

MyShield *Plus*

Here is Your new Insurance Policy. Please examine it together with the Policy Schedule to make sure that You have the protection You need.

It is important that the Policy, the Policy Schedule and any endorsements are read together with MyShield Policy and its endorsements to avoid misunderstanding.

How Your Insurance Operates

This Policy is a contract between Us, the Company, and You, the Insured named in the Policy Schedule based on the Application Form, declaration and any information given to the Company by or on behalf of the Insured Persons.

In consideration of You paying to Us the required premium, We agree to indemnify You in the manner and to the extent described in the Policy and in the Policy Schedule in respect of medical or other covered expenses incurred during the Policy Year, or any subsequent period for which You pay and We accept the required premium.

Our Promise of Service

We wish to provide You with a high standard of service and to meet any claims covered by this Policy honestly, fairly and promptly.

Free Look

If We are issuing this Policy to You for the first time, We will give You a "Free Look" period of 14 business days from the date You receive the Policy. If within this period, You inform Us in writing that You do not want the Policy, We will cancel it from its start date and refund in full the premium You have paid after deducting any expenses incurred in assessing the risk under the Policy, as long as no claim has been admitted under the Policy. Please note You are assumed to have received the Policy within 7 days after We have sent it by post.

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DEFINITIONS

Certain words have been defined below. These have the same meaning wherever they are used in the Policy, unless otherwise stated. The singular includes the plural and the masculine includes the feminine and neuter gender, and in each case vice versa, unless specifically indicated otherwise.

The Company, We, Our, Us

means Aviva Ltd.

You, Your, Insured

means the owner of the Policy who is named the Insured in the Policy Schedule.

Accident

means bodily injury caused solely by violent, accidental, external and visible means and not by sickness, disease or gradual physical or mental process.

Alternative Medicine Provider

Includes but not limited to a chiropractor, homeopath, osteopath, acupuncturist or Chinese Physician.

Annual Deductible

means the accumulative total amount of medical expenses paid or to be paid by an Insured Person during any one Policy Year in excess of which We will indemnify or compensate the Insured Person for medical expenses covered by MyShield.

Application Form

means the forms You signed to apply for this Policy from Us, including any written statement, representation or document given to the Company which contains information We relied on in issuing this Policy.

Benefits Schedule

means the schedule attached to this Policy which sets out the benefits and the amounts payable by Us for each specific benefit under this Policy.

Co-Insurance

means the amount as specified in the Benefits Schedule of MyShield to be borne by the Insured Person. It is obtained by multiplying the benefit payable in excess of the Annual Deductible with a fixed percentage as stated in the Benefits Schedule of MyShield.

Community Hospital

means the medical institution in Singapore that provide intermediate Inpatient convalescent and rehabilitative healthcare services to patients who do not require the care of Hospitals. This includes, but is not limited to, Ang Mo Kio - Thye Hua Kwan Hospital, Bright Vision Hospital, Kwong Wai Shiu Hospital, Ren Ci Community Hospital, St Andrew's Community Hospital, St Luke's Hospital and West Point Hospital.

Critical Illness

means any of the following Critical Illnesses:

CARDIOVASCULAR RELATED ILLNESSES

Heart Attack

Death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. This diagnosis must be supported by three or more of the following five criteria which are consistent with a new heart attack:

- History of typical chest pain;
- New electrocardiogram (ECG) changes proving infarction;
- Diagnostic elevation of cardiac enzyme CK-MB;
- Diagnostic elevation of Troponin (T or I);

- Left ventricular ejection fraction less than 50% measured 3 months or more after the event.

Coronary Artery By-Pass Surgery

The actual undergoing of open-chest surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. This diagnosis must be supported by angiographic evidence of significant coronary artery obstruction and the procedure must be considered medically necessary by a consultant cardiologist. Angioplasty and all other intra arterial, catheter based techniques, 'keyhole' or laser procedures are excluded.

Heart Valve Surgery

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

Surgery to Aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra arterial techniques are excluded.

Primary Pulmonary Hypertension

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

The NYHA Classification of Cardiac Impairment (Source: "Current Medical Diagnosis & Treatment - 39th Edition"):

- Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain.
- Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.
- Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

ORGAN FAILURE

Kidney Failure

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

Major Organ / Bone Marrow Transplantation

The receipt of a transplant of:

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

Other stem cell transplants are excluded.

