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Liberty Insurance

HEALTHCARE
Bảo hiểm Sức khỏe

Liberty HealthCare Insurance Policy Wording

Liberty Insurance

ABOUT LIBERTY
LIBERTY MUTUAL GROUP

Founded in 1912, Liberty Mutual Group is a Fortune 100 company and the second largest US-based international insurance company providing personal and commercial insurance.

Liberty Mutual Group has received financial strength ratings of "Excellent" (A) from the A.M. Best Company.

Liberty Mutual Group is one of the few insurance groups in the United States to have significant international operations which are managed through Liberty International and Liberty International Underwriters.

Liberty International provides small commercial and personal lines insurance through 14 countries in Argentina, Brazil, Chile, China, Colombia, Hong Kong, Poland, Portugal, Spain, Singapore, Thailand, Turkey, Venezuela and Vietnam.

Additionally, Liberty International Underwriters, a global specialty lines insurance and reinsurance business, writes casualty, specialty casualty, marine, energy, engineering and aviation through offices in Asia, Australia, Europe and North America. Liberty Syndicate at Lloyd's of London writes on a worldwide basis.

Headquartered in Boston, Massachusetts, Liberty Mutual Group employs over 45,000 people in more than 900 offices worldwide and has more than 100 billion US dollars in consolidated assets as of December 31st 2008.

LIBERTY VIETNAM

Liberty has had its presence in Vietnam since 2003 when Liberty Mutual Group opened its first representative office in Hanoi. During the November 2006 APEC meetings, we officially received our license from the Vietnam Government to operate a 100% U.S-owned general insurer serving businesses and individuals.

On 24th April 2007, Liberty Mutual announced the establishment of The Liberty Mutual Safe Work Collaborating Center at the National Institute of Occupational and Environmental Health (under the Ministry of Health). Its purpose is to research and implement projects that improve worker safety and reduce occupational injuries in Vietnam. As a leading global insurer, Liberty Mutual's presence in Vietnam is one of our long term commitment with dedicated resources to help people protect their companies and their families.

Effective from January 11th, 2008, Liberty has been officially allowed to provide insurance service directly to Vietnamese individuals, state owned enterprises and motor insurance including compulsory public liability. This is in addition to its existing license to sell insurance to all forms of commercial enterprises in Vietnam. Liberty is the first foreign insurer to expand full market access with the locally customized insurance products.

The company provides insurance services with global expertise and international service standard to Vietnamese individuals such as: Liberty MotoCare, Liberty AutoCare, Liberty HomeCare, Liberty HealthCare and Liberty TravelCare.

To commercial enterprises, Liberty provides a range of products to suite the needs: Property, Liability, Worker's Compensation, Personal Accident, Engineering insurance…

Especially, Liberty has designed a packaged product Liberty Dynamic SME for the needs of Offices, Retails shops, Service companies and Food & Beverage shops with the comprehensive coverage at an ecomomical price

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- 24/7 Customer Service Center Onecall **1800 599 998**
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- 24/7 towing service in case of car accident.

We Treat Customers the Way We Want to be Treated

LIBERTY HEALTHCARE INSURANCE POLICY WORDING

Based upon the Policyholder's application for insurance - through an Application Form and information provided therein as well as all other information provided to the Insurer in connection therewith – and due payment of the insurance premium in accordance with this Policy Wording, the Insurer agrees to insure the Insured against the covered bodily injury, sickness or disease or dental or being pregnant (if applicable) during the Insured Period and within the Limits of Liability, subject to the terms and condition of this Insurance Policy.

GENERAL PROVISION

1. Interpretation

1.1 In this Policy Wording, the Benefit Plan, the Policy Schedule, the Certificate and the Endorsements, unless the context otherwise requires, the following expressions shall have the meaning set forth below:

Application Form
A duly executed application form for Liberty Healthcare Insurance in the form as set forth by the Insurer from time to time.

Benefit Plan
The benefit plan issued by the Insurer. With respect to an Insured, the relevant benefit plan applicable to that Insured as provided in the Policy Schedule and the Certificate issued to such Insured.

Policy Schedule
The policy schedule issued by the Insurer to the Policy Holders and/or the Insured.

Certificate
The certificate of insurance issued by the Insurer to the Insured in the form of a healthcare card.

Insurance Policy
This Insurance Policy as described in Article 2.

Master Policy
Insurance Policy for Group.

Limit of Liability
The maximum limit of the Insurer's accrued liability for each Insured, for the whole Insured Period, with respect to each section as set out in Article 5 and the Benefit Plan.

Insurer
Liberty Insurance Limited.

Insured Period
With respect to an Insured, the insured period as provided in the Policy Schedule and the Certificate issued to such Insured.

Usual Country of Residence
With respect to a person, the country in which such person are living at the date of commencement of cover under the Insurance Policy and which is declared in the Application Form.

Accident

Any sudden and unforeseen event occurring during the Insured Period, which is caused by visible means, external of the Insured's body and violent, resulting in bodily injury.

Active Service

An Employee will be considered in Active Service on any day if he or she is then performing in the customary manner all the regular duties of his or her employment as performed or where capable of being performed on the last regularly scheduled work day.

A member of an Sponsoring Organization will be considered in "Active Service" on any day if he or she is then able to perform all the normal activities of a member of such Sponsoring Organization, and is confined neither at home nor in a medical facility.

A Dependant will be considered in "Active Service" on any day if he or she is then able to perform all the normal activities of a person in good health of the same age and sex, and is confined neither at home nor in a medical facility.

AIDS/HIV

Cover for treatment of Human Immunodeficiency Virus (HIV) and related illnesses including Acquired Immune Deficiency Syndrome (AIDS), its complications and all illnesses/conditions caused thereby and/or related thereto, including the consequences of treatment arising thereof which occurs during the Insured Period, including the subsequent renewal year(s) and manifests itself after five years of continuous coverage under the Policy from the first Effective Date.

This benefit is inclusive in the Limit of Liability for impatient and subject to a sub-limit of 10% of the Limit of Liability for impatient per Insured per lifetime.

