HEALTH INSURANCE FAMILY CARE

CHAPTER 1: DEFINITIONS

1. **Insurance Company.**
2. **Physician** is a person who has a legal medical practice license under the law of the Socialist Republic of Vietnam and only provides treatment to the Insured within the field of expertise with a practice license. Exclusion of a physician is the Insured Person or siblings, spouses, and children of the Insured Person. Doctors are also considered medical specialists.
3. **Special diseases** as cancer, tumor types, blood pressure, cardiovascular disease, gastritis, arthritis, hepatitis (A, B, C), gravel kinds of urinary system, chronic sinusitis little nh , diabetes, bronchial asthma, nephritis (excluding acute cases requiring urgent medical treatment).
4. **Pre-existing condition** is any diagnosed health condition of the Insured; or has symptoms that cause a normal person to seek medical treatment; or because of such a condition, the medical surgeon has advised the insured person to be treated regardless of whether the Insured Person has actually been treated.
5. **Child nursing expenses** include: Pediatric nutrition, pediatric testing, Immunization, Delivery of a baby right after Birth at a hospital being treated.
6. **Actual medical expenses** are expenses that are reasonably and medically necessary, as directed by the attending physician, arising when the Insured Person is required to treat an illness or maternity treatment for which such treatment is insured.
7. **Costs of routine and reasonable** is the medical necessary expenses do not exceed the general costs of providers of health services with the same level within the geography of the contract, which arise the cost, when providing equivalent therapeutic services or the level of treatment, services, or the provision of services for a similar illness.
8. **Policyholder** means the entity that signs the Insurance Contract with the Insurance company and is named as the Policyholder in the Policy.
9. **Medical facility** is a legal medical facility recognized by law, licensed for inpatient or outpatient treatment, not a place for relaxation or nursing or some special facility. reserved for the elderly, or to detoxify alcohol, drugs, drugs.
10. **Birth defects** are abnormal development of the shape, structure or position of a body part or structure right from the stage of development in the mother's uterus in the opinion of a doctor in the medical perspective.
11. **Outpatient treatment** is the treatment of an insured person at a licensed medical examination and treatment facility without being hospitalized, not inpatient or day treatment.
12. Inpatient treatment is medical treatment where the Insured Person is admitted to the hospital and stays overnight. A discharge from the hospital is required to make a claim for this benefit.
13. **Day treatment** is medical treatment when the Insured Person is required to go through hospital procedures and must be treated in a hospital bed but is not required to stay overnight. A discharge from the hospital is required to claim this benefit.
14. **Insurance start date** is the effective date of the First policy when the Policyholder joins this policy. For Policies that are not continually renewed annually, the start date of coverage is the effective date of the last policy in the new insurance period unless separately agreed.
15. **The effective date of coverage** is the date that each coverage period begins. For policies that are renewed continuously annually, the effective date is the renewal date. In this policy, Policy validity is calculated from 00: 01h of that day .
16. **Enrollment date** is the date the Insured begins to participate in an insurance policy .
17. **The Insured** is a person who is accepted by the Insurer as stated in the list of the Insured.
18. **Employee**: is a member of a company or organization that has a labor contract or probationary contract or legally recognized labor agreements with that company or organization.

19. **Dependents** include spouses, legal children. Children are persons 12 months to 18 years of age or 23 years of age who are attending full-time, unmarried courses and dependent on the Insured Person. All dependents must be named on the policy as the Insured.
20. **Hospitalization** is inpatient treatment for more than 24 hours and for day treatment. A discharge from the hospital is required to claim this benefit.
21. **Surgery** is a scientific method for the treatment of injury or disease, pregnancy by qualified surgeons through operations, including, but not limited to: The method has the equivalent of surgical results (stone dissipation, cataract laser irradiation. Minor surgery, procedures with medical instruments in the hospital.
22. **Critical condition** is the condition that in the opinion of the treating physician and / or insurance companies is a condition critical health need emergency treatment to avoid death or she ember drink serious to a permanent or current medical condition.
23. **Physiotherapy** is a treatment that uses physical methods to relieve pain, restore muscle function or normal daily activities of the patient as directed by the treating doctor.

