



International Health Contract

This International Health Contract is issued by
FWD Singapore Pte. Ltd.
who will pay the benefits of this **Policy**, subject to
the terms and conditions set out in this **Policy**.

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Table of Benefits

The benefit limits defined in the table below refers to the limit for one **Insured Person**.

Benefits	Benefit Limitations					
Hospitalisation Benefits						
Annual limit (maximum amount payable under Hospitalisation Benefits)	S\$100,000	S\$250,000	S\$500,000	S\$1,000,000	S\$2,000,000	S\$3,000,000
Deductible Option	S\$0, S\$1,000, S\$3,000, S\$5,000 or S\$10,000					
Hospital accommodation	Standard Single Room or Shared Room					
Worldwide emergency treatment	Accident: Paid in full; Illness: S\$25,000					
Hospital charges	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Accidental dental treatment	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Home nursing	30 days	30 days	30 days	30 days	30 days	30 days
Parent accommodation (per night)	S\$250	S\$250	S\$250	S\$250	S\$250	S\$250
Cancer treatment	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Kidney dialysis	-	-	S\$20,000	S\$30,000	S\$50,000	Paid in full
Organ transplant	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Pregnancy complications ¹	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
HIV / AIDS treatment (per lifetime)	-	-	-	S\$30,000	S\$30,000	S\$30,000
Psychiatric treatment (per lifetime)	-	-	-	S\$30,000	S\$30,000	S\$30,000
Congenital conditions (per lifetime)	-	-	-	S\$30,000	S\$30,000	S\$30,000
Pre-hospitalisation treatment	90 days	90 days	90 days	90 days	90 days	90 days
Post-hospitalisation treatment	90 days	90 days	90 days	90 days	90 days	90 days
Additional Benefits						
Hospital cash benefit (per day)	S\$100	S\$100	S\$150	S\$150	S\$200	S\$200
Accidental death and disability ²	S\$25,000	S\$50,000	S\$50,000	S\$100,000	S\$200,000	S\$500,000
No claim bonus	Yes	Yes	Yes	Yes	Yes	Yes
Reload benefit	Yes	Yes	Yes	Yes	Yes	Yes
Medical evacuation and repatriation	S\$1,000,000	S\$1,000,000	S\$1,000,000	S\$1,000,000	S\$1,000,000	S\$1,000,000
24/7 medical advice	Yes	Yes	Yes	Yes	Yes	Yes
Outpatient Benefits ³ (applicable only if You purchased this benefit as defined in Your Policy Schedule)						
Outpatient limit (maximum amount payable under Outpatient Benefit)	-	-	S\$5,000	S\$10,000	S\$15,000	Paid in full
Coinsurance option	-	-	10% or 20%			
Consultations, medications, diagnostic tests	-	-	Paid in full	Paid in full	Paid in full	Paid in full
Physiotherapy	-	-	14 visits	20 visits	Paid in full	Paid in full
Alternative medicine and treatment	-	-	S\$500	S\$1,000	S\$1,500	S\$1,500
Psychiatric and psychological care (per lifetime)	-	-	-	6 visits	8 visits	10 visits
Routine health checks and vaccinations	-	-	-	S\$250	S\$500	S\$1,000
Dental & Vision Benefits ³ (applicable only if You purchased this benefit as defined in Your Policy Schedule)						
Basic and routine dental work	-	-	-	S\$750	S\$1,250	S\$1,400
Complex dental work ¹	-	-	-			
Frames, lenses and eye checks (every 2 years)	-	-	-	S\$100	S\$200	S\$300
Maternity Benefits ¹ (applicable only if You purchased this benefit as defined in Your Policy Schedule)						
Pre-natal visits, delivery and post-natal visits	-	-	-	S\$8,000	S\$12,000	S\$20,000
Consultations, medications, diagnostics tests	-	-	-			
Newborn Care	-	-	-	S\$15,000	S\$20,000	S\$40,000

¹ 12 months waiting period applies

² Coverage amount for **Children** is 25% of this benefit

³ **Coinsurance** applies, as defined in **Your Policy Schedule**

1. Definitions

Any word or phrase appearing in **Capitalised Bold** within this Contract will have the meanings as stated below:

“**Accident**” or “**Accidental**” refers to a sudden, unexpected, unusual and specific event during the **Period of Insurance** which was not deliberate and caused by violent, external or visible means only. It happens at an identifiable time and place and, without being linked to any other cause, is the only cause of **Injury**.

“**Annual Limit**” refers to the maximum benefit payable under Hospitalisation Benefits to an **Insured Person** in a given policy year.

“**Application Form**” refers to the form attached to this **Policy** summarising the answers and information **You** provided to **Us** when applying for this **Policy**. **Our** decision to issue this **Policy** is based on the information on the **Application Form**.

“**Assisted Conception**” refers to the use of any intervening medical procedure to result in pregnancy. This includes but is not limited to Intra-uterine insemination (IUI) or In vitro fertilisation (IVF).

“**Child**” or “**Children**” refers to an **Insured Person** under this **Policy** who is 21 years of age or younger at the Coverage Start Date. In this **Policy**, children means **Your** biological children, **Your** adopted children or any other children for whom **You** are legally responsible in a parent/guardian-child relationship.

“**Coinsurance**” refers to the co-sharing of costs between **You** and **Us**. The percentage stated in **Your Policy Schedule** indicates the share that **You** need to pay towards **Your** Outpatient Benefits, and Dental and Vision Benefits claims.

“**Congenital Conditions**” refers to any medical condition and physical defects that have been, or believed to have been, in existence since birth.

“**Country of Residence**” refers to the country in which the **Insured Person** normally resides for a period of no less than six months in a given **Period of Insurance**.

“**Coverage Area**” means the geographic area of the world in which the **Insured Person** is covered for **Eligible Elective, Accidental** or **Emergency** treatments.

“**Dependant**” refers to **Your** legal spouse or **Your Children**.

“**Day Patient**” refers to an **Insured Person** that undergoes **Day-Care Treatment**. He/she requires a medically supervised recovery but does not occupy a bed overnight.

“**Day-Care Treatment**” means treatments or surgeries that do not require an overnight stay in a **Hospital** or day-care unit, where a discharge note or report will be issued. This does not include **Outpatient** treatment.

“**Deductible**” refers to the initial amount **You** need to pay for each year of insurance before **We** will make any payments. Deductible applies only to the Hospitalisation Benefits.

“**Direct Billing Service**” refers to the arrangement whereby **We** will pay **Eligible**, incurred medical expenses directly to **Your** medical service provider. **You** will remain responsible to pay for any costs that **You** are not **Eligible** for, under the benefits.

“**Eligible**” refers to persons, conditions, events, treatments and charges, which are covered by the **Insured Person’s** plan when **Premium** has been paid.

“**Elective**” refers to **Medically Necessary** non-**Emergency** treatments that can be planned and scheduled in advance.

“**Emergency**” refers to a life threatening medical condition or symptom caused by an **Illness** or **Injury** that requires immediate medical treatment within 24 hours of the emergency event, which without it could result in death or serious impairment of bodily function.

“**Endorsement**” is any additional document attached to this **Policy** outlining adjustments to the standard terms and conditions that **We** have made as a condition to providing this **Policy**.