Annual Medical Examination

Are tests/screenings that are undertaken without any clinical symptoms being present. Such tests include the following examinations performed, at an appropriate age interval, for the early detection of illness or disease:

- Vital signs (blood pressure, cholesterol, pulse, respiration, temperature etc.)
- Cardiovascular exam
- Neurological exam
- Cancer screening
- Well child test (for children up to the age of 6 years)

This benefit is also applied for Vaccination and Work Permit Medical Check-up.

Appliances

Devices and equipment when used as an integral part of a surgical procedure administered by a Medical Practitioner or Specialist.

Companion Bed

Hospital accommodation in respect of a parent or a legal guardian staying with an Insured, who is under 18 years of age, and is admitted as an inpatient in a Hospital. This is limited to only one parent/ guardian each night when the child is receiving covered hospital inpatient treatment for which the child is insured under this Insurance Policy.

Compassionate Visit

A relative or a friend of the Insured to visit the Insured who, when travelling alone, is hospitalised outside the Home Country or the Usual Country of Residence for a period exceeding 7 consecutive days, subject to a prior approval of the Insurer's Medical Assistance Provider and only when judged necessary by the Insurer's Medical Assistance Provider on reasonable medical and compassionate grounds.

Chinese Herbalist/Bonesetter/Acupuncturist

Chinese Herbalist/Acupuncturist shall mean a registered/listed Chinese Medicine Practitioner or any Chinese Medicine Practitioner who is being authorized or listed in the geographical area of his practice to render treatment.

Herbal Medication shall mean herbal medications prescribed by a registered Chinese Medicine Practitioner in writing, directly related to the diagnosis being treated.

Bonesetter shall mean a Chinese medicine surgical specialist registered or listed in the geographical area of his practice as a surgical specialist who renders treatment of musculoskeletal system, joint and soft tissue resulting from accident for internal or external bodily injuries.

This benefit includes consultation fee and medicine for the treatment, subject to the Limit of Liability for Chinese Herbalist/Bonesetter/Acupuncturist as stated in the Benefit Plan.

Day Case Treatment/ Day-Patient

Treatment in a Hospital where the Insured is usually admitted to a Hospital bed but does not stay overnight. Each hospital confinement must be for a minimum period of six (6) consecutive hours before any benefits hereunder 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.

If an Insured has undergone surgical treatment in a Physician's office or confined in a Hospital for less than 24 hours as a result of injury and disease, the Insurer shall pay the reasonable and customary charges, which is actually incurred by the Insured from the Physician and Hospital, and subject to the relevant Limit of Liability as set forth in the Policy Schedule.

Deductible/Co-insurance

The portion of costs for which the Insured is liable, as stated in the Policy Schedule.

Dependant

The legally married spouse or the adult domestic partner of the Insured. For domestic partner who is not legally registered, the Insurer may require the Insured to submit a signed affidavit attesting that the following conditions are met:

(1) share an exclusive, committed relationship and intend to do so indefinitely;

(2) live together for the past 12 months;

(3) are at least 18 years old;

(4) jointly responsible for each other's common welfare and are financially interdependent;

(5) not related; and

(6) not legally married or the domestic partner of anyone else.

Dependant also includes unmarried children (including natural children, step-children, foster children and legally adopted children) who are dependant on the Insured for support, Provided always that such children are not less than 15 days and less then 18 years old (or 23 provided that the dependent is in continuous full-time education).

Dental Services

Dental Service include:

Routine Oral Examination: Scaling and polishing is covered once a year per Insured.

Basic Dental Service: Extraction, amalgam, filling, x-rays, periodontal scaling is covered.

Major Dental Treatment: Removal of impacted, buried or unerupted teeth, root canal treatment, removal of solid odonomes, adpicectomy will be covered after the Insured has been insured by the Insurer covering Dental Services for at least **nine consecutive months**.

Crown, bridges and dentures will be covered after the Insured has been insured by the Insurer covering Dental Services for at least **twelve consecutive months**.

PROVIDED ALWAYS THAT these dental services are applied for sound natural teeth only and must be performed by a registered dentist who is licensed by relevant licensing authority to practice dentistry in the country where the dental treatment is given. The material being used for filling/crown/denture is limited to amalgam and porcelain and does not include precious metal/material.

Direct Settlement Network

Medical providers, details of which are listed separately and informed by the Insurer to the Policyholder, which agree to charge the Insurer directly for the treatment cost when the Insured present a valid designated Certificate. However, the Insured is responsible for repayment if such charges are not eligible under the Insurance Policy. Failure to re-pay by the Insured to the Direct Settlement Network, such ineligible expenses will result in the Insurer's right to suspend or cancel the Insurance Policy.

Effective Date

With respect to an Insured, the first date of the Insured Period of such Insured (either original or renewal, as the case maybe).

Elective Treatment

Elective treatment includes all non-emergency hospital/surgery treatment planned for in advance.

Employee

A person employed by an Employer under employment contract on a full time basis, unless otherwise agreed by the Insurer. This definition also includes a sole proprietor or partner or director of the Employer.

Employer

A company or an Sponsoring Organization through which the Master Policy is offered, effected or administered and to which the Master Policy is issued.

Emergency/Serious Conditions

Emergency/serious condition means a bona fide situation where there is a sudden change in an Insured's state of health, which requires urgent medical or surgical intervention within forty-eight hours of onset to avoid imminent danger to his/her life or health.

Emergency Dental Treatment following Accident

Treatment initially received within 24 hours of incurring accidental damage caused to sound, natural teeth, except when the accidental damage has been caused through eating, when given by a Medical or Dental Practitioner.

Emergency Medical Evacuation

The medically necessary expense of emergency transportation and medical care en route to move an Insured with a Serious Medical Condition insured under the Insurance Policy, to the nearest Hospital where appropriate medical care and facilities are available, as determined by the attending Medical Practitioner or Specialist in conjunction with the Insurer's medical advisors.

The 24-hour appointed assistance centre shall be contacted to obtain advance approval for any evacuation and to make the necessary transportation arrangements. Failure to do so invalidates a claim for such cost.

The Insurer will pay the cost of one Economy Class Return Airfare accompanying the Insured aged 18 years old or below during evacuation, when this is deemed necessary for medical reasons by the Insurer.

This benefit is also subject to the scope of coverage and exclusion specified in the Service Agreement between the Insurer and the Medical Assistance Provider, which coverage and exclusion have been informed by the Insurer to the Policyholder, subject to any changes from time to time as informed by the Insurer to the Policyholder.

