Smart*Care Executive*

Product Disclosure Sheet

Important Note

1. **Read this Product Disclosure Sheet before you decide to take out the Smart*Care Executive* Insurance Policy. Be sure to also read through the general terms and conditions.**

2. **You should satisfy yourself that this policy will best serve your needs. You should read and understand the insurance policy and discuss with the agent or contact the insurance company directly for more information.**

3. **Pursuant to Paragraph 5 of Schedule 9 of the Financial Services Act 2013, if you are applying for this Insurance wholly for purposes unrelated to your trade, business or profession, you have a duty to take reasonable care not to make a misrepresentation in answering the questions in the Proposal Form (or when you apply for this insurance). You must answer the questions fully and accurately.**

   Failure to take reasonable care in answering the questions may result in avoidance of your contract of insurance, refusal or reduction of your claim(s), change of terms or termination of your contract of insurance.

   The above duty of disclosure shall continue until the time your contract of insurance is entered into, varied or renewed with us.

   In addition to answering the questions in the Proposal Form (or when you apply for this insurance), you are required to disclose any other matter that you know to be relevant to our decision in accepting the risks and determining the rates and terms to be applied.

   You also have a duty to tell us immediately if at any time after your contract of insurance has been entered into, varied or renewed with us any of the information given in the Proposal Form (or when you applied for this insurance) is inaccurate or has changed.

1. What is this product about?

Smart*Care Executive* is a comprehensive medical insurance policy which covers medical cost incurred by you for hospitalization due to accidents or sickness. This policy also provides coverage for outpatient medical expenses for accident treatments within 14 days from the date of the accident. No coverage for outpatient medical expenses which is not related to the hospitalization.

This policy provides you with medical card facilities for cashless admission to any of our panel hospitals in Malaysia. Upon renewal, there will be no selective Renewal Loading or Exclusion on individual if a claim is made during the previous year. No restriction on lifetime limit for inpatient treatment. Full annual limit is restated at Policy Renewal.

2. What are the covers / benefits provided?

BENEFITS	PLAN 1	PLAN 2	PLAN 3
Overall Annual Limit (For Section A and Section B only)	RM50,000	RM40,000	RM30,000
Maximum Limit Per Disability (Benefits within Malaysia)	RM12,500	RM10,000	RM7,500
SECTION A: IN-PATIENT & DAYCARE SURGICAL PROCEDURE (per disability)			
Room & Board, daily maximum (Room Category)	RM200 (Standard Single Room)	RM130 (Double Bedded Room)	RM80 (Four Bedded Room)
Intensive Care Unit	Full Reimbursement		
Ambulance Prescription Drugs Nursing, Theatre Consumables & other Ancillary Charges	Full Reimbursement		

Surgeons' Fees Anaesthetist's Fees Diagnostic Procedures & Physiotherapy Physician Fees, one visit per day Specialist Fees, one visit per day	Full Reimbursement subject to Maximum Limit per Disability provided the charges are within the recommendations of the MMA Guidelines and Reasonable & Customary charges.		
Operating Theatre	Full Reimbursement		
SECTION B: OUT-PATIENT TREATMENT (per disability)			
Consultation & Diagnostic Procedures within thirty-one (31) days before hospital confinement	Full Reimbursement		
Post-Hospitalisation Care & Physiotherapy Treatment within thirty-one (31) days from hospital discharge	Full Reimbursement		
Accident & Emergency Treatment within fourteen (14) days from the date of the accident	Full Reimbursement		
SECTION C: SPECIAL BENEFITS (additional unit on top of the annual limit)			
Kidney Dialysis and Cancer Treatment, maximum per annum	RM8,000	RM5,000	RM3,000
Accidental Death Benefit	RM3,000	RM3,000	RM3,000

The benefits also include 0% government service tax charged on Room & Board, Medical Report Fees and Daycare Procedure.

Duration of cover is for one year. You need to renew your insurance cover annually.

3. How much premium do I have to pay?

The total premium that you need to pay depends on your age next birthday, gender, occupation, health status and the selected plan of your choice. However, this may vary depending on our underwriting requirements. Please refer below for the premium for standard risks:

Age-band	Plan 1		Plan 2		Plan 3	
	Male	Female	Male	Female	Male	Female
1-17	323	274	278	236	217	185
18-24	349	302	303	262	237	205
25-29	357	334	319	299	247	232
30-34	388	387	347	346	268	268
35-39	436	449	381	393	298	308
40-44	495	521	433	456	338	358
45-49	594	629	520	550	406	432
50-54	733	790	661	714	511	554
55-59	951	1,006	858	908	663	704
60-65 *	1,331	1,320	1,167	1,158	902	898
66-72 *	1,789	1,698	1,568	1,489	1,235	1,178

*Note: These premiums are applicable for policy on a Renewal Basis only.