“**Family Member**” means **Your** husband or wife or legally recognised partner, children, parents, brothers and sisters, parents-in-law, brothers-in-law, sisters-in-law, grandparents, grandparents-in-law, daughters-in-law, sons-in-law or grandchildren.

“**Hospice and Palliative Care**” refers to care provided to relieve suffering and to improve the quality of life of terminally ill patients. Terminally ill is any medical condition that, in the opinion of a **Medical Practitioner**, is expected to lead to death within the next 12 months.

“**Hospital**” refers to a facility that meets all of the following requirements:

- Is licensed as a hospital under the laws of the country where it operates;
- Has registered nurses and at least one **Medical Practitioner** stationed at all times;
- Is operated mainly to diagnose and treat injuries or illnesses on an in-patient basis;
- Has organised facilities for X-ray and major surgery; and
- Is not primarily a nursing facility, clinic, nursing home, convalescence Home, psychiatric facility, drug and alcohol rehabilitation facility, preventative medicine facility or hospice care (except for the terminally ill).

“**Hospitalisation**” or “**Hospitalised**” refers to when an **Insured Person** is confined to a **Hospital** for an overnight stay or longer, on the advice of a **Medical Practitioner** for treatment of an **Injury** or **Illness**.

“**Injury**” refers to a bodily injury caused only and directly by an **Accident** within the **Period of Insurance**. **Injury** is not due to any illness or disease.

“**Illness**” refers to deteriorating physical health because of a medical condition that:

- First started, was first contracted, or physical signs and symptoms were first displayed during the **Period of Insurance**;
- Was not caused by an **Accident**; and
- Needs a **Medical Practitioner**’s care and/or treatment.

“**Insured Person**” refers to the individual(s) named in the **Policy Schedule** covered under this **Policy**.

“**Letter of Guarantee**” refers to a guarantee of payment offered to medical service providers on behalf of an **Insured Person**, for the **Eligible** portion of treatment expenses.

“**Medical Practitioner**” refers to a person who has a medical degree, is licensed or registered in the country in which they operate, and is accredited by a medical board or equivalent organisation to render medical services, with the exception of **Family Members**.

“**Medical Specialist**” refers to a **Medical Practitioner** with necessary qualifications and expertise to practise as a recognised specialist of diagnostic techniques, treatment and prevention in a specific medical field of study, such as oncology or pediatric.

“**Medically Necessary**” refers to medical services, procedures or supplies that are:

- Required by a **Medical Practitioner** to treat an **Injury** or **Illness**. These services, procedures or supplies are necessary because without them, the patient’s medical condition will be adversely affected;
- Widely accepted within the medical profession in the country of treatment as being effective, appropriate and essential for treating a patient’s **Injury** or **Illness** based on recognised standards of the medical specialty involved;
- Not considered experimental and/or developmental in nature, or, if experimental and/or developmental in nature, is recognised by the Singaporean medical profession as having potential to become part of conventional medicine;
- Not **Elective**, preventative or screening in nature. These services, procedures or supplies are also not given to the patient for personal comfort or convenience, or for him or her to make a profit, or for the treating **Medical Practitioner** and/or medical service provider to make a profit; and
- Charged at fair market rates in **Our** opinion.

“**Nationality**” refers to the country of citizenship of the **Insured Person** as declared in their **Application Form** and from which a passport has been issued.

“**Newborn**” refers to an infant that is no older than 60 days from birth.

“Outpatient” refers to an **Insured Person** who is treated by a **Medical Practitioner** without being admitted as an overnight or **Day Patient**.

“Period of Insurance” refers to the period of time between the Coverage Start Date and Coverage End Date (both inclusive) as shown on the **Policy Schedule**.

“Policy Schedule” refers to the form attached to this **Policy** that shows important information about **You** and this **Policy**: the Policy Number, **Policyholder** and **Insured Person**’s personal details, **Period of Insurance**, **Annual Limit**, Benefits, Frequency of Premium Payment, and Premium Payable.

“Policyholder” refers to the named owner of this **Policy** as shown on the **Policy Schedule**.

“Pre-Authorisation” or **“Pre-Authorised”** refers to the process set out in Section 13(1) of this **Policy**.

“Pre-Existing Condition” refers to a medical condition that has one or more of the following characteristics at or prior to policy commencement:

- It was foreseeable;
- It was known or suspected by **You** or the **Insured Person**;
- It was in discussion between yourself and a medical professional; or
- It was found to be responsible for signs or symptoms **You** were experiencing.

“Premium” refers to the scheduled Premium Payable for this **Policy** as shown in the **Policy Schedule**.

“Product Summary” refers to the document attached to this **Policy** provided when **You** bought this **Policy**. It provides a summary of this product and its benefits.

“Reasonable and Customary” means generally prevailing and of normal standard for the medical condition concerned at the country and city where the **Insured Person** is treated, considering the treatment involved.

“Shared Room” means dual occupancy accommodation in a **Hospital**. If multiple levels of dual occupancy accommodation exist, it shall mean the lowest cost level providing for 2 patients in one room and a shared bathroom.

“Standard Single Room” means single occupancy accommodation in a **Hospital**. If multiple levels of single occupancy accommodation exist, it shall mean the lowest cost level providing for a single patient in one room with a private bathroom. Deluxe, executive rooms and suites, for instance, are not covered.

“Total and Permanent Disability” means that:

- **You** are disabled as a result of an **Accident** to the extent of being completely unable to engage in any occupation, business or activity for income, remuneration or profit. The disability must continue uninterrupted for at least six consecutive months from the time when disability started and must, in the view of a **Medical Practitioner**, be deemed permanent with no possibility of improvement in the foreseeable future; or
- **You** suffer total and irrecoverable loss of:
 - Entire sight in both eyes;
 - Use of any two limbs at or above the wrist or ankle; or
 - The entire sight in one eye and use of any one limb at or above the wrist or ankle.

“You”, “Your”, and “Insured Person” refers to the person who is insured by this **Policy** as shown on the **Policy Schedule**.

“We”, “Our”, “Us”, or “FWD”, refers to **“FWD Singapore Pte. Ltd.”**, the issuer of this insurance **Policy**.

2. General Provisions

1. INFORMATION ABOUT THIS POLICY

This Contract, the **Policy Schedule**, **Product Summary**, **Application Form**, and any **Endorsements** attached by **Us** collectively form this **Policy**, is proof of an insurance contract between the **Policyholder** and **Us**.

Please read carefully all of the information provided in this **Policy** to make sure **You** fully understand **Your** benefits, their limits, and **Our** mutual responsibilities towards this **Policy**.

Please inform **Us** immediately if any details in **Your Policy Schedule** are inaccurate or become inaccurate. The Law as per Section 25(5) of the Insurance Act requires that **We** inform **You** of **Your** duty to fully and faithfully tell **Us** everything **You** know or could reasonably be expected to know that is relevant to **Our** decision to insure **You**. Otherwise, **We** have the right to either decline **Your** claims or terminate this **Policy** and treat it as never having existed. In the event that **We** decide to maintain **Your** cover, **We** may charge an additional **Premium**. **We** may also terminate this **Policy** if any submitted claim is fraudulent, or if **We** are required to do so under any directives, laws, regulations or sanctions administered by any regulatory authorities in any country.