This benefit is not available for the Insured aged 70 or above.

Emergency Ward Treatment

Services performed in a Hospital casualty ward or emergency room for a period of not more than 24 hours Provided That these services are determined as serious conditions by the Medical attendance from Emergency Ward, which require an emergency treatment.

General Outpatient Services

Outpatient Services ordered, prescribed or performed by a Physician who is licensed as General Medical Practitioner and Outpatient Services rendered by Chinese Medicine Practitioner. Referral letter issued by a General Medical Practitioner is required for laboratory tests, x-ray, prescribed drugs, physiotherapy and chiropractic treatment.

Group

A group of Employees employed by one Employer and their Dependants; or a group of members of a Sponsoring Organization and their Dependants.

Sponsoring Organization

Trade Union or any other associations, organizations or institutions accepted by the Insurer to be a Policyholder of an Insurance Policy in which its members are insured.

Home Country

With respect to an Insured, the country of which the Insured holds a passport. Where the Insured holds more than one passport, the Home Country will be taken to mean the country which the Insured has declared on the Application Form.

Hormone Replacement Therapy

Hormone Replacement Therapy shall mean any consultation services and medication provided by a Physician (Medical Practitioner) for the treatment of hormonal imbalance in respect of pre- and post-menopausal symptoms only.

Hospital/Clinic

Any institution which is a legally licensed as a medical or surgical facility in the country in which it is located.

Hospital Services

Medical services rendered to the Insured only when appropriate diagnostic procedures and/or treatments are not available as outpatient services and when admittance as a registered inpatient or day-patient to a Hospital. Hospital Services include reasonable and customary charges, in the area where treatment is provided, for Hospital accommodation, the cost of the room, meal charges, all Hospital medical facilities and all medical treatments and medical services prescribed by a Physician, including intensive care unit accommodation where this is medically necessary.

Bodily Injury

Injury which is sustained by the Insured on any part of his/her body during the Insured Period and is caused by an Accident, which is caused by external means.

Insured

An Eligible Person for whom commencement of cover has been confirmed by the Insurer by issuing a Policy Schedule describing he/she as an Insured under such Insurance Policy.

Eligible Person

Eligible person as defined in Article 12.

Laboratory and X-Ray Services

Laboratory testing, radiographic and nuclear medicine procedures used to diagnose and treat medical conditions. Any such laboratory and X-Ray Services must be prescribed by a Physician.

Local Ambulance Services

The medically necessary road ambulance transportation services to and from a local Hospital.

Maternity Care

Pre-natal, childbirth, post-natal treatment and miscarriage, or abortion out of medical reason, or any complications arising from pregnancy for the Insured with respect to normal and complicated delivery and the after birth baby care incurred in the Hospital. The maximum coverage for general new-born baby care is 5 days immediate after birth; if there is inpatient treatment for sickness manifests itself within 30 days following birth, the maximum coverage is 30 days following birth.

Where this benefit is included in the Insurance Policy for an Insured, it will apply to pregnancies which actual date of birth is at least 12 months after the date of enrolment of this benefit of the Insured, except that it is a premature termination of pregnancy because of medical grounds and such pregnancy commences after the enrolment of this benefit of the Insured.

Medically Necessary

Treatment, service or procedure which in the opinion of a qualified Medical Practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards.

Medical Assistance Provider

The Medical Assistance Provider of the Insurer, which can be International SOS or any other similar providers as informed by the Insurer to the Policyholder from time to time.

New-Born Baby Care

A Maternity Care benefit extension for the general baby care, for the maximum of 5 days immediate after birth or inpatient treatment for sickness manifests itself within 30 days following birth. The benefit is limited for a maximum of 30 days of hospitalization per pregnancy.

An additional limit for new-born baby care is applied for inpatient treatment of an acute medical condition and any associated cost which presents symptoms at birth or which manifests itself within 30 days following birth when the Limit of Liability for Maternity is exhausted.

Nursing at Home/Home Nursing

The services of a legally Registered or Enrolled nurse in the Insured's abode when prescribed by a Physician for medical as distinct from domestic reasons immediately after or instead of Inpatient or Day Case Treatment. Cover will be limited to a maximum period of 182 days per Insured in any one insurance period of 12 months.

Occupation Classification

Class I – Professionals and occupations involving non-manual administration or clerical work solely in offices or similar non-hazardous places.

Class II - Persons engaged in work of a supervisory nature and others not in Class I whose duties may involve occasional light manual work but not using tools or machinery or expose them to any special hazard (e,g, Clerk-of-Work, Supervisor), Persons who are required to travel outside office for business or professional purposes but no engaging in manual labour. (e.g. Salesman).

Class III – Persons engaged in manual work not of particularly hazardous nature but involving the use of tools or light machinery (e.g. toolmaker, delivery service).

Class IV – Persons engaged in hazardous occupations, e.g. heavy manual work involving the use of heavy tools and machinery (e.g. construction worker).

Oncology

Treatment given for cancer received as an In-Patient or Day-Patient of the hospital.

If an Insured has undergone chemotherapy or radiotherapy for cancer treatment in a Physician's office or confined in a Hospital for less than 24 hours for such treatment, the Insurer will pay this Benefit for actual medical expenses charged by the Physician and/or the Hospital up to the maximum amount as shown in the respective Benefit Plan.

Organ Transplant

The medical treatment costs incurred in respect of kidney, heart, liver and bone marrow transplants only up to the respective Benefit Plan's sub-limits. The cost of acquisition of the organ and all costs incurred by the donor are not covered under this Insurance Policy.

Outpatient Services

Medical treatment provided to the Insured when the Insured is not a registered in-patient/day-patient in a Hospital, or in any other facility for medical care. Outpatient Services include services provided or prescribed by a Physician who is licensed as a general practitioner/registered Chinese Medicine Practitioner as well as specialists to whom the Insured has been referred to by another Physician, Laboratory testing, radiographic and nuclear medicine procedures used to diagnose and treat medical conditions. Laboratory and x-ray services have to be prescribed by a Physician.

Outpatient Services also include medication, the sale and use of which is legally restricted to prescription by a Physician, and do not include items that may be purchased without a Physician's prescription.