Fulminant Hepatitis

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

- rapid decreasing of liver size;
- necrosis involving entire lobules, leaving only a collapsed reticular framework;
- rapid deterioration of liver function tests;
- deepening jaundice; and
- hepatic encephalopathy.

End Stage Liver Failure

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

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

Liver disease secondary to alcohol or drug misuse is excluded.

End Stage Lung Disease

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

- FEV₁ test results which are consistently less than 1 litre;
- Permanent supplementary oxygen therapy for hypoxemia;
- Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO₂ ≤ 55mmHg); and
- Dyspnea at rest

The diagnosis must be confirmed by a respiratory physician.

CANCERS

Major Cancers

A malignant tumour characterised by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. This diagnosis must be supported by histological evidence of malignancy and confirmed by an oncologist or pathologist.

The following are excluded:

- Tumours showing the malignant changes of carcinoma-in-situ and tumours which are histologically described as pre-malignant or non-invasive, including, but not limited to: Carcinoma-in-Situ of the Breasts, Cervical Dysplasia CIN-1, CIN-2 and CIN-3;
- Hyperkeratoses, basal cell and squamous skin cancers, and melanomas of less than 1.5mm Breslow thickness, or less than Clark Level 3, unless there is evidence of metastases;
- Prostate cancers histologically described as TNM Classification T1a or T1b or Prostate cancers of another equivalent or lesser classification, T₁ N₀ M₀ Papillary micro-carcinoma of the Thyroid less than 1 cm in diameter, Papillary micro-carcinoma of the Bladder, and Chronic Lymphocytic Leukaemia less than RAI Stage 3; and
- All tumours in the presence of HIV infection.

NEUROLOGICAL DISEASES

Stroke

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

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

The following are excluded:

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

Coma

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

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

Coma resulting directly from alcohol or drug abuse is excluded.

Multiple Sclerosis

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

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

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

Muscular Dystrophy

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

Activities of Daily Living:

- (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.

Alzheimer's Disease / Severe Dementia

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

The following are excluded:

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

Motor Neurone Disease

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

Parkinson's Disease

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

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

Activities of Daily Living:

- (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.

Drug-induced or toxic causes of Parkinsonism are excluded.

Apallic Syndrome

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

Major Head Trauma

Accidental head injury resulting in permanent neurological deficit to be assessed no sooner than 6 weeks from the date of the accident. This diagnosis must be confirmed by a consultant neurologist and supported by unequivocal findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

The following are excluded:

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

BLOOD RELATED DISEASES

Aplastic Anaemia

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

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

The diagnosis must be confirmed by a haematologist.

HIV Due to Blood Transfusion and Occupationally Acquired HIV

- A) Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:
- The blood transfusion was medically necessary or given as part of a medical treatment;
 - The blood transfusion was received in Singapore after the commencement date or reinstatement date of insurance coverage under this Policy, whichever is the later;
 - The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
 - The insured does not suffer from Thalassaemia Major or Haemophilia.
- B) Infection with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the commencement date or reinstatement date of insurance coverage under this Policy, whichever is the later whilst the Insured was carrying out the normal professional duties of his or her occupation in Singapore, provided that all of the following are proven to the Company's satisfaction:
- Proof of the accident giving rise to the infection must be reported to the Company within 30 day of the accident taking place;
 - Proof that the accident involved a definite source of the HIV infected fluids;
 - Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented accident. This proof must include a negative HIV antibody test conducted within 5 days of the accident; and
 - HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

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

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

OTHERS

Deafness (Loss of Hearing)

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

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

Blindness (Loss of Sight)

Total and irreversible loss of sight in both eyes as a result of illness or accident. The blindness must be confirmed by an ophthalmologist.

Loss of Speech

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

Terminal Illness

The conclusive diagnosis of an illness that is expected to result in the death of the Insured Person within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed doctor. Terminal illness in the presence of HIV infection is excluded.

Major Burns

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

Paralysis (Loss of Use of Limbs)

Total and irreversible loss of use of at least 2 entire limbs due to injury or disease. This condition must be confirmed by a consultant neurologist. Self-inflicted injuries are excluded.

Progressive Scleroderma

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

The following are excluded:

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

Benign Brain Tumor

A benign tumour in the brain where all of the following conditions are met:

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

The following are excluded:

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

Dependant

means the Insured's legal spouse, parents, grandparents who are 75 years old or below at age next birthday at the Policy Commencement Date and/or biological or legally adopted children who are at least fifteen (15) days old.

