Group Medical Insurance Policy

Assicurazioni Generali S.p.A. Hong Kong Branch, 35th Floor, Tower Two, Times Square, 1 Matheson Street, Causeway Bay, Hong Kong. Tel: (852) 2521-0707, Fax: (852) 2521-8018, hereinafter called "the Company". The Company hereby agrees to insure those members as hereinafter provided to the intent that, if any such members while insured hereunder, as a result of accidental bodily injuries, disease or sickness, the Company will upon receipt of proof acceptable to the Company pay the relevant benefits as provided by this Policy.

This Policy is issued in consideration of the application by the Policyholder and the payment of the premiums computed and payable as provided hereafter.

IN WITNESS WHEREOF, Assicurazioni Generali S.p.A. Hong Kong Branch has caused this Policy to be executed at Hong Kong on the date shown in the Insurance Schedule.

Assicurazioni Generali S.p.A.
Hong Kong Branch

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(Authorized Signature)

IMPORTANT – The Policyholder is requested to read this Policy. If any error or mis-description is found, the Policy should be returned to the Company for correction.

INSURANCE SCHEDULE

Policy Number:

Date of Issue:

Policyholder's Name:

Policyholder's Address:

Policy Commencement Date:

Policy Anniversary:

Currency Basis:

Eligible Members:

(a) Existing employees shall be eligible on the commencement date.

(b) Future employees shall be eligible immediately on the date of employment.

(c) Maximum participating age is 65.

Members Classification:

Benefits Schedule: As per attached

Premium Payment Mode:

Premium Due Date:

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GENERAL CONDITIONS

Part I – Definitions

Unless otherwise required by the context, the following definitions shall control:

a) **"Company"** shall mean Assicurazioni Generali S.p.A. – Hong Kong Branch

b) **"Policy"** shall mean this agreement, any supplementary contracts, endorsements or attachments therein, any amendments thereto signed by the Company, and the application attached hereto of the Policyholder, which together constitute the entire contract between the parties.

c) **"Associated Policyholders"** as stated in the front page shall mean the subsidiaries or affiliated companies of the Policyholder whose members shall be insured under this Policy.

The Policyholder shall act for and on behalf of any and all of such Associated Policyholders in all matters pertaining to this Policy, and every act done by, agreement made with, or notice given to the Policyholder shall be binding on all such Associated Policyholders.

d) **"Commencement Date"** shall mean the date set out in the Insurance Schedule from which the insurance plan under this Policy is operative.

e) **"Effective Date"** of an insured member shall mean the commencement date of cover for an individual who has been enrolled with and accepted by the insurer after the Policy Commencement Date.

f) **"Period of Insurance"** shall mean the period set out in the Insurance Schedule during which the insurance plan under this Policy is operative.

g) **"Hospital"** shall mean any hospital legally authorized by the authorities of the place where it is situated to provide hospital services, or if Group Maternity & Obstetrical Benefit is included in the Policy, maternity home. "Hospital" does not include any hospital or portion of any institution which is operated as a convalescent or nursing home, rest home, home for the aged, a place for alcoholics or drug addicts or for any similar purpose.

h) **"Registered Medical Practitioner"** shall mean only a person other than an immediate family member or employee of the Policyholder or Associated Policyholder qualified by degree in Western Medicine and legally authorized in the geographical area of his practice to render medical and surgical services.

i) **"Insured Members"** shall mean Members as defined in the Insurance Schedule who, in accordance with the provisions of Part II, have been enrolled and are participating in the respective insurance plan under this Policy.

j) **"Eligible Members"** shall mean Members, who are aged between sixteen (16) and sixty-four (64) last birthday and have completed the required waiting period as stated in the Insurance Schedule and not otherwise disqualified, are entitled to participate in the respective insurance plan under this Policy.

k) **"Any One Disability"** shall mean all disabilities arising from the same cause including any all complications therefrom, except that after ninety (90) days following the latest discharge from

Hospital, or latest medical consultation or laboratory test. Any subsequent disability from the same cause after the said period shall be considered as a new disability.