Physician (Medical Practitioner)

A legally licensed medical practitioner recognised by the law of the country where treatment is provided and who, in rendering such treatment, is practising within the scope of his licensing and training.

Policyholder
The policyholder as stated in the Policy Schedule.

Policy Year
The time between 00.01 a.m. on the first day of the Insured Period and 11:59 pm on the last day of the Insured Period, both inclusive. All times are calculated as according to Vietnam standard time.

Pre & Post Hospitalisation Treatment
Will be covered as defined under Outpatient Services for a maximum period of 30 days immediately prior to hospitalisation and 90 days immediately following discharge from Hospital for the same medical condition per person. This benefit will be paid following the inpatient treatment or surgery. Reimbursement will be according to the date of the expenses incurred.

"Pre-existing Condition" means any Disability

(a) which existed before the Effective Date in respect of an Insured, which presented **signs or** symptoms of which the Insured **was aware or** should reasonably have been aware; or

(b) for which treatment, or medication, or advice, **or diagnosis** has been sought or received during the two (2) years prior to the Effective Date by **the Insured**; or

(c) which was known by the Insured to exist prior to the Effective Date whether or not treatment, or medication, or advice, or diagnosis was sought or received.

Prescribed Drugs
Medication, the sale and use of which is legally restricted to prescription by a Physician, Chinese Medicine Practitioner and not including items that may be purchased without a Physician's prescription.

Psychiatric Treatment
Treatment in a registered psychiatric unit of a Hospital, limited to 30 days per policy year after 24 month cover. Treatments must be pre-authorized by the Insurer.

Physiotherapy or Chiropractic Treatment
If while this coverage is in force, on account of accident, sickness or disease contracted during the term of this Insurance Policy, the Insured shall require treatment by a Physiotherapy or Chiropractic Treatment upon recommendation by attending Physician (Medical Practitioner) in writing, the Insurer will pay the actual, reasonable and customary expenses incurred and such payment shall not exceed the Limit of Liability and subject to the maximum number of visits per Policy Year stated in the Benefit Plan.

Reasonable and Customary
No benefit shall be paid for charges which are in excess of the general level of charges being made by other providers of similar standing in the locality where the charges are incurred, when providing like or comparable treatment, services or supplies for a similar Injury or Sickness. The Insurer will determine such charging scale by its own experience with referring to the industrial or government data, if available.

Repatriation
The Medical Assistance Provider will arrange for the return of the Insured who is dying or dead to the Home Country or Usual Country of Residence (at the choice of the representative of the Insured) by air and/or surface transportation following an Emergency Medical Evacuation where the Insured is evacuated to a place outside the Home Country or Usual Country of Residence for in-hospital treatment. The Insurer shall pay for the expenses necessarily and unavoidably incurred in the services so arranged by the service provider. The service provider reserves the right to decide the means or method by which such repatriation will be carried out having regard to all the assessed facts and circumstances.

The Medical Assistance Provider shall be contacted in advance for the arrangement of transportation of the mortal remains of an Insured, who dies outside his or her Home Country, from the place of death to the Home Country of such Insured.

This benefit is also subject to the scope of coverage and exclusion specified in the Service Agreement between the Insurer and the Medical Assistance Provider, which coverage and exclusion have been informed by the Insurer to the Policyholder, subject to any changes from time to time as informed by the Insurer to the Policyholder.

This benefit is not available for the Insured aged 70 or above.

Return of Minor Child
The return of minor child (aged below 18 years old and unmarried) to the Home Country or Usual Country of Residence if he/she is left unattended as a result of the accompanying insured Adult's Emergency Medical Evacuation.

Serious Medical Condition
The medical condition which in the opinion of the appointed service provider constitutes a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to the Insured's immediate or long-term health prospects. The seriousness of the medical condition will be judged within the context of the Insured's geographical location, the nature of the medical emergency and the local availability of appropriate medical care or facilities.

Specialist
A legally licensed medical practitioner registered and given accreditation as a Specialist recognised by the law of the country where treatment is provided.

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

Specialist Outpatient Services
Outpatient Services prescribed and provided by a specialist to whom the Insured has been referred by another Physician.

Standard Private Room
Single occupancy accommodation in a Hospital. If the hospital sub-divides Private Room into several levels, reimbursement will be based on the actual charge for the standard private room or the norm of the charges for Private Room of that particular hospital, whichever is lower.

Terrorist Act
Any act, including but not limited to the use of force or violence and/or the threat thereof, of any persons or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Terrorist Act shall also include any act, which is verified or recognized by the (relevant) government as an act of terrorism.

1.2 Headings are inserted for ease of reference and shall not be taken into consideration in the interpretation of this Policy Wording.

1.3 This Policy Wording is drafted and issued in Vietnamese, and may be translated into foreign languages for reference purpose. In case of discrepancy between Vietnamese version and the foreign language version, the version in Vietnamese shall prevail.

2. Insurance Policy

This Policy Wording, the Benefit Plan, the Policy Schedule, the Certificate and any Endorsements thereon constitute the entire agreement ("**Insurance Policy**") between the Insurer, the Policyholder and the Insured. These documents shall be applied in the following order of priority:

(i) The Endorsements;
(ii) the Certificate;
(iii) the Policy Schedule;
(iv) this Policy Wording; and
(v) the Benefit Plan.

No agent is authorized to alter or amend the Insurance Policy, or to waive any of its provisions. No change in this Insurance Policy shall be valid unless approved by the Insurer and evidenced by endorsement thereon, or by amendment hereto signed by an authorized representative of the Insurer.

3. Insurance Effectiveness

Subject to the terms and condition of this Insurance Policy, the Insurer's liability to an Insured under this Insurance Policy shall become effective from the commencement of the Insured Period with respect to such Insured, and will remain effective until the end of the Insured Period of such Insured unless otherwise terminated in accordance with this Insurance Policy.

4. Authorization

The authorized representative of an Insured shall have the right to act for that Insured if the Insured is incapacitated or deceased. Benefits are payable to the Insured or his/her authorized representative (if applicable) or to the Direct Settlement Network providers (if applicable). The Insurer may appoint independent claim administrators to settle claims on its behalf.