Please contact **Us** at +65 6715 9919 or FWDservices@safemeridian.com if **You** have any questions.

2. GOVERNING LAW AND CURRENCY

This **Policy** is governed by the Republic of Singapore's laws.

All amounts payable by **You** or from **Us** in relation to this **Policy** will be in Singapore dollars. **We** will convert any **Eligible** expenses **You** incur overseas into Singapore dollars at a reasonable foreign currency exchange rate **We** choose. **We** are not legally responsible for any exchange rate-related losses that **You** may incur.

We will not be liable to pay any claims made or to provide any benefit under this **Policy** if providing that benefit is prohibited under any directives, laws, regulations, or sanctions administered by regulatory authorities in any country.

3. WHEN INSURANCE COVER BEGINS AND ENDS

This is a 12-month **Policy**, providing insurance cover for the **Period of Insurance** and is valid within the **Coverage Area** (unless otherwise noted) stated in **Your Policy Schedule**. At the end of the **Period of Insurance**, if **We** offer **You** renewal terms, **You** may renew the **Policy** for further 12-month periods at the prevailing terms and conditions.

We will only pay for **Eligible** medical conditions that occur within the **Period of Insurance**. If **You** are receiving treatment at the time **Your Policy** ends, **We** will only pay benefits for **Eligible** expenses incurred before **Your Policy** ends.

4. BASIS FOR OFFERING THIS POLICY

A **Policyholder** must be between 18 and 65 years of age at the time of application. **Your Dependants** may be enrolled into the same plan. To be eligible, **Dependants** must be:

- Your legal spouse aged 65 or younger;
- Your child(ren) aged between 31 days and 21 years.

We have used the information **You** provided in the **Application Form** and other documents that **You** have submitted to determine whether to offer this **Policy**. If **Your** information shown in the **Application Form** is inaccurate or become inaccurate, **We** may adjust the **Premiums** after taking into account the accurate information.

If any information **You** provided is inaccurate or become inaccurate and if, based on the correct information, **We** would not have offered this **Policy**, **We** may terminate this **Policy** and treat it as never having existed.

5. CHILD POLICIES

When a **Child** is the only **Insured Person** under the **Policy**, they must be enrolled with a parent or guardian as the **Policyholder**. In this case, the parent or guardian (who is the **Policyholder**) will not be **Eligible** for benefits. Upon reaching the age of 22, **Your** child will become the **Policyholder**.

6. THIRD PARTIES

In accordance with the Contracts (Rights of Third Parties) Act (Chapter 53B), only parties directly involved in this **Policy** can enforce its terms.

3. Hospitalisation Benefits

This section describes the hospitalisation benefits as shown in the Table of Benefits. To ensure that **You** are **Eligible** for benefits, **You** are advised to seek **Pre-Authorisation** for treatments.

1. HOSPITAL ACCOMODATION

We will pay for daily hospital accommodation charges, up to the limit stated in the Table of Benefits, when **You** are hospitalised for an **Eligible** treatment. Depending on **Your** choice at application and as shown in **Your Policy Schedule**, **Your** plan will entitle **You** to either a **Single Standard Room** or a **Shared Room**.

In the event **You** are admitted into a higher room with higher corresponding treatment fees, **We** will only reimburse for accommodation and treatment at the cost which **You** would have been charged if **You** had stayed in the room type which **You** are entitled.

2. WORLDWIDE EMERGENCY TREATMENT

We will pay for the full **Hospitalisation** charges arising out of an **Emergency** treatment if **You** are traveling outside of **Your** selected **Coverage Area**. In the event such treatment is due to an **Illness**, the maximum benefit payable is capped at S\$25,000. Treatment due to an **Accident** is covered in full, up to **Your** chosen **Annual Limit**.

If the **Emergency** treatment occurs within **Your Coverage Area**, the benefit is payable up to **Your** chosen **Annual Limit**.

3. HOSPITAL CHARGES

We will pay for all of the following costs up to the limit stated in the Table of Benefits, when **Hospitalised** or admitted as a **Day Patient**, up to the level provided by **Your Policy**:

- **Day-Care treatment;**
- Surgery related costs including the medical charges of surgeons, anaesthesiologists, theatre charges, and charges for any equipment used during surgery, including recovery rooms charges;
- Specialist consultation fees;
- Prescribed medicines, drugs and dressings;
- Diagnostic tests including pathology, radiology, MRI, CT, PET scans, ECG/EKG;
- Intensive care including intensive care units, high dependency and coronary care units;
- Medical device surgically implanted as part of the treatment;
- Nursing care during hospital stay;
- Reconstructive treatment where medically required to restore the **Insured Person's** appearance after a covered **Illness, Injury**, or surgery within 2 years of the **Illness, Injury**, or surgery;
- Accidental treatment to teeth;
- Ambulance fee;
- Rehabilitation costs which includes prescribed therapies such as physical, occupational, and speech therapy; or
- **Hospice and Palliative Care** services for a terminal diagnosis.

4. ACCIDENTAL DENTAL TREATMENT

We will pay for restorative dental treatment required to treat or replace natural teeth lost or damaged following an **Accidental Injury** to the mouth within 30 days of the **Injury**, up to the limit stated in the Table of Benefits. Such treatment must be carried out by a **Medical Practitioner**.

What is not covered:

- Damage to mouth or teeth caused by eating or gradual deterioration; or
- Damage sustained to crowns, dentures, bridge work, or existing false teeth.

5. HOME NURSING

We will pay for the reasonable cost of home nursing up to the limit stated in the Table of Benefits when following a **Hospitalisation** and meeting all of the following criteria:

- **You** have been **Hospitalised** and home nursing is deemed **Medically Necessary** for **Your** recovery by the **Medical Practitioner** who treated **You** while **You** were **Hospitalised**;
- It starts immediately upon discharge and reduces the length of time the **Insured Person** would otherwise be required to stay in **Hospital**; and
- It is provided in the **Insured Person's** home by a qualified nurse where the nurse is needed to provide medical care, not personal assistance.

What is not covered:

- Related services or supplies not covered by this **Policy**; or
- Nursing Care where provided by a nurse who usually lives with the **Insured Person**, who is a member of the **Insured Person's** family or a **Family Member** of anyone **You** live with.

Home nursing provided as part of palliative care will be **Eligible** for benefits under the **Hospice and Palliative Care** limits.

6. PARENT ACCOMMODATION

In the event a **Child** is **Hospitalised**, **We** will pay for the cost of one parent or guardian to stay with the **Child** in the same **Hospital** room, up to the limit stated in the Table of Benefits, so long as it is permitted by the **Hospital**.

7. CANCER TREATMENT

We will pay for the following cancer treatment costs either when **Hospitalised** or as an **Outpatient**, up to the limit stated in the Table of Benefits:

- Fees directly related to cancer treatment, including tests, scans, consultations and drugs;
- Surgery, radiotherapy and chemotherapy; or
- Treatments after surgery, radiotherapy or chemotherapy.