l) **"Referral Letter"** shall mean any covered injury or sickness of which the covered Insured Member (or Dependant) receives treatment continuously for the same or closely related injury/sickness, and such continuous treatment is not interrupted for a period of more than ninety (90) consecutive days, then the concurrent due proof of referral by a registered medical practitioner for that treatment shall be regarded as a continuous and concurrent referral as from the date of last treatment of the same or closely related injury/sickness.

m) **'Policy Year"** shall mean the period beginning with the Policy Commencement Date and subsequent Policy Anniversaries.

n) **"Reasonable and Customary"** shall be deemed to refer to a charge for medical care which shall be considered reasonable and customary to the extent that it does not exceed the general level of charges being made by others of similar standing in the locality where the charge is incurred, when furnishing like or comparable treatment, services or supplies to individuals of the same sex and of comparable age, for a similar disease or injury."

o) A masculine personal pronoun as used herein includes the feminine wherever the context requires.

p) "**Medically Necessary**" shall mean Health care services and supplies which are determined by the Company to be medically appropriate, and all of the following:

i. necessary to meet the basic health needs of the Covered Person;

ii. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Health Service;

iii. consistent in type, frequency and duration of treatment with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company;

iv. consistent with the diagnosis of the condition;

v. required for reasons other than the convenience of the Covered Person or his or her Physician; and

vi. demonstrated through prevailing peer-reviewed medical literature to be either:

a) safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,

b) safe with promising efficacy,

c) for treating a life threatening Sickness or condition,

d) in a clinically controlled research setting; and

e) using a specific research protocol that meets world standards.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)
The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, or Sickness does not mean that it is a Medically Necessary Covered Health Service as defined herein. The definition of Medically Necessary used herein relates only to Coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

Part II – Individual Participation and Termination

Section 1 – Participation

a) Members already eligible on the Commencement Date shall, subject to (d) below, be eligible at such Commencement Date.

b) New Members shall become eligible for insurance on the day following the completion of the required waiting period, if any, as specified in the Insurance Schedule.

c) Members whose insurance has been terminated due to termination of membership and who re-apply for membership shall be considered as new Members.

d) The date of eligibility of a Member shall be a date on which the Member is actually performing his duties full time of at least thirty (30) hours per week. Any Member who may be on vacation, sick or absent from work for any other cause on the date on which, if present, he would have become eligible to participate, shall become eligible to do so immediately following his return to full-time active performance of his duties.

e) Every Member who fulfils the conditions necessary to participate as set forth in (a) to (d) above must elect to do so in writing within thirty-one (31) days from the date he becomes eligible. Otherwise, he shall be able to start participation only after he shall have furnished, at his own expense, evidence of his insurability satisfactory to the Company.

f) Each Eligible Member shall be insured on the first day on which he becomes eligible provided written notification from the Policyholder has been received and approved by the Company and the condition set forth in (e) above has been satisfied.

g) Participation of Members of the Associated Policyholders shall fulfil the conditions as set forth in (a) to (f) above.

Section 2 – Termination

The insurance of any Member shall automatically cease on the earliest of the following dates:

a) The date the Policy and any of the supplementary contracts are terminated, provided that for the avoidance of doubt termination of the Policy shall automatically terminate all of the supplementary contracts.

b) The date of the expiration of the period for which the last premium payment is made on account of the Member's insurance.

c) The date on which the Member enters full-time military, naval or air service.

d) The end of the Period of Insurance during which the Member attains the age of sixty-five (65) years.

e) The date communicated to the Policyholder by the Company by virtue of war, act of war, where such date shall be at the discretion of the Company.

f) Cessation of active work by a Member (or cessation of membership in good standing in the case of association) shall be deemed to constitute the termination of his membership, except that while a Member is temporarily on part-time employment or is absent on account of sickness or injury, membership shall be deemed to continue until premium payments for such Member's insurance are discontinued. "Part-time" employment shall mean a Member performs his duties less than thirty (30) hours per week.

g) The date on which his membership in the class or classes of Members insured is terminated.

h) The date on which active membership with the Policyholder is terminated, except that the Policyholder may elect to consider Members temporarily laid-off, given leave of absence or temporarily disabled, as remaining in active membership for purpose of this insurance, membership shall be deemed to continue until premium payments for such Member's insurance are discontinued.