Effective Date

means the date expressly stated by Us as the date on which the Insured Person's coverage under this Policy shall commence.

Full Medical Underwriting Option

means the underwriting option chosen by You where You elect to complete a medical history declaration giving details of the Insured Person's medical history which existed before the date of application for this Policy, including any Pre-Existing Conditions.

Hospital

means an institution which is legally licensed as a medical or surgical hospital in Singapore or the country in which it is located. It must be under the constant supervision of a Physician. This does not include any entity which is primarily a place for alcoholics or drug addicts, a nursing, rest or convalescent home or a home for the aged or any other similar establishment.

Illness

means a physical condition marked by pathological deviation from the normal healthy state.

Injury

means bodily injury caused solely and directly by an Accident.

Inpatient

means a person admitted to a Hospital for treatment for at least 6 consecutive hours and for which the Hospital makes a daily room and board charge. It also includes admission of any duration for the purpose of surgery and any preparation and procedure in connection with the surgery without incurring any room and board charge.

Insured Person

means the Insured and/or covered Dependant(s) whose name is included in the Application Form for this Policy and in respect of whom commencement of cover has been confirmed in writing by Us.

Medical Complaint

means a medical condition that requires immediate medical attention by a Physician within 24 hours of an occurrence of an Accident or Illness.

Medically Necessary

means those services and supplies provided by a Physician to identify or treat an Injury or Illness which has been diagnosed or is reasonably suspected to be, and are:

- (a) consistent with the diagnosis and treatment of the Insured Person's condition;
- (b) according to standards of good medical practice;
- (c) required for reasons other than for the convenience of the Insured Person or Physician; and
- (d) the most appropriate supply or level of service which can be safely provided to the Insured Person.

Any Goods and Services Tax (GST) paid in Singapore on a Medically Necessary service or supply is covered under this Policy.

Moratorium

means a waiting period of five (5) years from the Policy Commencement Date, or the date of Upgrade, or the date of the last reinstatement for an Insured Person, whichever is later, after which a particular Pre-Existing Condition will be covered subject to the terms and conditions of the Policy.

Moratorium Underwriting Option

means the underwriting option chosen by You where no medical declaration is required.

MyShield

means the Medisave-Approved Integrated Policy insured by Aviva Ltd.

Period of Insurance

means each term of cover under this Policy, which is for twelve (12) months and starts on the Policy Commencement Date or the Renewal Date, whichever is applicable.

Physician

means a person who is legally qualified in medical practice following attendance at a recognised medical school, to provide medical treatment and licensed by the competent medical authorities of the country in which treatment is provided but who should not be the Insured Person or the relative, sibling, spouse, child, parent of the Insured Person.

Policy Commencement Date

means the date cover under this Policy commences for the Insured Person(s). Any change in the Policy Commencement Date of MyShield will also result in the change of the Policy Commencement Date of this Policy and an endorsement will be issued to reflect the change.

Policy Schedule

means the schedule to this Policy which sets out key terms like the name of the Insured, the Insured Persons and the respective plan selected.

Policy Year

means a period of twelve (12) months starting from the Policy Commencement Date and each consecutive 12-month period for which this Policy is renewed.

Pre-Existing Condition

means any Injury, Illness, condition or symptom that existed prior to the Effective Date, the date of Upgrade or the date of the last reinstatement, whichever is later,:

- (a) for which treatment, medication, advice, or diagnosis has been sought or received or was foreseeable by You or the Insured Person;
- (b) for which an ordinary and prudent person with such Injury, Illness, condition or symptom would have sought advice or treatment in connection with his/her health; or
- (c) which You or the Insured Person knew existed, whether or not treatment, medication, advice, or diagnosis was sought or received.

Renewal Date

means the date on which the Policy is renewed for a further Period of Insurance.

Singapore Restructured Hospital

means the corporatised Singapore Government Hospitals and medical centres which include, but are not limited to, Singapore General Hospital, Changi General Hospital, KK Women's & Children's Hospital, Alexandra Hospital, Tan Tock Seng Hospital, National University Hospital, National Heart Centre, National Cancer Centre, Singapore National Eye Centre, National Skin Centre, Institute of Mental Health, National Neuroscience Institute, National Dental Centre, The Cancer Institute, The Eye Institute, The Heart Institute, Care Management Centre, Jurong Medical Centre and Singapore Footcare Centre.