CHAPTER II: SCOPE OF INSURANCE

This insurance policy indemnifies the Insured for medical expenses for the treatment of illness, disease, and maternity arising during the insurance period.
The benefits mentioned in the Policy are paid to the Insured in the event of medical expenses incurred as specified in this Policy.
Upon receipt of proof of claim, the Insurer pays the Benefit under the scope of this Policy in accordance with the Sub-Limits section of the Policy with the Maximum Limit stated in the Policy. dangerous. The above expenses are limited according to actual, customary and necessary expenses.

1. Hospital fees.

If the insured person was hospitalized, the insurance company will pay the insured costs of medical services or pharmaceuticals provided by the disease cabine , includes g oh m, but not limited to expenses fee follows:

- Standard bed, room, and meals at the hospital. For international hospitals, Tie n the room is limited to the standard room (not a special room);
- Cost of intensive care room (active treatment room);
- Administrative expenses, blood and plasma expenses ;
- Drugs and medications used while lying in bed ;
- Conventional braces, bandages and powders;
- Physiotherapy (if these costs are needed during hospitalization as directed by a doctor) ;
- Intravenous infusion;
- Examination or imaging such as X-rays, MRI, CT, PET (these tests must be prescribed by a doctor as necessary to assess the condition and must be part of the limb hospitalization fees (inpatient treatment and same-day treatment);
- Midwifery costs .

2. Surgical Procedures

Insurance companies pay for medical expenses related to the surgery inpatient, day surgery or outpatient surgery, including the cost of surgical procedures with tools and equipment necessary p customs implanted into the c Matt can to sustain life , or the equipment needed for surgery; expenses for surgery , surgery , anesthesia and general expenses for preoperative diagnosis and postoperative resuscitation, costs of organ transplants, expenses for re-surgery. Surgical costs do not include prognostic procedures.

3. Emergency treatment

An emergency service performed in the emergency room of a hospital or clinic for a critical condition.

4. Urgent shipping

Expenses for emergency and emergency transportation to bring an Insured Person in a tragedy to treatment in the emergency room of the hospital or the closest room with appropriate medical care.

5. Hospitalization Allowance
The insurance company pays the amount indicated on the benefit for each day of hospitalization for internal treatment
Overnight stay or day treatment.

6.Pre-hopitalization treatment
The insurance company pays for medical examination, diagnosis, related medical expenses and reviews necessary test (as directed by the physician) and directly related to the Insured Person's illness, illness, or pregnancy should be followed by intensive hospitalization, and these predictions are the basis directly let the treating doctor conclude that hospitalization is necessary. This fee is paid up to 15 days prior to admission.

7 .Post-hospitalization Treatment
The insurance company pays for the treatment expenses immediately after discharge as directed by the doctor treating the illness, illness or maternity of the Insured Person who has been hospitalized, including: re-examination fees, the cost of testing, tie m medicines immediately after discharge. This fee is paid up to 30 days after discharge.

8 . Home Nursing
The insurance company pays the insured person for the medical care services of a legally licensed nurse, which is enjoyed immediately upon departure from the hospital , at the Insured Person's place, Follow the prescription of the treating doctor within 30 days after discharge .

9. Burial cost
In case the insured dies within the scope of insurance liability, regardless of hospitalization or outpatient, the Insurer pays the funeral allowance as stated in the Policy.

10. New born care
Insurance company covers child support expenses actually incurred but do not exceed the limit on the Insurance Contract.

