DEFINITIONS OF TERMS

A. Activities of Daily Living – the following are considered as activities of daily living:

a. Eating
b. Bathing
c. Dressing
d. Toileting (being able to get on and off the toilet and perform personal hygiene functions)
e. Transferring (being able to get in and out of bed or a chair without assistance)
f. Maintaining continence (being able to control bladder and bowel functions).

B. Benefit Period - This covers the period established for sickness or injury due to one cause or related causes within which time the Insured Member can claim for benefits for eligible expenses up to the annual benefit limit.

C. Company – Etiqa Life and General Assurance Philippines, Inc.

D. Eligible Expense – refers to actual, necessary, reasonable and customary expenses incurred by the Insured Member in the course of the medical management of his/her illness/injury, subject to the limits of the plan.

E. Emergency – refers to medical conditions that require immediate medical attention wherein, unless the Insured Member is brought to the nearest medical facility for treatment, the Insured Member may lose his/her life or may suffer complications that would render him/her fully or partially incapacitated.

F. Excess – refers to the amount that exceeds the Insured Member's annual benefit limit.

G. Free-look period – refers to the number of days which starts from the time of the receipt of the contract by the policyholder until the last day of the policy period that the consumer may return or cancel the contract.

H. Hospital – Any private or government institution legally constituted and locally operated hospital or clinic duly registered with the Bureau of Medical Services, Department of Health. It shall have organized facilities providing medical, diagnostic and surgical facilities for the care and treatment of the sick and injured person on an inpatient basis under the supervision of a physician with 24-hour nursing service by registered graduate nurses and which is not other than incidentally a place of rest, for the aged, for drug addicts, alcoholics or convalescent home.

I. Ineligible Expense – refers to the expenses incurred by the Insured Member that has nothing to do with the direct medical management of the illness/injury but not limited to extra food, extra bed, telephone calls, etc.

J. Inpatient – refers to the benefit availment wherein an Insured Member has been admitted to a hospital, for a minimum of six (6) hours of stay, as a registered patient receiving appropriate medical services.

K. Insured Member – refers to the person Insured under this Policy.

L. Look-Back Period – refers to the period in the past in which the condition or disease existed.

M. Outpatient – refers to the benefit availment wherein an Insured Member is receiving medical services under the direction of a physician or a specialist, but not as inpatient.

N. Physician – A person licensed under the law to practice medicine and perform surgery in all aspects. Such physician shall not include you or any member of your immediate family as the spouse or any children brothers, sister or parents.

O. Policyholder - refers to the Policyholder named in the application. The Policyholder may be someone other than the Insured Member.

P. Pre-Existing Conditions – refers to any injury, illness or condition for which the Insured Member actually received medical advice, diagnosis, care or treatment at any time prior to the effective date of the Insured Member.

Q. Waiting period – refers to the period of time after the effectivity of the contract which must pass before some or all of the health care services or a select list of disease or illness start getting covered under the contract.

BENEFITS PROVISIONS

Subject to the terms and conditions of this Policy while in full force, the Company shall pay the benefits of this plan if the Insured Member dies due to natural causes and/or dies or is dismembered due to accident within one hundred eighty (180) days from the date of accident. The Company shall also pay medical costs incurred by the Insured Member through reimbursement up to the annual benefit limit of this plan as stated in the Policy Specification Page.

A. DEATH BENEFIT

Upon receipt by the Company of due proof of the death of an Insured Member, the Company shall pay to the designated beneficiary(ies) the amount of insurance as stated in the Policy Specification Page herein subject to the terms and conditions of this Policy.

B. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Company will pay the percentage of the amount of insurance stipulated in the Policy Specification for this coverage, if an Insured Member sustains accidental injuries effected directly and independently of all other causes and as a result of such injuries suffer, within one hundred eighty (180) days after the date of accident, any of the losses enumerated in the following Schedule of Indemnities, the Company shall, subject to the exclusions and provisions hereunder, pay to the Insured Member, if living, otherwise to his beneficiary(ies), the amount specified for such loss in accordance with the Schedule of Indemnities:

SCHEDULE OF INDEMNITIES

LOSS OF:	BENEFITS PAYABLE AS % OF AMOUNT OF INSURANCE
Life	100%
Both hands OR both feet OR sight of both eyes	100%
One hand AND one foot	100%
EITHER hand OR foot AND sight of one eye	100%
Injuries resulting being permanently bedridden	100%
Any other injury causing permanent total disablement	100%
Arm at OR above elbow	70%
Arm between elbow and writs	50%
One hand	50%
Four fingers and thumb of one hand	50%
Four fingers	35%
Thumb	15%
Index finger	10%
Middle finger	6%
Ring finger	5%
Little finger	4%
Metacarpals 1st or 2nd (additional) 3rd, 4th or 5th (additional)	3% 2%
Leg at OR above knee	60%
Leg below knee	50%
One foot	50%
All toes on one foot	25%

Big toe	5%
Any toe other than big toe, each	1%
Sight – one eye	50%
Hearing – both ears	50%
Hearing – one ear	25%

The policy shall terminate in the event of accidental death as provided therein or upon its expiry.

In any policy year, the aggregate benefits payable under the contract in respect of any one accident resulting on loss(es) within one hundred eighty (180) days from date of accident(s) shall not exceed the principal sum (e.g. loss of life, loss of both hands and feet, loss of sight of both eyes and either hand or foot, etc.).

In any policy year, the aggregate benefits payable under the Dismemberment benefit of the policy in respect of one or more accident(s) resulting in loss(es) within one hundred eighty (180) days from date of accident(s) shall not exceed the principal sum. (i.e. For subsequent accident resulting in any loss(es) which would make the aggregate benefits exceed the principal sum, the amount(s) payable under the Dismemberment benefit shall be the principal sum less the amount (s) paid for previous loss(es). However, the payment of the principal sum for such loss(es) shall not terminate the policy in so far as accidental death benefit is concerned.

In any policy year the amount of benefit payable for loss of life arising from independent/unrelated accident/event shall always be the principal sum

EXCLUSIONS

No payment shall be made under this benefit for any claim resulting from or caused directly or wholly, by:

1. Bodily or mental infirmity, hernia, ptomaine, or bacterial infection (except phylogenic infection which shall occur with the through an accidental cut or wound) or disease or sickness or any kind; or
2. Poison, gas or fumes (voluntarily or involuntarily taken), atomic explosions, nuclear fission or radioactive gas; or
3. Accident occurring while or because the Insured Member is affected by alcohol or any unprescribed drug; or
4. Suicide or any attempt threat while sane or insane; or
5. Participation in any brawl; or
6. Any violation or attempt of violation of the law or resistance to arrest; or
7. Murder or provoked assault; or
8. War, declared or undeclared, strike, riot, civil war, revolution or any war-like operations or while under orders for war-like operations or restoration of public order; or
9. Entering, operating, or servicing, ascending from or with any aerial or marine transportation operated by a commercial passenger

C. MEDICAL BENEFIT

The Company shall pay medical costs incurred by the Insured Member up to the annual benefit limit of this plan. The aggregate benefits payable in Items a to g below shall not exceed the annual benefit limit as stated in the Policy Specification Page.

a) **Room and Board Benefit**

The amount of this daily benefit shall be equal to the reasonable and customary charges made by the hospital for room and board, food and general nursing services except special nursing services.

Payment for Room and Board shall be made for the exact number of days subject to the accommodation type stated in the Policy Specification Page as charged by the hospital, including any fractional part of a day. The number of days that the Insured Member is confined in a Hospital shall be construed to be the number of days from which the Hospital charges for room and board. This can be determined by multiplying the room and board rate per day by the number of days for which the Insured Member was charged by the hospital. ICU confinements are also covered.