8. KIDNEY DIALYSIS TREATMENT

We will pay for the treatment costs for kidney dialysis when **Hospitalised** or as an **Outpatient**, when it is **Medically Necessary**, up to the limit stated in the Table of Benefits. **You** are entitled to this benefit only if **You** purchased an **Annual Limit** of \$ 500,000 or more, as defined in **Your Policy Schedule**.

9. ORGAN TRANSPLANT

We will pay for medical expenses related to the following transplants when it is **Medically Necessary**, up to the limit stated in the Table of Benefits:

- Cornea;
- Small intestine, kidney, pancreas, liver;
- Heart, lung; or
- Bone marrow.

What is not covered:

We will not pay for the search or transportation of an organ or bone marrow, or for any donor related expenses, including, but not limited to, the following:

- the harvesting of the organ;
- tissue matching fees; or
- hospital, medical or surgery costs of the donor.

10. PREGNANCY COMPLICATIONS

We will pay for **Hospitalisation** for maternity related conditions that are **Medically Necessary** and life threatening to the mother, up to the limit stated in the Table of Benefits, after the **Insured Person** has been continuously insured under the **Policy** for 12 months. These include but are not limited to:

- Acute nephritis (swelling and inflammation of the glomeruli, a part of the kidney that filters blood to remove waste);
- Pre-eclampsia (a pregnancy complication characterised by high blood pressure that occur during pregnancy and not before);
- Eclampsia (seizures in women previously diagnosed with pre-eclampsia);
- Missed abortion (retention of the dead embryo, fetus or other product of conception within the uterus or womb for two months or longer, with or without the knowledge of the mother);
- Ectopic pregnancy (where the fetus is growing outside the womb);
- Puerperal infection (bacterial infection of the uterus and surrounding areas after giving birth); or
- Other medical conditions related to pregnancy that is life threatening or require **Hospitalisation** as recommended by an attending **Medical Practitioner**.

What is not covered:

- The delivery itself (whether medically assisted or not). Such benefit will be covered by purchasing the optional Maternity Benefit; or
- Complications from IVF induced pregnancies, caesarean section, false labor, morning sickness and similar conditions associated with the management of a difficult pregnancy but are not medically distinct conditions.

11. HIV / AIDS TREATMENT

We will pay for treatments of HIV/AIDS, its symptoms and its related illnesses and conditions, up to the limit stated in the Table of Benefits, where the condition is confirmed and documented as having been contracted due to a blood transfusion or occupational accident.

You are entitled to this benefit only if **You** purchased an **Annual Limit** of S\$ 1,000,000 or more, as defined in **Your Policy Schedule**.

12. PSYCHIATRIC TREATMENT

We will pay for **Hospitalisation** treatment for psychiatric illnesses that are managed by a qualified psychiatrist, up to the limit stated in the Table of Benefits.

You are entitled to this benefit only if **You** purchased an **Annual Limit** of S\$ 1,000,000 or more, as defined in **Your Policy Schedule**.

13. CONGENITAL CONDITIONS

We will pay for **Medically Necessary** treatments of a **Congenital Condition** either when **Hospitalised** or as an **Outpatient**, up to the limit stated in the Table of Benefits.

You are entitled to this benefit only if **You** purchased an **Annual Limit** of S\$ 1,000,000 or more, as defined in **Your Policy Schedule**.

14. PRE-HOSPITALISATION TREATMENT

We will pay for **Outpatient** specialist consultations and the diagnostic tests the specialist may prescribe, up to the limit stated in the Table of Benefits, only when related to a subsequent **Eligible Hospitalisation** of the **Insured Person**. **We** will also pay for any medication or drug prescribed by a specialist to prepare the **Insured Person** for that **Hospitalisation**. This benefit applies only to the 90 days prior to the related **Hospitalisation**.

15. POST-HOSPITALISATION TREATMENT

We will pay for **Outpatient** treatments related to and following a **Hospitalisation** or **Day-Care Treatment**, up to the limit stated in the Table of Benefits, if the treatments are prescribed by the **Medical Practitioner** responsible for **Your Hospitalisation** care. This benefit applies only to the 90 days after discharge.

This includes rehabilitation related costs such as prescribed therapies including physical, occupational, and speech therapy. To be **Eligible** for this, the rehabilitation must start within 30 days of discharge following a **Hospitalisation**.

4. Additional Benefits

1. HOSPITAL CASH BENEFIT

We will pay a fixed amount up to the limit stated in the Table of Benefits for each night **Hospitalised**, when **You** are **Hospitalised** within the **Coverage Area** for treatment of an **Eligible** condition where the claim would have been covered by this **Policy** but decides not to claim against any other part of this **Policy**.

Examples of **Insured Person** not claiming benefits from **Us** may be due to submitting the claim to another insurer or to their employer, or no charges are incurred because the **Insured Person** has chosen a public or charitable **Hospital**.

2. ACCIDENTAL DEATH AND DISABILITY

We will pay **Your** legal representatives the benefit amount according to **Your** selected plan, if **You** suffer from an **Accident** and it solely and directly causes **Your** death or **Total and Permanent Disability** within 12 months of the **Accident**. The benefit amount payable for **Children** is limited to 25% of the limit stated in the Table of Benefits.

You are covered under this benefit up to age 65. The coverage for this benefit will cease on the policy anniversary following **Your** 65th birthday.

What is not covered:

- If **You** participate in recreational and sports activities managed by a licensed commercial operator and do not follow their rules and safety procedures (including wearing appropriate safety equipment) that the operator requires or recommends; or
- If **You** participate in recreational and sports activities as a professional or to receive a financial reward or incentive.

3. NO CLAIM BONUS

If **You** did not make any claims under the Hospitalisation Benefits in the previous policy year, **We** will provide additional **Annual Limit** calculated at 50% of **Your** selected plan's **Annual Limit**. The maximum additional Annual Limit is capped at 100% of **Your** selected plan's **Annual Limit**. If **Your** current No Claim Bonus is 50% or 100% and **You** make a claim, **Your** No Claim Bonus entitlement will reduce by 50% in the following year:

Current No Claim Bonus	Your No Claim Bonus at renewal	
	If You did not make a claim in the current year	If You made 1 or more claims in the current year
0%	50%	0%
50%	100%	0%
100%	100%	50%

If a claim is not payable because it does not exceed the **Deductible**, that will nonetheless count as a claim and **You** will not be **Eligible** for the No Claim Bonus entitlement.

Your No Claim Bonus entitlement at renewal will reset if **You** make changes to **Your** benefits.

4. RELOAD BENEFIT

If **You** remaining **Annual Limit** is insufficient to pay for the **Eligible** treatment under Hospitalisation Benefits, **We** will reload **Your** coverage by an amount equivalent to **Your Annual Limit** once in a policy year. The reloaded **Annual Limit** will only be available to cover for **Eligible** treatment under Hospitalisation Benefits arising from an **Accident** in the same policy year. The reload is only applicable once in a policy year.