11. Maternity and childbirth
a. Complications of pregnancy and birth difficulty
The insurance company covers medical expenses incurred due to complications during pregnancy, or during childbirth requiring obstetric procedures. A caesarean section is covered only if it is indicated by the doctor as necessary for the delivery, not including the required caesarean delivery (or re-surgery due to the requirement of prior surgery). Complications for pregnancy and delivery include and are not limited to the following:

i.Miscarriage or fetal death in the uterus;
ii.Pregnancy;
iii.Ectopic pregnancy;
iv.Postpartum death ;
v.Placenta loss in the uterus after birth;
vi.Abortion due to treatment;
vii.Variable values of the above reasons.

b. Ordinary birth

The insurance company covers the medical expenses incurred for the birth which usually include and are not limited to the following costs: midwifery, general hospital fees, specialist doctor, maternal care before and after the birth at this hospital.

CHAPTER III: EXCLUSION POINTS

The following treatments, items, conditions, activities and their associated costs or consequential costs are excluded in this Agreement and the Insurer is not liable for :

1. Outpatient treatment services. This exclusion will not apply if the Insured participates in the “Outpatient Treatment” benefit.
2. Home treatment services (not including home care nursing costs) or at a hydromotherapy or natural treatment clinic, spa, nursing home, nursing home, or other location that is not must be a Medical Facility.
3. Examination and physical exam including general physical exam, gynecological check-up, routine pregnancy check-up, immunization, vaccines and vaccines, routine eye exam, general hearing test , natural degenerative eye defects (including near, farsightedness, astigmatism), any surgery to correct degenerative hearing and vision defects, and pre-travel physical exam or go to work.
4. Birth defects , birth defects, diseases or genetic deformities with signs from birth.
5. Forms of outpatient treatment for teeth and related teeth (gums, gums). This exclusion does not apply if the Insured participates in the "Outpatient Treatment" or "Comprehensive Dental Treatment" benefit.
6. Treatment and surgery at the request of the Insured without relating to the normal surgical and treatment conditions as stipulated by the health sector.
7. Orthopedic orthopedic imaging, weight treatment and related consequences.
8. Family planning, infertility treatment, impotence treatment, sexual dysfunction, sex change, or any of the consequences or complications of the above treatment.
9. Special illness for the first year of coverage from the date of coverage commencement. This exclusion does not apply to group insurance contracts of 50 employees or more.
10. The illness is available for the first year of coverage commencing from the date of coverage. This exclusion does not apply to group policies of 50 employees or more.
11. Mental diseases, psychological disorders, "neurasthenia", body weakness (no medical cause), fatigue, regulatory eye fatigue, stress, leprosy, syphilis, gonorrhea , AIDS and related syndromes, venereal disease and other sexually transmitted diseases, occupational diseases.
12. Charges for the provision, maintenance or assembly of appliances or prostheses, orthopedic appliances, hearing or vision aids, crutches or wheelchairs or other appliances.
13. Consequences of using drugs, substances, drugs not prescribed by a specialist or prescribed drugs for the treatment of addiction diseases.
14. War or hostile acts including whether to declare war, terrorism, nuclear agents or radioactive substances.
15. Expenses for organ transplant plant organs such as organ donation, receipt, purchase, transportation and preservation. However, this insurance policy covers medical expenses for organ transplantation.
16. The treatment is not scientifically recognized, the treatment is experimental.
17. Costs and treatment for those who are not eligible for insurance.

CHAPTER IV - GENERAL CONDITIONS

1. Geographical scope

The geographical coverage covered by this insurance contract is the territory of the Socialist Republic of Vietnam, unless otherwise agreed. The geographical range used in the insurance contract is not subject to diplomatic agreements.

2. Subject of insurance

Age to participate in the insurance is from 12 months to 65 years (according to calendar year) and exclude people with cancer (dependents only), mental, permanent disability from 80% above. For Dependents, the Insurer only accepts insurance on the date of commencement of coverage, does not accept participation in insurance in the middle of the policy term, except:

- Dependents of new employees working for the Policyholder;
- Newly married spouse within the insurance period;
- Children of full age to participate in the insurance during the insurance period.

3. Insurance term

Is (01) the following year from the effective date of insurance, unless otherwise agreed upon with the Insurance Company .