b) **Special Hospital Services Benefit**

The amount of such benefits shall be paid equal to the reasonable and customary charges for prescribed medical supplies and the following services enumerated hereunder furnished by the hospital with respect to which daily room and board are payable as shown for this coverage:

i. use of operating room and treatment room;
ii. services of physicians, surgeons or anesthesiologist
iii. anesthesia and oxygen and the cost of administration thereof, dressings, sutures, casts, and other medical supplies
iv. medical supplies as expendable curative materials as drugs and medicines, dressing, ordinary splints, plaster casts, administration of blood and blood plasma, intravenous injections and solutions;
v. laboratory services, clinical and pathological;
    a. films and x-rays and their interpretations (cost of x-rays therapy, radium, cobalt and isotopes are excluded) and physical therapy;
vi. Chemotherapy, radiotherapy, physical therapy, speech therapy and dialysis are also covered subject to the “Special Procedures or New Modalities of Treatment” provisions in this Policy;
vii. All other expense directly related to the medical management of the illness/injury that resulted to an Insured Member’s confinement including Admission Kit.
viii. The following special procedures or new modalities of treatment covered as charged and will form part of the entire expense in the medical management of the illness:
    i. Lithotripsy
    ii. Arthroscopic procedures
    iii. Laparoscopic procedures
    iv. Laser Therapy (excludes use for correction of vision)
    v. Nuclear/Radioactive Isotope Scans
    vi. Cost of artificial limbs, joint prosthesis and heart valve prosthesis
    vii. Other new modalities of treatment for conditions with established etiologies and are used as alternative to the conventional or traditional procedures
    viii. Dialysis
    ix. Chemotherapy
    x. Radiation oncology/Therapeutic radiology

xi. Sclerotherapy
xii. Physical and Speech Therapy
xiii. Angiography
xiv. Tests involving the use of nuclear technologies (e.g. but not limited to Radionuclide Ventriculography, Thallium Stress Testing, Radionuclide/Thyroid Scan, Pyrophosphate Scintigraphy, Positron Emission Tomography, Radio Isotope Scanning)
xv. Thallium Scintigraphy
xvi. CT Scan/Magnetic Resonance Imaging
xvii. Pulmonary perfusion scan
xviii. Endoscopy
xix. Bone Densitometry Scan
xx. Anti-Nuclear Anti-Body (ANA)
xxi. C-Reactive Protein (Rheumatic and its complications)
xxii. Lupus cell exam
xxiii. Sleep therapy

EXCLUSIONS

No benefit is payable under hospital expense benefit for the following:

a. if the Insured Member is confined less than six (6) consecutive hours;
b. services of special nurse, assistant surgeons, or interns;
c. services in connection with pregnancy, including childbirth, miscarriage or any complications thereof;
d. charges for personal services such as registration fee, laundry, newspaper, extra meals, telephone calls, rent of radio, television, electric fan, copies of hospital records and other similar charges not covered;
e. charges for services not necessary for the treatment of injury or sickness.

c) **Surgical Expenses Benefit**

Upon receipt of due proof that an Insured Member as an inpatient has incurred expenses for a surgical operation performed by a legally qualified surgeon, the Company shall pay a surgical benefit in an amount equal to the sum charged for performing said operation, but subject to the limits that said benefits shall not exceed the amount applicable to that particular operation in the Schedule of Operations for Basic Medical Benefit (Annex A), multiplied by the factor stated therein.

This benefit shall be payable even if no hospital confinement is involved, provided that a legally qualified surgeon performs the surgery.

Surgical Benefits will be paid for each operation, subject to the following:

i. If two or more operations are performed in different parts of the body through different incisions at one time or during at one time or during any one continuous period of disability.
ii. When an Insured Member is attended by two or more surgeons in a surgical procedure, the benefit shall be the same as if only one surgeon has attended the operation.
iii. If two or more operative procedures are performed through a single incision, payment shall be made only for that one operation for which the largest amount of benefit payable
iv. If a single operation is performed in two or more steps, such operation shall be considered as one only.

v. Only one surgeon's fee is payable. Any other charges made by assistant surgeons are not payable.
vi. If the attending physician and the surgeon is one and the same person, only the surgeon's fee shall be payable.
vii. If the surgical operation is not shown in the Schedule of Operation, the Company reserves the right to determine the Annual benefit therefore. A surgical operation of equivalent gravity and severity shall be used as basis for the Company's settlement thereof.

d) **In-Hospital Physician's Visit Benefit**

If an Insured Member is registered as an interned patient in a Hospital, and receives necessary professional medical treatment from a legally qualified physician, the Company shall pay the expenses incurred for such Hospital visit or call to the Insured Member during his confinement. This can be determined by multiplying the doctor's rate per visit by the number of days for which the Insured Member was charged for room and board.