5. Coverage of Insurance

Subject to the terms and conditions of this Insurance Policy, and the applicable Limits of Liability, the Insurer will pay the Insured for the expenses necessarily and reasonably incurred by the Insured as a direct result of the Insured suffering bodily injury, sickness or disease or being pregnant (if applicable), during the Insured Period, PROVIDED ALWAYS THAT such expenses are actual and limited to usual, customary and reasonable charges in the country and area where treatment is provided.

6. Pre-existing Condition

Unless otherwise agreed by the Insurer in the Policy Schedule, all Pre-Existing Conditions are not covered under this Insurance Policy.

Notwithstanding the foregoing, if a Pre-existing Condition shall have been disclosed to the Insurer, the Insurer may agree to cover such Pre-existing Condition under the Policy after two years's continuous membership from the disclosure.

7. Pre-Authorization Requirement

The coverage of insurance is subject to the pre-notification or pre-authorization as follows:

All Elective Treatment must be supported by a full quotation and submitted to the Insurer 5 working days before treatment for assessment.

Elective Treatment outside the Usual Country of Residence is also subject to the following requirements:

(1) quotations for such Elective Treatment from the elected hospital must be obtained and submitted to the Insurer for pre-authorization at least 5 working days before the treatment is provided; and

(2) such Elective Treatment can also be provided after the pre-authorization has been granted by the Insurer. The Insurer will provide its pre-authorization only if the cost provided in the quotations submitted does not exceed the reasonable and customary charges in the countries and areas where such treatments are provided.

Failure to comply with these requirements shall invalidate the claim.

8. Territorial Scope

The coverage of insurance is subject to the geographical area as listed on the Policy Schedule and for which the appropriate zone premium has been paid. Treatment outside the territorial scope is not covered. For Zone 1, treatment in USA/Canada is subject to a deductible of covered medical expenses incurred, unless additional premium has been paid to remove the Deductible.

9. Conditions Precedent to Liability

Any liability of the Insurer to the Insured under this Insurance Policy shall be subject to the satisfaction of all the following condition precedent:

(a) the Insurer being furnished with all the required statements and declarations to be provided by the Policyholder and/or the Insured (parent or duly appointed guardian if the Insured is a minor) on an Application Form and the complete truth of all such statements and declarations.

(b) the complete truth and accuracy of all statements and declarations made in respect to any claim made against the Insurer by the Policyholder or any Insured under this Insurance Policy.

(c) the due and fully compliance with all the terms and conditions of this Insurance Policy insofar as they relate to anything to be done, restrained from doing or to be complied with by the Policyholder and/or any Insured.

10. Absolute Ownership

The Insurer shall unless otherwise expressly provided by an endorsement on this Insurance Policy be entitled to treat the Policyholder as the absolute owner of this Insurance Policy and shall not be bound to recognize any equitable or other claim to or interest in this Insurance Policy.

11. Data Required

The Policyholder shall furnish in writing to the Insurer, all information as the Insurer may require with regard to any matters pertaining to this Insurance Policy. All documents or information furnished to the Policyholder by an Insured in connection with insurance, together with such records as may have a bearing on the Policy, shall be opened for inspection by the Insurer at all reasonable times.

Clerical error in keeping the records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated. If the age or date of birth or other relevant facts relating to

an Insured shall be found to have been inadvertently misstated, and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of the Insurance Policy or the Insurer's decision to insure such Insured, at the Insurer's sole discretion, (A) the true age and facts shall be used in determining whether benefits are secured under the terms of the Insurance Policy, and in what amounts, and an equitable adjustment of premiums shall be made, or (B) his or her insurance shall be void and the Insurer shall limit the return of premiums in respect of such Insured.

12. Eligibility

1. For Individual policy:

The maximum age for enrolment is 64. Policyholder and Insured of all nationalities and their Dependants (other than newborn children) are eligible to join except for citizens of any of the UN and US. sanctioned countries, as amended from time to time.

Dependant's cover must be under the same Benefit Plan as the Insured on which he/she depends, and subject to prior acceptance by the Insurer. Minor child(ren) cannot independently insure under the Benefit Plan.

New-born children shall be eligible for insurance 15 days after the date of birth or 15 days after discharge from Hospital where the birth takes place, whichever is the later, upon submission of an application for insurance, subject to satisfactory evidence of good health and prior acceptance by the Insurer.

The coverage under this Insurance Policy is only applicable for those holding Class I and II occupations, unless otherwise agreed by the Insurer (with or without additional conditions/requirements). The Insured is required to inform the Insurer as soon as the occupation changes to Class III or IV. Failure to inform may result in a claim being denied or benefits terminated by the Insurer.

2. For Group policy:

The Employee and member of Sponsoring Organizations and the Dependant must be in Active Service at the inception date in order for eligible for this Insurance Policy, except for reasons of authorised routine paid leave-of-absence.

New-born children shall be eligible for insurance 15 days after the date of birth or 15 days after discharge from Hospital where the birth takes place, whichever is the later, upon submission of an application for insurance, subject to satisfactory evidence of good health and acceptance by the Insurer.

Citizens of any of the UN and US. sanctioned countries, as amended from time to time, are not eligible for the insurance under this Insurance Policy.

The maximum age for enrolment is 64.

The coverage under this Insurance Policy is only applicable for those holding Class I and II occupations, unless otherwise agreed by the Insurer (with or without additional conditions/requirements). The Insured is required to inform the Insurer as soon as the occupation changes to Class III or IV. Failure to inform may result in a claim being denied or benefits terminated by the Insurer.

13. Termination of Benefits

13.1 For Individual policy

The insurance under this Insurance Policy for an Insured shall be terminated at such time as the benefits applicable to such Insured shall have been exhausted or at midnight on the last day of the Insured Period with respect to such Insured. In the case where, at the time of termination, an Insured is confined in a Hospital for a sickness or injury covered under this Insurance Policy, then the time of termination shall be extended to the time (A) he/she no longer requires confinement for said Sickness or Injury or (B) the time his/her benefits for said Sickness or Injury is exhausted, whichever shall occur first. For the purpose of this part, "confinement" means a continuous period of not less than 18 hours as a registered bed patient in a Hospital.

13.2 For group policy

The insurance under this Insurance Policy for an Insured shall be terminated at such time as the benefits applicable to such Insured shall have been exhausted.