4. Verification

The Insurer reserves the right to appoint a medical professional and / or loss assessment specialist to conduct an Insured Person's health check and any information related to the resolution of the claim. any time. In addition, the Insurer reserves the right to request an autopsy in the event of a death, if this does not violate applicable laws or affect beliefs and customs. .

5. Insurance benefits

a. The duration of the insurance is greater than one year and not even the year, the benefits for a period in excess of an even number are specified as follows:
- To be entitled to a one-year benefit rate if the premium for the excess period is calculated according to the limitation fee;
- To be entitled to use the pro rata of the insurance benefit between the excess period and one year if the premium is calculated proratively.

b. One year term of coverage: access to one year of benefits.

c. Policy period less than one year: access to one-year benefit and short-term premium.

6. Short-term premium

a. For the term of 1 month = 1/4 of the annual premium
b. For the term of 2 months = 3/8 of the annual premium
c. For a period of 3 months = 1/2 annual premium
d. For a period of 4 months = 5/8 annual premium
e. For a term of 6 months = 3/4 the annual premium
f. For the term of 8 months = 7/8 annual premium
g. For periods of 8 months or more = Annual premium

7. Notification of authorization and assignment notice

The insurer is not required to accept any notices regarding the terms of trusts, charges, collateral, assignment or other transactions with or in connection with the Contract. this insurance.

8. Insurance validity / Waiting time

The Policy is effective after the waiting period below commencing from the Policy Date.

a. For insurance contracts under 50 employees
   i. Treatment of illness: 30 days;
   ii. Treatment of special diseases, available diseases: 12 months from the date of enrollment;
   iii. Maternity:
      - 60 days in the case of miscarriage, it is necessary to abort the pregnancy according to the prescription of the pregnant doctor;
      - 270 days for childbirth.

b. For Insurance contracts of 50 employees or more
   i. Disease treatment: waiting time is not applicable;
   ii. Available medical treatment: no waiting period (except for inpatient treatment at the start date of coverage);
   iii. Treatment of special diseases: no waiting time is applied;
   iv. Maternity: no waiting period is applied, benefits are paid as follows:
      - In case of miscarriage, it is necessary to abort as prescribed by the maternity doctor: the benefit is paid according to the ratio of the period from the date of enrollment to the date of commencement of maternity treatment with 60 days;
      - In case of giving birth: benefits are paid according to the ratio of the period from the date of joining the insurance to the date of birth and 270 days.

9. Termination of contract

a. If the Insured or the Legal Successor is dishonest in implementing the provisions of this code, the policy will cease to be valid and the Assured will not be entitled to any interest in the insurance contract. Premium paid is non-refundable.

b. In case either party requests to terminate the insurance contract, the requesting party must notify the other party in writing 30 days in advance from the date of the intention to terminate; The termination of the contract must comply with the provisions of the Law on Insurance Business and the Civil Code and comply with the following two cases:

- If the contract is agreed upon by both parties according to the insured person's request to terminate the insurance policy, the Company will refund 80% of the premium of the remaining effective period, provided that the That point the insurance policy has a compensation / premium ratio below 40%.
- If the contract is agreed upon by both parties according to the insurer's request to terminate the insurance contract, the insurer will refund 100% of the premium for the remaining period.

10. Responsibilities of the Policyholder and the Assured

a. To truthfully and fully declare insurance information as required by the Insurance Company, comply with the terms and conditions and pay the premium correctly and fully in accordance with the provisions of the Insurance Policy.

b. Report situations that could lead to a claim, be honest in reporting, and provide accurate documentation of insured risk.

c. In case the assured authorizes another person to receive the premium, there must be a legal power of attorney.