Limitations

When surgical procedure is done by another physician for which benefits are payable, payment hereunder is limited not to exceed:

i. the pre-operative period which includes all days of confinement up to but not including the date of surgical procedure, daily maximum amount multiplied by the number of days of such pre-operative period; or
ii. for post-operative treatment, the daily maximum amount multiplied by the number of days on which a visit/call is made.

Exclusions

The coverage under the in-hospital's physician's hospital visit does not apply to the following charges:

i. for more than one treatment, visit or call in any one calendar day; or
ii. for any treatment received for pregnancy or resulting childbirth, abortion or miscarriage or conditions which resulted from any one of these; or
iii. for any treatment by physical therapy or any medical check-up by x-ray examination or any other means which are purely for diagnostic purposes; or
iv. for any treatment received on the day of any surgical operation and during convalescence therefrom if the Insured Member is entitled to receive benefit from such surgical operation, regardless of whether or not the benefit for doctor visits or calls is greater than the surgical benefit; or
v. for any medical treatment involving dental care, eye examination for fitting of glasses, (including contact lenses), x-ray examinations, or supplies such as drugs, dressings or medicines.

e) **Out-patient Benefit**

The related medical costs incurred by the Insured Member for following are payable under this benefit:

i. Unlimited number of medical consultations and follow-up consultations including referral to accredited specialist(s);
ii. Administration of vaccine (except the cost of vaccine);

iii. Prescribed laboratory/diagnostic examinations for covered illnesses/injuries;
iv. Emergency treatment and minor surgeries not requiring confinement;
v. Emergency (first) dose of anti-rabies, anti-venom, and/or anti-tetanus, administered within the first 24 hours from consultation.

f) **Ambulance Service Benefit**

Emergency ambulance service expense incurred by the Insured Member is payable subject to the following conditions:

i. Coverage is up to the benefit limit as stated in the Policy Specification Page.
ii. Reimbursement of ambulance service expense is limited to one incident per Insured Member per Policy Year.

g) **Emergency Treatment in Foreign Territory**

The Company shall cover related medical expenses if the Insured Member suffers from any medically necessary treatment for emergency situation, occurring during the Insured Member's short travel (less than 30 days) outside the Philippines through a regularly scheduled commercial airline, as determined by the Physician.

Claims for expenditures made by or on behalf of an Insured Member in any foreign currency shall be converted to Pesos at the official buying rate for such currency that is in effect in the Philippines at the commercial banks at the time of the payment of such claim.

h) **Free Health Check as Partial Claim Bonus**

The Insured Member shall be entitled to Free Health Check thirty (30) days after the end of each policy year if the total claims for the policy year is less than fifty (50) percent of the annual premium paid. The Free Health Check shall include the following:

i. Complete Blood Count (CBC)
ii. Routine Fecalysis
iii. Routine Urinalysis
iv. Chest X-ray
v. Complete Physical Exam including:
    - Oral Exam
    - Visual Acuity
    - Medical History
vi. ECG for Insured Member 35 years old and above
vii. Pap smear for female Insured Member 35 years old and above

LIMITATIONS

The charges incurred by the Insured Member are payable subject to the following limitations:

1. The medical benefits of this Policy have a waiting period of seven (7) days from the effective date. There will be no coverage during the seven (7)-day waiting period.

2. Only Eligible Expenses that are necessary and reasonable shall be covered. This includes customary Physician's fees, hospitalization fees, medical supplies and medications incurred by the Insured Member.

3. The medical benefits of this Policy is 'on top of PhilHealth'. As such, completely filled out PhilHealth Form should always be filed within appropriate time during confinement to the appropriate section/person in the hospital. Failure to submit fully accomplished PhilHealth Form to the appropriate section/person in the hospital within the appropriate time prior to discharge does not constitute the Company's assumption on the coverage of the amount that PhilHealth would have shouldered. Any amount PhilHealth would have covered will be shouldered by the Insured Member.