Specialist

means a qualified and licensed Physician, possessing the necessary additional qualifications and expertise to practise as a recognised specialist of diagnostic techniques, treatment and prevention, in a particular field of medicine like psychiatry, neurology, pediatrics, endocrinology, obstetrics, gynaecology and dermatology.

Survival Period

means the period of 30 days from the date on which an Insured Person is diagnosed as suffering from a Critical Illness.

Upgrade

means a change in plan under Your MyShield Policy whereby the Insured Person's plan is changed to a new plan offering higher benefits, under the same MyShield Policy.

Waiting Period

means the period of 90 days from the Cover Effective Date of Critical Illness Benefit or date of last reinstatement of this Policy, whichever is later.

GENERAL CONDITIONS

It is an important part of Our contract that You observe the following General Conditions:

1. Eligibility

To be eligible for cover under this Policy, the Insured Person must be:

- (a) between 15 days old and 75 years old at age next birthday as at the Policy Commencement Date; and
- (b) an Insured Person covered under MyShield.

If You are confined in a Hospital on the date when Your cover would otherwise become effective, Your cover will not become effective until the date following Your discharge from the Hospital.

2. Cover Effective Date for Critical Illness Benefit

The Critical Illness Benefit under this Policy shall only apply to an Insured Person

- (a) who has passed his one-year old birthday; or
- (b) whose age next birthday does not exceed 65 years old.

If the Insured Person has not passed his one-year birthday on the Policy Commencement Date, his Critical Illness cover will only be effective on the day he turns one year old.

3. Geographical Scope

The Insured Person shall seek treatment in Singapore. Any treatment provided to the Insured Person outside Singapore is limited to benefits covered under SECTION III-COVERED BENEFITS, 3(d) (Inpatient Medical Complaint outside Singapore) as stated in MyShield.

4. Co-ordination of Benefits

If at the time of claim, the Insured Person has other medical insurance which makes provision for reimbursement of medical expenses, You shall advise Us of the details of such other policies and We shall not be liable to contribute more than the rateable proportion of such reimbursement.

5. Co-operation

We will not be liable under this Policy unless You, the Insured Person or his/her representatives

- (a) co-operate fully with Us and Our medical advisers;
- (b) fully and faithfully disclose all material facts and matters which the Insured Person knows or ought to know; and
- (c) on Our request sign any document to empower the Company to obtain relevant information, at the Insured Person's expense, from any doctor or Hospital or other sources.

6. Material Changes

We must be informed immediately in writing of any material change in information or circumstances whether relating to occupation, business or sporting activity affecting You or any Insured Person. We reserve the right either to continue cover for the Insured Person on terms and conditions We consider appropriate because of the material change in information or circumstances or to decline to continue cover under this Policy.

7. Renewal

Your cover is automatically renewed for a further Period of Insurance by payment of the renewal premium before the Renewal Date. On the Renewal Date, We may vary the benefits, cover and/or premium or even cancel all policies in a particular age group or of a plan type by giving thirty (30) days' advance notice in writing to You but We will not cancel any individual policy.

8. Cancellation

You may cancel the Policy by giving Us thirty (30) days' notice in writing. On the expiry of the period of thirty (30) days, the cover on all Insured Persons will terminate. However, cover for each Insured Person under MyShield will continue to remain in force provided they still satisfy the eligibility criteria as specified in the MyShield Policy.

Where premium is charged on an annual basis and You cancel the Policy during the Policy Year after the Free Look Period, there will be a pro-rated refund based on the number of unused days for the rest of the Policy Year. However, if a claim has arisen in respect of that Policy Year, no refund will be made.

Where premium is charged on a non-annual basis and You cancel the Policy, the Company is entitled to the balance of the premium payable for the entire Policy Year if a claim arises in respect of that Policy Year. The Company may deduct the balance of the premium from any claim amount due.

9. Misstatement or Change of Plan

At any time, the plan You choose to insure under this Policy must be the same plan as chosen under Your MyShield Policy. If the plan of any Insured Person is different from the plan insured under Your MyShield Policy, and the premium paid as a result is insufficient, We will collect the shortfall in premiums in cash or deduct from any claim payable under this Policy. The amount is computed from the Policy Commencement Date or Effective Date of the Change of Plan, if applicable. Any excess premium that may have been paid as a result of any misstatement or change of plan shall be refunded without interest.