Part III – Benefits

Section 1 – Extent of Benefits

a) All benefits indicated in the following sections are applicable without geographical limitation.

b) Benefits entitled by an Insured Member are subject to his benefit plan as stated in the Insurance Schedule.

c) All benefits included hereinafter are subject to a maximum limit which is calculated on a per disability basis and/or per policy year basis. In the event an Insured Member's effective date of insurance is other than the Commencement Date or Renewal Date as stated in the Insurance Schedule, his actual entitlement to out-patient benefits with a per policy year maximum limit shall be calculated on a pro rata basis, i.e. number of days of coverage being divided by number of days of the Period of Insurance and multiplied by the per policy year maximum limit.

d) Coinsurance for certain benefits in the form of percentage of reimbursement and/or corridor deductible can be selected by the Policyholder for Insured Members to share a portion of medical expenses with the Company in benefits payment. For a benefit with a percentage of reimbursement, the Company shall pay an amount equal to the medical expenses incurred multiplied by that percentage of reimbursement as stated in the Insurance Schedule. For a benefit with a corridor deductible amount the Company shall pay the balance of the eligible expenses over the corridor deductible amount as stated in the Insurance Schedule.

e) All benefits are applicable to the Insured Members, subject to the exclusions specified in Part IV of this Policy.

f) If there is any benefit change effective after an Insured Member has been hospitalized, the Company shall pay the benefits in accordance with the benefit plan effective on the first day he is admitted to the Hospital.

g) In the event of any subsequent Plan changes to Benefit amounts, reimbursement for any claims incurred after such a Plan change shall be based on the new Benefit amounts. However, if the Insured Person continues to be treated for a previous condition which had been treated within ninety (90) days preceding the effective date of such a change, claims payable for such a previous condition shall be based on the Benefit amounts applicable prior to such change. If, however, after the effective date of such change and the previous condition has not required any treatment for a continuous period of ninety (90) days, reimbursement for such a condition shall be based on the new Benefit amounts after the change in Plan.

Section 2 - Hospitalization & Surgical Benefits

a) Daily Room & Board

A hospitalization benefit shall be paid when, upon recommendation of a Registered Medical Practitioner, an Insured Member is registered as a bed patient in a Hospital. The amount of the said benefit shall be equal to the actual charges made by the Hospital during the Insured Member's confinement; but in no event shall the benefit under this Paragraph (a) exceed for any one day the rate of Daily Room & Board benefit or the maximum number of days for Any One Disability as set forth in the Insurance Schedule.

b) In-Hospital Doctor Visits

If an Insured Member on any day of hospital confinement shall be necessarily treated by a Registered Medical Practitioner on account of accidental bodily injury or sickness, the Company shall pay to the Insured Member an amount equal to the charges made by the practitioner for visits made for such treatment; but in no event shall the benefit under this Paragraph (b) exceed for any one day the maximum daily benefit or the maximum number of days for Any One Disability as set forth in the Insurance Schedule.

c) Hospital Special Services

In addition to the Daily Benefit under Paragraph (a) of this section 2, a special hospital service shall be paid during the time that an Insured Member is registered as a bed patient in a Hospital and is furnished or rendered any special hospital service which is regularly given by the Hospital for treatment of that disability. The amount of said benefit shall be equal to the actual charges made by the Hospital during the Insured Member's confinement; but in no event shall the benefit under this Paragraph (c) exceed the maximum Hospital Special Services benefit for disability limit as set forth in the Insurance Schedule.