4. Medical treatment regarding Human Immunodeficiency Virus Infection (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS) shall be covered up to the amount equal to thirty-percent (30%) of the Insured Member's annual benefit limit as stated in the Policy Specification Page.

PRE-EXISTING CONDITIONS

This Policy shall not cover any pre-existing injuries, illnesses or conditions at any time prior to the effective date of the Insured Member's contract, however, this Policy shall have look-back period of two (2) years from the effectivity of the contract. It means that any pre-existing injury, disease or illness that existed, happened or occurred beyond, or earlier than, the look-back period cannot be used as a ground to deny the claim for being based on pre-existing conditions.

This Policy shall have a free-look period of fifteen (15) days. The Policyholder may return or cancel the contract, and if ever payment has been made, the amount premium shall be returned in full to the Policyholder.

The waiting period on benefits of pre-existing condition in the contract should not exceed one year from the date of effectivity of the contract. Renewal contract of a previous contract with one year or more effectivity period, or continuous coverage exceeding one year, shall no longer contain exclusion on pre-existing condition for such previously covered disease or illness. For newly covered disease or illness, the one-year maximum waiting period for such disease or illness applies.

A pre-existing condition that was disclosed by Insured Member may be covered once accepted by the Company.

COORDINATION OF BENEFITS

This Policy shall not cover hospital confinement, services, supplies, treatment or any medical care which are furnished or for which benefits are payable under any other in force policy or plan, or under any extension of benefits provisions of any other such policy or plan which has been cancelled; provided, however, that if the benefits payable under such other policy or plan are less than the total expenses incurred by the Insured Member, the Company shall reimburse in an amount equal to the benefits provided under this Policy. In no instance, however, shall the total payments from this Policy and such other policy or plan exceed the total incurred expenses of the Insured Member.

EXCLUSIONS

No benefits are payable under the basic medical benefits in the following cases:

1. any injury or sickness caused by-

    a) self-destruction or any attempt there at including but not limited to, any form of suicide attempt, whether sane or insane;

    b) Insured Member's own misconduct/ gross negligence/ immoral habits, willful and unnecessary exposure to danger or hazard to health; or

    c) riot, brawl, civil commotion, insurrection, military service, naval service or air service in time of declared or undeclared war or in peace or while under orders for restoration of public orders or sustained from combat related activities; or

    d) travel in or on any aerial or submarine device except as passenger in a certificated passenger aircraft provided by a commercial airline or any regular and scheduled passenger trip over its established passenger route; or

    e) atomic explosions, nuclear fission or radioactive gas; or

    f) the taking, inhaling or absorbing of poison, gas or fumes, unless involuntary or accidental; or

    g) participation in or attempt to commit an assault or crime, violation of ordinances or attempt of violation of laws or resistance to arrest; or

    h) active participation in hazardous activities such as, but not limited to, bungee jumping, hang-gliding, scuba diving, mountain/wall climbing including professional sports;

2. Ineligible expenses and expenses that should be taken cared by any government programs such as PhilHealth and the likes;

3. Services rendered or supplies provided free of charge;

4. Maternity and maternity-related conditions and complications, unless Maternity Benefit is availed

5. Sterilization of either sex or reversal of such, artificial insemination, sex change, consultation/ confinement regarding infertility;

6. Non-recommended confinement, convalescent/domiciliary/custodial care, rest cures;

7. Dental-related cases that are not necessary for the repair or alleviation of damage caused solely by an accidental injury, unless Dental Benefits

8. Circumcision, cosmetic/aesthetic procedures except reconstructive surgery to treat functional defect(s) due to a covered disease or accidental injury;

9. Psychiatric disorders, psychosomatic conditions, treatment for any mental or nervous disorders, illness/injury/condition/complication due to too much alcohol intake and/or use of regulated/ prohibited drugs;

10. Treatment on alcoholism and drug abuse;

11. Acquisition of prosthetic appliances, artificial aids, durable equipment, surgically implanted devices and external prosthetic devises subject to coverage on "Special Procedures or New Modalities of Treatment";

12. Organ transplant expense relating to organ donation of the donating party/parties;
13. Check-ups and Diagnostics Procedures not recommended by Physician;
14. Take-home medicines, and vaccines except first dose of either anti-venom, anti-rabies and anti-tetanus;
15. Medico-Legal Fees including costs of Medical Certificates;
16. Congenital disease/deformity that is evident to the Insured Member at birth and can be clinically determined to be congenital; and
17. Medical and surgical procedures/diagnostic tests that are experimental in nature and/or not generally accepted by the medical profession such as, but not limited to, iridology, chiropractic services, acupuncture.