In the event You change the plan of Your MyShield Policy, the plan under this Policy shall be changed accordingly, subject to payment of additional premium, if any.

For avoidance of doubt, if, in spite of any Upgrade, any claim admissible under Your MyShield Policy is limited to the benefits under the plan prior to the Upgrade, the benefits payable under this Policy shall similarly be limited to the benefits under the plan prior to the Upgrade.

10. Termination of Insurance

An Insured Person's cover under this Policy will terminate automatically on the date any one of the following events first occurs:

- (a) upon death of an Insured Person;
- (b) on the expiry of the 30-day notice following the request for Cancellation by the Insured;
- (c) non-payment of the required premium due after the Grace Period; or
- (d) upon the termination of Your MyShield plan.

The Critical Illness Benefit of the Policy, as defined below under Covered Benefits, will cease automatically for an Insured Person on the date any one of the following events first occurs:

- (a) if a valid claim for Critical Illness Benefit for that Insured Person has been made; or
- (b) on the expiry of the Policy Year during which that Insured Person attains the age of 65 years old.

11. Grace Period

A grace period of thirty (30) days is allowed for payment of the required premium due. If the required premium is not paid on or before the last day of the grace period, the cover under the Policy will be treated as terminated on the premium due date and may only be reinstated with Our consent.

12. Reinstatement

If the Policy terminates due to non-payment of premium, You may apply to reinstate this Policy within thirty (30) days of the date of notice of Termination by providing Us with satisfactory evidence of insurability for each Insured Person at Your expense, provided the Insured Person for whom reinstatement is requested is not older than age 75 years next birthday on the date of reinstatement. All outstanding premiums must be received by Us before the Policy can be reinstated.

Treatment provided to the Insured Person after the date of Termination and within thirty (30) days of the date of notice of reinstatement will not be covered unless the treatment received as an Inpatient is for Injuries caused by an Accident occurring after the date of notice of reinstatement.

13. Misstatement of Age

If the age of any Insured Person has been misstated and the premium paid as a result is insufficient, any claim payable under this Policy shall be pro-rated based on the ratio of the actual premium paid to the correct premium which should have been charged for the entire Period of Insurance. Any excess premium that may have been paid as a result of any misstatement of age shall be refunded without interest. If at the correct age an Insured Person would not have been eligible for cover under this Policy, no benefit shall be payable, and Our liability shall be limited to the refund of the total premium paid without interest.

14. Age

For the purpose of determining premiums payable, an Insured Person's age shall be based on his/her age next birthday.

15. Payment of Benefits

Any benefits payable under this Policy shall be paid to You. The Insured's receipt or the receipt of the Insured's legal personal representative of any benefit payable under this Policy shall in all cases be deemed final and is a complete discharge of Our liability.

16. Full Disclosure

You are required to disclose fully and truthfully all material facts and circumstances to The Company up to the date full cover is provided in respect of any Insured Person.

Any non-disclosure or misrepresentation shall entitle the Company to declare this Policy void and avoid all liabilities existing under this Policy in respect of that Insured Person right from the Policy Commencement Date or date of reinstatement.

17. Fraud

If any claim shall in any respect be false or fraudulent or if fraudulent means or devices are used by the Insured Person or any Dependant or anyone acting on their behalf to obtain any benefit under this Policy, the Policy will be cancelled immediately and all benefits and premiums will be forfeited.

18. Trust

We will not recognise or be affected by any notice of trust, charge or assignment relating to this Policy.

19. Applicable Law

The terms and conditions of this Policy will be governed by and construed, determined and enforced according to the laws of Singapore.

20. Currency

Payment of all claims and benefits will be made in Singapore currency. Charges incurred in any other currency shall be payable in Singapore Dollars on the basis of the exchange rate used by Us on the date the claims were processed.

21. Exclusion of the Contracts (Rights of Third Parties) Act

The Contracts (Rights of Third Parties) Act 2001 and any subsequent amendments or replacements of that Act shall not apply to this Policy. A person who is not a party to this Policy shall have no right under the Act to enforce any of its terms.