The hospital special services covered under this Policy include:

1. Drugs, Medicines, Dressings, Ordinary Splints, Plaster Casts, Oxygen and its administration, and Intravenous Infusions;
2. X-ray, Electrocardiograms, Basal Metabolism Tests and other laboratory Examinations and Tests;
3. Administration of Blood or Blood Plasma, but not the cost of Blood or Blood Plasma unless in connection with a surgical operation recommended and performed by a Registered Medical Practitioner;
4. Physical Therapy;
5. Ambulance Service to and/or from the Hospital.

d) Surgical Benefit

In addition to the benefits under Paragraphs (a) and (b) of this Section 2, a surgical benefit shall be paid in an amount equal to the Surgical Classification for such operation as shown in Section 4 - Schedule of Operations by the maximum Surgical Benefit Classification limit per disability as shown in the Insurance Schedule and benefits for all surgical operations in respect of Any One Disability shall not exceed that limit either. Such benefit shall also become payable if the operation is performed in a clinic by a Registered Medical Practitioner. If two or more surgical procedures are performed during the course of a single operation through the same incision, reimbursement for expenses for all such procedures shall not exceed the amount indicated for that one of the surgical procedures performed for which the largest amount is payable. If X-ray, radium or any other radioactive substance are used for treatment in place of any cutting operation listed in the Schedule of Operations, the Company shall, subject to all of the other provisions of Surgical Benefit, reimburse the Reasonable and Customary Charges for such treatment up to the amount provided by the Schedule of Operations for the replaced cutting operation.

e) Anaesthetist's Fee

The Company shall reimburse an amount equal to the service charge rendered by the Anaesthetist during the operation or procedure as per surgical classification, however, the maximum benefit payable for Anaesthetist fee as set forth in the Insurance Schedule.

f) Operation Theatre

The Company shall reimburse an amount equal to the charges incurred by the Insured Member for the use of operation room, treatment rooms, and equipment and all other related expenses arising from the operation room during the operation or procedure as per surgical classification, however, the maximum benefit payable for Operation Theatre Fee as set forth in the Insurance Schedule.

g) Home Health Care

If an Insured Member on account of injury or sickness, (1) shall be confined as a resident patient in a Hospital at least 3 consecutive days, and as a result benefits are payable for daily room and board on any one of those days; and (2) with the approval of his attending Doctor, shall leave the Hospital and then immediately stay in a home suitable for recovery from the injury or sickness; and (3) during the stay in the home, shall incur medically necessary, reasonable and customary charges for the following home health care services and supplies which are medically necessary, reasonable and customary and provided by a home health care agency approved by the Company:

- Nursing services;
- Doctor's management fee;
- Laboratory examination limited to blood, urine and other body fluids examinations, electrocardiogram, pathological examination and lung function test by portable machine;
- Medicine and drugs;
- Dressings, sterile gloves, antiseptics, needles, syringes, sharp boxes, cotton wool, incontinence pad, mattress cover, braces, supports, splints, plaster casts and rental of durable medical equipments limited to hospital beds, physiotherapy equipments, oxygen administration equipment and intravenous infusion equipment;
- Physiotherapy, speech and occupational therapy;
- Oxygen and its administration;
- Blood or blood plasma and their administration;
- Ambulance service to and from the hospital.

The Company shall pay the actual charges for home care services and supplies incurred by the Insured Member for such disability subject to the maximum amount per each disability as specified in the Insurance Schedule.

h) In-Hospital Specialist Consultation

Should the attending physician or surgeon requires a second opinion or special treatment by another qualified specialist physician or surgeon as a result of bodily injury or sickness, the Company shall, upon receipt and approval of a written recommendation from the attending physician, pay an amount equal to the charges made by the specialist for visits made for such treatment up to the maximum limit per disability as set forth in the Insurance Schedule.

i) In-Hospital Private Registered Nurse

If an Insured Member requires a private registered nurse for such treatment, the Company shall, upon receipt and approval of a written recommendation from the attending physician, pay the maximum daily benefit or the maximum number of days per disability as set forth in the Insurance Schedule.

j) Surgical Supplies for Government Ward

The Company shall reimburse an amount equal to the charges incurred by the Insured Member for the use of surgical supplies, treatment rooms, and equipment and all other related expenses arising from the operation room during the operation or procedure as per surgical classification, however, the maximum benefit payable for surgical supplies as set forth in the Insurance Schedule. This shall not be applicable should the Insured Member be confined in a room type other than the general ward in a Hospital Authority hospital.

k) Increased Overseas Hospitalization Benefit (Due to Accident)

If an Insured Member, while travelling outside his Country of Residence, sustains an Injury and is confined in a Hospital there, the Company shall pay the actual expenses up to two hundred percent (200%) of the maximum amounts specified in the Insurance Schedule of this Policy.