GENERAL PROVISIONS

ENTIRE CONTRACT

This Policy, the Application Form and any Supplementary Contracts or Endorsements attached herewith and made part hereof constitute the entire contract between the parties. All statements made by the Insured Member shall, in the absence of fraud, be deemed as representations and not warranties and no statement shall void this Policy, or be used in defense of a claim thereunder, unless it is contained in the written application of the Policyholder and the Insured Member.

Only the President, an Executive Vice President or a Vice President of the Company has the power to amend, change or alter provisions of this Policy, and then only in writing. The Company shall not be bound by any promise or representation given by any person other than any one of the above-mentioned officials.

PREMIUM PAYMENT

This Policy shall not be valid and binding unless the premium has been paid. All premiums are payable at the Head Office or any duly authorized offices/channels on or before the due dates specified in the Policy Specifications Page.

The mode of payment is as specified in the Policy Specifications Page unless changed subject to the rules in effect at that time of change.

EFFECTIVITY OF THE POLICY

This Policy becomes effective only upon the payment of its initial premium and its delivery to the Policyholder while the Insured Member is alive and in good health. The Effective Date, shown in the Policy Specification Page will be used to determine premium due dates, policy years, and policy anniversaries.

GRACE PERIOD

A thirty-one (31) day grace period, without interest charge, shall be granted the Policyholder for the payment of every premium due after the first during period this policy shall continue to be in force. If any premium remains unpaid at the end of the grace period, this Policy shall automatically terminate at the expiration of the grace period.

Any claim that may arise during the grace period wherein the premium remains unpaid, the premium due will be deducted from the benefits payable.

RENEWAL

This Policy shall renew for a further term of one policy year on each policy anniversary by payment of the required premium due, except that if either the Policyholder or the Company has given written notice to terminate this Policy.

The premium may be changed by the Company on any renewal date depending on the aggregate claims experience of the plan's portfolio.

CANCELLATION

This Policy shall not be cancelled by the Company except upon prior notice thereof to the Policyholder, and no notice of cancellation shall be effective unless it's based on occurrence, after the effective date of this Policy, of one or more of the following:

a. non-payment of premiums;

b. conviction of crime arising out of acts increasing the hazard Insured Member against;

c. discovery of fraud or material misrepresentation;

d. discovery of willful or reckless acts or omissions increasing the hazard Insured Member against;

e. a determination by the Commissioner that the continuation of the policy would violate or would place the Company in violation of the Insurance Code.

All notices of cancellation shall be in writing, mailed or delivered to the Policyholder at the address shown in the policy, or application, and shall state which of the grounds set forth in this provision is relied upon and that upon written request of the Policyholder, the Company will furnish the facts on which the cancellation is based.

In the event of such cancellation, the Company shall refund the paid premiums less the earned portion thereof to the Policyholder. Likewise, if Policyholder cancels the policy for which no claim has been made, notice of which must be in writing, the Company shall retain the earned premium for the time the policy has been in force, computed in accordance with the Short Period Rate Scale indicated below:

Short Period Rate Scale					
No. of Months Covered	**Percentage of Retained Premium**	**No. of Months Covered**	**Percentage of Retained Premium**	**No. of Months Covered**	**Percentage of Retained Premium**
1 Month	20%	3 Months	50%	5 Months	80%
2 Months	35%	4 Months	65%	6 – 12 Months	100%

**Example: If annual premium is Php20,000 and policy is cancelled after 2 months, then amount to be returned = Php20000 x (1 – 35%) = 13,000 provided there is no claim in the Policy.*

TERMINATION OF INSURANCE

This Policy and the insurance hereunder shall automatically terminate on the earliest of the following dates, subject to the provisions of this Policy:

A. THE POLICY

1. the date the premium falls due if written notice that this Policy will not be renewed is given to the Company by the Policyholder on or before said due date;
2. the date of receipt by the Company of the Policyholder's written notice to terminate this Policy, if such notice is given during the grace period;
3. the date following the end of the grace period if the premium is not paid; or
4. the date of the Company's written notice of termination to the Policyholder when minimum participation requirements are not met.

