Group Health and Accident Insurance Policy

SME

Table of contents Page

AXA Group Health and Accident Insurance Policy (SME Package)

Remark: The English version is a translation of the original in Thai for information purpose only. In case of a discrepancy, the Thai original shall prevail.

AXA Group Health and Accident Insurance Policy
SME Package

In reliance upon statements contained in the insurance application, which is an integral part of this Policy, and in consideration of the premiums payable by the Policyholder or the Insured, and subject to the stipulations, general conditions, insuring agreements, exclusions, and attachments to this Policy, the Company agrees with the Insured as follows.

Section 1: Definitions

Unless specified otherwise in this Policy, words or expressions to which specific meanings have been ascribed in any part of this Policy will have the same meaning wherever they appear.

1.	**Company**	means	AXA Insurance Public Company Limited
2.	**Policy**	means	the schedule, Table of Benefits, conditions, exclusions, provisions, endorsements, special provisions, warranties and insurance application.
3.	**Policyholder**	means	The person(S) or the legal entity who owns the Policy and is named as the Policyholder in the schedule and pay a part of or the full insurance premium for the benefit of the Insured.
4.	**Insured**	means	an eligible employee or member of the Policyholder, who is named in the attachment to the schedule, or the attachment.
5.	**Dependents**	means	the Insured's dependents who are named in the attachment to the schedule, or the attachment, as follows: 1. the legitimate spouse of the Insured who is aged at least 18 years old and not older than 65 years of age at point of application and 2. the legitimate children of the Insured, or of the Insured's spouse, who are unmarried and unemployed, and are between the age of 15 days and 18 years, or 23 years if he or she is a full-time student.
6.	**Covered Persons**	means	the Insured and/or the Insured's eligible Dependents named in the schedule or the attachments.
7.	**Contributory Insurance**	means	insurance for which the premium is fully paid by the Insured, or for which the premium is partly paid by the Policyholder and partly contributed to by the Insured.
8.	**Non-contributory Insurance**	means	insurance for which the premium is fully paid by the Policyholder.
9.	**Table of Benefits**	means	the table listing the maximum benefit amounts for the respective Covered Persons.
10.	**Plan**	means	the coverage plan of the Axa Group Health and Accident Insurance Policy.
11.	**Area of Cover**	means	1. **Thailand** 2. **Asia** means, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal,

			Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, and Vietnam 3. **Worldwide excluding the USA** means, all countries around the world except the USA and its surrounding islands and 4. **Worldwide** means, all countries around the world.
12.	**Outside Area of Cover**	means	the coverage that is provided only for Emergency Medical Treatment not arising during travel undertaken directly for securing Medical Treatment, or that is prepared while a Covered Person travels out of the Area of Cover.
13.	**Emergency**	means	a sudden, serious, and unforeseen acute Medical Condition or injury requiring immediate medical treatment, that without treatment commencing within twenty-four (24) hours of the emergency event could result in death or serious impairment of bodily function.
14.	**Main Country of Residence**	means	the country in which a Covered Person resides for more than 185 days per year, that is specified as his or her address in the Policy.
15.	**Accident**	means	a sudden event resulting from an external factor, which leads to an unintended or unexpected result to a Covered Person.
16.	**Injury**	means	a bodily injury directly caused by an Accident arising separately from and independently of any other incident during the effectiveness of the insurance agreement.
17.	**Illness**	means	an illness or disease suffered by a Covered Person during the effectiveness of the insurance agreement.
18.	**Congenital Condition**	means	all kinds of congenital abnormalities, including physical anomalies happening during six months from birth, that are categorized as congenital malformations by the World Health Organization, and deformations or genetic abnormalities, including all kinds of hernia or epilepsy, except epilepsy caused by an Injury after the Covered Person has obtained the insurance.
19.	**Chronic Condition**	means	a Medical Condition or Illness that is persistent and lasting, or continues indefinitely, as diagnosed and concluded by a Physician.
20.	**Physician**	means	a person who has a medical degree and is duly registered with the Medical Council, and is licensed to practice the medical treatment profession in the locality in which the medical or surgical services are provided.
21.	**Dentist**	means	a person who has a dentistry degree and is duly registered with the Dental Council, and is licensed to practice the dental treatment profession in the locality in which the services are provided.
22.	**Traditional Chinese Medicine**	means	a diagnosis, Medical Treatment, or prevention of disease by any means provided by a registered traditional Chinese physician in the locality in which the services are provided.
23.	**Physiotherapist**	means	a person who is capable of practicing, and is licensed to

practice, physical therapy.