The increased hospitalization benefit shall not apply to hospitalization within the People's Republic of China including Hong Kong SAR and Macau SAR.

"Country of Residence" shall mean the country the Insured Member normally resides in and is employed there. In the event that the Insured Member has been assigned by his employer to work in another country for a continuous period for over ninety (90) days, this country will now be considered his Country of Residence for the purpose of this benefit.

l) Additional Benefit for Accident

If an Insured Member sustains accidental bodily injury and confines in a Hospital, the Company shall pay the usual and customary charges made by the Registered Medical Practitioner of Hospital necessarily incurred by the Insured Member in the treatment of such injury provided that the charge is in excess of all other maximum benefit amounts payable under this Policy subject to a maximum limit per disability as set forth in the Insurance Schedule.

Section 3 - Out-patient Benefits

a) Doctor's Consultation at Office / at Home and Medication

If, on account of accident, sickness or disease, an Insured Member requires treatment by a Registered Medical Practitioner or surgeon, the Company shall pay an amount equal to the actual expenses incurred which include consultation fee and cost of medicine up to the per day limit multiplied by the percentage of reimbursement and subject to the maximum number of visits per policy year as stated in the Insurance Schedule.

b) Out-patient Specialist Consultation and Medication

Should the attending physician or surgeon requires a second opinion or special treatment by another qualified specialist physician or surgeon for an Insured Member as a result of bodily injury or sickness, the Company shall, subject to the receipt and approval of a written recommendation from the attending physician, pay an amount equal to the actual expenses incurred, which include consultation fee and cost of medicine up to the per day limit multiplied by the percentage of reimbursement and subject to the maximum number of visits per policy year as stated in the Insurance Schedule.

c) Chinese Herbalist & Bonesetter with Medication

If, on account of accident, sickness or disease, an Insured Member requires treatment by a Registered Bonesetter & Chinese Herbalist, the Company shall pay an amount equal to the actual expenses incurred which include consultation fee and cost of medicine up to the per day limit multiplied by the percentage of reimbursement and subject to the maximum number of visits per policy year as stated in the Insurance Schedule.

d) Physiotherapist’s or Chiropractor’s Visit

If as a result of Injury or sickness, an Insured member shall necessarily incur expenses for Physiotherapist’s or Chiropractor’s consultation as recommended by a registered medical practitioner which shall include consultation fee and cost of medication, the Company shall make reimbursement for such expenses up to per day limit multiplied by the percentage of reimbursement and subject to the maximum number of visits per policy year as stated in the Insurance schedule.

e) Out-patient Diagnostic Laboratory Tests

Upon receipt and approval of due proof that an Insured Member has been unwell and as a result is recommended by a Registered Medical Practitioner to undergo laboratory tests for diagnostic purpose other than routine medical check-ups, the Company shall reimburse the actual expenses incurred for such tests up to the per disability limit multiplied by the percentage of reimbursement as stated in the Insurance Schedule. The term "out-patient Diagnostic Laboratory Tests" shall mean X-ray, electrocardiogram, blood test, urinalysis and other laboratory tests recommended by a Registered Medical Practitioner for diagnostic purpose excluding any such test which is taken by the Insured Member during his confinement in hospital, or an account of bodily injury or sickness due to pregnancy, including childbirth or miscarriage.

Part IV – Limitations, Exclusions & Claims Procedure

Section 1 – Limitations

a) When an Insured Member or dependant is entitled to benefits payable under the Employee's Compensation Ordinance and other group or individual insurance plans, the Company shall determine the order of benefits payment in accordance with the following criteria:

1. An insurance plan with no provision to co-ordinate with other benefits shall be considered to pay benefits before an insurance plan which has such a provision.
2. An insurance plan which covers the insured as a member shall be considered to pay its benefits before an insurance plan which covers the insured as a dependant.
3. If benefits are payable under Employee's Compensation Ordinance, the Company shall pay after benefits payment under the Employee's Compensation Ordinance is made.

