two (2) out of six (6) Activities Daily Living. These conditions have to be medically documented for at least thirty (30) days.

4.7-Less Severe Encephalitis

Inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection requiring hospitalization and resulting in significant neurological deficit persisting for at least fourteen (14) consecutive days. The diagnosis must be supported by appropriate investigations, proving acute viral infection of the brain, and confirmed by a Medical Practitioner who is a neurologist.

4.8-Loss of Sight in One Eye

Total and irreversible loss of sight in at least one (1) eye as a result of illness or injury. The blindness must be confirmed by a Medical Practitioner who is an ophthalmologist.

4.9-Moderately Severe Alzheimer's Disease

Deterioration or loss of intellectual capacity or abnormal behavior as evidenced by the clinical state and accepted standardized questionnaires or tests arising from Alzheimer's Disease or irreversible organic degenerative brain disorders, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in being unable to perform fine motor tasks such as writing, drawing or dressing, and presence of certain movement coordination and planning difficulties (apraxia), and requiring the intermittent assistance or supervision of the Insured. The diagnosis must be clinically confirmed by an appropriate consultant.

4.10-Moderately Severe Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord which requires hospitalization and results in significant neurological deficit persisting for at least fourteen (14) consecutive days. The diagnosis must be made by a Specialist and confirmed by the presence of bacterial infection in cerebrospinal fluid by lumbar puncture.

4.11-Moderately Severe Brain Damage

Accidental head injury causing significant functional impairment which has lasted for a minimum period of thirty (30) days from the date of the trauma or injury. The resultant significant permanent functional impairment must be confirmed by a Medical Practitioner who is a neurologist.

4.12-Moderately Severe Muscular Dystrophy

The diagnosis of muscular dystrophy must be confirmed by a Medical Practitioner who is a neurologist, and based on a combination of all of the following:

(a) Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
(b) Characteristic electromyogram; and
(c) Clinical suspicion confirmed by muscle biopsy.

The condition must result in the permanent inability to perform, without assistance, at least two (2) of the six (6) Activities of Daily Living.

4.13-Moderately Severe Paralysis

The total loss of function of one (1) limb, where it is full length of the upper limb or full length of the lower limb, due to injury or disease of the spinal cord or brain, where such functional loss is considered to be permanent and confirmed by a Medical Practitioner who is a neurologist.

4.14-Moderately Severe Parkinson's Disease

Unequivocal diagnosis of Parkinson's Disease must be confirmed by a Medical Practitioner who is a neurologist where the condition:

(a) cannot be controlled with medication;
(b) shows signs of progressive impairment; and
(c) must result in the permanent inability to perform, at least two (2) of the six (6) Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered. All other types of Parkisonism are excluded.

4.15-Moderately Severe Poliomyelitis

Unequivocal diagnosis of infection by the Poliovirus leading to paralytic disease must be evidenced by impaired motor function or respiratory weakness that has persisted for at least thirty (30) days. The diagnosis must be confirmed by a Medical Practitioner who is a neurologist and supported by the appropriate medical investigations.

Cases not involving paralysis will not be eligible for this. Other causes of paralysis are specifically excluded.

4.16-Severe Psychiatric Illness

A first definitive Diagnosis of Severe Depression, Schizophrenia or Bipolar Disorder by a Medical Practitioner who is a psychiatrist, which requires in-patient hospitalization for more than twenty-eight (28) consecutive days in the psychiatric unit of a designated hospital for Severe Psychiatric Illness as listed under 'List of Designated Hospitals for Severe Psychiatric Illness' on Our website. Such list may be varied, updated

and amended from time to time at Our discretion, and any change shall be deemed effective as of the date of publication on Our website (regardless of whether any notice is separately given).

For the avoidance of doubt, hospitalization must be primarily due to Severe Depression, Schizophrenia or Bipolar Disorder, and hospitalization solely due to any other cause or psychiatric condition is excluded. Further and notwithstanding the foregoing, Severe Depression, Schizophrenia or Bipolar Disorder due, whether in whole or in part, to drug, alcohol or substance abuse, and hospitalization for drug or alcohol rehabilitation are excluded.

4.17-Surgery for Subdural Haematoma

The actual undergoing of craniotomy or burr hole surgery to the head to drain subdural hematoma as a result of an accident. The need for the craniotomy or the burr hole surgery must be certified as Medically Necessary by a Medical Practitioner who is a neurosurgeon.

4.18-Surgical Removal of Pituitary Tumour

The undergoing of surgical removal of pituitary tumour necessitated as a result of symptoms associated with increased intracranial pressure caused by the tumour. The presence of the underlying tumour must be evidenced by appropriate imaging studies such as computerised tomography (CT) scan or magnetic resonance imaging (MRI). The surgery must be certified as Medically Necessary by a Medical Practitioner who is an endocrinologist or neurosurgeon.

Removal of pituitary microadenoma (tumor of size 1cm or below in diameter) is specifically excluded.

Group 5: Other Diseases

5.1-Acute Necrohemorrhagic Pancreatitis

Acute inflammation and necrosis of pancreas parenchyma, focal enzyme necrosis of pancreatic fat and haemorrhage due to blood vessel necrosis which must be treated with surgical clearance of necrotic tissue or pancreatectomy. The diagnosis must be based on histopathological features and confirmed by a Medical Practitioner who is a gastroenterologist.

Pancreatitis caused directly or indirectly, wholly or partly, by alcohol or drug abuse is excluded.

5.2-Adrenalectomy for Adrenal Adenoma

Adrenalectomy for treatment of malignant systemic hypertension that was secondary to an aldosterone secreting adrenal adenoma. The adrenalectomy must be Medically Necessary for the management of poorly controlled hypertension as confirmed by a Medical Practitioner who is an endocrinologist.

5.3-Amputation of One Foot due to Complication from Diabetes Mellitus

Complications of diabetes mellitus resulting in the amputation of one (1) foot at or above ankle as advised by a registered Specialist diabetologist as the only means to maintain life. Amputation of only toe or toes, or any other causes for amputation shall not be covered.

5.4-Coma for 48 hours

A state of unconsciousness with no reaction to external stimuli or internal needs which:

(a) Requires the use of life support systems for a continuous period of at least forty-eight (48) hours; and
(b) Results in permanent neurological deficit (s) with persisting clinical symptoms.

Coma secondary to alcohol or drug abuse shall not be covered.

5.5-Crohn's Disease (Regional Enteritis)

Crohn's Disease is a chronic granulomatous inflammatory disease of the intestine. The diagnosis must be confirmed by a Medical Practitioner who is a gastroenterologist or a consultant of the appropriate medical specialty, and supported by the characteristic histopathological features.

5.6-Diabetic Retinopathy

Diabetic Retinopathy shall mean advanced changes to the retinal blood vessels as a consequence of diabetes mellitus.

All of the following criteria must be met:

(a) Presence of diabetes mellitus at the time of Diagnosis of Diabetic Retinopathy;
(b) Visual acuity of both eyes is 6/18 or worse using Snellen eye chart;
(c) Actual undergoing of treatment such as laser treatment to alleviate the visual impairment; and
(d) The Diagnosis of Diabetic Retinopathy, the severity of visual impairment and the medical necessity of treatment must be confirmed by a Medical Practitioner who is an ophthalmologist.

5.7-Early Elephantiasis

End stage Lymphatic Filariasis, characterised by significant enlargement and disfiguration of the infected body area (legs, genitals or breasts) due to blockage of the lymphatic system by filariae parasites. The diagnosis must be supported by laboratory tests showing circulating filariae antigen or microfilariae in a blood smear (Wuchereria bancrofti or Brugia malayi).

Other forms of lymphedema or acute lymphangitis are excluded.

The diagnosis must be confirmed by a Medical Practitioner who is a Specialist or a consultant of the appropriate medical specialty.

5.8-Loss of Speech due to Vocal Cord Paralysis

Total and irrecoverable loss of the ability to speak due to vocal cords paralysis from any diseases or Injury, which must be established for a continuous period of three (3) months. The diagnosis must be confirmed by a Medical Practitioner who is an ear, nose and throat (ENT) Specialist.

All psychological causes leading to the Loss of Speech are excluded.

5.9-Moderately Severe Burns

Third Degree burns covering at least ten percent (10%) of the surface of the body of the Insured or Third Degree burns covering at least thirty percent (30%) of the surface of the face of the Insured as measured by The Rule of Nines or the Lund and Browder Body Surface Chart.

5.10-Moderately Severe Rheumatoid Arthritis

Widespread joint destruction as a result of severe Rheumatoid Arthritis with major clinical deformity of two (2) or more of the following joint areas:

(a) hands;
(b) wrists;
(c) elbows;
(d) cervical spine;
(e) knees; or
(f) ankles.

The diagnosis must be supported by all the following:

(a) Morning stiffness;
(b) Symmetric arthritis;
(c) Presence of rheumatoid nodules;
(d) Elevated titres of rheumatoid factors; and
(e) Radiographic evidence of severe involvement.

The severity of the disease shall be such that there will be at least two (2) of the Activities of Daily Living which the insured will, for a continuous period of at least three (3) months, have been unable to perform without the assistance of another person.

At Our discretion, confirmation of the diagnosis and the degree of disability may be required through an independent medical examination by a Specialist rheumatologist appointed by Us.

5.11-Osteoporosis with Fractures

The occurrence of Osteoporosis with Fractures where all of the following conditions are met:

(a) at least a fracture of the neck of femur or two (2) vertebral body fractures, due to or in the presence of osteoporosis; and
(b) bone mineral density measured in at least two (2) sites by dual-energy x-ray densitometry (DEXA) or quantitative CT scanning is consistent with severe osteoporosis (T-score of less than -2.5).

Actual undergoing of internal fixation or replacement of the fractured bone is required.

Coverage for Severe Osteoporosis will automatically cease at age seventy (70) (age next birthday) of the Insured.

5.12-Severance of One Limb

Loss of one limb shall mean severance of at least one (1) limb at or above wrist or ankle as a result of illness or injury.

5.13-Severe Central or Mixed Sleep Apnea

An unequivocal Diagnosis of Central Sleep Apnea or Mixed Sleep Apnea by a Medical Practitioner who is a Specialist in the relevant field, provided that such condition has been treated by a Medically Necessary permanent tracheostomy and proof of undergoing permanent tracheostomy can be provided.

Part 2: Special Diseases for Juvenile (For Age Next Birthday 1(15days) – 18)

1-Autism

A severe emotional disturbance of childhood characterised by qualitative impairment in reciprocal social interaction and in communication, language and social development.

A total of six (6) or more manifestations from (a), (b) and (c) below:

(a) Qualitative impairment of social interaction (at least two (2) manifestations):
  (i) Marked impairment in the use of multiple types of non-verbal behavior such as eye to eye gaze, facial expression, body postures, and gestures to regulate social interaction;
  (ii) Failure to develop peer relationships appropriate to developmental level;
  (iii) Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by lack of showing, bringing, or pointing out objects of interest); or
  (iv) Lack of social or emotional reciprocity;

(b) Qualitative impairment of communication (at least one (1) manifestation):
  (i) Delay in, or lack of, development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime);
  (ii) In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;
  (iii) Stereotyped and repetitive use of language or idiosyncratic language; or
  (iv) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(c) Restrictive and stereotyped patterns of behavior, interests, and activities (at least one (1) behavioral manifestation):
  (i) All-encompassing preoccupation with one (1) or more restricted, repetitive, and stereotyped patterns of interest that is abnormal either in intensity or focus;
  (ii) Apparently inflexible adherence to specific, non-functional routines or rituals;
  (iii) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements); or
  (iv) Persistent preoccupation with parts of objects.

Diagnosis must be confirmed by a pediatric psychiatrist and the condition must have continued without interruption for a period of at least six (6) months after diagnosis. Psychosocial Interventions and/or special education and/or behavior therapy should have been carried out.

Asperger syndrome and atypical autism are specially excluded.

2-Dengue Haemorrhagic Fever

The severe type of dengue virus infection characterised by all of the four symptoms, including high fever, haemorrhagic phenomena, hepatomegaly and circulatory failure (Dengue Shock Syndrome DSS - WHO DHF grades III and IV). The diagnosis of Dengue Haemorrhagic Fever must be confirmed by a registered Specialist in the relevant field.

Non-Haemorrhagic Dengue Fever is excluded.

3-Juvenile Huntington Disease

Confirmed by a registered specialist pediatrician of a definite diagnosis of Juvenile Huntington Disease with genetic test. There must be evidence of permanent and irreversible cognitive impairment and neurological deficit including all of the following:

(a) Bradykinesia, stiffness and rigidity; and
(b) Impaired voluntary movement; and
(c) Oromotor dysfunction including speech and swallowing impairment confirmed by registered speech therapist.

4-Kawasaki Disease

Diagnosis must be based on blood tests to detect mild anaemia, a white blood cell count above normal, and an elevated erythrocyte sedimentation rate which indicates blood vessel inflammation. A sharp rise in the number of platelets, the major clotting element in the blood must also be detected.

Payment will only be paid if diagnostic tests reveal the presence of coronary aneurysm or other heart or blood vessel abnormality which necessitates surgical treatment.

5-Marble Bone Disease (Osteopetrosis)

Marble Bone Disease is characterized by increased bone density, brittle bone and skeletal abnormalities. The Insured must be diagnosed as the intermediate type (also called "Marble Bone Disease") and confirmed with the occurrence of all the following conditions by a registered Specialist in the relevant field:

(a) The results of physical examination of the insured by a registered Specialist in the relevant field that the insured suffers from cranial nerve palsy; and
(b) The results of blood test confirmed pancytopenia; and
(c) The result of x-ray studies reveal diffuse abnormal hardening of bones, multiple fracture and joint deformity.

Diagnosis of Osteopetrosis must be confirmed by a registered Specialist acceptable to Us.

6-Osteogenesis Imperfecta

The occurrence of Osteogenesis Imperfecta – Type III where all of the following conditions are met:
(a) The result of skin biopsy is positive for Diagnosis of Osteogenesis Imperfecta – Type III;
(b) The result of X-ray studies reveals multiple fractures of bones and progressive kyphoscoliosis;
(c) There is evidence of growth retardation and hearing impairment as a result of the disease; and
(d) The Diagnosis is confirmed by a Medical Practitioner who is a pediatrician.

7-Rheumatic Fever with Valvular Impairment

A confirmed diagnosis by a registered pediatric cardiologist of acute rheumatic fever. There must be involvement of one (1) or more heart valves with at least moderate valve incompetence (means regurgitant fraction of twenty percent (20%) or above) and/or moderate valve stenosis (means valve area of thirty percent (30%) or less of normal value) attributable to rheumatic fever as confirmed by quantitative investigations of the valve function by a registered cardiologist. The valve incompetence and/or valve stenosis must persist for at least six (6) months.

8-Severe Asthma

The Insured suffers from severe asthma which is characterised by at least four of the following criteria:

(a) History of status asthmaticus within the past two (2) years;
(b) Significant and continuous reduction in exercise tolerance;
(c) Chest deformities resulting from chronic hyperinflation;
(d) The need for medically prescribed oxygen therapy at home; or
(e) Continuous daily use of oral corticosteroids (for a minimum period of at least six (6) months).

9-Still's Disease

This is characterised by high fever and signs of systemic illness that exists for months before the onset of arthritis. The insured also suffers from cardinal disorders including high spiking, daily (quotidian) fevers, evanescent rash, arthritis, splenomegaly, lymphadenopathy, serositis, weight loss, neutrophilic leukocytosis, increased acute phase proteins and seronegative tests for ANA and RF. Payment will only be made if the Insured condition is serious enough to be advised by a doctor to have knee or hip replacement for the treatment of the disease.

The diagnosis must be confirmed by a pediatric rheumatologist.

10-Type 1 Diabetes Mellitus

The occurrence of Type 1 Diabetes Mellitus where all of the following conditions are met:

(a) The diagnosis is confirmed by a registered pediatric endocrinologist; and
(b) The disease has persisted for at least six (6) months following such Diagnosis, during which period insulin administration on a daily basis is Medically Necessary to regulate glucose metabolism.

Type 2 Diabetes Mellitus is specially excluded.

11-Type I Juvenile Spinal Amyotrophy

The Insured must be Unequivocally Diagnosed as a Type I Juvenile Spinal Amyotrophy which is an infantile form of spinal muscular atrophy characterised by progressive dysfunction of the anterior horn cells in the spinal cord and brainstem cranial nerves with profound weakness and bulbar dysfunction. Electromyography and muscle biopsy are needed to confirm this Unequivocal Diagnosis.

12-Type II Juvenile Spinal Amyotrophy

The Insured must be Unequivocally Diagnosed as a Type II Juvenile Spinal Amyotrophy which is an infantile form of spinal muscular atrophy characterised by progressive dysfunction of the anterior horn cells in the spinal cord and brainstem cranial nerves with profound weakness and bulbar dysfunction. Electromyography and muscle biopsy are needed to confirm this Unequivocal Diagnosis.