The insurance under this Insurance Policy for an Insured, who is an Employee, shall also be automatically terminated on the earliest of the following dates:

(a) the date on which the Employee ceases to be eligible for insurance as required in Article 12;
(b) the date the Master Policy terminates;
(c) the date of an Employee's termination of employment;
(d) the date of expiration of the period for which the last premium payment must be made in respect of the Employee's insurance;
(e) the Employee is resident in USA/Canada for a period in excess of twelve consecutive weeks.

In the cases of (a), (c) or (e) above, the Policyholder shall be entitled to a return of premium with respect to that Insured, less the amount due to the Insurer for the period during which the Policy had been in force for such Insured, computed on the pro-rata basic Provided Always that there is no claim with respect of such Insured and there is no violation under the Insurance Policy at that time.

The insurance under this Insurance Policy for an Insured, who is an Dependent, shall automatically terminate on the earliest of the following dates:

(a) the date the Dependant ceases to be eligible as a Dependant as defined hereunder Definition of Dependant;
(b) the date the Master Policy terminates;
(c) the date the relevant Insured (on which the Dependent depend)'s benefits under the Master Policy terminate;
(d) the date of expiration of the period for which the last premium payment is made in respect of the Dependent's insurance;
(e) the Dependent is resident in USA/Canada for a period in excess of twelve consecutive weeks.

In the cases of (a), (c) or (e) above, the Policyholder shall be entitled to a return of premium with respect to that Insured, less the amount due to the Insurer for the period during which the Policy had been in force for such Insured, computed on the pro-rata basic Provided Always that there is no claim with respect of such Insured and there is no violation under the Insurance Policy at that time.

The insurance under this Insurance Policy for an Insured, who is a member of an Sponsoring Organization, shall also be automatically terminated on the earliest of the following dates:

(a) the date such Insured ceases to be eligible as member of such Sponsoring Organization;
(b) the date such Insured ceases to meet any conditions to be eligible for the insurance under this Insurance Policy as set forth in the Policy Schedule;
(c) the date the Master Policy terminates;
(d) the date of expiration of the period for which the last premium payment is made in respect of the such Insured's insurance;

(e) the Insured is resident in USA/Canada for a period in excess of twelve consecutive weeks.

In the cases of (a), (b), or (e) above, the Policyholder shall be entitled to a return of premium with respect to that Insured, less the amount due to the Insurer for the period during which the Policy had been in force for such Insured, computed on the pro-rata basic Provided Always that there is no claim with respect of such Insured and there is no violation under the Insurance Policy at that time.

Provided that, for all cases, if an Insured is hospitalised for a covered Sickness or Injury at the time of such termination then the time of termination shall be extended to the time he or she is discharged from hospital after having completed the medical treatment for the said Sickness or Injury or the time his benefits for said Sickness or Injury shall have been exhausted, whichever shall occur first.

For the purpose of this part, Hospitalisation means a continuous period of not less than 18 hours as a registered bed patient in a Hospital.

14. Termination

The Insurer may terminate this Insurance Policy at any time by giving 30 days' notice by registered letter to the Policyholder at his last known address and in such even the Insurer will return to the Policyholder the premium paid less pro-rata portion thereof for the period during which the Policy Insurance had been in force.

The Insurance Policy may be terminated by the Policyholder at any time by giving written notice to the Insurer. If no claim has been submitted to the Insurer during the period during which the Insurance Policy had been in force, the Policyholder shall be entitled to a return of premium, less the amount due to the Insurer for the period during which the Policy had been in force, computed on the pro-rata basic Provided Always there is no violation under the Insurance Policy at that time.

In all cases, this Policy Insurance is subject to a minimum premium of VND2,000,000 plus tax (if any) for each Insurance Policy or Endorsement.

The Policyholder shall return to the Insurer the current policy document, schedule and medical card on or before the date of termination.

This Insurance Policy shall also be terminated upon termination of benefits of all Insured under the Insurance Policy.

15. Co-ordination of Benefits/Other Insurance/ Subrogation

All persons insured by any other medical or accident insurance policy shall be informed to the Insurer and a copy of that policy including the benefit schedules shall be provided to the Insurer.

This Insurance Policy will not provide indemnity other than on a proportional basis if the Insured has any other insurance in force or is entitled to indemnity from any other source in respect of the same Injury, Sickness or expenses.

In the event of Injury involving the actions or negligence of a third party, the Policyholder and the Insured shall use their best endeavours to claim from such third party for the full amount of the loss.

The Insurer shall not pay any claim involving a third party until all reasonable steps have been taken to obtain reimbursement. No Policyholder or Insured shall negotiate, settle, compromise, release, or otherwise discharge any claim against such a party without the Insurer's prior express written consent.

The Insurer has full rights of subrogation and may take proceedings in the Insured's name, but at the Insurer's expense, to recover for the Insurer's benefit, the amount of any payment made under this Insurance Policy including but not limited to the cost of such proceedings.

16. Classification

With respect to Master Policy, if the insurance is based on group classification and if more than one classification is designated in the Policy Schedule, the Insured shall be eligible for the Benefits applicable to his or her classification on the date of his or her enrolment. Thereafter if his or her classification changes, the Medical Benefits applicable to such Insured Member shall be changed upon satisfactory proof of such change and the date as agreed from the Insurer, except that when the Insured Member is on account of injury or disease not actively working in full time employment on such date, such Insured Member's Medical Benefits shall not be changed until the date on which he or she returns to full time active work.

The Policyholder shall notify the Insurer of all such changes in classification within one month after the Classification Change Date and the Policyholder shall pay the required premiums from the date for the revised Medical Benefits resulting from any such change in classification. If individual contributions are required under the Master Policy, the Policyholder shall make the necessary adjustment in such contributions with respect to all Insured Members affected by a change in classification.

17. Examination

The Insurer shall have the right and opportunity through his medical representative to examine any Insured Member whenever and as often as may be reasonably required within the duration of any claim. In addition the Insurer shall have the right to require an autopsy in the case of death, where this is not forbidden by law or religious belief.

18. Medical Evaluation

We reserve the right to request further tests and/or evaluation where We decide that a condition being claimed for may be directly or indirectly related to an excluded condition.