24. **Nurse** means a person who is licensed to practice the nursing profession in accordance with the law.

25. **Fees for Nursing Services** means expenses regularly charged by a Hospital or medical center for services provided by professional Nurses to a Covered Person when the Covered Person is an inpatient.

26. **Inpatient** means a person who is treated in a Hospital and, according to a Physician's opinion, must be accommodated in the Hospital for at least six consecutive hours, and must be registered as an Inpatient.

27. **Outpatient** means a person receiving a Medical Service in an outpatient department or emergency room of a Hospital, medical center, or clinic, for a condition which, by diagnosis and indication according to the Medical Standards, does not require admission as an inpatient.

28. **Hospital** means any medical facility that provides medical services and can accommodate overnight patients, with an adequate number of medical personnel and facilities, especially a major operating room, as well as a complete range of services and is registered as a hospital in accordance with the law on medical facilities in that locality.

29. **Clinic** means a modern medical facility licensed under the law, that is operated by a Physician who provides Medical Treatment and diagnosis services, and is unable to accommodate overnight patients.

30. **Medical Standards** means the international medical basis or guidelines that give rise to an appropriate course of treatment for a patient, according to Medical Necessity and consistent with conclusions drawn from Injury records, findings, diagnosis results or any other reason.

31. **Medical Necessity** means any eligible Treatment, test, medication, or stay in Hospital or part of a stay in Hospital which:
    - is not being undertaken for the convenience of the Insured, the treating Physician, Hospital or clinic; and
    - is required for the diagnosis, direct Treatment and medical management of an eligible Medical Condition suffered by the Insured as prescribed by his Physician; and
    - must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity; and
    - must conform to the professional Medical Standards widely accepted; and
    - shall be considered and approved by the Insurer and their medical advisors as the most appropriate, cost effective, Conventional Treatment and not of an Experimental, investigational, research or preventive nature.

32.	**Reasonable and Customary Charges**	means	any medical expenses and/or reasonable costs comparing to those charged to general patients for services provided by a Hospital, or medical center or clinic where a Covered Person is treated. For the avoidance of doubt when comparing treatment, the Company will take into account the complexity of the procedure and the standard of the medical facility where the treatment is received.
33.	**Medical Condition**	means	any disease, Injury, Illness, including mental Illness, that has been diagnosed and concluded by a Physician.
34.	**Pre-existing Condition**	means	any Medical Condition preceding the Policy Commencement Date, or plan upgrade date, whichever date is later: • for which the Covered Person has been diagnosed; or, • for which the Covered Person has sought or received medication, advice, or Treatment, or, • which the Covered Person should reasonably, based on the Company's independent appointed Physician's opinion, have known about, or, • for which the Covered Person have experienced symptoms even if the Covered Person has not consulted a Physician or was not diagnosed before the start of the cover.
35.	**Associated Medical Condition**	means	any symptom, disease, injury, or illness that is: • a medical condition caused by or related to directly or indirectly to a Pre-existing condition; or • a medical condition in which the underlying condition (disease, injury, or illness) is generally known to be same with the underlying disease that cause a Pre-existing condition; or • a risk factor that is generally or directly known to be a medical condition that may cause or is arising from a medical condition that may cause pre-existing condition.
36.	**Terrorist Act**	means	the use of force or violence and/or threat thereof, by any person or group of persons, whether alone or on behalf of or in connection with any organization or government, that is done for political, religious, ideological or similar purposes, including the intention to put any government and/or the public, or any section of the public, in fear.
37.	**Surgery**	means	a surgical procedure, or an insertion of any device into the body.
38.	**Medical Treatment**	means	treatment by Surgery or medication that is provided by a Physician, including: 1. examination and diagnosis – the provision of advice and examination to diagnose the disease 2. inpatient treatment – a Medical Treatment that requires the Covered Person to stay in a Hospital for one night or more, 3. outpatient Surgery or procedure – a Surgery or procedure that can be performed without requiring the Covered Person to