Second Medical Opinion Service

As part of Our promise of care, you are given the access to some of the highest ranked medical institutions in the US through International SOS for a Second Medical Opinion Service once your Big 3 Disease or Crisis (if applicable) claim is approved.

What is Second Medical Opinion Service?
The objective of the Second Medical Opinion Service is to meet the public's increasing demands for the best possible medical treatment bearing in mind the continual development of leading edge treatments for major diseases. This is why We offer the Second Medical Opinion Service to Our valuable Insured via International SOS.

Under this distinguished service, the Insured has access to a panel of world-class specialists at leading medical institutions in the US to obtain alternative advice on the Insured's medical condition and confirmation of the diagnosis in the event that the Insured's Big 3 Disease or Crisis (if applicable) claim is approved.

Panel of Second Medical Advice Specialists
The Panel provides you access to some of the highest ranked medical institutions in the US, together with more than 15,000 leading specialists who practice there, including:

- Harvard Medical School
- Johns Hopkins Hospital, Baltimore
- Massachusetts General Hospital
- Brigham and Women's Hospital, Boston
- Dana-Faber Cancer Institute
- Cedars-Sinai Medical Center, Los Angeles

How to seek Second Medical Opinion Service?
When the Insured has been diagnosed with one of the Big 3 Diseases or Crises (if applicable), the Insured is required to follow the instructions below to obtain the Second Medical Opinion Service. Call International SOS at (852) 3122 2900 and request the Second Medical Opinion Service. Within 24 hours International SOS will confirm membership and whether the medical condition is eligible for the service.
Service Flow
1) Receive "Information Request Form" from International SOS via fax or email. International SOS will advise the medical documents required. 2) International SOS will assess the case and reply to the Insured if his/her case is eligible for the service. The Insured needs to complete the **Information Request Form** and send to International SOS together with the relevant medical documents for the Second Medical Opinion Report*. (via courier or registered mail) 3) The Panel of Second Medical Opinion will send an acknowledgement to International SOS after receipt. If additional medical information is required, the Panel of Second Medical Opinion will inform International SOS who will in turn contact the Insured. 4) After evaluation, the written Second Medical Opinion report and advice will be faxed/ emailed to International SOS within 3-5 US working days depending on the complexity of the report. 5) Upon receipt of the Second Medical Opinion report, International SOS will send it to the Insured and his/her treating physician, as required. If requested, International SOS will arrange transportation, accommodation and admission to the identified treating facility and with a medical escort, if medically necessary. ALL RELATED COSTS to International SOS WILL BE BORNE BY THE INSURED. *Second Medical Opinion Report is US$850. (The cost may be reviewed from time to time)

The information above is for reference only and none of the above is binding upon Us or International SOS.

The service is provided by International SOS and it is not guaranteed renewable. We shall not be responsible for any act or failure to act on the part of International SOS and the professionals. Details of the services may be revised from time to time without Our prior notice.

Note:

1) We, the medical panel, International SOS and/ or any of its affiliates, record, share, use and archive your personal data in pursuance of the services being offered to you as well as for their training and quality assurance purposes . The failure to provide the relevant personal data may result in the said service providers being unable to provide the relevant services to you.

2) The Second Medical Opinion Service provided to you is purely advisory and recommendatory in nature and is not a substitute for medical services. It is for you and your physician or consulting hospital to decide the appropriate medical course of action to be pursued. The International SOS, and/ or its affiliates and the panel providing the medical opinion do not have any authority or responsibility to determine the benefits/ amounts payable, its eligibility, claim processing etc.

EasyCover Critical Illness Plan
Policy Provisions

(To age 100 plan)

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

EasyCover Critical Illness Plan

Contents

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1. Definitions

Accident refers to an unforeseen, unexpected, violent, and involuntary external event or contiguous series of events of an accidental and visible nature which is the sole and direct cause of a bodily injury and independently of any other causes (including but not limited to illness or any naturally occurring condition or degenerative process) while this Policy is in force.

Activities of Daily Living refers to the following activities:

(i) 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.
(ii) Dressing - The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
(iii) Transferring - The ability to move from a bed to an upright chair or wheelchair and vice versa.
(iv) Mobility - The ability to move indoors from room to room on level surfaces.
(v) Toileting - The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
(vi) Feeding - The ability to feed oneself once food has been prepared and made available.

Age refers to the age of the Insured on his or her next birthday unless otherwise specified.

Anaesthetist, Medical Practitioner, Specialist or Surgeon refers to a person other than the Policy Owner, the Insured, an insurance agent, business partner(s), employee/employer or a relative of any of them (unless approved in advance by Us in writing) who is registered and licensed with the Health Bureau of Macau under the Decree-Law No. 84/90/M, amended by Decree-Law No. 20/98/M and Law No. 18/2020 of Macau or otherwise legally authorized and entitled to practice western medical and surgical services in any country in accordance with the laws of that country, and who is acceptable to Us. An Anaesthetist cannot be the attending Medical Practitioner or Surgeon operating on the Insured.

Big 3 Disease(s) refers to Cancer, Heart Attack and Stroke of the Crises.

Basic Plan refers to the plan EasyCover Critical Illness Plan as shown in the Policy Schedule.

Beneficiary refers to a person chosen by Policy Owner to receive the Death Benefit under this Policy at the death of the Insured.

Chinese Medicine Practitioner refers to a person other than the Policy Owner, the Insured, an insurance agent, business partner(s), employee/employer or a relative of any of them (unless approved in advance by Us in writing) who is registered with the Health Bureau of Macau under the Decree-Law 84/90/Mas as an herbalist or an acupuncturist, or registered with the local medical authorities at the place of treatment if the treatment is received outside Macau.

Clinical Surgery refers to a Medically Necessary Out-patient procedure, which is performed either in the office or clinic of a Medical Practitioner or in the outpatient department or emergency department of a Hospital.

Commencement Date refers to the date of premium commencing and the date used for determining the issue age of the Insured and is shown in the Policy Schedule.

Crisis refers to a Disease listed under “Crises covered in EasyCover Critical Illness Plan” in Appendix 1: List of Diseases Covered. Any diagnosis of a Crisis for the purpose of claiming the Crisis Benefit must fulfil the meaning together with the terms and conditions stated under the heading of that Crisis in Appendix 2: Definition of Crisis.

Current Sum Insured refers to the Initial Sum Insured less any benefits paid under Special Disease Benefit pursuant to Clause 4.2 and Critical Medical Care Benefit pursuant to Clause 4.3 of the Benefit Provisions of this

Policy. The Current Sum Insured is the amount on which calculation of the Crisis Benefit and Death Benefit is based, and shall be deemed to be zero once the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured.

Day Patient refers to an Insured receiving medical services or treatments given in medical clinic, day case procedure centre or Hospital where the Insured is not in Hospitalisation.

Disease(s) refers to the Disease(s) covered under this Policy as set out in Appendix 1: List of Diseases Covered. Each Disease is further defined in Appendix 2 or Appendix 3.

Eligible Expenses refers to reasonable and customary charges incurred for Medically Necessary treatment, services or supplies rendered with respect to the same Big 3 Disease for which the Crisis Benefit claim is paid or payable.

Reasonable and customary refers to a fee or expense which:
1. is actually charged for Medically Necessary treatment, supplies or medical services;
2. does not exceed the usual or reasonable average level of charges for similar treatment, supplies or medical services in the location where the expense is incurred;
3. does not include charges that would not have been made if no insurance existed.

We may adjust benefit(s) payable under this Policy for fees or expenses that We judge not to be reasonable and customary after comparing with fee schedules used by the government, relevant authorities or recognised medical associations in the location where the fee or expense is incurred.

Endorsement refers to an additional document attached to this Policy that outlines any adjustments that We make to this Policy.

Expiry Date refers to the Policy Anniversary immediately preceding the 100th birthday of the Insured.

First Confirmed Diagnosis refers to the first time that a diagnosis of a Disease is made by a Medical Practitioner and confirmed by histopathological and / or cytopathological patterns and / or radiological tests, blood tests and / or other laboratory tests results. Date of diagnosis of a Disease suffered by the Insured will be the day when tissue specimen, culture, blood specimen or any other laboratory investigation upon which the diagnosis is determined is first taken from the Insured. For Cancer and Carcinoma-in-situ or Early Stage Malignancy of Specific Organs, a diagnosis based on history, physical and radiological findings only will not meet the standards of diagnosis required by this Policy.

First Symptoms refer to any condition, Disease or any of its direct causes in respect of an Insured, where the Insured and / or the Policy Owner was aware or should reasonably have been aware of signs or symptoms of the condition, Disease, or where any laboratory test or investigation showed the likely presence of the condition or Disease.

Hospital refers to a medical facility that meets all of the following requirements:
1. is licensed as a hospital under the laws of the country where it operates;
2. is supervised by Medical Practitioners and provides twenty-four (24) -hour care by Qualified Nurses;
3. is operated mainly to diagnose and treat injuries or illnesses on an In-patient basis;
4. has diagnostics and major surgery facilities; and
5. is not primarily a clinic, nursing facility, nursing home, convalescence home, psychiatric facility, drug and alcohol rehabilitation facility, preventative medicine facility, homeopathic facility or hospice care.

Hospitalise and **Hospitalisation** refer to the period when the Insured stays in a Hospital as an In-patient for Medically Necessary treatment of an illness, Injury or a Big 3 Disease. The Hospital stay must be for at least six (6) continuous hours or, if this does not happen, the Hospital must charge for room and board. The Insured

cannot leave the Hospital before he or she is discharged. Hospitalisation ends when the Hospital issues its final accounts in preparation for the Insured to formally leave, or be discharged from, the Hospital.

Initial Sum Insured refers to the amount shown on the Policy Schedule or Endorsement as the "Sum Insured" when this Policy is issued, or as amended subsequently at the Policy Owner's request (to increase or decrease) in accordance with Our then applicable rules and regulations, which forms the basis for calculation of the Special Disease Benefit, Critical Medical Care Benefit, Additional 50% Coverage Benefit for Big 3 Diseases (if applicable) and Additional Medical Coverage for Big 3 Diseases (if applicable). For the avoidance of doubt, any payments made under this Policy will not affect the Initial Sum Insured.

Injury refers to bodily damage to the Insured caused solely and directly by an Accident that occurs while this Policy is in force.

In-patient refers to the Insured is admitted to a Hospital on the written recommendation of a Medical Practitioner or Specialist to receive Medically Necessary treatment for an illness, Injury or a Big 3 Disease that cannot be provided safely outside the Hospital premises.

Insured refers to the person insured by this Policy and is shown on the Policy Schedule or any Endorsement.

Intensive Care Unit refers to the unit in a Hospital that has one-to-one nursing care, where patients undergo specialised resuscitation, monitoring and treatment procedures. The unit must be staffed twenty-four (24) hours a day with highly trained nurses, technicians and Medical Practitioners, and be equipped with life-saving medical equipment to continuously assess vital body functions.

Invasive Life Support refers to a medical service, procedure or supply which is necessary and is:

- Extracorporeal Membrane Oxygenation (ECMO); or
- Left ventricular assist device (LVAD) or intra-aortic balloon pump; or
- Ventilatory support by invasive artificial airway (endotracheal tube or tracheostomy tube) for a minimum of three (3) days.

The following are not covered: Prolonged admission and ventilation in Intensive Care Unit or surgery done for organ donation; admission to Intensive Care Unit or surgery for cosmetic, weight reduction or gender transformation purposes; hospitalisation for psychiatric or mental illness; surgery to correct vision or refractory disorder; or hospitalisation to High Dependency Unit (HDU), or general hospital ward. However, ventilation by any non-invasive ventilator such as CPAP, BiPAP or Face mask, is specifically excluded.

Medically Necessary refers to a medical service, procedure or supply which is necessary and is:

1. consistent with the diagnosis and customary medical treatment for the Insured's Disease;
2. recommended by a Medical Practitioner for the care or treatment of the Insured's Disease involved and must be widely accepted professionally in Macau as effective, appropriate and essential based upon recognized standards of the health care specialty involved; and
3. not furnished primarily for the personal comfort or convenience of the Insured or any medical service provider. Experimental, screening and preventive services or supplies are not considered Medically Necessary.

Out-patient refers to when the Insured receives Medically Necessary western medical treatment for the Big 3 Disease in the office or clinic of a Medical Practitioner or in the outpatient department or emergency department of a Hospital.

Policy consists of this policy document, its Policy Schedule, application form, any Endorsement and / or any supplement.

Policy Anniversary refers to the same date each year as the Commencement Date while this Policy is in force.

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Policy Date refers to the date when coverage under this Policy becomes effective as shown in the Policy Schedule or the Reinstatement Date, whichever is later.

Policy Owner, **You or Your** refers to the person who owns this Policy as shown in the Policy Schedule or any Endorsement.

Policy Schedule refers to the document attached to this Policy. The Policy Schedule shows important information about this Policy, including the policy number, the premium payable, the benefits of this Policy and other particulars.

Policy Year refers to a period of twelve (12) consecutive calendar months from the Commencement Date and every succeeding twelve (12) consecutive calendar months period after that.

Prescribed Diagnostic Imaging Tests refers to computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.

Qualified Nurse(s) refers to a person other than the Policy Owner, the Insured, an insurance agent, business partner(s), employee/employer or a relative of any of them (unless approved in advance by Us in writing) who is legally recognised to perform services in the specialist area of their titled profession by the relevant government-recognised registration body in Macau, or in the region in which he or she practises.

Rehabilitation Centre refers to a registered institution (other than a Hospital) which provides physiotherapy, occupational therapy and other rehabilitative treatment for physical injury, dysfunction or disability.

Reinstatement Date refers to the date that We approve an application to reinstate this Policy.

Special Disease refers to a Disease listed under "Special Diseases covered in EasyCover Critical Illness Plan" in Appendix 1: List of Diseases Covered. Any diagnosis of a Special Disease for the purpose of claiming the Special Disease Benefit must fulfil the meaning together with the terms and conditions stated under the heading of that Special Disease in Appendix 3: Definition of Special Disease.

Standard Private Room refers to a standard single occupancy room with an adjoining bathroom for the Insured's use during his or her Hospitalisation, but does not include any Hospital room that has its own kitchen, dining or sitting room.

Standard Semi-private Room refers to a single or double occupancy room in a Hospital, with a shared bath or shower room.

Standard Ward Room refers to a room type in a Hospital that is of a quality below a Standard Semi-private Room.

Term Critical Illness Series means EasyCover Critical Illness Plan and other selected critical illness insurance term plan(s) as specified by Us from time to time.

Total Claims refer to the aggregate amount of the Special Disease Benefit, Crisis Benefit, Critical Medical Care Benefit and / or the Death Benefit payments.

We, **Us** or **Our** refers to FWD Life Insurance Company (Macau) Limited, the issuer of this Policy.

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2. General Provisions

2.1 The Policy

This Policy is governed by the laws of Macao Special Administrative Region of China (Macau) and is proof of an insurance contract between You and Us. Once this Policy has commenced, insurance is provided regardless of the Insured's occupation, or the countries that the Insured travels to or resides in.

The Policy Owner and the Insured are required to provide truthful and accurate information during the application of this Policy. We have issued this Policy after taking into account the information provided by You and the Insured (if they are different people) during application process and payment of the premium as shown in the Policy Schedule. This information provided is considered representations and not warranties.

2.2 Cooling-off Period

If Policy Owner is not completely satisfied with this Policy, and Policy Owner has not made a claim, Policy Owner can cancel it by giving a written notice to Us. Such notice must be signed by the Policy Owner and received directly by Us together with this Policy (if received) within twenty one (21) calendar days immediately following:

(1) the day We deliver this Policy to the Policy Owner or Policy Owner's nominated representative; or
(2) the day We deliver a cooling-off notice (separate from the policy) to the Policy Owner or Policy Owner's nominated representative informing Policy Owner about this Policy and the right to cancel within the stated 21 calendar day period;

whichever is earlier.

This twenty-one (21) calendar day period is called the cooling-off period. Policy Owner can cancel this Policy and receive premiums without interest back. We follow the cooling-off period principles set out by Monetary Authority of Macao to protect customers.

2.3 Alterations and Company Notices

No alterations in the terms and conditions and provisions of this Policy will be valid unless made in an Endorsement and / or any supplement to this Policy and issued by Us. No agent or other persons have the authority to change or waive any provision of this Policy.

If We need to send You any notices, We will send them to Your latest correspondence address recorded in Our records, and such notice will be deemed to have been received by the Policy Owner forty-eight (48) hours after posting.