B. THE INSURANCE COVERAGE

1. the date this Policy terminates;
2. the termination date as stated in the Policy Specifications Page;
3. the date of expiration of the period for which the last premium payment is made on account of the member's insurance;
4. the policy anniversary following the Insured Member's 71st birthday;

5. the date the Insured Member enters into military service or any non-combatant unit auxiliary to said military service of any country at war whether or not such war is declared. The insurance coverage, however, shall be resumed upon his return from the military service and upon advice of the Insured Member to the Company of his return from the military service and payment of his premium;
6. the date the Insured Member dies;

C. DEPENDENTS INSURANCE IN FAMILY COVERAGE

1. the date the Insured Member's insurance terminates;
2. the policy anniversary following the dependent's:
    i. Legal Spouse and Parents – 71st birthday
    ii. Children and Siblings – 23rd birthday;
3. the date of expiration of the period for which the last premium payment is made on account of the dependent's insurance;
4. the date the dependent enters into military service or any non-combatant unit auxiliary to said military service of any country at war whether or not such war is declared;
5. the date the dependent dies.

Termination of the Policy shall be without prejudice to any claims arising prior to such termination.

NOTICE OF CLAIM

Written notice of claim must be given to the Company at its Home Office immediately, but in any event not later than thirty (30) days after the occurrence or commencement of any expenses covered by this Policy. Failure to give notice within the time provided in this Policy shall not invalidate any claim if notice was given as soon as was reasonably possible.

SUFFICIENCY OF NOTICE

Written notice of claim given by or in behalf of the Insured Member or beneficiary, to the Company or to any authorized representative of the Company, with information sufficient to identify the Insured Member, shall be deemed to be notice to the Company.

CLAIM FORMS

The Company upon receipt of a notice of claim will furnish to the claimant such forms as are usually required by the Company for filing proofs of treatment case. If such forms are not so furnished by the Company within fifteen (15) days after its receipt of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made. All certificates, information and evidence, other than the usual claim forms, which the Company may reasonably require in support of a claim, shall be furnished by the Insured Member.

Completed claim forms and written proof of loss must be furnished to the Company within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time.

PAYMENT OF BENEFITS

The benefit will be paid to the designated beneficiary provided that the Company receives written consent of any person having a contractual interest on this policy.

Where the Company believes the beneficiary to be incompetent, and receives certificate signed by a physician, the Company will be entitled to pay the benefit to the beneficiary's appointed guardian and the receipt given by such person shall discharge the Company from further liability under this policy.

If the Insured Member dies before the payment of the benefit is made, the benefit will be payable to the designated beneficiary.

In case of accidental death of the Insured Member, the benefit shall be payable to the designated beneficiary(ies) subject to the conditions set in the beneficiary provision. Accidental death benefits in case of accidental death of insured dependents shall be payable to the Insured Member.

For any dependents in Family Coverage, the benefit will be paid to the Insured Member subject to the conditions set in the beneficiary provision.

LEGAL ACTION CLAUSE

Unless the claim has been rejected, no legal action may be filed before the end of sixty (60) days after proof of loss has been filed in accordance with the applicable provisions of the Policy. In any event, no legal action may be filed after one (1) year from the time the claim is denied or decided.

DESIGNATION AND CHANGE OF BENEFICIARY

Upon the request of the Policyholder, the Company will pay to another person authorized by the Policyholder to receive such payment or to the Physician or Hospital which provided medical treatment. If the Policyholder dies before the payment of the benefit is made, the benefit will be paid to the designated beneficiary in the Application Form.