			be admitted as an inpatient in a Hospital and 4. outpatient treatment – a Medical Treatment in an outpatient department or emergency room of a Hospital, medical center, or clinic, for a condition which, by diagnosis and indication according to the Medical Standards, does not require admission as an inpatient.
39.	**Single Injury or Illness**	means	any Illnesses for the same cause, including complications consequential to those Illnesses, or any Illnesses simultaneously occur for other causes during a confinement in a Hospital, provided that an Injury or Illness occurs later than ninety (90) days, in the case of an inpatient, or fourteen (14) days, in the case of an outpatient, after the most recent Medical Treatment will be considered a new Illness or Injury.
40.	**Lifetime**	means	the period in which a Covered Person is alive or until the Covered Person reaches the maximum age allowable under this Policy, whichever is earlier. This does not refer to the duration of the Policy.
41.	**Year**	means	a period of 12 calendar months from the date the Policy comes into effect, or is renewed.
42.	**Maximum Limit**	means	the total amount of benefits per year per Covered Person to be paid by Company.
43.	**Deductible**	means	the first amount of the loss that a Covered Person must be liable to pay before benefits under the Policy are payable by the Company according to the terms of the insurance agreement.
44.	**Copayment**	means	liabilities between the Insurance Company and the Insured who shall co-pay the medical fee payable according to the sum insured after Deductible (if any).
45.	**Experimental**	means	any Medical Treatment modality and medicines in the Company's reasonable opinion, whose efficacy and safety have yet to be established, that lacks the authoritative evidence-based clinical studies. These treatment modalities or medicines are generally not accepted by the medical community as proven to be effective or are not recognized by the professional medical organizations as conforming to accepted medical practice. This definition also refers to the use of off-label drugs, equipment used for purposes other than those defined under their license or which are undergoing study, research or testing.

Section 2: General Conditions

1. **Insurance agreement**

This insurance agreement is established based upon the Company's reliance on the Policyholder's and/or the Covered Persons' statements in the insurance application, health declaration, and any other additional declarations that the Policyholder and/or the Covered Persons have signed in evidence of the acceptance of the insurance agreement. The Company therefore issues this Policy.

If the coverage has been provided based on the Insured knowingly misrepresenting the facts in the declarations under the first paragraph, or knew of any facts but failed to disclose them to the Company, whereby if the Company had known those facts, it might have been convinced to charge a higher premium or refuse to enter into the insurance agreement, this insurance agreement will become void in accordance with section 865 of the Civil and Commercial Code and the Company will be entitled to nullify this agreement.

The Company shall not disclaim liability based on any statements except those declared by the Insured in the document under the first paragraph.

2. **Breach of the insurance agreement**

If a Covered Person breaches any condition of the Policy, or dishonestly claims or attempts to claim compensation, the Company will:

2.1 refuse to pay the compensation and

2.2 refuse to renew the Policy or

2.3 specify the conditions of the Policy that are different from the original ones or

2.4 immediately revoke the Policy and the entire coverage.

3. **Incontestability**

The Company will not contest or challenge the validity of this insurance agreement if the Policy has been in effect for a period of two years or more from the date the Policy comes into effect or the date of the Company's approval of additional benefits under this Insurance Agreement, whichever happens later, except in the case of default of premium payment. However, upon the approval of additional benefits, the Company may dispute or object to the incompleteness of this Insurance Policy regarding such additional benefits only.

If the Company becomes aware of any information based upon which the agreement can be nullified, but does not exercise its right of nullification within one month from the date that information is known to the Company, the Company may no longer nullify the validity of the agreement on these grounds.