2.4 Policy Owner

Under this policy document, the words You, Your or Policy Owner refer to the person who owns this Policy as shown on the Policy Schedule or any Endorsement.

As the Policy Owner, You are the only person who can request changes to, and exercise the rights and privileges related to this Policy while this Policy is in effect.

If You hold this Policy on trust for a beneficiary by virtue of an express trust, We will consider any rights or options exercised by You in relation to this Policy as being made with the consent of, and for the sole benefit of, the beneficiary(ies) of that trust. We will not contact that beneficiary to confirm their consent.

You are entitled to any proceeds of this Policy that do not result from the death of the Insured. If You die, the proceeds will be payable to the appointed executors or administrators for and on behalf of Your estate, unless You are also the Insured, in which case the proceeds will be paid to the Beneficiary.

2.5 Beneficiary

Beneficiary refers to a person nominated by You to receive any proceeds of this Policy if the Insured dies. Your nominated Beneficiary is entitled to any benefits of this Policy if the Insured dies.

If a Beneficiary dies before the Insured, his or her share of the policy benefits will be redistributed to any surviving Beneficiaries in proportion to their nominated share (or equally if no nomination has been made).

If both the Insured and a Beneficiary die in the same incident and the official time of death is recorded as being the same time, We will determine the distribution of the proceeds of this Policy as if the elder of the two people had died first.

If You have not nominated any Beneficiaries, or if all of the Beneficiaries die before the Insured, We will pay the proceeds to You, or the appointed executors or administrators for and on behalf of Your estate (if You die).

During the Insured's lifetime, the Beneficiary has no right to and cannot request any changes to, claim benefits from, or exercise any rights and privileges in relation to this Policy.

2.6 Changes of Policy Owner and Beneficiary

While this Policy is in effect, the Policy Owner and the Beneficiary may be changed if You (as the current Policy Owner) submit a written request to Us. After assessing that We have all of the relevant information, We will process and register this change in Our records and such change will be effective from the date We approve the request (irrespective of whether the Policy Owner and/or the Insured is/are alive on that date).

2.7 Assignment

You can assign this Policy as collateral for a loan, however unless You inform Us in writing of the assignment, and We make a record of this assignment, We will not be bound by this assignment. You are responsible for the validity of the assignment and instructing Us any benefits under this Policy are paid to the assignees. Any payment We make before We record the assignment will not be affected by the assignment. Any money owed to Us under this Policy will take priority over any rights of any assignee(s).

2.8 Increase in Initial Sum Insured

While this Policy is in effect and the Insured is alive, provided that no claims have been made, You can request in writing to increase the Initial Sum Insured before the first Policy Anniversary subject to Our

applicable rules and procedures (including but not limited to the relevant underwriting requirements). We will review the request and may request further information before accepting or declining the request. If We approve the request, We will register this change in Our records and such change will be effective from the Policy Date. We will send an Endorsement to Your latest correspondence address in Our records.

2.9 Reduction in Initial Sum Insured

While this Policy is in effect and the Insured is alive and subject to the minimum Initial Sum Insured determined by Us in Our sole discretion, provided that no benefit has been claimed, You can request in writing to reduce the Initial Sum Insured subject to Our applicable rules and procedures. We will review the request and may request further information before accepting or declining the request. If We approve the request, We will register this change in Our records and such change will be effective from the date We approve the request. We will send an Endorsement to Your latest correspondence address in Our records.

2.10 Surrender

While this Policy is in effect and the Insured is alive, You can request to surrender this Policy by sending Us a completed surrender form or by any other means acceptable by Us, and subject to Our applicable rules and procedures. This Policy has no cash values and no benefits will be payable upon surrender. This Policy will be terminated on the date We approve the request.

2.11 Misstatement or Non-disclosure

We have used the information, including but not limited to Age, gender and other material facts, provided by You and the Insured (if they are different people) during the application process to determine whether to offer this Policy.

If the Insured's Age or gender shown in the Policy Schedule is incorrect, We will calculate any amount paid or payable or benefit accruing according to how much the premiums paid would have purchased at the time of the application on the basis of the correct Age and/or sex. However, any recalculated amount will not be more than the original benefit which is specified in the Policy Schedule or any Endorsement.

We may cancel this Policy and treat it as having never existed if (i) any information provided by You and the Insured during the application process is incorrect and if, based on the correct information, We would not have offered this Policy; or (ii) any material facts were not disclosed during the application process which may affect Our risk assessment. In this situation, We will refund any premium(s) paid without interest after deducting any benefits that We have paid. We will send written notification of the cancellation to Your correspondence address in Our records.

2.12 Incontestability

Except in instances of fraud or non-payment of premium, We waive Our rights to cancel this Policy and treat it as having never existed after it has been in effect for one (1) year (meaning the Insured has been alive) from the Policy Date, or the Reinstatement Date (if this Policy is reinstated).

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2.13 Payment Currency

All amounts that We or You are required to pay in relation to this Policy will be paid in the currency shown in the Policy Schedule provided that We have the absolute discretion to accept payment in another currency.

2.14 Third Party Contractual Right

Any person who is not a party to this Policy has no rights to enforce any of its terms.

2.15 General Interpretation and Application

Where the context requires, words importing one gender shall include the other gender, and singular terms shall include the plural and vice versa. Headings are for convenience only and shall not affect the interpretation of this Policy. References to sections, clauses, provisions and schedules are to sections, clauses, provisions and schedules to this Policy. Should any conflict arise in respect of the interpretation of any provision in this Policy and any other material otherwise produced by Us, then the provisions of this Policy shall prevail.

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3. Premiums and Reinstatement Provisions

3.1 Payment of Premiums

The first premium is due on the Commencement Date. If this is not paid within thirty (30) calendar days of the Policy Date, this Policy shall be deemed null and void. In this situation, We will not be legally obliged to pay any benefits under this Policy.

Subsequent premiums must be paid during the term of this Policy. Premiums must be paid at a frequency We agree with You.

We provide a thirty (30)-day grace period from the due date of any premium(s). If We still do not receive this premium after the thirty (30)-day grace period, We will terminate this Policy effective from the date the unpaid premium was due.

The premium of this Policy is not guaranteed. We reserve the right from time to time to review, vary and significantly increase all or any of the premium stated in the Policy Schedule or any Endorsement attached to this Policy due to factors including but not limited to claims experience and policy persistency, provided any premium review shall be applied to all other policies of the same kind.

In addition, if Additional Medical Coverage for Big 3 Diseases is selected, the premium of Additional Medical Coverage for Big 3 Diseases is not guaranteed and will be determined annually at Our sole discretion based on the Age of the Insured at the Policy Anniversary, and the premium of the Policy will change every year.

We reserve the right to revise, amend or modify this Policy at each Policy Anniversary, and We will notify You in writing at least thirty (30) calendar days before the Policy Anniversary after which the revisions will take effect. If You refuse to accept the revisions, We can terminate this Policy when You have not paid the premium for thirty (30) calendar days from when it was due.

3.2 No re-underwriting except in limited circumstances

While this Policy is in force, We will not have the right to re-underwrite this Policy irrespective of any change in health conditions of the Insured after the date of Endorsement, Commencement Date or the Policy Date, whichever is the earlier.

We shall not have the right to re-underwrite this Policy irrespective of any change. This restriction applies to any change including but not limited to where there is any upgrade or downgrade of any benefits, or any addition or removal of any benefits, as permitted under this Policy, regardless of where they are set out in this Policy.

Notwithstanding the second paragraph of this clause, We will have the right to re-underwrite this Policy only under the following circumstances –

1. Where the Policy Owner requests Us to re-underwrite this Policy for reduction in premium loading or removal of case-based exclusion(s) according to the Company's underwriting practices. For the avoidance of doubt, We will not have the right to terminate this Policy if any of the aforesaid requests is rejected by Us or the re-underwriting result is not accepted by the Policy Owner;
2. At any time where the Policy Owner requests to subscribe additional benefits (if any) or switch to another insurance plan which provides upgrade or addition of benefits (in which cases the re-underwriting shall be limited to such upgrade or additional benefits).
   (i) However, at any time where the Policy Owner requests to unsubscribe the additional benefits (if any) in this Policy, or switch to another insurance plan which provides downgrade or reduction of benefits, We will not have the right to re-underwrite this Policy but shall have the discretion

to accept or reject the request according to its prevailing practices in handling similar requests; and

(ii) We will not have the right to terminate this Policy if any of the aforesaid requests is rejected by Us or the re-underwriting result is not accepted by the Policy Owner;

We and Policy Owner acknowledge that –

3. if under the terms of this clause, We have the right, or is required, to re-underwrite this Policy based on certain factors including but not limited to health conditions, smoking status, occupations, residency and financial conditions, We will, in accordance with the terms of this clause and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and
4. as a result of re-underwriting, this Policy may be terminated, new premium loading may be applied, existing premium loading may be adjusted upwards or downwards, new case-based exclusion(s) may be applied, and existing case-based exclusion(s) may be revised or removed.

3.3 Deduction of Outstanding or Unpaid Premium

If there are any outstanding or unpaid premium(s) under this Policy, We will deduct these amounts from any benefits or proceeds payable under this Policy.

Upon the payment of Death Benefit or Crisis Benefit, if You are paying the premium(s) at a frequency other than annually (for example, monthly), We will deduct from the benefit(s) the amount of unpaid premiums (if any) for the Policy Year in which the Insured died or the Crisis Benefit is paid (as the case may be).

3.4 Reinstatement

If this Policy was terminated because of unpaid premiums, We may agree to reinstate this Policy, subject to the terms and conditions of this Policy and the applicable rules and procedures at that time, if You:

1. apply to Us in writing within one (1) year from the date of a default in payment of premium pursuant to which this Policy was terminated;
2. provide Us with satisfactory evidence that the Insured still qualifies for this Policy based on the same factors that We used when assessing the initial application; and
3. repay all unpaid premiums (with interest at an interest rate that We set).

We may refuse the application for reinstatement or may adjust the terms of this Policy. This Policy will only take effect again from the Reinstatement Date.

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4. Benefit Provisions

While the coverage of this Policy is in effect and subject to the terms, conditions, exclusions, limitations and restriction contained in this Policy (including any attached endorsements), We will, upon receipt of due proof and Our approval, pay the benefit(s) in accordance with the Benefit Provisions.

We will pay the Crisis Benefit, Special Disease Benefit and Critical Medical Care Benefit only where the First Symptoms appear, the condition occurs and the diagnosis or surgery relating to the relevant Disease, illness or Injury occurs after the first ninety (90) calendar days from the Policy Date. This first ninety (90) calendar days limitation does not apply if any Disease, illness or Injury is solely and directly caused by an Accident and independently of any cause.

4.1 Crisis Benefit

While this Policy is in force, if the Insured has the First Confirmed Diagnosis of a Crisis, We will pay to the Policy Owner the Crisis Benefit equivalent to one hundred percent (100%) of the Current Sum Insured.

This Crisis Benefit will only be paid once until the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured.

If Additional Medical Coverage for Big 3 Diseases is not selected when Crisis Benefit is payable for Big 3 Diseases, upon payment of the Crisis Benefit for Big 3 Diseases, Our liability (if any) under this Policy shall be limited to the Life Enrichment Program, subject to Clause 4.8 below.

4.2 Special Disease Benefit

While this Policy is in force, if the Insured has the First Confirmed Diagnosis of a Special Disease, We will pay to the Policy Owner a benefit of thirty-five percent (35%) of the Initial Sum Insured in respect of that Special Disease (except Carcinoma-in-situ or Early Stage Malignancy of Specific Organs, Angioplasty of Coronary Artery and Special Diseases for Juvenile).

The benefit payable for each of (i) Carcinoma-in-situ or Early Stage Malignancy of Specific Organs, (ii) Angioplasty of Coronary Artery and (iii) Special Diseases for Juvenile is equal to the lesser of:

(i) Thirty-five percent (35%) of the Initial Sum Insured; or
(ii) HK$400,000 / US$50,000 (in the case of Hong Kong dollar and United States dollar denominated Policies respectively) per life of each claim under all policies of Term Critical Illness Series.

Each Special Disease can be claimed once only under this Policy, except the following:

(a) *Carcinoma-in-situ or Early Stage Malignancy of Specific Organs*

More than one (1) claim for Special Disease Benefit can be made in respect of Carcinoma-in-situ or Early Stage Malignancy of Specific Organs under the Policy. To be eligible for the second and subsequent claim, the claim must be in relation to a covered organ of a Carcinoma-in-situ or Early Stage Malignancy (as defined and classified under the "Appendix 3: Definition of Special Disease") that is different from the organ(s) which was/were covered under the previous claim for the Special Disease Benefit (for which benefit has been paid). If the relevant covered organ has both a left and a right component (such as, but not limited to, the lungs or breasts), the left side and right side of the organ shall be considered one and the same organ ("Paired Organ").

(b) *Angioplasty of Coronary Artery*

A maximum of two (2) claims for Special Disease Benefit can be made in respect of Angioplasty of Coronary Artery under this Policy, provided that the second claim for Special Disease Benefit has fulfilled the relevant additional condition(s) and / or requirement(s) as set out in the respective definitions of Angioplasty of Coronary Artery under the "Appendix 3: Definition of Special Disease".

If more than one (1) conditions are diagnosed as arising from the same Disease, though they may exist in different stages, conditions or forms, We will only pay one benefit for the condition for which the highest benefit amount under Clause 4.1, Clause 4.2 and Clause 4.3 is payable.

If more than one (1) conditions are diagnosed in any component of a Paired Organ, though they may exist in different stages, conditions or forms, We will only pay one benefit for the condition for which the highest benefit amount under Clause 4.1, Clause 4.2 and Clause 4.3 is payable.

This benefit will be payable until the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured. Upon the payment of claims under this Special Disease Benefit, the Current Sum Insured of this Policy will be reduced accordingly. Death Benefit, Crisis Benefit and future premium will be reduced accordingly. The benefit payable under each claim of Special Disease Benefit will in no event be higher than the Current Sum Insured.

4.3 Critical Medical Care Benefit

While this Policy is in force, if it becomes Medically Necessary for the Insured to be Hospitalised in an Intensive Care Unit for three (3) or more consecutive days with the use of Invasive Life Support, We will pay to the Policy Owner the Critical Medical Care Benefit which is equal to the lesser of the following:

(i) Twenty percent (20%) of the Initial Sum Insured; or
(ii) HK$400,000 / US$50,000 (in the case of Hong Kong dollar and United States dollar denominated Policies respectively) per life of each claim under all policies of Term Critical Illness Series.

If one or more than one illness or Injury (including their complications and Hospitalisation in Intensive Care Unit) arising from a single and same incident are diagnosed, though they may exist in different stages, conditions or forms, We will only pay one benefit for the illness or Injury (including their complications and Confinement in Intensive Care Unit) for which the highest benefit amount under Clause 4.1, Clause 4.2 and Clause 4.3 is payable.

This benefit will be payable until the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured. Upon the payment of claims under this Critical Medical Care Benefit, the Current Sum Insured of this Policy will be reduced accordingly. Death Benefit, Crisis Benefit and future premium will be reduced accordingly. The payment under Critical Medical Care Benefit will in no event be higher than the Current Sum Insured.

This benefit will be payable only once under this Policy.

4.4 Waiver of Premium upon Crisis Benefit Claims paid/payable for Big 3 Diseases

While the Policy is still in force, if Additional Medical Coverage for Big 3 Diseases is selected when the Crisis Benefit is payable for Big 3 Diseases, We will waive the balance of premiums payable under this Policy. Without prejudice to Clause 3.3, The first premium to be waived will be the one falling due immediately after the date of the First Confirmed Diagnosis of the Big 3 Disease which is the subject of

the Crisis Benefit claim, except any premium falling due shall continue to be paid pending Our approval of a claim for this benefit. Following such approval, We will refund any premiums paid to this Policy which are later waived.

Regardless of the mode of payment of premiums selected under this Policy, any waiver of premiums shall be effected as if the Policy were on a monthly premium mode. However, there will be no waiver of any premium the due date of which is more than one (1) year before the day of receipt by Us of written notice of the Crisis Benefit claim for Big 3 Diseases.

4.5 Additional 50% Coverage Benefit for Big 3 Diseases

Subject to Our applicable rules and procedures at that time, You may select the Additional 50% Coverage Benefit for Big 3 Diseases when You apply for Your Policy. If You select this benefit, it will be set out in Policy Schedule or Endorsement.

Once the Crisis Benefit has been paid/or is payable for Big 3 Diseases and while the Policy is still in force, We will pay to the Policy Owner the Additional 50% Coverage Benefit for Big 3 Diseases equivalent to fifty percent (50%) of the Initial Sum Insured.

This benefit is in addition to other benefits payable under this Policy and is payable when the Crisis Benefit is payable for Big 3 Diseases under the Policy.