22. Pre-Existing Conditions

All Pre-Existing Conditions are excluded under this Policy unless

- (a) if You have chosen the Full Medical Underwriting Option, the Pre-Existing Condition has been declared by You and specifically accepted by Us, in writing, to be covered under this Policy;

Or

- (b) if You have chosen the Moratorium Underwriting Option, and during the 5-year Moratorium in which the Insured Person remains in continuous cover under this Policy, the Insured Person has not, in relation to a Pre-Existing Condition:
- (i) experienced symptoms;
 - (ii) sought advice or tests from a Physician, Specialist or Alternative Medicine Provider (including checkups for that Pre-Existing Condition);
 - (iii) required treatment or medication; or
 - (iv) received treatment or medication

in which case, We will cover that Pre-Existing Condition under this Policy . However, if at any time, during the 5-year Moratorium, the Insured Person undergoes any of the above, then that particular Pre-Existing Condition shall be permanently excluded under this Policy.

If You have already been insured under this Policy but do not fall within (a) or (b) above and We had previously excluded a Pre-Existing Condition, then the Moratorium Underwriting Option shall apply. The 5-year Moratorium will be deemed to have commenced from the Policy Commencement Date.

For the avoidance of doubt, the Moratorium will **not apply to**:

- (i) the Critical Illness Benefit even if you had chosen the Moratorium Underwriting Option; and
- (ii) the following list of Pre-Existing Conditions. These Pre-Existing Conditions shall be permanently excluded under the Policy if You have chosen the Moratorium Underwriting Option:
 - Heart Attack, heart bypass, angioplasty
 - Chronic obstructive lung disease, chronic cor pulmonale, pulmonary hypertension
 - Stroke
 - Liver cirrhosis
 - Paralysis

- Osteoporosis
- AIDS or HIV infection
- Thalassaemia Intermediate/ major
- Diabetes with complications such as protein in urine or eye problem
- Kidney failure
- Organ transplantation
- Systemic lupus erythematosus (SLE)
- Muscular dystrophy
- Multiple sclerosis
- Alzheimer's disease
- Dementia
- Any form of Cancer (other than skin cancer)
- Autism

COVERED BENEFITS

While this Policy is in force, the Insured Person under this Policy will be covered for the following benefits, where applicable, as shown in the Policy Schedule.

OPTION A BENEFITS

1. Co-Insurance Benefit

We shall reimburse You the amount of Co-Insurance payable by You in respect of a covered claim under your MyShield policy provided that:

- (i) the claim is first payable under MyShield (other than Medishield); and
- (ii) the claim does not exceed the maximum claim limits as stated in the MyShield Benefits Schedule.

For the avoidance of doubt, We shall not pay the Co-Insurance amount on any excess over the maximum claim limits stated in the MyShield Benefits Schedule.

2. Critical Illness Benefit

Subject to Clause 2 of the General Conditions, We shall pay the Critical Illness Benefit as shown in the Benefit Schedule of this Policy provided that

- (i) the Insured Person is diagnosed to be suffering from any one of the Critical Illnesses; and
- (ii) the Insured Person is still alive after the Survival Period.

For the avoidance of doubt, if the Critical Illness diagnosed is Major Cancer, Coronary Artery By-pass Surgery and/ or Heart Attack, the Critical Illness Benefit is payable only after the Waiting Period.

For an Insured Person whose child(ren) is/are entitled to free coverage under this Policy, We shall pay the Critical Illness Benefit only if the Insured Person is diagnosed as suffering from:

- (i) Major Cancer;
- (ii) Major Organ / Bone Marrow Transplantation;
- (iii) Major Burns;
- (iv) Major Head Trauma; or
- (v) Kidney Failure

subject to the Survival Period and the Waiting Period (if applicable).

For the avoidance of doubt, notwithstanding any other provision to the contrary, We shall not pay the Critical Illness Benefit to an Insured Person whose child(ren) is/are entitled to free coverage if the Critical Illness is not one of the five illnesses named above.

3. Hospital-related Benefits

(a) Hospital Cash Benefit

We shall pay You the Hospital Cash Benefit as shown in the Benefit Schedule of this Policy in the event of hospitalisation provided that:

- (i) the claim is payable under MyShield (other than MediShield);
- (ii) the hospital admission is recommended by a Physician as Medically Necessary; and
- (iii) the Insured Person stays in a hospital ward lower than what he is entitled to under his chosen plan.