4. **Governing law**

This Policy is governed by, and interpreted in accordance with, the laws of Thailand. The Policyholder and/or the Covered Persons agree that Thai law is the exclusive law for settling all disputes arising from or in connection with this Policy.

5. **Amendment to the Policy**

Any amendment to this Policy will be valid only if it is agreed to by the Company, and will become effective only after the Company, through its authorized person, records it on the Policy or issues an attachment.

The conditions, coverage, and exclusions under this Policy may be amended only on the renewal date of this Policy, subject to the Company's consideration and approval at that time. The Company will inform the Policyholder of any amendments in writing in advance, by sending written notice thereof to the address last given by the Policyholder at least 15 days before the

expiration date of the Policy.

For the purpose of receiving notices from the Company, the Policyholder must inform the Company whenever the address of the Policyholder and/or any Covered Person changes.

6. **Premium payment and commencement of coverage**

6.1 Annual premium payment

6.1.1 In the first year of this Policy, the Insured must pay the annual premium before or on the inception date. The coverage will commence from the inception date as stated in the Policy Schedule and/or Renewal Certificate in the case of renewal.

6.1.2 In subsequent renewal years, the premium must be paid within 31 days from the expiry date stated in the Policy Schedule and as agreed upon by the Company, the Company will continue the coverage and the Company will not re-apply the conditions of Waiting Period and Pre-existing Conditions to the Policy.

6.1.3 If the Insured does not pay the premium within the specified period, it shall be deemed that the Insured does not wish to renew the Insurance Policy and the coverage hereunder shall expire as indicated in the Insurance Policy Schedule.

6.2 Consecutive monthly premium payment

6.2.1 In the first month, the insured must pay the premium immediately before or on the inception date. The coverage will commence from the inception date as stated in the Policy Schedule and/or renewal certificate.

6.2.2 For subsequent premium installment, the premium must be paid within 31 days from the due date. If the premium is paid, the coverage on this policy is deemed to have been continuously in force from the previous insurance period and the Company will not re-apply the conditions of Incontestability or objection of the completeness of the insurance contract, Waiting Period and Pre-existing Conditions to the Policy.

If the Company is unable to collect the insurance premium after this time, the Policy will be terminated on the last date the premium that has been paid can purchase the coverage.

6.3 Monthly premium payment

6.3.1 In the first month, the insured must pay the premium immediately before or on the inception date. The coverage will commence from the inception date as stated in the Policy Schedule and/or renewal certificate.

6.3.2 For subsequent premium installment, the premium must be paid within 31 days from the due date. If the premium is paid, the coverage on this policy is deemed to have been continuously in force from the previous insurance period and the Company will not re-apply the conditions of Incontestability or objection of the completeness of the insurance contract, Waiting Period and Pre-existing Conditions to the Policy.

If the Company is unable to collect the insurance premium after this time, the Policy will be terminated on the last date the premium that has been paid can purchase the coverage.

6.4 In the event that there are claims to be paid during the 31 days from the payment due date and the Company is still unable to collect the premium, the Company will deduct the outstanding premium from the payable claim amount under this insurance policy and reimburse the remaining balance to the Insured or the beneficiary (in case of loss of life).

7. **Misstatement of age or Main Country of Residence**

If any Covered Person's age or Main Country of Residence is misstated, thereby causing the Company:

7.1 to receive a premium less than the prescribed rate, the amounts of benefits payable

under this Policy will be adjusted to the amounts of protection that the premium received would have purchased at the Covered Person's actual age and/or Main Country of Residence. If the Covered Person is not eligible for the coverage under this Policy based on his or her actual age or Main Country of Residence, the Company will not pay any benefits but will return the premium paid hereunder in full. If the Company finds that there was a claim record under the prevailing Policy, the Company will return the premium based on the remaining period from the date the Company is aware of that cause.

7.2 to receive a premium more than the prescribed rate, the Company will return the excess premium to the Policyholder and/or the Covered Person. However, this condition will not apply retroactively to the premiums paid for the past Policy Years.