This benefit will be payable once under this Policy, and this benefit amount paid shall not be deducted from the Current Sum Insured of this Policy.

4.6 Additional Medical Coverage for Big 3 Diseases

Subject to Our applicable rules and procedures at that time, You may select the Additional Medical Coverage for Big 3 Diseases when You apply for Your Policy. If You select this benefit, it will be set out in Policy Schedule or Endorsement.

Once the Crisis Benefit has been paid and/ or is payable for Big 3 Diseases and while the Policy is still in force, if the Eligible Expenses incurred in respect of the same Big 3 Disease for which the Crisis Benefit claim are paid or payable have reached the lower of the total Initial Sum Insured under all policies of the Term Critical Illness Series with Additional Medical Coverage for Big 3 Diseases or HK$500,000 / US$62,500 (in the case of Hong Kong dollar and United States dollar denominated Policies respectively), We will reimburse Eligible Expenses incurred in respect of that Big 3 Disease in excess of the aforesaid threshold under Hospitalisation Benefits, Surgical Benefits and Other Benefits in accordance with Clause 4.6.1 and Clause 4.6.2, up to the lesser of:

(1) one hundred percent (100%) of the total Initial Sum Insured under all policies of the Term Critical Illness Series with Additional Medical Coverage for Big 3 Diseases; or
(2) HK$1,000,000 / US$125,000 (in the case of Hong Kong dollar and United States dollar denominated Policies respectively) per life under all policies of the Term Critical Illness Series with Additional Medical Coverage for Big 3 Diseases,

provided that the Eligible Expenses for that Big 3 Disease are incurred within two (2) years from the date of the First Confirmed Diagnosis of such Big 3 Disease.

If You can obtain a refund of any expenses otherwise recoverable under this benefit from any other sources, We will only pay the portion of these expenses in excess of the refund obtained from other sources up to the above limit. You must tell Us if the Insured can obtain a refund of all or part of the

Eligible Expenses otherwise recoverable under this benefit from any other sources. If We have paid a benefit which is recoverable from another source, You must refund this amount to Us.

The Policy will be terminated once the above maximum limit for the Eligible Expenses is reached or upon expiry of this benefit, which is two (2) years after the date of the First Confirmed Diagnosis of such Big 3 Disease (whichever is earlier).

4.6.1 Hospitalisation Benefits, Surgical Benefits and Other Benefits under Additional Medical Coverage for Big 3 Diseases

Hospitalisation Benefits

We will reimburse the Eligible Expenses described below (subject to any other maximum limits as set out in this Policy or any Endorsement) if the Insured is Hospitalised in a Standard Semi-private Room or a room of lower level for the treatment of the same Big 3 Disease for which the Crisis Benefit claim is paid or payable:

1. Room and Board

We will reimburse one hundred percent (100%) of the Eligible Expenses for room and board (Standard Semi-private Room level or below) when the Insured is Hospitalised.

2. Intensive Care Unit Charges

We will reimburse one hundred percent (100%) of the Eligible Expenses if the Insured is Hospitalised in an Intensive Care Unit on the written recommendation of the Insured's attending Medical Practitioner.

If We make the reimbursement for Intensive Care Unit charges, We will not pay the benefit under Room and Board under item 1 in Clause 4.6.1.

3. Medical Practitioner's Hospital Visit and Specialist's Fee

While the Insured is Hospitalised, We will reimburse one hundred percent (100%) of the Eligible Expenses charged:

- by the Insured's attending Medical Practitioner to visit the Insured; and
- for Specialist treatment recommended in writing by the Insured's attending Medical Practitioner.

4. Miscellaneous Hospital Medical Charges

We will reimburse one hundred percent (100%) of the Eligible Expenses charged by the Hospital or Clinical Surgery for the following items:

- Drugs and medicines required by the Insured;
- Dressing, ordinary splints and plaster casts but excluding special braces, artificial limbs, appliances and equipment;
- Laboratory examinations;
- Electrocardiograms;
- Physiotherapy;
- Basal metabolism tests;
- X-ray examinations;
- Medical report charges as a result of tests and examinations;
- Administration of blood and blood plasma but excluding costs of blood or blood plasma;

- Local ambulance service to or from where the Insured is Hospitalised; and
- Use of post-operative recovery room.

For clarity, We will not cover:

a) non-medical miscellaneous charges, such as guest meals, personal wi-fi, telephone, photocopying, taxis and personal items;
b) items that have not been recommended in writing by the Insured's attending Medical Practitioner;
c) narcotics used by the Insured (unless taken as prescribed by a Medical Practitioner); or
d) any genetic testing, medical services, procedures or supplies which are not Medically Necessary.

We have the right to determine whether a particular service or charge will be reimbursed under this benefit.

5. Hospital Companion Bed

We will reimburse one hundred percent (100%) of the expenses charged by the Hospital in which the Insured is Hospitalised on the charge for an extra bed for one (1) person who accompanies the Insured in Hospital during his / her Hospitalisation.

6. Private Nursing Care's Fee

We will reimburse one hundred percent (100%) of the Eligible Expenses for private nursing services provided by a Qualified Nurse if the services have been recommended in writing by the Insured's attending Medical Practitioner following the Insured's surgery or after the transfer from an Intensive Care Unit to another ward within the Hospital.

We will only pay for charges for one Qualified Nurse who provides the services at any one time.

Surgical Benefits

We will reimburse one hundred percent (100%) of the Eligible Expenses (subject to any other maximum limits as set out in this Policy or any Endorsement) charged to the Insured during his or her Hospitalisation or Clinical Surgery for treatment of the same Big 3 Disease for which the Crisis Benefit claim is paid or payable, including the charges for consultation, medication, the Surgeon's fee, Anaesthetist's fee, operating theatre fee and other Eligible Expenses for items and equipment used during the procedures.

Other Benefits

1. Post-hospitalisation Out-patient

If the Insured's attending Medical Practitioner recommends the Insured to undergo follow-up Out-patient consultations after the Hospitalisation or Clinical Surgery for the same Big 3 Diseases for which the Crisis Benefit claim is paid or payable, We will reimburse one hundred percent (100%) of the Eligible Expenses for the consultations following the Insured's discharge or the Clinical Surgery.

We will only pay for one (1) consultation per day.

We will also reimburse one hundred percent (100%) of the Eligible Expenses for any prescribed medication given and diagnostic tests taken which relate to the Hospitalisation or Clinical Surgery.

We will only pay this benefit if the Insured's attending Medical Practitioner has made the recommendation in writing, and We will not pay any Post-hospitalisation Out-patient Benefit for any treatment from a Chinese Medicine Practitioner, chiropractor treatment, podiatry consultation or physiotherapy, regardless of whether such consultation relates to the follow-up Out-patient consultations.

We will only pay this benefit if We have paid a benefit under Hospitalisation Benefits or Surgical Benefits under Clause 4.6.1, and is subject to any other maximum limits as set out in this Policy or any Endorsement.

2. Post-hospitalisation Home Nursing

If the Insured's attending Medical Practitioner believes that it is Medically Necessary to have nursing support after Hospitalisation and/or surgical treatment for the same Big 3 Diseases for which the Crisis Benefit claim is paid or payable, we will reimburse one hundred percent (100%) of the Eligible Expenses for a Qualified Nurse to attend the Insured's home within the thirty one (31) calendar days immediately after the Insured's discharge following surgery or Intensive Care Unit admission.

We will only pay this benefit if we have paid a benefit under Hospitalisation Benefits or Surgical Benefits and the Insured's attending Medical Practitioner has made a recommendation in writing, and the services relate directly to the same Big 3 Diseases for which the Crisis Benefit claim is paid or payable. This benefit is restricted to nursing services provided by one (1) Qualified Nurse at any time, and is subject to any other maximum limits as set out in the Policy or any Endorsement, even if the Insured is Hospitalised more than once.

3. Non-surgical Cancer Treatment

If the Crisis Benefit is payable for a Cancer and the Insured's attending Medical Practitioner or Specialist considers non-surgical cancer treatment (including chemotherapy, radiotherapy, immunotherapy, targeted therapy and cancer hormonal therapy) is Medically Necessary for that Cancer, We will reimburse one hundred percent (100%) of the Eligible Expenses of this treatment, including oncology drugs. We will reimburse the costs of both In-patient and Out-patient treatment, subject to any other maximum limits as set out in this Policy or any Endorsement.

4. Prescribed Diagnostic Imaging Tests

We will reimburse one hundred percent (100%) of the Eligible Expenses on Prescribed Diagnostic Imaging Tests performed in a setting for providing medical services to a Day Patient recommended in writing by the Insured's attending Medical Practitioner for the investigation or treatment of the same Big 3 Diseases for which the Crisis Benefit claim is paid or payable, subject to any other maximum limits as set out in this Policy or any Endorsement.

5. Rehabilitation Treatment

If We have paid Hospitalisation Benefits or Surgical Benefits, We will reimburse one hundred percent (100%) of the Eligible Expenses the Insured incurred in a Rehabilitation Centre for rehabilitation treatment recommended in writing by the Insured's attending Medical

Practitioner, provided that for each occasion of rehabilitation treatment the Insured's stay at the Rehabilitation Centre is for at least six (6) continuous hours, and subject to any other maximum limits as set out in this Policy or any Endorsement.

4.6.2 Limitation on Additional Medical Coverage for Big 3 Diseases

Without prejudice to the maximum limit of the Additional Medical Coverage for Big 3 Diseases, if on any day of Hospitalisation, the Insured is Hospitalised in a room of a higher level than a Standard Semi-private Room at his own choice, the amount of Eligible Expenses reimbursable pursuant to Clause 4.6 shall be reduced by multiplying the following percentage:-

Actual room type	**Standard Ward Room**	**Standard Semi-private Room**	**Standard Private Room**	**Level above the Standard Private Room**
Percentage applied to the Eligible Expenses	100%	100%	50%	25%

The above adjustment shall not be applied if the Hospitalisation in room of a higher level than a Standard Semi-private Room is necessitated by the following reasons:

1. unavailability of accommodation at the specified ward class due to ward or room shortage for emergency treatment;
2. isolation purposes that require a specific class of accommodation; or
3. other reasons not involving personal preference of the Policy Owner and/or the Insured which We regard as valid at Our discretion.

4.6.3 Claimable Amount Estimate

Before the Insured receives Medically Necessary services for a Big 3 Diseases, the Policy Owner may request Us to provide an estimate on the amount that may be claimed under Benefit Provisions. The Policy Owner shall provide Us with the estimated fees to be incurred as furnished by the Hospital and/or attending Medical Practitioner as required by the laws and regulations regulating the private healthcare facilities in Macau at the time of request. Upon receiving the request, We will inform the Policy Owner of the claimable amount estimate under Benefit Provisions based on the estimation furnished by the Hospital and/or attending Medical Practitioner. Our estimate is for reference only, and the actual amount claimable by the Policy Owner shall be subject to the final expenses as evidenced required by Us.

4.7 Death Benefit

If the Insured dies while this Policy is in force, and before the Expiry Date, We will pay to the Beneficiary(ies) one hundred percent (100%) of the Current Sum Insured under the Policy as Death Benefit.

No benefit will be payable under this Death Benefit if the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured at the time of the death of the Insured.

4.8 Life Enrichment Program

While this Policy is in force and the Insured is still alive, when Crisis Benefit is payable for Big 3 Diseases, We will provide a Life Enrichment Program to the Insured and the fee will be waived. The Life Enrichment Program is available once per Insured.

The Life Enrichment Program is a rehabilitation program which will start within six (6) calendar months from the payment date of the Crisis Benefit claim for Big 3 Diseases.

Details of the Life Enrichment Program will be determined at Our sole discretion at the time the services are provided, and the services may be provided by third party service providers as We may designate. We will not be responsible for any act or failure to act on the part of the service providers and their healthcare network teams (if any). We reserve the right to revise the Life Enrichment Program at any time without prior notice.

4.9 Non-participating

This Policy is non-participating and will not share in the divisible surplus of Our life insurance funds.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

5. Medical Check-up Coupon

While this Policy is in force and the Insured is still alive, a Medical Check-up Coupon will be offered to the Insured by third party service providers, designated by Us, on each of the 2nd, 4th, 6th, 8th and 10th Policy Anniversaries, subject to the following:

1. The Policy was issued at the Insured's Age of eighteen (18) or above;
2. The Policy has been in effect for at least two (2) Policy Years; and
3. All premiums due have been paid.

If the Policy was issued at the Insured's Age of seventeen (17) or below, this Medical Check-up Coupon will be available biennially to the Insured starting from the Policy Anniversary of the Insured's Age of twenty (20) if the Policy is still in force.

The Insured is entitled to a maximum of five (5) medical check-ups coupon per life under all policies of Term Critical Illness Series. The terms and conditions of the check-up service will be determined at the sole discretion of Us at the time the services are provided.

We reserve the right to amend any of the above benefits without prior notice to the Policy Owner and / or the Insured.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

6. Option to Convert to A New Whole Life Critical Illness Protection Plan

Subject to the then applicable rules and procedures, Policy Owner can choose to convert the entire amount or any portion of the Initial Sum Insured under this Policy to a new whole life critical illness protection plan with limited premium payment term ("New Policy") that We then offer without providing further evidence of insurability of the Insured within thirty-one (31) calendar days immediately before or after any Policy Anniversary, provided that all of the following conditions are fulfilled:

(i) This Policy has been in effect for at least two (2) Policy Years;
(ii) This Policy is issued without loading premium and / or additional individual exclusions;
(iii) This Policy remains in force till the respective Policy Anniversary when the option under Clause 6 is exercised;
(iv) The issuance of the New Policy is subject to its availability when this option is exercised;
(v) No benefit under section 4 has been paid, or is payable under this Policy;
(vi) All premiums that are due under this Policy have been paid;
(vii) The Insured's Age is or below fifty-five (55) when the New Policy is issued;
(viii) The term and conditions of the New Policy (including but not limited to the benefits payable, exclusions applied and diseases covered) will be subject to the then applicable policy provisions of the New Policy, and may be different from this Policy;
(ix) The application and successful issuance of the New Policy will be subject to the terms and conditions as determined by Us from time to time and at Our sole discretion at the time of application, including but not limited to Our prevailing rules and regulations (including minimum/maximum issue age and minimum sum insured) and any maximum aggregated limit prescribed by Us on the sums insured per Insured under specified critical illness protection plans;
(x) If only a portion of the Initial Sum Insured is converted, the Policy may be continued for the remaining years and the premiums shall be reduced accordingly provided always that the Policy meets Our rules then in effect, including but not limited to the minimum Initial Sum Insured and premiums then in effect;
(xi) The New Policy will become effective on or after the respective Policy Anniversary of this Policy if your application is accepted and this Policy will be terminated on the date of the New Policy is in effect;
(xii) This option can be exercised once only and once exercised is irrevocable; and
(xiii) The premium of the New Policy shall be determined in accordance with the Insured's Age and Our prevailing premium rates when this option is exercised.

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7. Exclusions

This following applies only to Crisis Benefit, Special Disease Benefit, Critical Medical Care Benefit and Additional Medical Coverage for Big 3 Diseases (if applicable).

This Policy shall not cover any loss / claim directly or indirectly caused by or resulting from any of the following:

1. Intentional self-inflicted Injury or attempted suicide, while sane or insane and while intoxicated or not.
2. The participation in any criminal event.
3. Any condition arising out of consumption of poisoning drugs, psychiatric drug, drug abuse, alcohol abuse, abuse of solvents and other substances unless prescribed by a Medical Practitioner for treatment.
4. Human Immunodeficiency Virus (HIV) related illness, including Acquired Immunization Deficiency Syndrome (AIDS) and / or any mutations, derivations or variations thereof, which is derived from an HIV infection (Except "HIV due to Blood Transfusion" and "Occupationally Acquired HIV" as defined under Appendix 2: Definition of Crisis).

Please refer to item 1 under Other Benefits in Clause 4.6.1 for exclusions for Post-hospitalisation Out-patient and item 4 under Hospitalisation Benefits in Clause 4.6.1 for exclusions for Miscellaneous Hospital Medical Charges (if applicable).

7.1 Waiting Period

We will not pay the Crisis Benefit, Special Disease Benefit, Critical Medical Care Benefit, Additional 50% Coverage Benefit for Big 3 Diseases (if applicable) and Additional Medical Coverage for Big 3 Diseases (if applicable) where the First Symptoms appear, the condition occurs and the diagnosis or surgery relating to the relevant Disease, illness or Injury occurs within the first ninety (90) calendar days from (i) the Policy Date; and (ii) if Additional 50% Coverage Benefit for Big 3 Diseases and/or Additional Medical Coverage for Big 3 Diseases is/are selected, the date of Endorsement. This first ninety (90) calendar days limitation does not apply if any Disease, illness or Injury is solely and directly caused by an Accident and independently of any cause.