If an Insured Member or dependant has, in accordance with the above criteria, claimed against the Employee's Compensation Ordinance or other insurance plans first, the benefits payable under this Policy shall be limited to the balance of expenses not covered by benefits already claimed or that calculated from the Insurance Schedule, whichever is less.

b) Each hospital confinement must be for a minimum period of six (6) consecutive hours before any benefits are payable, except that no minimum period of hospital confinement is required if such confinement is in connection with a surgical operation, accidental emergency treatment or if the Hospital makes a charge for room and board.

c) No benefit shall be payable under the Policy and the supplementary contracts for pre-existing conditions of an Insured Member or dependant. A pre-existing condition shall mean any disease or injury for which an Insured Member or dependant received medical treatment, medical diagnosis, care, consultation, or service; or took prescribed drugs or medicine for a period of time (pre-existing time period) immediately before the effective date of insurance for that person.

1. For a policy with less than ten (10) Insured Members, the pre-existing time period is one hundred and eighty (180) days. If the Insured Member or dependant has a pre-existing condition, the Company shall not pay benefits for any expenses incurred due to that condition until that person has been continuously insured under this Policy for one year.
2. For a policy with ten (10) or more Insured Members, the pre-existing time period is ninety (90) days. If the Insured Member or dependant has a pre-existing condition, the Company shall not pay benefits for any expenses incurred due to that condition until the earliest of the following occurs:
   i) The completion of ninety (90) consecutive days (while the Insured Member or dependant is insured under this Policy). During this time, the Insured Member or dependant receives no medical treatment, incurs no medical expense, and takes no prescribed drugs to that condition; or

ii) The date the Insured Member or dependant has been insured under this Policy for one year.

Section 2 – Exclusions

The Company shall not pay expenses incurred as a result of:

a) Mental disorders, psychotic or neurotic (including their physiological or psychosomatic manifestations); insanity or self-infliction;

b) Rest cures or sanitarian care; special nursing care;

c) Congenital anomalies; sterilization of either sex; infertility; contraception; pregnancy, childbirth, miscarriage, abortion, pre-natal care, postnatal care and other complications arising therefrom, unless a supplementary contract of Group Maternity & Obstetrical Benefit is attached to this Policy;

d) Hospitalization primarily for diagnosis, X-ray examinations, or physical therapy, or hospitalization and special hospital services so rendered and performed not recommended and approved by a Registered Medical Practitioner or surgeon;

e) Room, board, general nursing care and other hospital services not relating to the diagnosis or treatment of the condition for which the hospital confinement is required; non-medical personal services such as radio, telephone and the like;

f) Cosmetic surgery/treatment for beautification purpose, or plastic surgery for any pre-existing condition;

g) Out-patient treatment for physical therapy and chiropractor unless referred and recommended by a registered medical practitioner and subject to the maximum of fifteen (15) visits per policy year;

h) Routine physical examinations, medical check-ups (unless such benefit is stated in the Insurance Schedule) and tests which are not medically necessary; vaccination and immunization injections;

i) Dental examinations, treatment and surgery unless such benefit is stated in the Insurance Schedule;

j) Experimental medical treatment which, at the time it is provided, is not considered safe, effective and appropriate for the injury or sickness, and is not accepted as standard treatment for the injury or sickness by physicians in Hong Kong;

k) Eye refraction or fitting of glasses; procurement or use of special braces, prosthetic appliances or equipment such as artificial limbs, hearing aids and the like;

l) Drug addiction or alcoholism;

m) Injury or sickness arising directly or indirectly from war, declared or undeclared, strike, riot, civil commotion, or any warlike operation;

n) Professional sports;

o) Injury sustained or sickness contracted as a direct result of participation in illegal acts (except traffic and pedestrian offenses); such acts include but are not limited to burglary, robbery, failure to obey an

order given by an officer of the law, drug abuse, use of explosives or incendiary devices (unless permit has been issued), assault and battery, etc;

p) Venereal Diseases or their sequelae; AIDS (Acquired Immunization Deficiency Syndrome) and ARC (AIDS Related Complex);

q) This policy shall not cover medical expenses in excess of Reasonable and Customary charges;

r) Non-Medically Necessary Health Services.