11. Terms of automatically adding or removing personnel

Any new employee of the Policyholder will automatically be insured with the sum insured not exceeding the sum insured as indicated in the Policy or the most recently valid Amendment. The Policy also automatically removes the currently insured employees from the Policyholder's list of employees, provided the Policyholder notifies the Insurer of the personnel adjustment at the end of each month. of the insurance period. The notice must be made in writing and confirmed by the Insurance Company. The premium is calculated on the basis of the ratio of the insured period or the termination of insurance after the Policyholder has stated the personnel adjustment. Auto insurance does not apply to any employee whose sum is insured in excess of the current maximum insured of current group members, and does not apply to foreigners and relatives. Insurance for the above items is only available upon request and approval of the Insurer.

The parties agree that the insured employees must have an employment agreement with the Policyholder in accordance with the Vietnamese Labor Law.

The parties also agree to apply an automatic salary adjustment clause according to the employment agreement of the Policyholder with the employee, provided that the Policyholder must update the change of the total salary fund or the salary details. monthly. Insurance premiums will be adjusted according to the variable salary.

12. Currency clause

Under this clause, the parties agree that premiums and indemnities under the terms and conditions of the contract may be paid in a currency other than that indicated in the insurance policy with a billion price is the selling rate of the Bank for Foreign Trade of Vietnam at the time of fee payment or the time of receiving compensation.

In the case of the insurance premium adjustment, the exchange rate is also applied according to the above principle.

In case the premium or compensation is paid in VND, this rate is the USD / VND selling rate of the Bank for Foreign Trade of Vietnam at the time of remittance**.**

13. Fee Payment Guarantee Terms.

a. The parties agree and acknowledge that, notwithstanding any contrary conditions in this Policy, and on the basis of compliance with Section b set forth below (but without prejudice to the interests of the parties under This Policy), a prerequisite for binding the Insurer's liability under the Policy, Certificate of Reinsurance, Amendment, or Provisional Certificate of Insurance is the premium. Insurance has been paid or is in fact fully remitted to the Insurance Company, Broker or Insurance Agent that has issued or arranged the Policy in accordance with the following provisions:

¡. If the insurance period is 30 days or more stations, within 30 days from:
Effective date of Policy, Certificate of renewal of insurance or Certificate of provisional insurance; or the effective date specified in each Amendment (if any) issued under the Policy, Certificate of Reinsurance, Certificate of Provisional Insurance.
Issue date of Policy or Amendment (if any) issued under Policy, Certificate of renewal of insurance or Provisional certificate of insurance if the date of issue of these documents occurs after 30 the effective date specified in such documents, or

ii. If the Insurance Company accepts to pay the premium by installments, within 30 days from:
Effective date of Policy, Certificate of renewal or Provisional Certificate of Insurance for the first payment period and agreed dates for subsequent payment periods, or
The effective date specified in each Amendment granted under the Policy for the first payment period and the agreed dates for subsequent payment periods, or
Issue date of Policy or Amendment, if any, issued under Policy, Certificate of renewal of insurance, Certificate of provisional insurance if the date of issue of these documents occurs after 30 of the effective date specified in those documents for the first payment period and the dates agreed upon for the subsequent payment period,

iii. If the insurance period less than 30 days, the premium must be paid as soon as there is debt notice but no later than 1 5 days from the effective date of the insurance contract or amended and supplemented, if any, granted under the Insurance Contract . Certificate of renewal or provisional insurance certificate .

b. In the event that the above premium has not been fully paid for the Insurance Company , Broker, or Insurance Agent as declared according to the calculation and time specified above (the guarantee period premium payment), the validity of insurance under the Policy, Certificate of renewal, Amendment, or Certificate of Provisional Insurance will be deemed to be terminated from the expiration date of the Policy. payment guarantee period and the Insurer will be exempt from all liabilities from then on and in this case, the insurance company will be entitled to a pro rata premium of the date the Policy was made. valid but not less than US$ 25.

c. The parties also agreed that in case the premium above was bar cost or the fact that transferred full payment for the insurance company , broker or agent insurance after billing period prescribed fee (premium payment guarantee period), the Policy , Certificate of renewal , Amendment or provisional certificate of insurance will re-take effect and the Insurer will be responsible for from that point onwards but is exempt from all liabilities incurred before that late date of payment.