7.2 Suicide

If the Insured commits suicide within twelve (12) calendar months from the Policy Date (or the Reinstatement Date, whichever is later), Our legal responsibility will be limited to the total premium amount paid to Us without interest, after deducting any policy benefits that We have paid and any outstanding amounts owed to Us. This applies regardless of whether the Insured was sane or insane when committing suicide.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

8. Claim Provisions

8.1 Notice of Claim

Written notice of any claim for Death Benefit, Crisis Benefit, Special Disease Benefit, Critical Medical Care Benefit and Additional Medical Coverage for Big 3 Diseases (if applicable) must be given to Us within thirty (30) calendar days (and in any case no later than six (6) calendar months) from the date of death of the Insured, the date of the relevant medical treatment or First Confirmed Diagnosis of such respective Crisis or Special Disease (as applicable). Any claims for Death Benefit, Crisis Benefit, Special Disease Benefit, Critical Medical Care Benefit and Additional Medical Coverage for Big 3 Diseases (if applicable) received after the said six (6)-month period shall not be accepted, unless We in Our sole discretion decide otherwise.

8.2 Proof of Loss

Upon receipt of a notice of claim, We will provide the claimant with such forms as it requires for the filing of proof of loss.

Written proof of loss satisfactory to Us must be given to Us within ninety (90) calendar days after the time the proof is required or as soon thereafter as is reasonably possible, and in no event, except in the absence of legal capacity, later than six (6) calendar months from the time the proof is required.

All certificates, information and evidence required by Us shall be furnished at the expense of the claimant.

The Insured shall, at Our request and expense, submit to a medical examination by a designated Medical Practitioner in Macau, when and so often as We may reasonably require.

8.3 Proof of Occurrence

Proof of occurrence of any insured event must be supported by:

1. a Medical Practitioner;
2. confirmatory investigations including but not limited to clinical, radiological, histological and laboratory evidence; and
3. if the Insured event requires a surgical procedure to be performed the procedure must be the usual treatment for the condition and be Medically Necessary.

We must be satisfied with the proof of the occurrence of any insured event. We reserve the right to require the Insured to undergo an examination or other reasonable tests to confirm the occurrence of an insured event.

All certificates, information and evidence required by Us will be furnished at the expense of the claimant.

The Insured shall, at Our request and expense, submit to a medical examination by a designated Medical Practitioner in Macau, when and so often as We may reasonably require.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

8.4 Abandoned Claims

If We decline any claim under this Policy and the Policy Owner does not initiate any legal action in respect of such claim within twelve (12) calendar months from the date of such decline, the claim for all purposes shall be deemed abandoned and shall not thereafter be recoverable.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

9. Termination Provisions

This Policy will automatically end on the earliest of the following:

1. The death of the Insured;
2. The Expiry Date of this Policy;
3. The date of Policy surrender. Such date is determined in accordance with Our applicable rules and regulations in relation to Policy surrender;
4. On the premium due date, if the Policy Owner has not paid the premium within the thirty (30)-day grace period;
5. The Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured (except if Additional Medical Coverage for Big 3 Diseases is selected, and when Crisis Benefit is payable for Big 3 Diseases, this Policy will be terminated when Additional Medical Coverage for Big 3 Diseases has been paid or terminated in accordance with Clause 4.6). All riders (if any) will also be terminated once the Total Claims paid and / or payable reach one hundred percent (100%) of the Initial Sum Insured; and
6. When the entire amount of the Initial Sum Insured under this Policy is converted to a whole life critical illness protection plan with limited premium payment term in accordance with clause 6 subject to Our relevant rules at the time of conversion.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

10. Obligation to Provide Information

The Policy Owner acknowledges that We and/or Our affiliates are obliged to comply with legal and/or regulatory requirements in various jurisdictions as promulgated and amended from time to time, such as the United States Foreign Account Tax Compliance Act, and the automatic exchange of information regime ("AEOI") followed by the Financial Services Bureau (the "Applicable Requirements"). These obligations include providing information of clients and related parties (including personal information) to relevant local and international authorities and/or to verify the identity of the clients and related parties. In addition, Our obligations under the AEOI are to:

1. identify accounts as non-excluded "financial accounts" ("NEFAs");
2. identify the jurisdiction(s) in which NEFA-holding individuals and NEFA-holding entities reside for tax purposes;
3. determine the status of NEFA-holding entities as "passive non-financial entities (NFEs)" and identify the jurisdiction(s) in which their controlling persons reside for tax purposes;
4. collect information on NEFAs ("Required Information") which is required by various authorities; and
5. furnish Required Information to the Financial Services Bureau.

The Policy Owner agrees that from time to time We shall have the right to request from the Policy Owner, and disclose to relevant authority(ies), various information about the Policy Owner, the Beneficiary and this Policy as required under Applicable Requirements for the following purposes:

1. for Us to issue this Policy to the Policy Owner;
2. for Us to provide benefits available to the Policy Owner and / or the Beneficiary under the terms of this Policy; and / or
3. for this Policy to remain in force in accordance with its terms.

In addition, the Policy Owner agrees to notify Us in writing within thirty (30) days if there is any change to any of the information previously provided to Us that relates to Our legal obligations under this clause (whether at time of application or at any other time).

If the Policy Owner does not provide such information within the time period as reasonably requested by Us, notwithstanding any other provisions of this Policy, We shall be entitled to, to the extent permitted by Applicable Requirements:

1. report this Policy and/or information about the Policy Owner and/or the Beneficiary to relevant authority(ies);
2. terminate this Policy and refund any premium, after deducting any benefits We have paid, and any amounts owed to Us; or
3. take any such other action as may be reasonably required including but not limited to making adjustments to the values, balances, benefits or entitlements under this Policy.

Prior to the expiry of such time period and notwithstanding any other provisions of this Policy, We shall have the sole discretion to suspend or defer any transaction or provision of any services to the Policy Owner under this Policy, including the payment of any benefit, if any information reasonably requested by Us under Applicable Requirements remains outstanding.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

Appendix 1: List of Diseases Covered

Crises covered in EasyCover Critical Illness Plan	
Group 1: Cancer - Cancer	
Group 2: Diseases related to Organ Failure - Aplastic Anaemia - Chronic Liver Disease - Chronic Lung Disease - End Stage Lung Disease (including Chronic Obstructive Lung Disease, Severe Bronchiectasis and Severe Emphysema) - Fulminant Hepatitis - HIV Due to Blood Transfusion	- Major Organ Transplantation (lung, pancreas, liver, bone marrow) - Medullary Cystic Disease - Occupationally Acquired HIV - Severe Pulmonary Fibrosis - Severe Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis - Surgical Removal of One Lung
Group 3: Diseases related to Circulatory System - Cardiomyopathy - Coronary Artery Disease Surgery - Eisenmenger's Syndrome - Heart Attack - Heart Valve Surgery - Infective Endocarditis - Kidney Failure	- Major Organ Transplantation (kidney, heart) - Other Serious Coronary Artery Disease - Primary Pulmonary Arterial Hypertension - Stroke - Surgery to Aorta
Group 4: Diseases related to Nervous System - Alzheimer's Disease - Apallic Syndrome - Bacterial Meningitis - Benign Brain Tumour - Blindness - Creutzfeld-Jacob Disease - Encephalitis - Loss of Hearing - Major Head Trauma - Motor Neurone Disease	- Multiple Sclerosis - Muscular Dystrophy - Paralysis - Parkinson's Disease - Poliomyelitis - Progressive Bulbar Palsy - Progressive Muscular Atrophy - Progressive Supranuclear Palsy - Severe Myasthenia Gravis
Group 5: Other Diseases - Amputation of Feet due to Complication from Diabetes Mellitus - Chronic Adrenal Insufficiency - Chronic Relapsing Pancreatitis - Coma - Crohn's Disease - Ebola - Elephantiasis - Loss of Independent Existence - Loss of Limbs - Loss of Speech	- Major Burns - Necrotizing Fasciitis - Pheochromocytoma - Severe Osteoporosis - Severe Rheumatoid Arthritis - Systemic Sclerosis - Terminal Illness - Ulcerative Colitis

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Special Diseases covered in EasyCover Critical Illness Plan	
Group 1: Cancer - Carcinoma-in-situ of Specific Organs (all organs except skin, including but not limited to the organs listed below) a) Breast b) Cervix Uteri c) Colon and Rectum d) Fallopian Tube e) Liver f) Lung g) Nasopharynx h) Ovary i) Pancreas j) Penis k) Stomach and Esophagus l) Testis m) Urinary Tract (for the purpose of in-situ cancers of the bladder, stage Ta of papillary carcinoma is included) n) Uterus o) Vagina	- Early Stage Malignancy of Specific Organs a) Chronic Lymphocytic Leukaemia b) Prostate c) Thyroid d) Non Melanoma Skin Cancer
Group 2: Diseases related to Organ Failure - Acute Aplastic Anaemia - Biliary Tract Reconstruction Surgery - Liver Surgery - Miliary Tuberculosis - Moderately Severe Chronic Lung Disease	- Moderately Severe Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis - Skin Transplantation - Surgical Removal of One Kidney
Group 3: Diseases related to Circulatory System - Angioplasty for Carotid Arteries - Angioplasty of Coronary Artery - Cardiac pacemaker / defibrillator insertion - Carotid Artery Surgery - Early Cardiomyopathy - Early Renal Failure - Insertion of a Vena-Cava Filter	- Keyhole Coronary Bypass Surgery - Minimally Invasive Surgery to Aorta - Percutaneous Valve Surgery - Pericardiectomy - Secondary Pulmonary Hypertension
Group 4: Diseases related to Nervous System - Cochlear Implant Surgery - Cerebral Aneurysm Requiring Surgery - Early Amyotrophic Lateral Sclerosis - Early Multiple Sclerosis - Early Progressive Bulbar Palsy - Early Progressive Muscular Atrophy - Less Severe Encephalitis - Loss of Sight in One Eye - Moderately Severe Alzheimer's Disease - Moderately Severe Bacterial Meningitis	- Moderately Severe Brain Damage - Moderately Severe Muscular Dystrophy - Moderately Severe Paralysis - Moderately Severe Parkinson’s Disease - Moderately Severe Poliomyelitis - Severe Psychiatric Illness - Surgery for Subdural Haematoma - Surgical Removal of Pituitary Tumour

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

Group 5: Other Diseases - Acute Necrohemorrhagic Pancreatitis - Adrenalectomy for Adrenal Adenoma - Amputation of One Foot due to Complication from Diabetes Mellitus - Coma for 48 hours - Crohn's Disease (Regional Enteritis) - Diabetic Retinopathy	- Early Elephantiasis - Loss of Speech due to Vocal Cord Paralysis - Moderately Severe Burns - Moderately Severe Rheumatoid Arthritis - Osteoporosis with Fractures - Severance of One Limb - Severe Central or Mixed Sleep Apnea
Special Diseases for Juvenile (age next birthday 1 (15 days) – 18) covered in EasyCover Critical Illness Plan	
- Autism - Dengue Haemorrhagic Fever - Juvenile Huntington Disease - Kawasaki Disease - Marble Bone Disease (Osteogenesis) - Osteogenesis Imperfecta	- Rheumatic Fever with Valvular Impairment - Severe Asthma - Still's Disease - Type 1 Diabetes Mellitus - Type I Juvenile Spinal Amyotrophy - Type II Juvenile Spinal Amyotrophy

Appendix 2: Definition of Crisis

Group 1: Cancer

1.1-Cancer

(a) Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue; or

(b) Any occurrence of histologically confirmed leukemia, lymphoma or sarcoma.

The following tumours are excluded:

(i) Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as pre-malignant;

(ii) All skin cancers, unless there is evidence of metastases or the tumour is a malignant melanoma of greater than 1.5mm maximum thickness as determined by histological examination using the Breslow method;

(iii) Prostate cancers which are histologically described as TNM Classification T1(a) or T1(b), or are of another equivalent or lesser classification;

(iv) Papillary micro-carcinoma of the thyroid;

(v) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification; and

(vi) Chronic lymphocytic leukaemia less than RAI Stage I or Binet Stage A-I.

Group 2: Diseases related to Organ Failure

2.1-Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one (1) of the following:

(a) blood product transfusion;
(b) marrow stimulating agents;
(c) immunosuppressive agents; or
(d) bone marrow transplantation.

2.2-Chronic Liver Disease

End stage liver failure with increasing jaundice that in general medical opinion will not improve in future and resulting in either ascites or encephalopathy.

Liver disease secondary to alcohol or drug abuse is excluded.

2.3-Chronic Lung Disease

The Diagnosis of interstitial fibrosis requiring at least intermittent oxygen therapy and showing consistent reduction in FEV1 of one (1) litre or less under appropriate medication. Diagnosis, severity and test results must be confirmed by a Medical Practitioner.

2.4-End Stage Lung Disease (including Chronic Obstructive Lung Disease, Severe Bronchiectasis and Severe Emphysema)

The final or end stage of lung disease, causing chronic respiratory failure, as demonstrated by all of the following:

(a) FEV1 test results consistently less than one (1) litre;
(b) Requiring permanent supplementary oxygen therapy for hypoxemia;
(c) Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO2 \leq 55mmHg$); and
(d) Dyspnea at rest.

The diagnoses must be confirmed by a pulmonologist.

2.5-Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by a Hepatitis virus, leading precipitously to liver failure. The diagnosis in respect of this illness must be based on the meeting of all of the following criteria:

(a) A rapidly decreasing liver size;
(b) Necrosis involving entire lobules, leaving only a collapsed reticular framework; and
(c) Rapid deterioration of liver function tests.

Evidence of the following must be produced:

(a) Liver function test to show massive parenchymal liver disease; and
(b) Objective signs of portasystemic encephalopathy.

2.6-HIV Due to Blood Transfusion

The Insured being infected by HIV provided that:

(a) The infection is due to a blood transfusion received after commencement of the policy; and
(b) The institution which provided the transfusion admits liability or there is a final court verdict that cannot be appealed indicating such liability; and
(c) The infected Insured is not a haemophiliac.

This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS.

Infection in any other manner, including infection as a result of sexual activity or intravenous drug use is excluded. The insurer must have open access to all blood samples and be able to obtain independent testing of such blood samples.

2.7-Major Organ Transplantation (lung, pancreas, liver, bone marrow)

The actual undergoing of a transplant of the lung, pancreas, liver or bone marrow as a recipient. Inclusion on an official organ transplant waiting list, for any of the above organs, also qualifies for benefits. The transplant must be Medically Necessary and based on objective confirmation of organ failure.

2.8-Medullary Cystic Disease

A hereditary kidney disorder characterised by gradual and progressive loss of kidney function because of cysts in the kidney medulla.

Diagnosis must be supported by imaging evidence of multiple medullary cysts with cortical atrophy.

2.9-Occupationally Acquired HIV

Infection with the Human Immunodeficiency Virus (HIV) where the virus is acquired as the result of:

(a) An injury occurring during the course of the Insured's normal occupation; or
(b) Occupational handling of blood or other body fluids.

The following conditions must be fulfilled for a valid claim:

(a) The infection must have incurred while the Insured worked in his/her profession;
(b) The Insured must provide the negative result of a test for HIV-virus or antibodies to HIV virus that was made within five (5) days after the reported incident; and
(c) HIV virus or HIV antibodies must be proven within twelve (12) months after the incident.

2.10-Severe Pulmonary Fibrosis

Severe and diffuse type of pulmonary fibrosis requiring extensive and permanent oxygen therapy at least eight (8) hours per day.

The diagnosis must be confirmed with lung biopsy and by a Specialist in respiratory medicine.

2.11-Severe Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis

Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis means an autoimmune illness in which tissues and cells are damaged by deposition of pathogenic autoantibodies and immune complexes.

The diagnosis of S.L.E. with Lupus Nephritis will be based on the following conditions:

(1) Clinically there must be at least four (4) out of the following presentations suggested by The American College of Rheumatology:

1.1 Malar rash;
1.2 Discoid rash;
1.3 Photosensitivity;

1.4 Oral ulcers;
1.5 Arthritis;
1.6 Serositis;
1.7 Renal disorder;
1.8 Leukopenia (<4,000/μL), or Lymphopenia (< 1,500/μL), or Haemolytic anaemia, or Thrombocytopenia (< 100,000/μL); or
1.9 Neurological disorder;

AND

(2) Two (2) or more of the following tests being positive:
2.1 Anti-nuclear Antibodies;
2.2 L.E. cells;
2.3 Anti-DNA; or
2.4 Anti-Sm (Smith IgG Autoantibodies);

AND

(3) There is lupus nephritis causing impaired renal function with a creatinine clearance rate of thirty (30) ml per minute or less.