For the avoidance of doubt, We will not pay the Hospital Cash Benefit in the event of a day surgery, confinement in Community Hospital, confinement in private Hospital or if there is no hospital stay involved.

(b) Ambulance Fees or Transport by Taxi to Hospital

The one-way transportation within Singapore of the Insured Person by either road ambulance or land taxi to a Hospital, provided that:

- (i) the Insured Person is hospitalised within 24 hours for treatment of Illness or Injury covered under the MyShield Policy, subject to the limits specified in the Benefits Schedule; and
- (ii) the Inpatient claim is payable under MyShield (other than MediShield).

(c) Accommodation Benefit for Parent/ Guardian of Insured Child

We shall pay the accommodation charges incurred by one parent or guardian sharing the Hospital room of an Insured Person who is below nineteen (19) years old at age next birthday, provided the Insured Person is treated for Illness or Injury at a Hospital as an Inpatient covered under the MyShield Policy, subject to the limits specified in the Benefits Schedule, and the Inpatient claim is payable under MyShield (other than MediShield).

(d) Post-Hospital Follow-up TCM Treatment

Charges incurred, up to the amount stipulated in the Benefits Schedule, for post-hospital follow-up Traditional Chinese Medicine (TCM) treatment up to a maximum period of ninety (90) days after the date of discharge from a Hospital.

The following conditions must be met:

- (i) Referrals must be made by the same attending Physician from Restructured Hospitals.
- (ii) TCM treatment must be carried out at the TCM clinic of a Restructured Hospital and administered by a TCM Practitioners registered under the TCM Practitioners Board.
- (iii) The hospitalisation claim must first be payable under MyShield (other than MediShield).
- (iv) The hospitalisation is a result of an Accident and the TCM treatment must be for the same injury or illness for which the Insured Person received Inpatient treatment due to the Accident, provided that such injury or illness is covered by the Policy.

We will not pay the Post-Hospital Follow-up TCM Treatment Benefit following a day surgery, confinement in Community Hospital or if there is no hospital stay involved.

4. Free Coverage for Child(ren)

We shall extend the benefits under Option A Plan 2 (as set out in the Benefits Schedule) of this Policy for free to an Insured Person

- (i) who is entitled to free coverage under MyShield; and
- (ii) whose parents are both insured under this Policy on or before the Policy Commencement Date and covered under Option A.

If the Insured Person ceases to enjoy free coverage under MyShield, this Benefit will similarly cease for that Insured Person under this Policy.

OPTION B BENEFITS

5. Deductible Benefit

We shall reimburse You the amount of Annual Deductible payable by You in respect of a covered claim under your MyShield policy.

CLAIMS CONDITIONS

We will act in good faith in all Our dealings with You. In return, You must ensure that the following are observed:

1. Making a Claim

- (i) For the Co-insurance Benefit, Deductible Benefit, Accommodation for Parent/ Guardian of Insured Child Benefit and Hospital Cash Benefit

The claim would be processed together with the claim under MyShield.

- (ii) For Critical Illness Benefit

- (a) We must be given written notice of the Critical Illness of any Insured Person within 30 days of diagnosis or occurrence.

- (b) Any written notice given by or on behalf of the Insured Person containing sufficient particulars for Us to identify the Insured Person will be considered sufficient notice. If the notice is not given to Us within the requisite time, We will still accept submission of a claim if it can be shown that it was not reasonably possible to give such notice and that notice was given to Us as soon as it was reasonably possible.

- (c) For the processing of a claim for Critical Illness Benefit, We may require any or all of the following at your cost:-

- Certificates, medical reports, information and evidence in such form and nature as We may prescribe;
- Evidence to establish the continuing health condition of the Insured Person
- That the Insured Person be available for examination by our approved Physician when required and if the Insured Person is residing outside Singapore, We may require him to come to Singapore for such medical examination;
- Proof of the Insured Person's date of birth and if the date of birth and/or age given to Us is incorrect, then We will not be liable to pay more than the amount that We would have had to pay if the date of birth and/or age had been correctly stated to Us.