CHAPTER V: COMPENSATION I COMPENSATION

1. Compensation Procedure (applies to all major programs and add-ons)

When requesting compensation from the Insurer, the Assured or a legal heir or an Insured Person's authorized person must submit the following documents within 180 days of the date of termination of the Insured Person's treatment, discharge or death. Past the above time limit, the claim will be denied part or all of the compensation amount, except in force majeure cases**.**

a. The request for compensation is fully declared in the form of the Insurance company , signed by and the name of the company in the name of the Policyholder (unless otherwise agreed);
b. Certificate of injury (in case of permanent injury); death certificate (in case of death);
c. Certificate of legal inheritance, if any (in case of death);
d. Written leave of appointment of the treating doctor (in case the Insured Person must take leave for medical treatment);
e. Medical documents (for invoices and payment documents, the Insurance company only accepts originals):

- Certificate of discharge, Certificate of surgery (in case of surgery);
- Order or test results, XQ, CT ...
- Prescriptions, drug invoices, receipts for collection of hospital fees and receipts (according to the form of the Ministry of Finance).

f. Timesheet, labor contract / employment agreement, payroll certified by the employer or salary account statement. For probationary employees, provide a valid job offer.

g. Home care nurse service:
- If the nurse is sent by a medical facility: The Insured Person provides the Billing, Receipt, and Referral Form of the medical facility.
- If freelance nurse : The insured person provided a copy of the nurse 's degree and the nurse's receipt.

h. Provide identification seconds in case a loved one claims

i. Other relevant documents upon request.

2. Compensation term.

The insurance company informs the result and settles compensation to the insured, heir, or legal representative within a maximum of 15 working days from the date of receipt of complete application and Invalid.

3. Time limit for complaints:

The period of time that the Insured or the Legal Successor can file a claim against the Insurance Company for the payment of insurance premium is **3 years** from the date the Assured or the legal heir or the legal authorized person. receive a notice of settlement result from the Insurance Company. Past the above time limit, all claims will be void.

The parties mutually agree that all disputes or conflicts occurring between the parties related to the Insurance Contract will be resolved at the court of the State of the Socialist Republic of Vietnam in accordance with the Laws of the State of the Socialist Republic of Vietnam.

4. General information on compensation often

All documents and documents, (including snail bills, certificates, X-rays) that the Insurer requests assistance to pay for insurance (indemnity only), including All health results and any details of the Insured Person's medical history shall be made available to the Insurer at no cost to the Insurer, if required, prior to any payment. Any insurance (indemnity) is completed.

In the event of a lack of medical information or a need for clarification, the Insured Person shall be responsible for adding such information to the Insurer and the Insurer shall not incur any additional charges for such information. .

5. Co-insurance / Co-insurance

Co-Insurance, Duplicate Insurance is applicable to medical expenses for the treatment of illness or maternity, but not in conjunction with benefits that cover only injury or death due to illness.

If at the time of the construction of the insured event, the insured person was being insured by another Insurance program (except Social Insurance), any medical expenses associated with the same treatment. The medical condition will not be covered by the same insurance carrier simultaneously.

CHAPTER VI: EXPANSION TERMS

1. Insurance benefits do not increase fees

Special agreement on indemnity advance: In case the insured is hospitalized, under special circumstances:

- Insurance company may agree to advance indemnity according to the estimated indemnity amount up to a maximum of VND 10 million provided that the topical amount is generally estimated based on hospital diagnoses exceeding VND 5,000,000.

- If the Insurance company is unable to provide an advance payment within 24 hours of an emergency, the Policyholder can rely on the Insurer's written confirmation, providing it to the affected employee. His accident is a reasonable advance.

- The Policyholder then promptly informs the Insurance Company of the advance amount, provides Medical Documents, Medical Advice Request (confirmed by the Insurance Company), and the Insurance Company. Insurance Policyholder has the responsibility to reimburse Policyholder this advance within 15 days.