We reserve the right to change this definition from time to time to reflect the changes in qualitative or quantitative medical categorization of this illness so as to give effect to the original intent of this definition.

2.12-Surgical Removal of One Lung

Complete surgical removal of the entire right or entire left lung necessitated by an illness or accident of the Insured. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a pulmonologist or thoracic surgeon.

Group 3: Diseases related to Circulatory System

3.1-Cardiomyopathy

Impaired ventricular function of variable aetiology, resulting in permanent and irreversible physical impairments to the degree of at least Functional Class 4 of the New York Heart Association Functional Classification of Cardiac Impairment. The diagnosis must be confirmed by a consultant cardiologist and supported by the appropriate test results including echocardiography.

Cardiomyopathy caused by alcohol or drug abuse is specifically excluded.

Class 4 of the New York Heart Association Classification of cardiac impairment means that the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination & laboratory studies.

3.2-Coronary Artery Disease Surgery

The actual undergoing of open-chest surgery to correct or treat coronary artery disease (CAD) by way of coronary artery by-pass grafting.

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

3.3-Eisenmenger's Syndrome

Eisenmenger's Syndrome shall mean the occurrence of a reversed or bidirectional shunt as a result of pulmonary hypertension, caused by a heart disorder.

All of the following criteria must be met:

(a) Presence of permanent physical impairment classified as NYHA IV; and
(b) The diagnosis of Eisenmenger's Syndrome and the level of physical impairment must be confirmed by a Medical Practitioner who is a cardiologist.

3.4-Heart Attack

The death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The diagnosis must be supported by all of the following:

(a) a history of typical chest pain;
(b) new electrocardiogram (ECG) changes indicating acute myocardial infarction; and
(c) elevation of cardiac enzymes CK-MB or cardiac troponin T/I > 0.5 ng/ml.

Provided other criteria are met but cardiac enzymes are not available, echocardiographic proof of death of a portion of the heart muscle with the evidence of reduction in left ventricular ejection fraction of less than fifty percent (50%) or significant hypokinesia, akinesia, or wall motion abnormalities consistent with a heart attack having occurred will be considered.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes including but not limited to angina are excluded.

3.5-Heart Valve Surgery

Open heart valve surgery requiring median sternotomy, performed to replace or repair one (1) or more heart valves, as a consequence of defects that cannot be repaired by intra arterial catheter procedures alone. The surgery must be performed after a recommendation by a consultant cardiologist.

3.6-Infective Endocarditis

Infective Endocarditis shall mean inflammation of the inner lining of the heart caused by infectious organisms.

All of the following criteria must be met:

(a) Positive result of the blood culture proving presence of the infectious organism;
(b) Presence of at least moderate valve incompetence (means regurgitant fraction of twenty percent (20%) or above) or moderate valve stenosis (means valve area of thirty percent (30%) or less of normal value) attributable to Infective Endocarditis; and
(c) The diagnosis of Infective Endocarditis and the severity of valvular impairment must be confirmed by a Medical Practitioner who is a cardiologist.

3.7-Kidney Failure

End stage renal failure presenting chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated, or renal transplant is carried out.

3.8-Major Organ Transplantation (kidney, heart)

The actual undergoing of a transplant of the heart or kidney as a recipient. Inclusion on an official organ transplant waiting list, for any of the above organs, also qualifies for benefits. The transplant must be Medically Necessary and based on objective confirmation of organ failure.

3.9-Other Serious Coronary Artery Disease

Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded).

For purposes of this definition, "major coronary artery" refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

3.10-Primary Pulmonary Arterial Hypertension

Primary Pulmonary Hypertension is the pathological increase of pulmonary pressure due to structural, functional or circulatory disturbances of the lung leading to right ventricular enlargement. The disease must result in permanent irreversible physical impairment to the degree of at least Class 4 of the New York Heart Association Classification of cardiac impairment.

Class 4 of the New York Heart Association Classification of cardiac impairment means that the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination & laboratory studies.

3.11-Stroke

Any cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by all of the following conditions:

(a) evidence of permanent neurological damage confirmed by a consultant neurologist at least four (4) weeks after the event; and
(b) findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke.

The following are excluded:

(a) Transient Ischaemic Attacks;
(b) vascular disease affecting the eye or optic nerve; and
(c) ischaemic disorders of the vestibular system.

3.12-Surgery to Aorta

Means the actual undergoing of surgery via thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta, a coarctation of the aorta or a traumatic rupture of the aorta. 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.

Group 4: Diseases related to Nervous System

4.1-Alzheimer's Disease

Progressive deterioration or loss of intellectual capacity or abnormal behavior as evidenced by the clinical state and accepted standardized questionnaires or tests arising from Alzheimer's Disease or irreversible organic degenerative brain disorders, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in significant reduction in mental and social functioning requiring the continuous care and supervision of the Insured. The diagnosis must be clinically confirmed by an appropriate consultant.

4.2-Apallic Syndrome

Universal necrosis of the brain cortex, with the brainstem remaining intact. Diagnosis must be confirmed by a neurologist and condition must be documented for at least one (1) month.

4.3-Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit. Confirmation of bacterial infection in cerebrospinal fluid by lumbar puncture is required. Permanent functional neurological impairment lasting for a minimum period of thirty (30) days has to be confirmed by a consultant neurologist.

4.4-Benign Brain Tumour

A non-cancerous tumour in the brain or meninges within the cranium, giving rise to characteristic signs of increased intra-cranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.

The following are excluded:
(a) cysts;

(b) granulomas;
(c) malformations in, or of, the arteries or veins of the brain;
(d) haematomas;
(e) tumours in the pituitary gland or spine; and
(f) tumours of the acoustic nerve.

4.5-Blindness

Total and irreversible loss of sight in both eyes as a result of illness or injury. The blindness must be confirmed by a Medical Practitioner who is an ophthalmologist.

4.6-Creutzfeld-Jacob Disease (CJD)

The occurrence of Creutzfeld-Jacob Disease or Variant Creutzfeld-Jacob Disease which is characterised by rapidly progressive dementia and directly in the Insured's permanent inability to perform at least two (2) of the ADLs.

The diagnosis must be made by Specialist with appropriate testing such as electroencephalogram (EEG) with result of a specific type of abnormality in CJD and magnetic resonance imaging (MRI) showing specificity of brain degeneration.

Other common causes of dementia should be ruled out by a spinal tap. Disease caused by human growth hormone treatment is excluded.

4.7-Encephalitis

Severe inflammation of brain substance which results in significant and permanent neurological deficit lasting at least thirty (30) days as certified by a Medical Practitioner specialising in neurology.

4.8-Loss of Hearing

Means irrecoverable loss of hearing in both ears, with an auditory threshold of more than eighty (80) decibels in all frequencies, as a result of sickness or injury.

Only Insured aged three (3) (age next birthday) or above on first diagnosis is eligible to receive a benefit under this illness.

4.9-Major Head Trauma

Accidental head injury causing significant and permanent functional impairment which has lasted for a minimum period of three (3) months from the date of the trauma or injury. The resultant significant permanent functional impairment must be confirmed by a neurologist.

4.10-Motor Neurone Disease

Motor neurone disease supported by definitive evidence of appropriate and relevant neurological signs that has persisted for at least ninety (90) days. The diagnosis must be made by a Medical Practitioner as progressive and supported by appropriate investigations.

4.11-Multiple Sclerosis

A disease due to demyelination of neurological brain tissue. A consultant neurologist must make a diagnosis of Clinically Definite Multiple Sclerosis. The diagnosis must be supported by all of the following:

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

4.12-Muscular Dystrophy

The diagnosis of muscular dystrophy confirmed by a consulting neurologist, and based on a combination of all of the following:

(a) Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
(b) Characteristic electromyogram; and
(c) Clinical suspicion confirmed by muscle biopsy.

4.13-Paralysis

The total loss of function of two or more limbs due to injury or disease of the spinal cord or brain, where such functional loss is considered to be permanent by a neurologist.

4.14-Parkinson's Disease

Unequivocal diagnosis of Parkinson's Disease by a consulting neurologist where the condition:

(a) cannot be controlled with medication;
(b) shows signs of progressive impairment; and
(c) must result in the permanent inability to perform, without assistance, at least three (3) of the six (6) Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinsonism are excluded.

4.15-Poliomyelitis

Infection with the polio virus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness that has persisted for at least ninety (90) days.

Poliomyelitis not involving paralysis is excluded. Other causes of paralysis are specifically excluded.

4.16-Progressive Bulbar Palsy

Neurological disorder with paralysis in the head region, difficulties in chewing and swallowing, problems in speaking, persistent signs of involvement of the spinal nerves and the motor centres in the brain and spastic weakness and atrophy of the muscles of the extremities. The disease must be unequivocally diagnosed by a consultant neurologist. These conditions have to be medically documented for at least three (3) months.

4.17-Progressive Muscular Atrophy

Confirmation of definitive diagnosis of Fried-Emery, Kugelberg-Welander, Aran-Duchenne or Vulpian-Bernhardt Muscular Atrophy by a consultant neurologist. The diagnosis must be supported by muscle biopsy and CPK estimates. These conditions have to be medically documented for at least three (3) months.

4.18-Progressive Supranuclear Palsy

Progressive Supranuclear Palsy shall mean a degenerative neurological disease characterised by supranuclear gaze paresis, pseudobulbar palsy, axial rigidity and dementia.

The diagnosis of Progressive Supranuclear Palsy must be confirmed by a Medical Practitioner who is a neurologist.

4.19-Severe Myasthenia Gravis

Severe Myasthenia Gravis shall mean an acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatiguability.

All of the following criteria must be met:

(a) Presence of muscle weakness categorized as Class III, IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
(b) The diagnosis of Myasthenia Gravis and categorization must be confirmed by a Medical Practitioner who is a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere
Class II: Eye muscle weakness of any severity, mild weakness of other muscles
Class III: Eye muscle weakness of any severity, moderate weakness of other muscles
Class IV: Eye muscle weakness of any severity, severe weakness of other muscles

Class V: Intubation needed to maintain airway

Group 5: Other Diseases

5.1-Amputation of Feet due to Complication from Diabetes Mellitus

Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Specialist in diabetology as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation shall not be covered.

5.2-Chronic Adrenal Insufficiency

Chronic Adrenal Insufficiency shall mean a chronic disorder of the adrenal glands resulting in insufficient secretion of steroid hormones.

All of the following criteria must be met:

(a) Continuous hormone replacement therapy has been instituted and the therapy is expected to last for the whole life of the Insured; and
(b) The diagnosis of Chronic Adrenal Insufficiency must be confirmed by a Medical Practitioner who is an endocrinologist.

5.3-Chronic Relapsing Pancreatitis

More than three (3) attacks of pancreatitis resulting in pancreatic dysfunction causing malabsorption needing enzyme replacement therapy.

The diagnosis must be made by a gastroenterologist and confirmed by Endoscopic Retrograde Cholangio Pancreatography (ERCP).

Chronic Relapsing Pancreatitis caused by alcohol use is excluded.

5.4-Coma

A state of unconsciousness with no reaction to external stimuli or internal needs which:

(a) Requires the use of life support systems for a continuous period of at least ninety-six (96) hours; and
(b) Results in permanent neurological deficit with persisting clinical symptoms.

For the above definition, the following is not covered:

(a) Coma secondary to alcohol or drug abuse.

5.5-Crohn's Disease

Crohn's Disease is a chronic granulomatous inflammatory disease of the intestine. The diagnosis must be confirmed by characteristic histopathological features.

The disease must have resulted in at least one (1) of the following intestinal complications:

(a) Fistula Formation (Excluding Fistula-in-ano);
(b) Obstruction; or
(c) Perforation (not caused by an intervention).

5.6-Ebola

Infection with the Ebola virus where the following conditions are met:

(a) presence of the Ebola virus has been confirmed by laboratory testing;
(b) there are ongoing complications of the infection persisting beyond thirty (30) days from the onset of symptoms; and
(c) the infection does not result in death.

5.7-Elephantiasis

The result and complication of filariasis, characterised by massive swelling in the tissues of the body as a result of obstructed circulation in lymphatic vessels. Unequivocal diagnosis of elephantiasis must be clinically confirmed by an appropriate Specialist, including laboratory confirmation of microfilariae, and must be supported by Our medical adviser.

The benefit does not cover Lymphoedema caused by infection with a sexually transmitted disease, trauma, postoperative scarring, congestive heart failure, or congenital lymphatic system abnormalities.

5.8-Loss of Independent Existence

Inability to perform at least three (3) of the Activities of Daily Living as defined in the Policy (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months and leading to a permanent inability to perform the same. For the purpose of this definition, the word "permanent" shall mean beyond the hope of recovery with current medical knowledge and technology. The Diagnosis of Loss of Independent Existence must be confirmed by a Medical Practitioner.

For Insured aged five (5) (age next birthday) or below at first diagnosis, the benefit is payable if the inability to perform two (2) out of six (6) ADLs persist till five (5) years old (age next birthday).

All psychiatric related causes are excluded.

5.9-Loss of Limbs

Complete severance of two (2) or more limbs above the wrist or ankle as a result of accident or disease.

5.10-Loss of Speech

Total and irrecoverable loss of the ability to speak due to physical damage to the vocal cords which must be established for a continuous period of three (3) months. Medical evidence is to be supplied by an appropriate Specialist and to confirm injury or disease to the vocal cords.

5.11-Major Burns

Means tissue injury causing third degree or full thickness burns to at least twenty percent (20%) of the body surface area.

5.12-Necrotizing Fasciitis

Necrotizing Fasciitis shall mean a quickly progressing infection of soft-tissue that starts in the subcutaneous tissue spreading along the fascial planes.

All of the following criteria must be met:

(a) Aggressive surgical debridement has been carried out to remove all the necrotic tissue; and
(b) The diagnosis of Necrotizing Fasciitis must be confirmed by a Medical Practitioner.

5.13-Pheochromocytoma

Pheochromocytoma shall mean a neuroendocrine tumor of the adrenal or extra-adrenal chromaffin tissue resulting in excessive secretion of catecholamines.

All of the following criteria must be met:

(a) Surgical removal of the tumor must have been performed; and
(b) The diagnosis of Pheochromocytoma must be confirmed by a Medical Practitioner who is an endocrinologist.

5.14-Severe Osteoporosis

Osteoporosis is a degenerative bone disease that results in loss of bone. The diagnosis must be supported by a bone density reading which satisfies the World Health Organization (WHO) definition of osteoporosis with a bone density reading T-score of less than –2.5. There must also be a history of three (3) or more osteoporotic fractures involving femur, wrist or vertebrae. These fractures must directly cause the Insured's permanent inability to perform at least three (3) of the ADLs.

Coverage for Severe Osteoporosis will automatically cease at age seventy (70) (age next birthday) of the Insured.

5.15-Severe Rheumatoid Arthritis

Widespread joint destruction as a result of severe Rheumatoid Arthritis with major clinical deformity of three (3) or more of the following joint areas:

(a) hands;
(b) wrists;
(c) elbows;
(d) cervical spine;
(e) knees; or
(f) ankles;

The diagnosis must be supported by all the following:

(a) Morning stiffness;
(b) Symmetric arthritis;
(c) Presence of rheumatoid nodules;
(d) Elevated titres of rheumatoid factors; and
(e) Radiographic evidence of severe involvement.

The severity of the disease shall be such that there will be at least two (2) of the Activities of Daily Living which the insured will, for a continuous period of at least six (6) months, have been unable to perform without the assistance of another person.

5.16-Systemic Sclerosis

Systemic Sclerosis shall mean a chronic systemic autoimmune disease characterised by tissue fibrosis, small blood vessel vasculopathy and the development of auto-antibodies.

All of the following criteria must be met:

(a) Evidence must be provided that at least one (1) of the following organs is involved:
    (i) esophagus;
    (ii) lung;
    (iii) heart; or
    (iv) kidney;

AND

(b) The diagnosis of Systemic Sclerosis and the organ involvement must be confirmed by a Medical Practitioner who is a Rheumatologist and Immunologist.

5.17 -Terminal Illness

The conclusive diagnosis of an illness that is expected to result in the death of the Insured within twelve (12) months. This diagnosis must be supported by a Specialist and confirmed by Our appointed doctor.

5.18-Ulcerative Colitis

Ulcerative Colitis shall mean acute Fulminant Ulcerative Colitis with life threatening electrolyte disturbances usually associated with intestinal distention and a risk of intestinal rupture, involving the entire colon with severe bloody diarrhoea and systemic signs and symptoms and for which the treatment is frequently total colectomy and ileostomy. Diagnosis must be based on histopathological features and surgery in the form of colectomy and/ or ileostomy should form part of the treatment.