Here is an example of possible events if **You** purchased a plan with an **Annual Limit** of S\$100,000:

Example	Events	You remaining Annual Limit	What We will pay	What happens next during the remaining policy year
#1	You make an Accident -related claim of S\$120,000	S\$100,000	S\$120,000 (Reload benefit is applied. S\$100,000 is paid from Your Annual Limit and S\$20,000 is paid from Reload Benefit)	You have S\$80,000 remaining from Reload Benefit which can be used for Accident -related claim under Hospitalisation Benefits
#2	You first make an Illness -related claim of S\$120,000	S\$100,000	S\$100,000 (due to an Illness -related claim, Reload benefit is not applied)	You have exhausted the Annual Limit and cannot make further claims unless it is an Accident -related claim.
	After the first claim, You make a second claim of S\$100,000 due to an Accident	S\$0	S\$100,000 (Reload benefit is applied. S\$100,000 is paid from Reload Benefit)	You have exhausted the Annual Limit and Reload Benefit, and cannot make further hospitalisation claims.

5. MEDICAL EVACUATION AND REPATRIATION

You can claim this benefit if:

- **You** are in a life-threatening medical condition because **You** suffer an unexpected **Illness** or **Injury** outside **Your Country of Residence** and **We** believe it is **Medically Necessary** to move **You** to a medical facility for treatment;
- **You** need to return to **Your Country of Residence** to recover, or for continued treatment after **You** have been moved to an overseas medical facility for treatment as described above; or
- **You** die after suffering an unexpected **Illness** or **Injury** outside **Your Country of Residence**.

What **We** will pay:

If **You** suffer an **Injury** or **Illness**:

- **We** will pay for any necessary expenses **We** spend when using an air ambulance, surface ambulance, regular air transport, railroad, land or sea transport, or any other appropriate method to transport **You** to the medical facility for treatment; or
- **We** will pay for the administrative fees **Your** airline or travel agent charges for changing **Your** travel dates and/or destinations if **You** are able to use **Your** existing return ticket to travel back to **Your Country of Residence**.

If **You** die:

- **We** will pay the necessary expenses that **We** spend to return **Your** body to **Your Country of Residence** or country of **Nationality** (as elected by **Your** legal representative). These expenses include charges for services and supplies provided by the overseas mortician or undertaker such as the cost of embalment and cremation (if so elected by **Your** legal representative) and a basic casket or urn. These expenses do not include those related to religious ceremonies or rites.

You should note that:

- To be **Eligible** for this benefit, **You** or **Your Family Member** must call **Our** Emergency Assistance at +65 6715 9919 and **We** will make the final decision on the most appropriate medical facility and transport method based on **Your** location and **Our** assessment of the severity of **Your** medical condition or circumstances.
- If **You** die, this **Policy** will automatically terminate once **Your** body has cleared customs in **Your Country of Residence** or country of **Nationality** unless multiple people are insured under this **Policy**, in which case insurance coverage will cease for **You** but will continue for all other **Insured Persons**.
- This service does not replace local emergency services and will not provide search and rescue services.

What is not covered:

- Any childbirth or pregnancy complications, unless these complications endanger the mother's life, or the unborn **Child(ren)**'s life during the first twenty-eight (28) weeks of pregnancy; or
- Treatment of injuries or **Illness** sustained at an altitude of three thousand (3,000) metres and above.

6. 24/7 MEDICAL ADVICE

Our Emergency Assistance is available on a 24/7 basis to provide medical information and advice to the **Insured Person** over the telephone. This is not a medical consultation service and any advice provided should not be taken as a diagnosis or treatment. **Our** Emergency Assistance will refer the **Insured Person** to a **Medical Practitioner**, when necessary.

5. Optional Outpatient Benefits

This section is applicable if **You** have purchased Outpatient Benefits, as defined in **Your Policy Schedule**. Outpatient Benefits are subjected to **Coinsurance** and is eligible for **Direct Billing Services**.

1. CONSULTATIONS

We will cover visits to a general practitioner (GP) or **Medical Specialist** for a diagnosis or treatment where the **Insured Person** is not **Hospitalised**, up to the limit stated in the Table of Benefits.

2. MEDICINES

We will pay for the reasonable cost of medicines and drugs which are **Medically Necessary**, and prescribed by **Your Medical Practitioner** as well as dressings used during **Your** consultation, up to the limit stated in the Table of Benefits.

3. DIAGNOSTIC TESTS

We will pay for tests prescribed by a treating **Medical Practitioner** to assist with a diagnosis, up to the limit stated in the Table of Benefits:

- Pathology (e.g. blood and urine tests);
- Radiology (e.g. X-rays);
- Advanced Diagnostics (e.g. MRI, CT, PET scans); or
- Other diagnostic tests such as an ECG/EKG or hearing test.

4. PHYSIOTHERAPY

We will pay the reasonable cost of physiotherapy treatments following a **Hospitalisation** or **Day-Care** treatment for an **Eligible** medical condition, up to the limit stated in the Table of Benefits. Such treatment must be given by a qualified practitioner who is registered to practice where the treatment takes place.

5. ALTERNATIVE MEDICINE AND TREATMENT

We will pay for complementary therapies or treatments provided by a chiropractor, osteopath, acupuncturists, homeopath or traditional chinese medicine practitioner, up to the limit stated in the Table of Benefits, if they are qualified and registered to practice where the treatment takes place.

Additionally, the cost of any chinese medicine prescribed by a traditional chinese medicine practitioner will also be covered.

6. PSYCHIATRIC AND PSYCHOLOGICAL CARE

We will pay for treatment of psychiatric or psychological conditions that have been referred by **Your Medical Practitioner**, up to the limit stated in the Table of Benefits. Such treatment must be provided by a **Medical Specialist** who is a licensed psychiatrist or psychologist.

7. ROUTINE HEALTH CHECKS

We will pay for the reasonable cost of a health check-up, up to the limit stated in the Table of Benefits, provided that it is under the supervision of a **Medical Practitioner**. Check-ups may include but not limited to blood tests, cardiac risk assessment, colonoscopy, or gastroscopy.

8. VACCINATIONS

We will pay for the cost of vaccinations and immunisations up to the limit stated in the Table of Benefits.

Vaccinations and immunisations for **Newborn** and **Children** must be recommended by the American Center for Disease Control (CDC), World Health Organization (WHO) or by the health authority of **Your Country of Residence** or **Nationality**.

6. Optional Dental and Vision Benefits

This section is applicable if **You** have purchased Dental and Vision Benefits, as defined in **Your Policy Schedule**. Dental and Vision Benefits are subjected to **Coinsurance**.

1. BASIC AND ROUTINE DENTAL WORK

We will pay for the following basic and routine dental work up to the limit stated in the Table of Benefits:

- Routine dental check-ups such as scaling and polishing, up to twice for each **Period of Insurance**;
- Extractions;
- Sealant and fillings (standard amalgam or composite);
- Root canal treatment; or
- Related X-Rays.

2. COMPLEX DENTAL WORK

We will pay for the following complex dental work, up to the limit stated in the Table of Benefits, after the **Insured Person** has been continuously covered under the **Policy** for 12 months or more from the Policy Issue Date (as shown in the **Policy Schedule**) or date of endorsement, whichever is later:

- Implants;
- Bridgework;
- Crowns; or
- Inlays and onlays.

Any dental work not listed under Basic and Routine Dental Work will be covered as part of this benefit.