19. Reasonable Precautions and Material Changes

Insured Members shall take all reasonable precautions to prevent and minimize any Accident, Injury, Sickness or expense and the Insurer must be informed immediately in writing of any material information or change of circumstances whether relating to job occupation, avocation, sporting activity or otherwise which may increase the possibility or likely magnitude of a claim under this Policy.

The Insurer shall have the right to continue coverage on terms and conditions it considers appropriate to such changes in material information or circumstances or to decline to continue coverage under this Policy. No claim arising from or related to such changes shall be met until and unless the Insurer has been advised of such changes, and has agreed to continue the coverage.

20. Return to Home Country/Change of Usual Country of Residence

For citizens of the USA or Canada who return to their Home Country and for citizens of other countries who plan to reside in USA/Canada for a period in excess of 12 weeks, the Plan will be terminated automatically. The Insured Member shall notify the Insurer of the date of his return to the Home Country or change of Usual Country of Residence to USA/Canada within thirty days of the date of such return/ change. Premium paid will be refunded according to the Termination Article.

For changes of residence other than the USA or Canada during the Policy Year, the Insurer will charge or refund the premium on short-period basis in accordance with the Termination Article. However, the Insurer reserves the right to refuse to offer cover in certain countries.

As a condition precedent to liability under this Policy, the Insurer must be informed immediately in writing of any change in the Usual Country of Residence of the Policyholder or any Insured Member. A change in the Usual Country of Residence shall be deemed to mean the Insured Member ceasing to reside in his Usual Country of Residence, or intending to be relocating in another country for a period in excess of 12 weeks.

The Insurer must be informed of the location of any Dependants whose Usual Country of Residence is different from that declared for the Policyholder in the Application Form, and the Insurer reserves the right to decline to cover such Dependants under this Policy.

The Insurer reserves the right to decline to offer renewal to any member whose Usual Country of Residence has changed during the policy year.

21. Claims Procedure

Insured are free to obtain medical service from either of the followings:

Option 1 – Self-Paid

Written proof of claim must be submitted to the Insurer or to the appointed independent claims administrator within ninety (90) days, starting from the first date of treatment of the insured event or in case of maternity, the date of delivery for which the claim is made, unless otherwise agreed by the Insurer. Failure to claim within the time required by the Policy may invalidate the claim.

Proof of Claim: Original documents of medical reports, test results, prescription, supporting invoices and receipts must be submitted with a fully completed claim form, signed by the treating Physician and the claimant. Photocopies are not acceptable.

Reimbursement: Any claim made by an Insured for the incurred actual expenses shall be reimbursed in Vietnam Dong subject to the prevailing regulations of Vietnamese government on foreign exchange management Provided That if the expenses incurred in foreign exchange, the applicable exchange rate shall be the exchange rate for bank transfer published by Vietcombank, Ho Chi Minh city at the time the expenses was incurred.

For hospital, surgery and day-care treatment please refer to "Elective Treatment – Pre-authorization requirement".

Option 2 – Direct Billing Service

Direct Billing Service is a cashless service provided by the Insurer that allows Insured to receive General Outpatient Services and Hospital treatment at the Insurer's appointed healthcare providers. For elective hospital treatment, Insured has to follow the "Elective Treatment-Pre-authorization requirement". The Insurer will issue a Letter of Guarantee for Payment if the medical condition is covered by the Insurance Policy.

Insured is required to present his/her Medical Card with other identity document for verification. In any event, authorization of payment and/or payment that shall have been made by the Insurer for a claim which is not covered under the Insurance Policy or when the limit of liability is exceeded, the Insured and/or the Policyholder will be responsible for repayment to the Insurer the costs of ineligible treatment within 31 days from the date the Insurer issues the repayment notice.

22. Fraud

1. For individual policy

If any claim shall in any respect be false or fraudulent or if fraudulent means or devices are used by the Insureds or anyone acting on his/her behalf to obtain benefits hereunder then the Insurance Policy shall be immediately terminated and all benefits and return premiums will be forfeited.

2. For group policy

If any claim shall in any respect be false or fraudulent of if fraudulent means or devices are used by the Policyholder or anyone acting on the Policyholder's behalf to obtain benefits hereunder then the Master Policy shall be immediately cancelled and all benefits and premiums will be forfeited.

In the event of a false of fraudulent claim by an Insured then his or her insurance shall be cancelled immediately and all benefits and premium will be forfeited. This shall not prejudice the Master Policy which shall remain in force.

23. Exclusions

The following treatments, conditions, activities, items and their related expenses are excluded from the insurance and the Insurer shall not be liable for:

(1) Treatments of mental illness, behavioural, psychiatric disorders including but not limited to depression, eating disorder, sleeping disorders or any neuroses and their physiological or psychosomatic manifestations except pre-authorized hospitalisation treatment.

(2) Services or treatments at any institution that is mainly a long-term care facility, spa, hydro-clinic, or sanatorium and that provides only incidental or limited hospital services.

(3) Tests and treatments relating to birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions. Treatment for learning problems or speech defects of a dependent child. Foetal surgery.

(4) Tests and treatments relating to infertility, contraception, sterilisation, inducing pregnancy or any abortion, caesarean section performed due to non-medical reason and the consequences of treatments.

(5) Tests and treatments not undertaken by or on the recommendation of a Physician, Chinese Medicine Practitioner, or which is reasonably considered by the Insurer's medical advisors as not medically necessary.

(6) All dental/orthodontic treatment, unless explicitly stated on the Policy Schedule.

(7) Routine eye and ear examinations, including the cost of spectacles, contact lenses, correction of eye visions or eye refraction.

(8) Treatments arising out of addictive conditions/disorders such as abuse of drug or alcohol.

(9) Treatments for self-inflicted injury or suicide.

(10) Routine medical examinations and preventive treatment (including vaccinations or inoculations, preventative medicine and test), unless otherwise explicitly provided and endorsed on the Schedule

(11) Tests primarily not incident to treatment or diagnosis of a covered Sickness or Injury; or any treatment which is not medically necessary. Treatment of an optional nature. Treatment by a family member. In addition, the Policyholder/Insured Member as doctor/nurse treats themselves or dependants in the hospitals/clinics/medical establishments where they are working.

(12) Prostheses, corrective devices and medical appliances, as well as artificial heart implantation, mono or bi-ventricular assist device(s), except standard surgical implants. Charges for the procurement or use of special braces, appliances, wheel chairs, crutches or other equipment.