Appendix 3: Definition of Special Disease

Part 1: For all Insured

Group 1: Cancer

1.1-Carcinoma-in-situ of Specific Organs

Carcinoma-in-situ shall mean a histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma in all organs except skin, including but not limited to any one of the following covered organ groups, and subject to any classification stated:

(a) Breast, where the tumour is classified as TIS according to the TNM Staging method;
(b) Colon and rectum;
(c) Liver;
(d) Lung;
(e) Nasopharynx;
(f) Ovary and/or fallopian tube, where the tumour is classified as TIS according to the TNM Staging method or FIGO* Stage 0;
(g) Pancreas;
(h) Penis;
(i) Stomach and esophagus;
(j) Testis;
(k) Urinary tract, for the purpose of in-situ cancers of the bladder, stage Ta of papillary carcinoma is included;
(l) Uterus, where the tumour is classified as TIS according to the TNM Staging method; or cervix uteri, classified as cervical intraepithelial neoplasia grade III (CIN III) or carcinoma in situ (CIS); or
(m) Vagina or vulva, where the tumour is classified as TIS according to the TNM Staging method or FIGO* Stage 0.

For purposes of this Policy, Carcinoma-in-situ must be confirmed by a biopsy.

* FIGO refers to the staging method of the Federation Internationale de Gynecologie et d'Obstetrique.

1.2-Early Stage Malignancy of Specific Organs

Early Stage Malignancy shall mean the presence of one (1) of the following malignant conditions:

(a) Papillary micro-carcinoma of the thyroid;
(b) Tumour of the prostate histologically classified as T1a or T1b according to the TNM classification system;
(c) Chronic lymphocytic leukaemia classified as RAI Stage I or Binet Stage A-1; or
(d) Non melanoma skin cancer of maximum thickness of 1.5mm or less as determined by histological examination using the Breslow method.

The Diagnosis must be based on histopathological features and confirmed by a Medical Practitioner.

Pre-malignant lesions and conditions, unless listed above, are excluded.

Group 2: Diseases related to Organ Failure

2.1-Acute Aplastic Anaemia

Acute reversible bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with any one (1) of the following:

(a) Marrow stimulating agents;
(b) Immunosuppressive agents; or
(c) Bone marrow transplantation

The diagnosis must be confirmed by a Medical Practitioner who is a hematologist or oncologist.

2.2-Biliary Tract Reconstruction Surgery

The undergoing of biliary tract reconstruction surgery involving choledochoenterostomy, necessitated diseases or trauma of the biliary tract. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a hepatologist or abdominal surgeon.

Biliary atresia is excluded.

2.3-Liver Surgery

Partial hepatectomy of at least one (1) entire left or entire right lobe of the liver necessitated by an illness or accident of the Insured. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a hepatologist or abdominal surgeon.

Liver surgery required due to a disorder caused by alcohol or drug abuse or required for purposes of organ donation are excluded.

2.4-Miliary Tuberculosis

Tuberculosis with wide dissemination into the whole body in which minute tubercles are formed in one (1) or more organs of the body as a result of infection with tubercle bacilli.

Miliary Tuberculosis caused by HIV infection is excluded.

2.5-Moderately Severe Chronic Lung Disease

The Diagnosis of interstitial fibrosis requiring at least intermittent oxygen therapy and showing consistent reduction in FEV 1 of one point two (1.2) litres or less under appropriate medication. Diagnosis, severity and test results must be confirmed by a Medical Practitioner.

2.6-Moderately Severe Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis

Moderately Severe Systemic Lupus Erythematosus (S.L.E) with Lupus Nephritis means an autoimmune illness in which tissues and cells are damaged by deposition of pathogenic autoantibodies and immune complexes and damage of the kidney function.

The diagnosis of S.L.E. with Lupus Nephritis will be based on the following conditions:

(1) Clinically there must be at least four (4) out of the following presentations suggested by The American College of Rheumatology.

1.1 Malar rash;
1.2 Discoid rash;
1.3 Photosensitivity;
1.4 Oral ulcers;
1.5 Arthritis;
1.6 Serositis;
1.7 Renal disorder;
1.8 Leukopenia (<4,000/μL), or Lymphopenia (< 1,500/μL), or Haemolytic anaemia, or Thrombocytopenia (< 100,000/μL); or
1.9 Neurological disorder;

AND

(2) Two (2) or more of the following tests being positive:

2.1 Anti-nuclear Antibodies;
2.2 L.E. cells;
2.3 Anti-DNA; or
2.4 Anti-Sm (Smith IgG Autoantibodies);

AND

(3) There is lupus nephritis causing impaired renal function with a creatinine clearance rate of 50 ml per minute or less.

2.7-Skin Transplantation

The actual undergoing of a transplant of skin as a recipient. Skin transplantation for the treatment of loss of skin following a disease or an injury. The skin grafting should cover at least ten percent (10%) of the body surface area as measured by The Rule of Nines or the Lund and Browder Body Surface Chart. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a Specialist of dermatology or plastic surgeon.

2.8-Surgical Removal of One Kidney

The complete surgical removal of one (1) kidney necessitated by disease or accident of the Insured. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a nephrologist or surgeon.

Removal of the kidney for purposes of organ donation is excluded.

Group 3: Disesases related to Circulatory System

3.1-Angioplasty for Carotid Arteries

Angioplasty shall mean the treatment of stenosis of fifty percent (50%) or above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met:

(a) Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and
(b) The Diagnosis and medical necessity of the treatment must be confirmed by a Medical Practitioner who is a Specialist in the relevant field.

3.2-Angioplasty of Coronary Artery

Treatment for narrowing or obstruction in one (1) or more major coronary arteries, by a balloon angioplasty, Percutaneous Transluminal Coronary Angioplasty (PTCA), atherectomy or similar intra-arterial catheter procedure. The angioplasty must be considered Medically Necessary by a consultant cardiologist, and there must be angiographic evidence of at least fifty percent (50%) stenosis in the affected coronary artery.

To be eligible for a second claim under Coronary Angioplasty, in addition to the abovementioned criteria, the treatment must also be performed on a location of stenosis or obstruction in a major coronary artery where no stenosis greater than sixty percent (60%) was identified in the coronary angiogram relating to the first claim of this illness, for which benefit has been paid.

For purposes of this definition, “major coronary artery” refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

3.3-Cardiac Pacemaker / Defibrillator Insertion

Insertion of a permanent cardiac defibrillator that is required as a result of serious cardiac arrhythmia which cannot be treated via any other method. The surgical procedure must be certified to be Medically Necessary by a registered Specialist in the relevant field.

Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be Medically Necessary by a registered Specialist in the relevant field. This benefit includes pacemakers deployed for cardiac resynchronisation therapy.

3.4-Carotid Artery Surgery

The undergoing of endarterectomy of the carotid artery which has been necessitated as a result of:

(a) at least fifty percent (50%) narrowing of the inner surface of the common or internal carotid artery as evidenced by an angiogram or any appropriate imaging studies such as computerised tomography (CT) scan or magnetic resonance imaging (MRI) or other appropriate diagnostic test(s); and
(b) experience of a Transient Ischaemic Attack (TIA).

The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a neurologist or vascular surgeon.

Endarterectomy of blood vessels other than the carotid artery are specifically excluded.

3.5-Early Cardiomyopathy

Condition of impaired ventricular function resulting in significant physical impairment of at least Class three (3) of the New York Heart Association (NYHA) classification of cardiac impairment. Cardiomyopathy includes dilated, hypertrophic and restrictive cardiomyopathy. The diagnosis and severity must be certified by a Medical Practitioner who is a cardiologist and supported by the appropriate test results including echocardiography.

Class 3 of the New York Heart Association Functional Classification of cardiac impairment means that the patient is symptomatic with marked limitation of physical activity. Comfortable at rest, but less-than-ordinary activity causes fatigue, palpitation, or dyspnea.

Cardiomyopathy caused by alcohol or drug abuse is specifically excluded.

3.6-Early Renal Failure

Chronic kidney disease with impaired renal function persisting for a period of six (6) consecutive months or more. There must be laboratory evidence (at least two (2) tests taken with an interval of two (2) months) that shows that renal function is severely decreased with a glomerular filtration rate (GFR) of less than 15 ml/min/1.73m^2 body surface area. The diagnosis and severity must be confirmed by a Medical Practitioner who is a nephrologist.

3.7-Insertion of a Vena-Cava Filter

The insertion of a vena-cava filter after there has been documented proof of recurrent pulmonary emboli and failure of anticoagulation therapy. The need for the insertion of a vena-cava filter must be certified to be Medically Necessary by a Medical Practitioner who is a cardiologist or pulmonologist.

3.8-Keyhole Coronary Bypass Surgery

The first time undergoing of bypass graft surgery via “keyhole” access for the correction of the narrowing or blockage of one (1) or more coronary arteries. The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a consultant cardiologist.

Angioplasty and all other intra-arterial, catheter based techniques, or laser procedures stent insertion are excluded.

3.9-Minimally Invasive Surgery to Aorta

The undergoing of surgery via minimally invasive or intra arterial techniques to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta, as evidenced by a cardiac computerised tomography (CT) scan or magnetic resonance imaging (MRI) or other appropriate diagnostic test(s). For the purpose of this definition, aorta means the thoracic and abdominal aorta but not its branches.

The surgery must be certified to be Medically Necessary by a Medical Practitioner who is a cardiologist or vascular surgeon.

3.10-Percutaneous Valve Surgery

Percutaneous valve surgery refers to percutaneous valvuloplasty, percutaneous valvotomy and percutaneous valve replacement, where the procedure is performed entirely via intravascular catheter based techniques. These surgical procedures must be certified to be Medically Necessary by a Medical Practitioner who is a cardiologist.

3.11-Pericardiectomy

The undergoing of a pericardiectomy or undergoing of a surgical procedure requiring keyhole cardiac surgery to treat pericardial disease. These surgical procedures must be certified to be Medically Necessary by a Medical Practitioner who is a cardiologist.

3.12-Secondary Pulmonary Hypertension

Secondary pulmonary hypertension with established right ventricular hypertrophy leading to the presence of permanent physical impairment of at least Class 3 of the New York Heart Association Classification of cardiac impairment. The diagnosis must be confirmed by a Medical Practitioner who is a cardiologist and supported by data provided through cardiac catheterization.

Class 3 of the New York Heart Association Functional Classification of cardiac impairment means that the patient is symptomatic with marked limitation of physical activity. Comfortable at rest, but less-than-ordinary activity causes fatigue, palpitation, or dyspnea.

All primary idiopathic pulmonary hypertension are specifically excluded. Pulmonary hypertension caused directly or indirectly by congenital heart disease are excluded.

Group 4: Diseases related to Nervous System

4.1-Cochlear Implant Surgery

The undergoing of a surgical cochlear implant is required due to permanent damage to the cochlea or auditory nerve, where all the following criteria are met:

(a) The Insured suffered from severe to profound sensorineural hearing impairment in both ears for over three (3) consecutive months; and

(b) There is limited benefit with the appropriate fitted hearing aid.

The surgical procedure as well as the insertion of the implant must be certified to be Medically Necessary by a Medical Practitioner who is an ear, nose and throat (ENT) Specialist.

Only Insured aged three (3) (age next birthday) or above on first diagnosis is eligible to receive a benefit under this illness.

4.2-Cerebral Aneurysm Requiring Surgery

The actual undergoing by the Insured of intracranial surgery via a craniotomy to clip, repair or remove an aneurysm of one (1) or more of the cerebral arteries. Catheter and intravascular technique are specially excluded from this condition.

4.3-Early Amyotrophic Lateral Sclerosis

Characterised by muscular weakness and atrophy, evidence of anterior horn cell dysfunction, visible muscle fasciculations, spasticity, hyperactive deep tendon reflexes and exterior plantar reflexes, evidence of corticospinal tract involvement, dysarthric and dysphagia. The diagnosis must be made by a Specialist with appropriate neuromuscular testing such as Electromyogram (EMG). The disease must result in significant physical impairment (as evidenced by the Insured's permanent inability to perform at least two (2) of the ADLs).

4.4-Early Multiple Sclerosis

A disease due to demyelination of neurological brain tissue. The diagnosis of Clinically Definite Multiple Sclerosis must be confirmed by a Medical Practitioner who is a neurologist and supported by all of the following:

(a) Investigations which unequivocally confirm the diagnosis to be Multiple Sclerosis;
(b) Multiple neurological deficits which occurred over a continuous period of at least thirty (30) days; and
(c) Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

4.5-Early Progressive Bulbar Palsy

Neurological disorder with paralysis in the head region, difficulties in chewing and swallowing, problems in speaking, persistent signs of involvement of the spinal nerves and the motor centres in the brain and spastic weakness and atrophy of the muscles of the extremities. The disease must be confirmed by a Medical Practitioner who is a neurologist. The condition must result in the permanent inability to perform, without assistance, at least two (2) of the six (6) Activities of Daily Living. These conditions have to be medically documented for at least thirty (30) days.

4.6-Early Progressive Muscular Atrophy

Confirmation of definite diagnosis of Fried-Emery, Kugelberg-Welander, Aran-Ducheme or Vulpian-Bernhardt Muscular Atrophy by a consultant neurologist. The diagnosis must be supported by muscle biopsy and CPK estimates. The condition must result in the permanent inability to perform, without assistance, at least two (2) out of six (6) Activities Daily Living. These conditions have to be medically documented for at least thirty (30) days.

4.7-Less Severe Encephalitis

Inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection requiring hospitalization and resulting in significant neurological deficit persisting for at least fourteen (14) consecutive days. The diagnosis must be supported by appropriate investigations, proving acute viral infection of the brain, and confirmed by a Medical Practitioner who is a neurologist.

4.8-Loss of Sight in One Eye

Total and irreversible loss of sight in at least one (1) eye as a result of illness or injury. The blindness must be confirmed by a Medical Practitioner who is an ophthalmologist.

4.9-Moderately Severe Alzheimer's Disease

Deterioration or loss of intellectual capacity or abnormal behavior as evidenced by the clinical state and accepted standardized questionnaires or tests arising from Alzheimer's Disease or irreversible organic degenerative brain disorders, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in being unable to perform fine motor tasks such as writing, drawing or dressing, and presence of certain movement coordination and planning difficulties (apraxia), and requiring the intermittent assistance or supervision of the Insured. The diagnosis must be clinically confirmed by an appropriate consultant.

4.10-Moderately Severe Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord which requires hospitalization and results in significant neurological deficit persisting for at least fourteen (14) consecutive days. The diagnosis must be made by a Specialist and confirmed by the presence of bacterial infection in cerebrospinal fluid by lumbar puncture.

4.11-Moderately Severe Brain Damage

Accidental head injury causing significant functional impairment which has lasted for a minimum period of thirty (30) days from the date of the trauma or injury. The resultant significant permanent functional impairment must be confirmed by a Medical Practitioner who is a neurologist.

4.12-Moderately Severe Muscular Dystrophy

The diagnosis of muscular dystrophy must be confirmed by a Medical Practitioner who is a neurologist, and based on a combination of all of the following:

(a) Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
(b) Characteristic electromyogram; and
(c) Clinical suspicion confirmed by muscle biopsy.

The condition must result in the permanent inability to perform, without assistance, at least two (2) of the six (6) Activities of Daily Living.

4.13-Moderately Severe Paralysis

The total loss of function of one (1) limb, where it is full length of the upper limb or full length of the lower limb, due to injury or disease of the spinal cord or brain, where such functional loss is considered to be permanent and confirmed by a Medical Practitioner who is a neurologist.

4.14-Moderately Severe Parkinson's Disease

Unequivocal diagnosis of Parkinson's Disease must be confirmed by a Medical Practitioner who is a neurologist where the condition:

(a) cannot be controlled with medication;
(b) shows signs of progressive impairment; and
(c) must result in the permanent inability to perform, at least two (2) of the six (6) Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered. All other types of Parkisonism are excluded.

4.15-Moderately Severe Poliomyelitis

Unequivocal diagnosis of infection by the Poliovirus leading to paralytic disease must be evidenced by impaired motor function or respiratory weakness that has persisted for at least thirty (30) days. The diagnosis must be confirmed by a Medical Practitioner who is a neurologist and supported by the appropriate medical investigations.

Cases not involving paralysis will not be eligible for this. Other causes of paralysis are specifically excluded.

4.16-Severe Psychiatric Illness

A first definitive Diagnosis of Severe Depression, Schizophrenia or Bipolar Disorder by a Medical Practitioner who is a psychiatrist, which requires in-patient hospitalization for more than twenty-eight (28) consecutive days in the psychiatric unit of a designated hospital for Severe Psychiatric Illness as listed under 'List of Designated Hospitals for Severe Psychiatric Illness' on Our website. Such list may be varied, updated

and amended from time to time at Our discretion, and any change shall be deemed effective as of the date of publication on Our website (regardless of whether any notice is separately given).