3. FRAMES & LENSES

We will pay for the cost for eyeglasses (frames and corrective lenses) and contact lenses, up to the limit stated in the Table of Benefits, when prescribed by an ophthalmologist or optometrist for the purpose of correcting a vision problem (such as myopia or short sightedness). Where **You** renew and remain continuously covered under the **Policy**, this benefit is payable once every 2 years.

4. EYE CHECKS

We will pay for one session of eye examination by an ophthalmologist or optometrist, up to the limit stated in the Table of Benefits. In the event the examination finds that corrective lenses are unnecessary, benefits will only be payable from Routine Health Checks under Outpatient Benefits. Where **You** renew and remain continuously covered under the **Policy**, this benefit is payable once every 2 years.

7. Optional Maternity Benefits

This section is applicable if **You** have purchased Maternity Benefits, as defined in **Your Policy Schedule**. Maternity Benefits are applicable to female **Insured Person**, either **You** or **Your** legal spouse, aged 18 to 45. Maternity benefits are only available 12 months from the Policy Issue Date (as shown in the Policy Schedule) or date of endorsement, whichever is later. This benefit ceases on the policy anniversary following the **Insured Person's** 45th birthday.

In the event of pregnancy spanning two policy years as well as multiple pregnancies within a policy year, **You** are entitled to only one policy year's benefit limit.

1. PRE-NATAL CHECKUPS & TREATMENTS

We will pay for the cost of pre-natal check-ups, treatments, medicines and recognised supplements prescribed by the treating **Medical Practitioner** for **You** or **Your** spouse's pregnancy up to the limit stated in the Table of Benefits.

2. DELIVERY

We will pay for the following costs related to **Your** delivery up to the limit stated in the Table of Benefits:

- **Hospitalisation** costs (the room type provided will be the same as **You** chosen accommodation under Hospitalisation Benefits);
- Obstetrician or midwife's fees (including for home deliveries unless such delivery is not recommended by the obstetrician);
- Medical care required by the mother and child immediately following delivery; or
- **Elective** caesarean only covers up to the cost as it was a normal delivery, the usual cost of which will be determined by **Us**.

3. POST-NATAL TREATMENTS

We will pay for post-natal treatments and medicines as prescribed by **Your** treating **Medical Practitioner** for up to 30 days after delivery, up to the limit stated in the Table of Benefits.

Eligible Outpatient treatments for the mother after that time may be claimed under **Outpatient** Benefits.

4. NEWBORN CARE

We will pay the Newborn Care benefit as set out in the Table of Benefits, for **Hospitalisation** and **Day-Care Treatments** of a **Newborn**, for up to 30 days from birth.

8. When Benefits Are Not Payable

This section outlines scenarios that this **Policy** does not insure against. If **We** refuse a claim because of one or more of the below scenarios or as a result of a breach of this **Policy**, and **You** disagree with **Our** decision, **You** are responsible for proving that **We** are legally responsible for that claim. **Our** payment of a claim will not affect **Our** ability to refuse a subsequent claim under any of the other scenarios. These General Exclusions apply to the whole **Policy**.

1. GENERAL EXCLUSIONS

We are not legally responsible for claims that are directly or indirectly caused by, or result from the following:

- a. **Pre-Existing Conditions** and any related, associated or consequential disabilities which were not disclosed to **Us** before the Policy Issue Date or any condition which **We** have not agreed in writing to cover under this **Policy**;
- b. **Congenital Conditions**, unless **You** purchased Hospitalisation Benefits with an **Annual Limit** of S\$1,000,000 or more;
- c. Assisted conception, contraception, sterilisation, infertility treatment, or abortion or miscarriage unless there is a threat to the mother's life during the abortion or miscarriage;
- d. Sexually transmitted disease;
- e. Medical consultations, examinations or tests undertaken for preventive purpose or which are not **Medically Necessary**, unless it is payable under Your purchased Outpatient Benefit;
- f. Treatments that experimental, unproven or for cosmetic purpose;
- g. Gender reassignment surgery or therapy, or hormone replacement therapy;
- h. Refractive defects of the eye and correctional surgery or treatment;
- i. Any deliberate act by **You** or the **Insured Person** giving rise to the incident such as self-inflicted **Injury**, suicide or attempted suicide, regardless of sanity;
- j. Abuse of alcohol, illegal drugs, or medicines not prescribed to the **Insured Person** by a **Medical Practitioner** or taken in excess of prescribed quantities;
- k. Sleep disorders, and eating disorders such as anorexia nervosa and bulimia;
- l. Treatment of personality disorders of any kind;
- m. Developmental disorders such as learning, behavioural and social difficulties. This includes but not limited to dyslexia, attention deficit hyperactivity disorder (ADHD), speech disorders and short stature;
- n. Death or **Injury** related to participation in professional sports, or deliberate exposure to danger except in an effort to save human life;
- o. Treatment (including mechanical ventilation) that will not, or is not expected to, result in the **Insured Person's** recovery or restore the **Insured Person** to his/her previous state of health;
- p. Costs related to assisted living that is not medical treatment, such as aged home care;
- q. Genetic testing and stem cell treatment;
- r. **Hospitalisation** treatment for convalescence, rehabilitation, supervision or which in the opinion of **Our Medical Practitioner**, could be properly treated as an **Outpatient**;
- s. **Your** participation in war, riot, revolution or any similar event;
- t. The consequences of war, riot, revolution or any similar event are not covered if **You** are travelling to a country out of **Your Country of Residence** that is already going through these events prior **Your** visit. However, if **You** are already present in a country out of **Your Country of Residence** and there is an outbreak of such an event then **You** will be covered for up to 60 days from the date of outbreak of the event;
- u. Travel costs incurred travelling to **Your** place of treatment and hotel accommodation;
- v. **Elective** treatment needs following from travel outside of **Your Coverage Area** where the travel was for the purpose of obtaining treatment (**We** will consider **Your** medical condition and treatment needs prior to travel and any advice **Your** treating **Medical Practitioner** may have provided **You**);
- w. Costs arising out of complications or giving rise to extended hospital stay as a result of failure to follow medical advice of a treating **Medical Practitioner** or **Hospital**;
- x. Any **Accident** to an **Insured Person** which arises in the course of his or her occupation if such occupation falls within the following categories or involves the following activities: air crew, ship crew, professional sportspersons, diving, oil-rig platform and/or offshore work, fire-fighting, police, naval, military, air force service or operations (other than as a serviceman in the Singapore National Service undergoing reservist training) and any hazardous occupations; or
- y. All expenses which are not **Reasonable and Customary**, at **Our** sole discretion.

2. WAITING PERIOD

This is the period of time after being enrolled that an **Insured Person** must wait before benefits are payable. Within the first 12 months from the Policy Issue Date or Date of Endorsement, whichever is later, the following benefits will not be payable:

- Maternity Benefits;
- Complex dental work under Dental and Vision Benefits; and
- Pregnancy Complications under Hospitalisation Benefits.

9. Premiums Payable for this Policy

1. PREMIUMS YOU NEED TO PAY

To enjoy the benefits provided by this **Policy**, please pay each **Premium** before it is due. **You** have a grace period of 60 days for each **Premium** payable. During the grace period, **You** will not be entitled to any claims, guarantees through pre-authorisation or emergency assistance services.