8. **Renewal of the Policy**

The term of this Policy is one year. The Company may refuse renewal of this Policy by giving prior written notice at least 30 days before the date this Policy comes to an end, provided that the Company gives the reason for refusal.

Even if the Company will renew this Policy, the Company reserves its right to adjust the terms and conditions, including the premium rates, to suitably reflect the risk levels and increased ages, as well as the record of claims under this Policy, subject to the Covered Persons' qualifications according to the Company's insurance underwriting criteria and the prevailing premium rates.

The Company must notify the Policyholder if there is any change, addition, or extension to the coverage conditions, or exclusions, and other attachments that are the essence of this Policy.

9. **Premium adjustment**

The Company may adjust the premium for a Policy Year, to reflect the age ranges and claim records of the respective Covered Persons. The Company will give prior written notice thereof to the Policyholder.

10. **Date of entitlement to the coverage**

10.1 In the case of Non-contributory Insurance, the date of entitlement to the coverage is the date of employment, or the date of completion of a probationary period of the Insured, or other date as specified by the Policyholder in the group insurance application.

10.2 In the case of Contributory Insurance, the Insured must pay a premium contribution:

10.2.1 on the commencement date of the insurance, if the application for insurance is before the commencement of the insurance,

10.2.2 on the date of application for insurance, if the insurance is applied for within 30 days from the commencement date of the insurance,

10.2.3 on the date of becoming an Insured, in the case of a new employee, or

10.2.4 on the date on which the Company agrees to underwrite the insurance, if the insurance applied for is after the expiration of the period specified in 10.2.2

If the Insured is unable to work on a normal full-time basis due to an Injury or Illness on the date of entitlement to the coverage, it will be deemed that the date of entitlement to the coverage applicable to him or her is the first date of his or her return to work on a full-time basis, and the Company will provide coverage from the date the Insured returns to work.

11. **Coverage for Dependents**

11.1 Dependents will be covered under this Policy only if the Insured remains covered under this Policy.

11.2 If a Dependent is treated in a Hospital before or on the effective date of the insurance, this

Policy will not provide coverage to him or her until he or she is fully cured and discharged from the Hospital.

12. **Termination of coverage**

12.1 This Policy will automatically terminate upon the occurrence of any of the following events:

12.1.1 The Policyholder or the Insured fails to pay a premium as specified in clause 6, premium payment and commencement of coverage, of the general conditions.

12.1.2 On the expiration date of the coverage as specified in the schedule at midnight, Thailand time in the Policy Year when the Insured is 99 years of age.

12.1.3 On the date either party exercises its right to terminate the Policy according to clause 14, termination of the Policy, of the general conditions.

12.2 The coverage of each of the Insured will automatically terminate upon the occurrence of any of the following events:

12.2.1 On the date the Insured retires or resigns. The Company will return the premium to the Policyholder or the Insured after deducting a proportionate amount thereof for the period during which this Policy is in effect. If the Company has paid compensation under the Policy during that Policy Year, no premium will be returned.

12.2.2 When the Insured dies due to an illness. The Company will return the premium to the Policyholder and/or the beneficiaries after deducting a proportionate amount thereof for the period during which this Policy is in effect, provided no claims was paid out for that Policy Year.

12.2.3 On the expiration date of the coverage at midnight, Thailand time, as specified in the schedule, provided that the Company has refused renewal of the Policy for the respective Insured by sending a written notice to the Policyholder at least thirty (30) days before the expiration of the Policy, to the last known address or email address.

12.2.4 On the date of expiration or termination of employment of the Insured. The Company will return the premium to the Policyholder or the Insured after deducting a proportionate amount thereof for the period during which this Policy is in effect. If the Company has paid compensation under the Policy during that Policy Year, no premium will be returned.

12.3 The coverage of each of the eligible Dependents will automatically terminate upon the occurrence of any of the following events:

12.3.1 On the anniversary of a Policy Year, when the Dependent ceases to be a Dependent as defined herein.

12.3.2 When the Dependent dies due to an illness. The Company will return the premium to the Insured or the beneficiaries after deducting a proportionate amount thereof for the period during which this Policy is in effect.