(13) Elective cosmetic surgery. Treatment related to or arising from the removal of healthy, surplus or fat issue or other treatment undergone for cosmetic or psychological reasons, including but not limited to hair loss treatment, freckle, hyperpigmentation, etc…

(14) Maternity Care. No benefit shall be payable, unless otherwise explicitly provided and endorsed in the Schedule.

(15) Tests and treatments of sexually transmitted diseases and treatment of impotence or any related condition.

(16) All organ transplantation except as herein defined.

(17) Acquisition of the organ itself and all expenses incurred by the donor.

(18) Tests and treatments for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive unless the qualified period has been fulfilled and subject to the sub limit as stated in the Schedule.

(19) Pre-Existing Conditions or any related, associated or consequential disabilities, unless disclosed to and accepted in writing by the Insurer.

(20) Alternative treatment, such as aroma therapy and naturopathy.

(21) Charges exceeding the reasonable and customary range as defined.

(22) Non-approved Elective Treatment (refer to Definition).

(23) All transportation costs incurred for trips specifically made for the purpose of obtaining medical treatment, if not part of an Emergency Medical Evacuation and except as defined under Local Ambulance Services.

(24) Experimental and yet to be scientifically proven medical treatment.

(25) Treatments for Injury or Sickness incurred while serving as a member of police or military forces or as a result of performing Class III or IV occupation (unless otherwise agreed in advance by the Insurer).

(26) Treatments for injuries or diseases sustained while participating in (including any practice or conditioning program for) any sport, contest or competition including but not limited to the following activities: Racing of any form other than on foot including but not limited to auto or car racing, professional sport, contact sport, motorcycle racing, powerboat racing, and dressage competition; skydiving, parasailing, hang-gliding, flying (other than as a fare-paying passenger on a duly licensed commercial aircraft), caving, rock or mountain climbing (with or without the use of ropes or other equipment), bun gee jumping, non-recreational scuba-diving, scuba diving to a sea-depth of greater than twenty (20) meters, polo, steeple chasing or any other hazardous activity, unless declared to and accepted by the Insurer or deliberate exposure to exceptional danger (except in an effort to save human life);

(27) Tests and treatments for sleep-related breathing disorders, including snoring, fatigue, jet lag or work-related stress or any Related Condition.

(28) Dietary supplements and substances which are available naturally and that can be purchased without prescription, including but not limited to vitamins, minerals.

(29) Non-medical services, including the issue of medical certificates and attestations and examinations as to suitability or travel.

(30) Treatment for Injury or Sickness resulting from war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power.

(31) Treatment for Injury or Sickness resulting from Terrorist Act.

(32) Exposure to nuclear energy, ionizing radiation or radioactive contamination of any kind.

(33) Participation in an illegal act including resultant imprisonment or Incompliance with all statutory obligations, such as violation of traffic law that includes but is not limited to: speeding, passing red lights, driving in the dark without the headlights' working, etc.

(34) Any costs incurred outside of the Policy Year or for any period for which the appropriate premium has not been paid (however, the Insurer shall agree to cover the costs after the premium shall be paid).

(35) All Emergency Medical Evacuation/Repatriation/Return of Mortal Remains not approved in advance by the appointed Assistance Centre.

(36) Any other exclusion on Medical Evacuation/Repatriation/Return of Mortal Remains Benefits specifically stated in the Service Agreement with the Medical Assistance Provider, as amended from time to time.

(37) Other exclusions as set forth in the Policy Schedule.

24. Law and Practice

The parties hereto agree that the Law and practice of the Socialist Republic of Vietnam shall govern and control in the event of any conflict or dispute between the parties with regard to the Policy.

In the event of any dispute or conflict arises under or in connection with this Policy, the parties shall resolve the dispute in question first by negotiation and amicable conciliation. If no resolution of the dispute or conflict could be reached within thirty (30) days from the date on which one party notifies the other party of the dispute arisen, the parties agree to submit themselves to the exclusive venue and jurisdiction of the competent courts of the Socialist Republic of Vietnam for the resolution.

PREMIUM WARRANTY

1. Notwithstanding anything herein contained to the contrary, and subject only and without prejudice to clause 2 hereinafter set out, it is hereby declared and agreed that it is a condition precedent to liability under this Policy, Renewal Certificate, Endorsement or Cover Note that any premium due must be paid and actually received in full by the Company, the registered broker or registered agent through whom this Policy was effected:

   (a) where the period of insurance is more than 30 (thirty) days, within 30 (thirty) days from the:

      (i) INCEPTION date of the cover under the Policy, Renewal Certificate or Cover Note; or

      (ii) EFFECTIVE date of the cover stated on each Endorsement, if any, issued under the Policy, Renewal Certificate or Cover Note; or

      (iii) where the ISSUANCE date of the Policy or the Endorsement, if any, issued under the Policy, Renewal Certificate or Cover Note is more than 30 (thirty) days from the inception date or effective date, the premium must be paid upon presentation of the Debit Note(s); or

   (b) where the Company has allowed payment of that premium by installments

      (i) within 15 days from INCEPTION date of the cover under the Policy, Renewal Certificate or Cover Note for the first installment and thereafter from the agreed dates on which the subsequent installments become payable; or

      (ii) Any Endorsement, if any, issued under the Policy, Renewal Certificate or Cover Note, the premium must be paid on the due date of latest installment and before the expiry date of the Policy

      (iii) where the period of insurance is less than 30 (thirty) days, the premium must be paid upon presentation of the Debit Note(s).

2. In the event any of the abovementioned premium is not paid in full to the Insurer, registered broker or registered agent as described above in the manner and within the time stipulated above (the "premium warranty period"), the cover under this Policy, Renewal Certificate, Endorsement or Cover Note shall be deemed to have terminated automatically from the expiry of the premium warranty period and the Insurer shall be discharged from all liability therefrom but without prejudice to any liability incurred before that date and the Insurer shall be entitled to a pro-rata time on risk premium.

3. In the event accumulative claims amounts exceed the outstanding premiums, all the outstanding premiums will be paid immediately to the Insurer.

IMPORTANT NOTICE

We would remind that you must disclose to us, fully and faithfully, the facts you know or ought to know, otherwise you may not receive any benefit from your Policy.