If **We** do not receive the **Premium** due within the grace period, this **Policy** will be terminated automatically.

The **Premiums** that **You** pay for this **Policy** is not guaranteed and may be adjusted at the policy renewal date. This **Policy** is not a Medisave-approved **Policy** and **You** may not use Medisave to pay the **Premium** for this **Policy**.

10. Coverage Renewal and Changes to Policy

1. COVERAGE RENEWAL

This **Policy** is an annual contract. At the end of each policy year, **We** may notify **You** on the renewal terms of **Your Policy** and **Your Policy** will automatically renew based on these terms. Any renewal offer to **You** shall be made at least 30 days prior to **Your Policy** expiration. If offered renewal, **You** can choose not to renew by informing **Us** at least 7 days before the end of the **Period of Insurance**.

We will provide **You** a notice 30 days prior to **Your Policy** expiration if **We** are not expecting to renew **Your Policy**. The maximum age **We** may offer **You** with renewal terms is 75 years old.

2. CHANGES TO ADDRESS, COUNTRY OF RESIDENCE OR NATIONALITY

Change in address

You must inform **Us** within 30 days if **You** change **Your** residential address.

Change in Country of Residence or Nationality

If **You** change **Your Country of Residence** or **Nationality**, **You** must notify **Us** immediately as different regulations and **Premiums** may apply. **We** do not provide coverage in selected countries and will advise whether **Your Policy**'s coverage can continue according to the **Country of Residence**.

Your Country of Residence must be within **Your** chosen **Coverage Area**. Should that change, **You** need to advise **Us** immediately and request a change in **Your Coverage Area**. **We** will notify **You** on the revised **Premiums**.

3. CHANGES TO COVERAGE

When renewing **Your Policy**, **You** may also request to make changes to **Your** Plan. If **Your** request is to increase **Your** benefits, **You** will need to complete the health questionnaire declarations. **We** retain the right to accept, decline, or apply special terms to such requests.

4. CHANGES TO PREMIUM FREQUENCY

You may request in writing to change the Premium Payment Frequency shown in the **Policy Schedule**. **We** will confirm **Our** approval in writing along with the date from which the change will be effective.

5. ADDITION OF DEPENDANTS

You may apply to add a **Dependant** at any time by writing in to **Us**. **You** will need to complete the health questionnaire declarations for such requests and **We** retain the right to accept, decline or apply special terms and adjust the **Premium** that you pay for this **Policy**.

6. ADDITION OF NEWBORN

Without health questionnaire

You may add a **Newborn** as a **Dependant** without having to complete the health questionnaire declarations, and without being imposed with special terms or conditions, provided that:

- the birth mother has been insured with **Us** for at least 12 months on a plan with Maternity Benefits, as defined in **Your Policy Schedule**; and
- **You** apply for the **Newborn** to be added as a **Dependant** within 30 days of birth.

For **Newborn** added through this option, **Congenital Condition** is covered provided that such conditions are not evident to the **Policyholder** or birth mother at the Policy Issue Date (as shown in the **Policy Schedule**).

With health questionnaire

Any child born as a result of **Assisted Conception** can be added to **Your Policy** only by completing the health questionnaire declarations, and only 31 days after the date of birth. We will assess such application separately, which does not guarantee **Our** offer of cover for the **Newborn**.

7. POLICY SUCCESSION

If **You**, as the **Policyholder**, should die during the **Period of Insurance**, **Your** surviving spouse covered by the **Policy** will automatically become the **Policyholder**. If **You** leave no surviving spouse, the eldest **Insured Person** (or their legal guardian, if the **Insured Person** is below age 18) covered by the **Policy** will automatically become the **Policyholder**.

Unless an **Endorsement** states otherwise to reflect the change of **Policyholder** under circumstances described in the immediate paragraph above, **We** shall treat the **Policyholder** as the absolute owner of this **Policy** and **We** are not bound to recognise any other claim to, or interest in, this **Policy**.

11. Claiming For Your Benefits

1. PRE-AUTHORISATION

Certain benefits provided by this Policy require **You** to obtain Pre-Authorisation to ensure that benefits are payable. **You** or **Your Family Member** can do so by contacting **Our** service provider at **+65 6715 9919**. Pre-authorisation is a process that ensures the treatment is **Eligible** for claim and direct billing can be arranged accordingly. When obtaining pre-authorisation, **You** will need to provide **Us** with **Your** treatment plans and **Medical Practitioner's** contact details.

When **You** apply for pre-authorisation, **Our** staff will review if the treatment **You** intend to undergo is eligible for claim. Once a treatment is Pre-Authorised by **Us**, **We** will send a confirmation to **You** in writing and will issue a Letter of Guarantee (LOG) to **Your Hospital** to allow them to invoice **Us** directly for **Your Eligible** costs. **We** recommend **You** submit **Your** request for Pre-Authorisation at least 5 working days prior to the scheduled date of treatment as benefits may be declined or reduced where Pre-Authorisation is required but not obtained.

In the event of an **Emergency** hospital admission, **You** or **Your Family Member** must contact **Us** or **Our** service provider at **+65 6715 9919** as soon as possible and within 24 hours, or benefits may be limited or declined. If there are changes to the treatment or diagnosis, or if the **Hospital** stay becomes longer than expected, **We** will need to review and issue a revised Pre-Authorisation. This will be organised by the **Hospital** if they have accepted **Direct Billing Services**.

You will remain responsible for any uncovered costs to **Your Hospital** on discharge.

Pre-authorisation is required for the following benefits:

- Treatments requiring **Hospitalisation** or **Day-Care Treatment** services;
- Advanced diagnostics (e.g. MRI, CT, PET scans);
- Nursing Care at home;
- Rehabilitation;
- HIV/AIDS Treatment;

- Cancer Treatment;
- Kidney Dialysis;
- Medical Evacuation and Repatriation Benefits;
- Physiotherapy under Outpatient Benefit; or
- Delivery under Maternity Benefit.

2. HOW TO CLAIM

We always aim to settle **Your** claims directly with **Your** medical service provider through **Direct Billing Services**. If we cannot do this for any reason, or if you chose to decline **Direct Billing Services**, **You** will need to pay the provider and submit a claim to **Us** for reimbursement on **Eligible** expenses. To make a claim, please access **Our** claims portal at www.fwd.com.sg.

Medical Benefits

You must inform **Us** of any medical claims no later than 90 days of a treatment. Medical claims received more than 90 days after date of treatment will be declined. For claims related to Accidental Death and Disability, **You** must inform **Us** no later than 30 days of an incident which may result in a claim under this **Policy**.

You must lodge **Your** claim through **Our** website and provide **Us** with any information and assistance that **We** need to process **Your** claim, including attending court to give evidence.

At **Your** own expense, **You** must provide all documentation **We** request to assess **Your** claim. This includes but is not limited to:

- Medical reports and evidence;
- Pre-authorisation confirmation;
- Original invoices and receipts;
- Police reports; and
- Accurate English translations (confirmed by oath if necessary) of any documents if **We** require.

We have the right to reject claims if **You** cannot provide the necessary documentation that **We** request. At **Our** expense, **We** may ask any **Insured Person** to be medically examined (including a post-mortem examination) when there is a claim for **Injury, Illness** or death.