If no beneficiary is alive on the date of the Insured Member's death, or if the Insured Member fails to designate a beneficiary, or the designated beneficiary is disqualified as ordered by law, the benefits shall be payable to the first surviving class of the following order of classes of beneficiaries deemed named by the Insured Member:

The deceased Insured Member's

(1) widow or widower;
(2) surviving, legitimate, legitimated, legally adopted and recognized natural children;
(3) surviving illegitimate children without distinction;
(4) surviving parents;
(5) surviving brothers and sisters of the full blood;
(6) surviving brothers and sisters of the half-blood; or
(7) executors, administrators or assigns.

Any such payment shall discharge the Company to the extent of the amount paid.

The change of beneficiary shall take effect on the date the notice was signed whether or not the Insured Member is living at the time of endorsement, but without prejudice to the Company on account of any benefit payment made by it before the proper endorsement of such change is affected on the Company records.

If there are two or more beneficiaries in the same class entitled to the proceeds of the insurance, they shall share equally. Any minor's share shall be paid to him in the manner provided for by law.

The beneficiary of any dependent of an Insured Member, if Family Coverage is provided for by this Policy, shall be the Insured Member.

If the Insured Member dies before the payment of the benefit is made, the benefit will be paid to the designated beneficiary of the Insured Member.

PHYSICAL EXAMINATION AND AUTOPSY

The Company at its own expense shall have the right and opportunity to have the person or any individual whose injury or sickness is the basis of claim examined by a physician designated by it, when and as often as it may reasonably require during the pendency of a claim under this Policy and make an autopsy in case of death, where it is not forbidden by law.

ELIGIBLE INDIVIDUAL

Any individual who is up to seventy (70) years old is eligible for insurance.

FAMILY COVERAGE

Family Coverage may be availed, however, only the following dependents (as of policy anniversary) can be included/covered under the said Coverage:

A. Married Insured Member
    a. Legal Spouse who are 18 years old to 70 years old
    b. Children who are at least 30 days old to 22 years old
B. Single Parent Insured Member
    a. Children who are at least 30 days old to 22 years old
C. Single Insured Member
    a. Parents who are 18 years old to 70 years old
    b. Siblings who are at least 30 days old to 22 years old

Under the said coverage, the premium for the Family Unit will be as one (1) and the coverage will only be effective if Family Coverage is stated under Class in the Policy Specifications Page. The premium for Family Coverage will be adjusted upon termination of membership of a dependent. The Insured Member can terminate the Family Coverage only during policy anniversaries.

If the insurance of the Insured Member under this plan terminates due to any reason, the Family Coverage terminates. However, the coverage for each of the Family Member may continue under an Individual coverage.

MISSTATEMENT OF AGE

If the age of the Insured Member has been misstated, the amount payable under this Policy shall be that amount which the premium would have purchased at the correct age. However, if according to the correct age of the Insured Member, he is not eligible for coverage under this Policy, the liability of the Company shall be limited to the refund of premiums collected for such Insured Member.

NON-PARTICIPATING

The Company does not allot any dividends in this Policy.

ASSIGNMENTS

The Company is not bound by any assignment of this Policy unless duly endorsed on this Policy. The Company assumes no responsibility for the effect, sufficiency, or validity of any assignment. The Company has the right not to endorse any reassignment by any assignee.

NON-APPLICABILITY OF ARTICLE 1250 (REPUBLIC ACT NO. 386)

Article 1250 of the Civil Code of the Philippines (Republic Act No. 386) which reads:
"In case an extraordinary inflation or deflation of the currency stipulated should supervene, the value of the currency at the time of establishment of the obligation shall be the basis of payment."
is understood and agreed not to apply in determining the extent of any liability of the Company in this Policy.

IMPORTANT NOTICE

The INSURANCE COMMISSION, with offices in Manila, Cebu and Davao, is the government office in charge of the enforcement of all laws related to insurance and has supervision over insurance providers and intermediaries. It is ready at all times to assist the general public in matters pertaining to insurance.

For any inquiries or complaints, please contact the Public Assistance and Mediation Division (PAMD) at the Insurance Commission's Office located at 1071 United Nations Avenue, Ermita, Manila with telephone numbers +632-8523-8461 to 70 and email address publicassistance@insurance.gov.ph. The official website of the Insurance Commission is www.insurance.gov.ph.