Section 3 – Notice of Claim

a) Written notice of any hospital confinement or operation on which a claim may be based must be submitted to the Company within ninety (90) days after the completion of treatment or the date of discharge from the Hospital. Claims in respect of Out-patient benefits, should be submitted to the Company within ninety (90) days from the date of receipts. All claims must be submitted with original copies of receipts and itemized bills with diagnosis certified by the attending registered medical practitioner and a fully completed claim form supplied by the Company.

b) Notice given by or on behalf of the claimant to the Company with particulars sufficient to identify the Insured Member shall be deemed to be notice to the Company. Failure to furnish notice within the time provided in the Policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

Section 4 – Filing Proof of Loss

Affirmative proof of loss acceptable to the Company, including original copies of receipts and itemized bills, for which claim may be based together with a fully completed claim form supplied by the Company must be furnished by the Policyholder to the Company within ninety (90) days after the termination of the period for which claim is made. Should the submitted documents require verification or other necessary actions, they shall be returned to the Policyholder for such actions and must be re-submitted to the Company within ninety (90) days after the termination of the period for which claim is made.

Section 5 – Examination

The Company shall have the right and opportunity to examine any Insured Member in respect of whom a claim has been submitted when and so often as it may reasonably require during pendency of a claim, and also the right and opportunity to make or have made an autopsy in case of death where it is not forbidden by law.

Section 6 – Payment of Claim

All benefits that pertain to any Insured Member shall be paid by cheque or bank autopay to the order of the Policyholder, unless the Policyholder requests otherwise, or the Company, in its discretion, considers it preferable to make the payment in another manner.

Section 7 – Subrogation Rights

In the event of any payments for benefits provided to an Insured Member under the Policy, the Company, to the extent of such payment, shall be subrogated to all rights or recovery such Insured Member has against any person or organization; and the Insured Member shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

Section 8 – Currency

Claims for expenses made by an Insured Member in any foreign currency shall be converted to local currency at the official buying rate for such currency that is in effect in Hong Kong at the commercial banks at the time of the payment of such claim.

Part V – Other Provisions

Section 1 – Premium

a) During the Period of Insurance, the premium for insurance under this Policy shall be based upon the premium rates shown in the Insurance Schedule. The Company shall have the right to change the rate at which premium shall be calculated, (1) on any Policy Renewal Date, and (2) on any Premium Due Date provided the rate that is then being charged has been in effect for at least twelve (12) months and provided further that the Company notifies the Policyholder at least thirty-one (31) days in advance of such Premium Due Date.
b) Premium adjustments, if any, shall be effective immediately following the effective date of enrolment, benefit change or termination of any Insured Member.
c) Premiums are payable by the Policyholder either annually or semi-annually or quarterly or monthly, as specified in the Insurance Schedule, in advance, to the Company. The first premium shall be payable at the Commencement Date and subsequent premiums shall be due and payable on the Premium Due Dates as stated in the Insurance Schedule.

Section 2 – Grace Period, Termination and Reinstatement of Policy

a) A grace period of thirty-one (31) days following the Premium Due Date shall be allowed to the Policyholder for the payment of any premium after the first. If any premium is not paid in respect of

this Policy or any of the supplementary contracts before the expiration of the relevant grace period, this Policy and the relevant supplementary contracts (if any) shall automatically terminate at the expiration of the grace period, except that if the Policyholder shall have given the Company written notice in advance of an earlier date of termination, this Policy and the relevant supplementary contracts shall terminate as of such earlier date. The Policyholder shall be liable to the Company for the premiums for the time the Policy and any of the supplementary contracts in force during the grace period.

b) The Company reserves the right to terminate this Policy and any of the supplementary contracts on any premium due date when fewer than the total number of Members then eligible for insurance are insured, if the insurance plan is non-contributory, or less than seventy-five per cents (75%) of the total number of members then eligible, if the insurance plan is contributory, provided that the Company shall give the Policyholder at least thirty-one (31) days of its intent to terminate.

c) At any Policy Anniversary, both the Policyholder and the Company may cancel this Policy and any of the supplementary contracts by giving the other party at least thirty-one (31) days notice before Policy Anniversary of its intent to terminate.