Hospital Cash Benefit

If **You** are claiming for a cost partly covered by another insurer or Government Program (social security, etc.), **We** will accept the original reimbursement statements from the other insurer or Government agency as proof and for **Our** documentation.

Should **We** have questions or have requested for additional evidence after reviewing **Your** claim, **You** will be required to respond to our queries or requests before any benefits can be paid. **We** may request for instance:

- Medical Reports or other information about **Your** condition and treatment;
- The results of an independent medical examination that **We** may ask and at **Our** expense; and
- Written confirmation from **You** confirming **You** cannot claim against another individual, company or insurer.

We reserve the right to conduct a review of **Your** treatment to determine if the treatment is appropriate based on established clinical and medical practice, and in our reasonable opinion.

3. HOW DOES DEDUCTIBLE AND COINSURANCE WORK

If **You** chose a **Deductible** option of S\$1,000:

Sequence of events	Claim amount	You will pay	We will pay
Your medical bill Eligible for reimbursement under Hospitalisation Benefits	S\$1,800	S\$1,000	S\$800
You make another claim Eligible for reimbursement under Hospitalisation Benefits	S\$1,800	None, You have already paid the full amount of Your Deductible in the same Period of Insurance	S\$1,800

If **You** chose a **Coinsurance** option of 10%:

Sequence of events	Claim amount	You will pay	We will pay
Your bill under Outpatient or Dental and Vision Benefits	S\$180	S\$18	S\$162
You make another claim under Outpatient or Dental and Vision Benefits	S\$200	S\$20, You will continue to bear 10% of the total cost of each claim	S\$180

4. THINGS TO KNOW

If **You** are entitled to a refund, reimbursement or compensation from any other person or source (including other insurance policies, transport providers, accommodation providers, manufacturers, employment benefits or government schemes), the amount that **We** are legally responsible to pay for any given benefit is limited to the portion that those third-parties are not required to pay, up to the limit for that benefit stated in the Table of Benefits. If **You** purchased more than one **Policy** issued by **Us**, **Your** insurance coverage will be limited to only one **Policy** – the **Policy** providing **You** the highest benefit level for any given benefit.

We reserve the right to lodge a report with the Singapore or local police if **You** submit a dishonest, intentionally exaggerated, or fraudulent claim. **You** must return any amount paid in excess of what **You** are not covered for under this **Policy** and that **We** have paid on **Your** behalf.

If **You** become aware of any legal action against **You** in connection with matters related to this **Policy**, **You** must inform **Us** immediately. **You** should also promptly forward every communication that **You** receive relating to the action. **You** must inform **Us** of any matter relating to the action before communicating to any third party (including the police). **You** or any person acting for **You**, must not negotiate, admit or reject any claim without **Our** prior written approval.

We can take over any rights to defend or settle any claim and to take proceedings in **Your** name to enforce **You** or **Our** rights against any other person. **We** may also take proceedings at **Our** own expense and for **Our** own benefit, albeit in **Your** name, to recover any payment **We** have made under this **Policy** to anyone else.

12. Termination Provisions

1. TERMINATION OF THIS POLICY

This **Policy** will be terminated automatically at the first instance of any of the following:

- In the event of a **Policyholder's** death and there are no other **Insured Person** to succeed as the **Policyholder**;
- This **Policy** has reached the Coverage End Date and is not renewed;
- **We** do not receive the **Premium** within the 60-day grace period;
- **You** notify **Us** that **You** would like to terminate **Your Policy**; or
- Any other event that leads to termination as stated in this **Policy** such as providing inaccurate information, submitting a fraudulent claim or **We** are required to do so by any directives, laws, regulations, or sanctions administered by regulatory authorities in any country.

If **You** have chosen Annual payment frequency (as defined in **Your Policy Schedule**) and **You** choose to terminate **Your Policy** early, **We** will refund the unused portion of **Your Premium** after deducting administrative fee determined by **Us** (subjected to prevailing GST), if there were no claims during the **Period of Insurance**. If there is a claim made, no refund of **Premium** will be made.

If **You** have chosen Monthly payment frequency (as defined in **Your Policy Schedule**) and **You** choose to terminate **Your Policy** early, no refund of **Premium** will be made.

As this is a short-term health policy, **We** are not required to renew this **Policy**. **We** may terminate this **Policy** by giving **You** 30 days' notice in writing.

2. FREE-LOOK PERIOD

You have 14 days to review this **Policy** and decide if it is suitable for **Your** needs. If **You** find that this **Policy** is unsuitable, **You** may write in to **Us** within 14 days after **You** receive it and **We** will refund any **Premium** paid. **We** consider this **Policy** delivered from the time **We** email it to **You**.

13. Customer Care Process

1. IF YOU HAVE A CONCERN

Please contact **Us** at **+65 6715 9919** or **www.fwd.com.sg** if **You** have any concern relating to this **Policy**, or are not pleased with how **Your** claim was handled. Here are **Your** options and how **We** will respond to **Your** concerns:

We will acknowledge receipt of **Your** feedback within three working days while **We** look into the matter. **We** may contact **You** for further information if required within seven working days. **We** will provide **You** with a full reply within 14 working days. If **You** are not satisfied with how **Your** feedback was handled, **You** can write to:

The Chief Executive Officer (CEO)
FWD Singapore Pte. Ltd.
6 Temasek Boulevard,
#18-01 Suntec Tower Four,
Singapore 038986

We will respond to **Your** letter within three working days of receipt of **Your** letter to the **CEO**. If **We** cannot reach a mutually acceptable agreement, **We** will refer **You** to the Financial Industry Disputes Resolution Centre (FIDReC), an independent dispute resolution centre for resolution of disputes involving financial institutions and consumers. FIDReC's address is:

Financial Industry Disputes Resolution Centre Ltd
36 Robinson Road,
#15-01 City House,
Singapore 068877
Tel: +65 6327 8878
Fax: +65 6327 8488, +65 6327 1089
Email: info@fidrec.com.sg Web: www.fidrec.com.sg

Please remember to quote **Your** policy number in any communication with **Us** or with FIDReC.

2. MEDIATION AND ARBITRATION

Any unresolved dispute must first be referred to FIDReC as above. If the sum involved in the dispute is outside the jurisdiction of FIDReC, **You** and **Us** agree to resolve the dispute through mediation via the Singapore Mediation Centre in accordance with their mediation rules.

If **You** agree to take part in the mediation, both **You** and **Us** will participate in good faith and agree to adhere to the terms of any settlement reached.

If **You** choose to not participate in mediation or if mediation fails, the dispute will be referred to and finally resolved by arbitration in Singapore according to the Arbitration Rules of the Singapore International Arbitration Centre that apply at the point in time.

14. Policy Owners' Protection Scheme

This **Policy** is protected under the Policy Owners' Protection Scheme (the Scheme) which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage of this **Policy** under the Scheme is automatic and no further action is needed from **You**.

For more information on the types of benefits that are covered under the Scheme as well as the limits of coverage, where applicable, please contact **Us** or visit the General Insurance Association (www.gia.org.sg) or SDIC websites (www.sdic.org.sg).