For the avoidance of doubt, hospitalization must be primarily due to Severe Depression, Schizophrenia or Bipolar Disorder, and hospitalization solely due to any other cause or psychiatric condition is excluded. Further and notwithstanding the foregoing, Severe Depression, Schizophrenia or Bipolar Disorder due, whether in whole or in part, to drug, alcohol or substance abuse, and hospitalization for drug or alcohol rehabilitation are excluded.

4.17-Surgery for Subdural Haematoma

The actual undergoing of craniotomy or burr hole surgery to the head to drain subdural hematoma as a result of an accident. The need for the craniotomy or the burr hole surgery must be certified as Medically Necessary by a Medical Practitioner who is a neurosurgeon.

4.18-Surgical Removal of Pituitary Tumour

The undergoing of surgical removal of pituitary tumour necessitated as a result of symptoms associated with increased intracranial pressure caused by the tumour. The presence of the underlying tumour must be evidenced by appropriate imaging studies such as computerised tomography (CT) scan or magnetic resonance imaging (MRI). The surgery must be certified as Medically Necessary by a Medical Practitioner who is an endocrinologist or neurosurgeon.

Removal of pituitary microadenoma (tumor of size 1cm or below in diameter) is specifically excluded.

Group 5: Other Diseases

5.1-Acute Necrohemorrhagic Pancreatitis

Acute inflammation and necrosis of pancreas parenchyma, focal enzyme necrosis of pancreatic fat and haemorrhage due to blood vessel necrosis which must be treated with surgical clearance of necrotic tissue or pancreatectomy. The diagnosis must be based on histopathological features and confirmed by a Medical Practitioner who is a gastroenterologist.

Pancreatitis caused directly or indirectly, wholly or partly, by alcohol or drug abuse is excluded.

5.2-Adrenalectomy for Adrenal Adenoma

Adrenalectomy for treatment of malignant systemic hypertension that was secondary to an aldosterone secreting adrenal adenoma. The adrenalectomy must be Medically Necessary for the management of poorly controlled hypertension as confirmed by a Medical Practitioner who is an endocrinologist.

5.3-Amputation of One Foot due to Complication from Diabetes Mellitus

Complications of diabetes mellitus resulting in the amputation of one (1) foot at or above ankle as advised by a registered Specialist diabetologist as the only means to maintain life. Amputation of only toe or toes, or any other causes for amputation shall not be covered.

5.4-Coma for 48 hours

A state of unconsciousness with no reaction to external stimuli or internal needs which:

(a) Requires the use of life support systems for a continuous period of at least forty-eight (48) hours; and
(b) Results in permanent neurological deficit (s) with persisting clinical symptoms.

Coma secondary to alcohol or drug abuse shall not be covered.

5.5-Crohn's Disease (Regional Enteritis)

Crohn's Disease is a chronic granulomatous inflammatory disease of the intestine. The diagnosis must be confirmed by a Medical Practitioner who is a gastroenterologist or a consultant of the appropriate medical specialty, and supported by the characteristic histopathological features.

5.6-Diabetic Retinopathy

Diabetic Retinopathy shall mean advanced changes to the retinal blood vessels as a consequence of diabetes mellitus.

All of the following criteria must be met:

(a) Presence of diabetes mellitus at the time of Diagnosis of Diabetic Retinopathy;
(b) Visual acuity of both eyes is 6/18 or worse using Snellen eye chart;
(c) Actual undergoing of treatment such as laser treatment to alleviate the visual impairment; and
(d) The Diagnosis of Diabetic Retinopathy, the severity of visual impairment and the medical necessity of treatment must be confirmed by a Medical Practitioner who is an ophthalmologist.

5.7-Early Elephantiasis

End stage Lymphatic Filariasis, characterised by significant enlargement and disfiguration of the infected body area (legs, genitals or breasts) due to blockage of the lymphatic system by filariae parasites. The diagnosis must be supported by laboratory tests showing circulating filariae antigen or microfilariae in a blood smear (Wuchereria bancrofti or Brugia malayi).

Other forms of lymphedema or acute lymphangitis are excluded.

The diagnosis must be confirmed by a Medical Practitioner who is a Specialist or a consultant of the appropriate medical specialty.

5.8-Loss of Speech due to Vocal Cord Paralysis

Total and irrecoverable loss of the ability to speak due to vocal cords paralysis from any diseases or Injury, which must be established for a continuous period of three (3) months. The diagnosis must be confirmed by a Medical Practitioner who is an ear, nose and throat (ENT) Specialist.

All psychological causes leading to the Loss of Speech are excluded.

5.9-Moderately Severe Burns

Third Degree burns covering at least ten percent (10%) of the surface of the body of the Insured or Third Degree burns covering at least thirty percent (30%) of the surface of the face of the Insured as measured by The Rule of Nines or the Lund and Browder Body Surface Chart.

5.10-Moderately Severe Rheumatoid Arthritis

Widespread joint destruction as a result of severe Rheumatoid Arthritis with major clinical deformity of two (2) or more of the following joint areas:

(a) hands;
(b) wrists;
(c) elbows;
(d) cervical spine;
(e) knees; or
(f) ankles.

The diagnosis must be supported by all the following:

(a) Morning stiffness;
(b) Symmetric arthritis;
(c) Presence of rheumatoid nodules;
(d) Elevated titres of rheumatoid factors; and
(e) Radiographic evidence of severe involvement.

The severity of the disease shall be such that there will be at least two (2) of the Activities of Daily Living which the insured will, for a continuous period of at least three (3) months, have been unable to perform without the assistance of another person.

At Our discretion, confirmation of the diagnosis and the degree of disability may be required through an independent medical examination by a Specialist rheumatologist appointed by Us.

5.11-Osteoporosis with Fractures

The occurrence of Osteoporosis with Fractures where all of the following conditions are met:

(a) at least a fracture of the neck of femur or two (2) vertebral body fractures, due to or in the presence of osteoporosis; and
(b) bone mineral density measured in at least two (2) sites by dual-energy x-ray densitometry (DEXA) or quantitative CT scanning is consistent with severe osteoporosis (T-score of less than -2.5).

Actual undergoing of internal fixation or replacement of the fractured bone is required.

Coverage for Severe Osteoporosis will automatically cease at age seventy (70) (age next birthday) of the Insured.

5.12-Severance of One Limb

Loss of one limb shall mean severance of at least one (1) limb at or above wrist or ankle as a result of illness or injury.

5.13-Severe Central or Mixed Sleep Apnea

An unequivocal Diagnosis of Central Sleep Apnea or Mixed Sleep Apnea by a Medical Practitioner who is a Specialist in the relevant field, provided that such condition has been treated by a Medically Necessary permanent tracheostomy and proof of undergoing permanent tracheostomy can be provided.

Part 2: Special Diseases for Juvenile (For Age Next Birthday 1(15days) – 18)

1-Autism

A severe emotional disturbance of childhood characterised by qualitative impairment in reciprocal social interaction and in communication, language and social development.

A total of six (6) or more manifestations from (a), (b) and (c) below:

(a) Qualitative impairment of social interaction (at least two (2) manifestations):
  (i) Marked impairment in the use of multiple types of non-verbal behavior such as eye to eye gaze, facial expression, body postures, and gestures to regulate social interaction;
  (ii) Failure to develop peer relationships appropriate to developmental level;
  (iii) Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by lack of showing, bringing, or pointing out objects of interest); or
  (iv) Lack of social or emotional reciprocity;

(b) Qualitative impairment of communication (at least one (1) manifestation):
  (i) Delay in, or lack of, development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime);
  (ii) In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;
  (iii) Stereotyped and repetitive use of language or idiosyncratic language; or
  (iv) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(c) Restrictive and stereotyped patterns of behavior, interests, and activities (at least one (1) behavioral manifestation):
  (i) All-encompassing preoccupation with one (1) or more restricted, repetitive, and stereotyped patterns of interest that is abnormal either in intensity or focus;
  (ii) Apparently inflexible adherence to specific, non-functional routines or rituals;
  (iii) Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements); or
  (iv) Persistent preoccupation with parts of objects.

Diagnosis must be confirmed by a pediatric psychiatrist and the condition must have continued without interruption for a period of at least six (6) months after diagnosis. Psychosocial Interventions and/or special education and/or behavior therapy should have been carried out.

Asperger syndrome and atypical autism are specially excluded.

2-Dengue Haemorrhagic Fever

The severe type of dengue virus infection characterised by all of the four symptoms, including high fever, haemorrhagic phenomena, hepatomegaly and circulatory failure (Dengue Shock Syndrome DSS - WHO DHF grades III and IV). The diagnosis of Dengue Haemorrhagic Fever must be confirmed by a registered Specialist in the relevant field.

Non-Haemorrhagic Dengue Fever is excluded.

3-Juvenile Huntington Disease

Confirmed by a registered specialist pediatrician of a definite diagnosis of Juvenile Huntington Disease with genetic test. There must be evidence of permanent and irreversible cognitive impairment and neurological deficit including all of the following:

(a) Bradykinesia, stiffness and rigidity; and
(b) Impaired voluntary movement; and
(c) Oromotor dysfunction including speech and swallowing impairment confirmed by registered speech therapist.

4-Kawasaki Disease

Diagnosis must be based on blood tests to detect mild anaemia, a white blood cell count above normal, and an elevated erythrocyte sedimentation rate which indicates blood vessel inflammation. A sharp rise in the number of platelets, the major clotting element in the blood must also be detected.

Payment will only be paid if diagnostic tests reveal the presence of coronary aneurysm or other heart or blood vessel abnormality which necessitates surgical treatment.

5-Marble Bone Disease (Osteopetrosis)

Marble Bone Disease is characterized by increased bone density, brittle bone and skeletal abnormalities. The Insured must be diagnosed as the intermediate type (also called "Marble Bone Disease") and confirmed with the occurrence of all the following conditions by a registered Specialist in the relevant field:

(a) The results of physical examination of the insured by a registered Specialist in the relevant field that the insured suffers from cranial nerve palsy; and
(b) The results of blood test confirmed pancytopenia; and
(c) The result of x-ray studies reveal diffuse abnormal hardening of bones, multiple fracture and joint deformity.

Diagnosis of Osteopetrosis must be confirmed by a registered Specialist acceptable to Us.

6-Osteogenesis Imperfecta

The occurrence of Osteogenesis Imperfecta – Type III where all of the following conditions are met:
(a) The result of skin biopsy is positive for Diagnosis of Osteogenesis Imperfecta – Type III;
(b) The result of X-ray studies reveals multiple fractures of bones and progressive kyphoscoliosis;
(c) There is evidence of growth retardation and hearing impairment as a result of the disease; and
(d) The Diagnosis is confirmed by a Medical Practitioner who is a pediatrician.

7-Rheumatic Fever with Valvular Impairment

A confirmed diagnosis by a registered pediatric cardiologist of acute rheumatic fever. There must be involvement of one (1) or more heart valves with at least moderate valve incompetence (means regurgitant fraction of twenty percent (20%) or above) and/or moderate valve stenosis (means valve area of thirty percent (30%) or less of normal value) attributable to rheumatic fever as confirmed by quantitative investigations of the valve function by a registered cardiologist. The valve incompetence and/or valve stenosis must persist for at least six (6) months.

8-Severe Asthma

The Insured suffers from severe asthma which is characterised by at least four of the following criteria:

(a) History of status asthmaticus within the past two (2) years;
(b) Significant and continuous reduction in exercise tolerance;
(c) Chest deformities resulting from chronic hyperinflation;
(d) The need for medically prescribed oxygen therapy at home; or
(e) Continuous daily use of oral corticosteroids (for a minimum period of at least six (6) months).

9-Still's Disease

This is characterised by high fever and signs of systemic illness that exists for months before the onset of arthritis. The insured also suffers from cardinal disorders including high spiking, daily (quotidian) fevers, evanescent rash, arthritis, splenomegaly, lymphadenopathy, serositis, weight loss, neutrophilic leukocytosis, increased acute phase proteins and seronegative tests for ANA and RF. Payment will only be made if the Insured condition is serious enough to be advised by a doctor to have knee or hip replacement for the treatment of the disease.

The diagnosis must be confirmed by a pediatric rheumatologist.

10-Type 1 Diabetes Mellitus

The occurrence of Type 1 Diabetes Mellitus where all of the following conditions are met:

(a) The diagnosis is confirmed by a registered pediatric endocrinologist; and
(b) The disease has persisted for at least six (6) months following such Diagnosis, during which period insulin administration on a daily basis is Medically Necessary to regulate glucose metabolism.

Type 2 Diabetes Mellitus is specially excluded.

11-Type I Juvenile Spinal Amyotrophy

The Insured must be Unequivocally Diagnosed as a Type I Juvenile Spinal Amyotrophy which is an infantile form of spinal muscular atrophy characterised by progressive dysfunction of the anterior horn cells in the spinal cord and brainstem cranial nerves with profound weakness and bulbar dysfunction. Electromyography and muscle biopsy are needed to confirm this Unequivocal Diagnosis.

12-Type II Juvenile Spinal Amyotrophy

The Insured must be Unequivocally Diagnosed as a Type II Juvenile Spinal Amyotrophy which is an infantile form of spinal muscular atrophy characterised by progressive dysfunction of the anterior horn cells in the spinal cord and brainstem cranial nerves with profound weakness and bulbar dysfunction. Electromyography and muscle biopsy are needed to confirm this Unequivocal Diagnosis.

Second Medical Opinion Service

As part of Our promise of care, you are given the access to some of the highest ranked medical institutions in the US through International SOS for a Second Medical Opinion Service once your Big 3 Disease or Crisis (if applicable) claim is approved.

What is Second Medical Opinion Service?
The objective of the Second Medical Opinion Service is to meet the public's increasing demands for the best possible medical treatment bearing in mind the continual development of leading edge treatments for major diseases. This is why We offer the Second Medical Opinion Service to Our valuable Insured via International SOS.

Under this distinguished service, the Insured has access to a panel of world-class specialists at leading medical institutions in the US to obtain alternative advice on the Insured's medical condition and confirmation of the diagnosis in the event that the Insured's Big 3 Disease or Crisis (if applicable) claim is approved.

Panel of Second Medical Advice Specialists
The Panel provides you access to some of the highest ranked medical institutions in the US, together with more than 15,000 leading specialists who practice there, including:

- Harvard Medical School
- Johns Hopkins Hospital, Baltimore
- Massachusetts General Hospital
- Brigham and Women's Hospital, Boston
- Dana-Faber Cancer Institute
- Cedars-Sinai Medical Center, Los Angeles

How to seek Second Medical Opinion Service?
When the Insured has been diagnosed with one of the Big 3 Diseases or Crises (if applicable), the Insured is required to follow the instructions below to obtain the Second Medical Opinion Service. Call International SOS at (852) 3122 2900 and request the Second Medical Opinion Service. Within 24 hours International SOS will confirm membership and whether the medical condition is eligible for the service.
Service Flow
1) Receive "Information Request Form" from International SOS via fax or email. International SOS will advise the medical documents required. 2) International SOS will assess the case and reply to the Insured if his/her case is eligible for the service. The Insured needs to complete the **Information Request Form** and send to International SOS together with the relevant medical documents for the Second Medical Opinion Report*. (via courier or registered mail) 3) The Panel of Second Medical Opinion will send an acknowledgement to International SOS after receipt. If additional medical information is required, the Panel of Second Medical Opinion will inform International SOS who will in turn contact the Insured. 4) After evaluation, the written Second Medical Opinion report and advice will be faxed/ emailed to International SOS within 3-5 US working days depending on the complexity of the report. 5) Upon receipt of the Second Medical Opinion report, International SOS will send it to the Insured and his/her treating physician, as required. If requested, International SOS will arrange transportation, accommodation and admission to the identified treating facility and with a medical escort, if medically necessary. ALL RELATED COSTS to International SOS WILL BE BORNE BY THE INSURED. *Second Medical Opinion Report is US$850. (The cost may be reviewed from time to time)

The information above is for reference only and none of the above is binding upon Us or International SOS.

The service is provided by International SOS and it is not guaranteed renewable. We shall not be responsible for any act or failure to act on the part of International SOS and the professionals. Details of the services may be revised from time to time without Our prior notice.

Note:

1) We, the medical panel, International SOS and/ or any of its affiliates, record, share, use and archive your personal data in pursuance of the services being offered to you as well as for their training and quality assurance purposes . The failure to provide the relevant personal data may result in the said service providers being unable to provide the relevant services to you.

2) The Second Medical Opinion Service provided to you is purely advisory and recommendatory in nature and is not a substitute for medical services. It is for you and your physician or consulting hospital to decide the appropriate medical course of action to be pursued. The International SOS, and/ or its affiliates and the panel providing the medical opinion do not have any authority or responsibility to determine the benefits/ amounts payable, its eligibility, claim processing etc.