4. What are the fees and charges I have to pay?

What you have to pay in addition to the premium

i. Stamp Duty – RM10.00
ii. Service Tax - 6% of premium (for Corporate policy)

What is included in the premium

i. Commissions paid to insurance intermediaries (for Individual policy) – 15% of premium
ii. Commissions paid to insurance intermediaries (for Corporate policy) – 10% of premium

5. What are some of the key terms and conditions that I should be aware of?

Age Limit

- New Application : 15 days old to 59 as of your next birthday
- Renewal : Up to age 72 provided you were already a member on your 59th birthday
- If you are an existing policyowner who wants to upgrade your plan, it can only be done at renewal before 59 years old of your next birthday.

Importance of Disclosure

- You must disclose all material facts such as personal particulars, occupation and any medical condition which you already had when you apply for the policy. This includes any medical condition or symptoms whether or not being treated and any previous medical condition which recurs or which you should reasonably have known about even if you have not consulted a medical practitioner. If you are in any doubt you should disclose the medical condition.
- Failure to notify AXA of all material facts and medical condition may result in claims being refused or cover withdrawn.

Cash Before Cover

- It is fundamental and an absolute special condition of this insurance that the premium due must be paid and received by us before cover commences. This insurance policy is automatically null and void if this condition is not complied.

Cooling-off period

- You may cancel your policy by returning the policy within 15 days after you have received the policy. The premiums that you have paid (less medical expenses incurred) will be refunded to you.

Waiting Period

- The eligibility for benefits under the policy will only start 30 days after the effective date of the policy except for accidental injuries.
- For specified illness, eligibility for benefits under the policy will only start 120 days after the effective date of the policy.

Claim Procedures

- All Insured Persons will be given an AXA Healthcare Card. With this card, you have access to our panel hospitals throughout Malaysia. We will obtain the preliminary diagnosis from Medical Report completed by your attending physician (which may take 1 to 2 hours). It is best for you to arrange such report before hospital admission for pre-planned treatment. You may be required to make personal deposit as required by the hospital's regulations.
- After validation of your preliminary diagnosis to determine that the condition requiring treatment is a covered condition under the policy, an initial Guarantee Letter will be issued to the hospital for your admission, subject to the benefit limits.
- Upon discharge, the hospital will provide the final diagnosis and itemised bill for us to settle the valid medical bill (which may take 1 to 2 hours). Any ineligible or excess expenses not covered are to be settled by you.
- In the circumstances that your preliminary diagnosis may not be easily ascertainable or that your condition requiring treatment may not be covered under the policy, you are advised to pay for your own treatment first and file a claim after discharge.
- Please notify us within 30 days of any occurrences for admission to non-panel hospital, outpatient treatment or any claim which has been settled by you. Please submit the claim form, original itemised bills, receipts and other relevant claims documents to us for processing. For non-panel hospitals, you will be compensated on reimbursement basis.
- The cashless benefit applies to hospital admissions only. Pre-hospitalization, consultations, diagnostic procedures and post-hospitalization costs are on reimbursement basis.
- You cannot make multiple claims on medical expenses.

Daycare Procedure

- Daycare Surgical Procedures are performed as an outpatient without confinement in hospital. No minimum hour of stay is required for eligibility for a claim. Daycare Surgical Procedures should include minor operations such as but not limited to: simple excision of pilonodal cyst, cataract removal, colonoscopy that is commonly performed safely on an Outpatient basis. Any Daycare Surgical Procedures done for investigative and diagnostic purposes not related to treatment for any specified disabilities is not covered.

Upgraded Room & Board Co-Payment

- If you are hospitalized at a Room & Board category that is better and cost more than your eligible benefit, you need to bear 20% of the cost of all other eligible benefits described in the Table of Benefits. If the Room & Board is of the same category but cost is higher than your entitlement, you need to pay the differences in Room & Board only.

Note: This list is non-exhaustive. Please refer to the policy contract for the terms and conditions under this policy.

6. What are the major exclusions under this policy?

Generally, the policy does not cover

- Pre-existing illness.
- Specified Illnesses occurring during the first one hundred and twenty (120) days of continuous cover.