d) Whenever this Policy or any of the supplementary contracts is terminated either by the Policyholder or by the Company, any premiums that are outstanding and unpaid up to the date of termination of this Policy or of any of the supplementary contracts shall be paid by the Policyholder, and any premium that have been paid to cover the period after the date of termination of this Policy or of any of the supplementary contracts shall be refunded by the Company after deducting all the claim payments made or to be for that period.

e) Termination and non-renewal of this Policy or of any of the supplementary contracts either by the Policyholder or by the Company shall be without prejudice to any valid claim arising prior to the date of termination but the incurred date of such claim shall be limited to the last day of the Period of Insurance.

f) After termination of the Policy or of any of the supplementary contracts, the Policyholder may apply for reinstatement which shall be subject to the consent of the Company to terms and conditions which the Company may impose.

Section 3 – Renewal

This Policy and each of the supplementary contracts (if any) are issued for the Period of Insurance as stated in the Insurance Schedule and at the end of such may be renewed subject to the consent of the Company at such premium rates as may be determined by the Company.

Section 4 – Data Required

a) The Policyholder shall keep a record with respect to each Insured Member under this Policy, showing the Member's name, sex, age or date of birth, the date insurance became effective, the date insurance terminated, and such other data as may be necessary to carry out the terms of this Policy.

b) Clerical error in keeping the records shall not invalidate insurance in force, but upon the discovery of such error, an equitable adjustment shall be made.

c) The Policyholder shall furnish the Company with all information and proofs with the Company may reasonably require with regard to any matters pertaining to the Policy. All documents furnished to the Policyholder by any Member in connection with the insurance, and other records as may have a bearing on the insurance under this Policy, shall be open for inspection by the Company at all reasonable times.

Section 5 - Misstatement

a) If the age or date of birth or other relevant facts relating to a Member shall be found to have misstated and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of this Policy, the true age and facts shall be used in determining whether insurance is in force under the terms of this Policy and the benefits payable therefrom, and an equitable adjustment of premiums shall be made.

b) Where a misstatement of age or other relevant facts has caused a Member to be insured hereunder when he is otherwise ineligible for insurance or where such statement has caused a Member to remain insured when he would otherwise be disqualified for further insurance in accordance with the terms and limitations of this Policy, his insurance shall be void and there shall be a return of premium paid in respect of the Member after deducting any claim paid, provided always that when there is fraud on the part of the Policyholder or Member, no premiums paid are to be returned.

Section 6 – Assignment

No benefits under this Policy can be assigned.

Section 7 – Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and may be enforced in accordance with the law of Hong Kong.

Section 8 – Legal Proceedings

No action in law or in equity shall be brought to recover on this Policy prior to the expiration of ninety (90) days after proof of claim has been filed in accordance with the requirements of this Policy, nor shall such

action be brought at all unless brought within two (2) years from the expiration of time within which proof of claim is required by this Policy.

Section 9 – The Contract

a) All statement made by the Policyholder, or by the Insured Members, shall, in the absence of fraud, be deemed representations and not warranties, and no statement avoid the insurance, or be used in defence of a claim under it, unless it is in writing.

b) The rights of the Policyholder or any Insured Member or of any beneficiary under the Policy shall not be affected by any provision other than those contained in this Policy or in the copy of the Policyholder's application attached hereto, or in the Medical Health Statement, or in any other document which constitutes part of the entire contract.

c) No agent is authorized to alter or amend this Policy, to accept premium in arrears, to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this Policy shall be valid unless approved by the Company and evidenced by endorsement hereon, or by amendment hereto signed by the Company.

Section 10 – Arbitration

If any difference shall arise as to the amount to be paid under this Policy, such difference shall be determined by arbitration in accordance with the prevailing Arbitration Ordinance. If the parties fail to agree upon the choice of arbitration or umpires, then the choice shall be referred to the Chairman for the time being of the Hong Kong International Arbitration Centre. It is hereby expressly stipulated that it shall be a condition precedent to any right of action or suit upon this Policy that an arbitration award shall be first obtained.