- (iii) For the Ambulance Fees or Transport by Taxi to Hospital Benefit and Post-Hospital Follow-up TCM Treatment Benefit

You must complete our Claim Form and submit it to Us as soon as possible after an Insured Person seeks covered treatment. In respect of Our Claim Form:

- the Insured Person or the Insured Person's legal personal representative(s) must complete all the questions in Section A and sign it;

- the treating Physician must complete all questions in Section B, affix his rubber stamp on the Claim Form and sign it; and
- all supporting medical information (including originals of all relevant documents and bills) must be submitted to Us within 30 days after the treatment begins or as soon as possible after such information is reasonably available, whichever is earlier. We will not accept photocopies of the relevant documents.

Failure to observe these conditions for making a claim, without any reasonable explanation, may invalidate a claim.

2. Proof of Claim

All relevant original documentation and receipts together with a fully completed Claim Form signed by the treating Physician must be submitted to the Company within the time limits defined above. Photocopies are not acceptable. If on a balance of probabilities based on medical facts, it is appropriate for the Company to decline a claim by virtue of the Pre-Existing Conditions Exclusion, the Insured Person shall have the right and obligation to produce such medical evidence as the Company may reasonably require to enable it to reconsider the claim.

3. Examinations

The Company shall have the right and opportunity through its medical representatives to examine the Insured Person whenever and as often as it may reasonably require during the duration of any claim. In addition, the Company shall have the right to require a post-mortem examination, where this is not forbidden by law.

4. Legal Proceedings

No action in law or equity shall be brought under the Policy until after the expiration of sixty (60) days from the date a satisfactory proof of claim has been furnished to the Company according to the terms and conditions of this Policy.

5. Arbitration

Any difference of medical opinion in connection with the results of any Accident, illness, death or expense will be settled between two medical experts appointed respectively in writing by the two parties to the dispute. Any difference of opinion between the two medical experts shall be referred to an umpire, who shall have been appointed in writing by the two medical experts at the outset.

GENERAL EXCLUSIONS

In addition to the General Exclusions as defined in Your MyShield policy, the following treatment items, conditions, activities and their related or consequential expenses are excluded from the Policy and The Company will not be liable for them:

- (i) Pre-Existing Conditions are excluded, unless:
 - (a) You have chosen the Full Medical Underwriting Option and the Pre-Existing Conditions have been declared by you and specifically accepted by Us in writing to be covered under the Policy.
 - (b) You have chosen the Moratorium Underwriting Option and satisfy the Moratorium terms and conditions as stated in the Policy. However, the Moratorium will not apply to the Critical Illness Benefit.
- (ii) Any costs arising from admission to a Hospital before the Effective Date of the Policy.

Please refer to Your MyShield Policy contract for the full list of exclusions. If We say that because of an Exclusion, any loss, damage, cost or expense is not covered by this Policy the burden is on You to prove otherwise.

IMPORTANT:

The Insured is requested to read this Policy. If any error or mis-description is found, the Policy should be returned to the issuing office for correction.

		MyShield Plus		
		Plan 1	Plan 2	Plan 3
	Hospital Ward Type	Any Private Ward	Any Government/ Restructured Ward	B1 Government/ Restructured Ward
OPTION A				
1	Co-Insurance Benefit	As-incurred under MyShield		
2	Critical Illness Benefit (up to age 65) (per Lifetime)	\$10,000	\$10,000	\$10,000
3	Hospital-related Benefits			
	(a) Daily Hospital Cash Benefit [^] (per day)	\$300	\$150	\$100
	(b) Ambulance Fees/ Transport by Taxi to Hospital (per injury or illness)	\$80	\$80	\$80
	(c) Accommodation Benefit for Parent/ Guardian of Insured Child ⁺ (per day)	\$80 Up to 10 days	\$65 Up to 10 days	\$50 Up to 5 days
	(d) Post-Hospital Follow-up TCM [#] Treatment (up to 90 days after discharge) (per visit)	\$45	\$45	\$45
4	Free Coverage for Child(ren)*	Yes	Yes	N.A.
OPTION B				
5	Deductible Benefit	As-incurred under MyShield		
[^] For admission to government / restructured hospitals of wards lower than that of chosen plan. This excludes day surgery, confinement in Community Hospital and confinement in private Hospital. ⁺ Insured Child refers to the Insured Person who is below 19 years old at age next birthday. [#] Traditional Chinese Medicine [*] Based on benefits under Option A Plan 2, up to 20 years old at age next birthday, provided both parents take up MyShield Plus Plan 1 or 2 and are covered under Option A.				