- Any medical or physical conditions arising within the first thirty (30) days of the Insured Person's cover or date reinstatement whichever is latest except for accidental injuries.
- Plastic/Cosmetic Surgery, circumcision, eye examination, glasses and refraction or surgical correction of nearsightedness and the use or acquisition of external prosthetic appliances or devices.
- Dental conditions including dental Treatment or oral Surgery except as necessitated by Accidental Injuries to sound natural teeth.
- Private nursing, illegal drugs, intoxication, sterilization, sexually transmitted diseases, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) and HIV related Diseases.
- Any treatment or surgical operation for congenital abnormalities or deformities including hereditary conditions.
- Pregnancy, childbirth (including surgical delivery), miscarriage, abortion, and prenatal or postnatal care and surgical, mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility. Erectile dysfunction and tests or treatment related to impotence or sterilisation.
- Hospitalisation primarily for investigatory purposes, diagnosis, x-ray examination, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any Treatment which is not Medically Necessary and any preventive Treatments.
- Suicide, attempted suicide or intentionally self-inflicted Injury while sane or insane.
- War or any act of war, criminal or terrorist activities, active duty in any armed forces, direct participation in riot, strikes and civil commotion or insurrection.
- Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.
- Expenses incurred for donation of any body organ by an Insured Person and costs of acquisition of the organ including all costs incurred by the donor during organ transplant.
- Investigation and Treatment of sleep and snoring disorders, hormone replacement therapy and alternative therapy.
- Care or Treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity.
- Psychotic, mental or nervous disorders, (including any neuroses and their physiological or psychosomatic manisfestations).
- Costs/expenses of services for a non-medical nature.
- Sickness or Injury arising from racing of any kind (except foot racing), and hazardous sports, winter sports, professional sports and illegal activities.
- Private flying other than as a fare-paying passenger in any commercial scheduled airlines licensed to carry passengers over established routes.
- Expenses incurred for sex changes.

Note: This list is non-exhaustive. Please refer to the policy contract for the full list of exclusions under this policy.

7. What is Pre-Existing Conditions?

Pre-existing Conditions mean Disabilities that the Insured Person has reasonable knowledge of. An Insured Person may be considered to have reasonable knowledge of a pre-existing condition where the condition is one for which:

(a) the Insured Person had received or is receiving treatment;
(b) medical advice, diagnosis, care or treatment has been recommended;
(c) clear and distinct symptoms are or were evident; or
(d) its existence would have been apparent to a reasonable person in the circumstances.

8. What is Specified Illness?

Specified Illness means the following Disabilities and its related complications, occurring within the first one hundred and twenty (120) days of Insurance of the Insured Person:

- Hypertension, diabetes mellitus and cardiovascular disease;
- All tumours, cancers, cysts, nodules, polyps, stones of the urinary system and biliary system;
- All ear, nose (including sinuses) and throat conditions;
- Hernias, haemorrhoids, fistulae, hydrocele, varicocele;
- Endometriosis including disease of the reproduction system;
- Vertebro spinal disorders (including disc) and knee conditions.

9. Can I cancel my Policy?

You may cancel your policy at any time by giving a written notice to the Company. Upon cancellation, you are entitled to a certain amount of refund of the premium provided that you have not made a claim on the policy. Policyholder shall be entitled to a refund of premium as follows:-

Period Not Exceeding	Refund of Annual Premium
15 days (for renewal only)	90%
1 month	80%
2 months	70%
3 months	60%
4 months	50%
5 months	40%
6 months	30%
7 months	25%
8 months	20%
9 months	15%
10 months	10%
11 months	5%
Exceeding 11 months	No refund

10. What do I need to do if there are changes to my contact details?

It is important that you inform us of any change in your contact details to ensure that all correspondences reach you in a timely manner.

11. Where can I get further information?

Should you require additional information about our Smart*Care Executive* Policy, you may contact us or your insurance agent.For additional information about medical and health insurance, please refer to the *insuranceinfo* booklet on 'Medical & Health Insurance', which is available at all our branches. You can also obtain a copy of the booklet from your insurance agent or visit www.insuranceinfo.com.my.

Customer Service Centre
AXA Affin General Insurance Berhad (23820-W)
Ground Floor, Wisma Boustead,
71 Jalan Raja Chulan,
50200 Kuala Lumpur, Malaysia
Tel: (603) 2170 8282
Fax: (603) 2031 7282
Email: customer.service@axa.com.my
Website: www.axa.com.my

12. Any other types of Medical and Health Insurance cover available?

Smart*Care Optimum*