2. Insurance benefits have increased fees

a. Outpatient treatment:
On the basis that the Insured has paid the premium, the Insurer agrees to cover the following outpatient treatments with the coverage specified in the Policy.
i. Outpatient treatment: The insurance company pays outpatient treatment fees incurred at medical facilities, including:
- Medical expenses;
- The cost of medicine according to the doctor's prescription;
- Expenses for X-rays, tests, radiation therapy, light therapy prescribed by the doctor and necessary for the diagnosis and treatment of the disease;
- Cost of Physiotherapy prescribed by the doctor, reasonable and necessary;
- Expenses for periodic pregnancy check-ups.

ii. Basic Dental Treatment: The Insurance company pays the following basic dental treatment costs incurred at medical facilities, including:
- Examination and diagnosis of disease;
- X-ray;
- Treatment of gingivitis (only gums);
- Filling (amalgam or composite);
- Treatment of dental pulp;
- Pathological tooth extraction (not accompanied by surgery).

b. Comprehensive dental treatment:
On the basis that the Insured has paid the premium, the Insurer will pay the following Dental Care costs incurred at the medical facility with the coverage limit specified in the policy of insurance. , include
i. Basic dental treatment
- Examination and diagnosis of disease;
- X-ray;
- Treatment of gingivitis (rot of the gums);
- Filling (amalgam or composite);
- Treatment of dental pulp;
- Pathological tooth extraction (not accompanied by surgery).

ii. Special dental treatment
- Taking tartar (2 times / 1 year);
- Extraction of teeth needing surgery;
- Root teeth:
- Get tartar tumors (take tartar under the gum);
- Apical surgery (root removal surgery).
- When the Insured participates in this benefit, the Basic Dental Treatment costs under the Outpatient Treatment Benefit will not apply.

iii. Exclusion: The following dental treatment costs are not covered under this benefit
- Dentures (repair, renew, repair or replace dentures);
- Orthodontic orthodontic beauty; -

- Accidental tooth damage.

CHAPTER VII: DEATH AND PERMANENT DISABLEMENT FOLLOWING ACCIDENT; MATERNITY

1.Coverage

Under this provision, the Insurer agrees to extend coverage in the event of the Insured Person's death or permanent disability due to physical causes (including but not limited to: illness, disease , maternity, food / drink poisoning, poison gas inhalation, noxious fumes) in accordance with the exclusions listed below without the general exclusion terms of this agreement with the Sovereign recorded in the Policy Contract. In the event that the Insured does not specify The Beneficiary, or the Beneficiary has died or is missing for a certain period of time, the Insurer pays compensation to the Legal Successor in accordance with the Law of Inheritance.

2.Exclusion Terms

The insurance company is not responsible for compensation in case of death or permanent injury due to the following direct or indirect causes:

a. Due to accidental causes;
b. Willful act caused by the Insured or the beneficiary of the insurance benefit ;
c. The Insured uses or is under the influence of alcohol, beer, drugs and other similar stimulants. Stimulants are understood as a rule that the Insured person uses to cause addiction, causing nerve paralysis and cannot control his / her actions which are prohibited by law;
d. Pre-existing illness, unless the Insured has been insured for 24 consecutive months;
e. Special illness, unless the Insured Person has participated in this insurance for 24 consecutive months;
f. Birth defects, mental illness ;
g. Treat or use drugs not as directed by your treating doctor;
h. Treatment is not scientifically recognized, treatment is experimental;
i. The insured violates laws, rules, regulations of local authorities or social organizations;
j. Maternity cause , unless the insured has been insured for more than 12 months
k. War (whether or not to declare war), hostile or warlike acts, civil war, riot, riot, or civil commotion;
l. Due to acquired immunodeficiency syndrome (AIDS), AIDS-related diseases or the AIDS virus; or gonorrhea, syphilis, or other sexually transmitted diseases;

The determination of the rate of permanent disability is based on Appendix 1 - Permanent disability payment rate table.