12.3.3 When the coverage for the Insured comes to an end according to the conditions in clause 12.2 The Company will return the premium to the Policyholder, or the Insured, or the beneficiaries, after deducting a proportionate amount thereof for the period during which this Policy is in effect. If the Company has paid compensation under the Policy during that Policy Year, no premium will be returned.

12.3.4 When the Insured ceases to be an Insured as defined herein.

The coverage under each of the insuring agreements and/or attachments will terminate when the compensation paid by the Company reaches the maximum benefit limit specified herein.

13. **Change of country of residence**

The Policyholder and/or the Covered Person must report to the Company if any of the

Covered Persons changes his or her Main Country of Residence, which may affect his or her entitlement to the benefits under the Policy. If the Policyholder and/or the Covered Person fail to do so, the Company will comply with the provisions specified in clause 7, misstatement of age or Main Country of Residence, of the general conditions.

14. **Termination of the Policy**

14.1 The Policyholder may terminate this Policy by sending written notice thereof to the Company. The Insured will be entitled to a refund of the premium for the unexpired term of insurance, after deduction of a proportionate amount of premium for the period during which this Policy is in effect, based upon the following short rate table.

Table of short rate premium	
Coverage period (not exceeding/month(s))	**% of the full-year premium**
1	15
2	25
3	35
4	45
5	55
6	65
7	75
8	80
9	85
10	90
11	95
12	100

14.2 The Company may terminate this Policy by sending written notice at least 30 days in advance to the Insured by registered mail or electronic means in accordance with the law on electronic transactions to the address or email address last given by the Policyholder. The Company will return the premium to the Policyholder after deducting a proportionate amount thereof for the period during which this Policy is in effect. The Company will not pay any compensation after the termination of this Policy.

The termination of the Policy by either party according to the conditions under this clause must be made for the whole Policy. Cancellation of certain parts of the coverage during the Year is not permitted. If the Company has paid compensation under this Policy during that Policy Year, no premium will be refunded. The Company will not pay any compensation after the termination of this Policy.

15. **Dispute settlement by arbitration**

If there is any dispute, conflict, or claim under this Policy, between a person who is entitled to exercise a claim hereunder and the Company, and if that person wishes and deems it appropriate to settle the dispute by arbitration, the Company agrees to have the dispute settled by arbitrators in accordance with the rules of arbitration of the Office of the Insurance Commission (the OIC).

16. **Right of examination**

The Company reserves the right to examine the medical history of the Insured as deemed appropriate for this Insurance Policy and may require to have an autopsy report if deem necessary

and to the extent permitted by the law.

If the Covered Person fails to allow the Company to examine his or her records of Medical Treatment and diagnosis to support its consideration of benefit payment, the Company may refuse to provide coverage to that Covered Person.

17. **Report and claim for benefits under the Policy**

17.1 The Policyholder, the Insured, a Covered Person, or his or her representative, as applicable, must report to the Company without delay in the case of an Injury or Illness that may be a cause of a claim for benefits under the Policy, or immediately in the case of death, unless it can be proven that it is impractical to do so due to any necessary and reasonable cause, but will be made as soon as it is practical.

17.2 Before a Covered Person will have Medical Treatment as an inpatient, or a planned Surgery or procedure in a Hospital, the Policyholder, the Covered Person, or the Hospital must check with the Company to ensure his or her entitlement to the coverage according to the conditions of the Policy. The Company will issue a written confirmation specifying the following details:

17.2.1 that the course of treatment is suitable under the coverage provided by the Policy,

17.2.2 that the course of treatment is indeed medically necessary,

17.2.3 that the course of treatment will incur Reasonable and Customary Charges, and

17.2.4 that the expenses incurred by the Medical Treatment do not exceed the remaining benefits under the Policy.

If there is an excess between the medical expenses covered by the Company and the medical expenses charged by the Hospital when the Covered Person is discharged, the Policyholder or the Covered Person must pay it, including other expenses not related to the Medical Treatment, to the Hospital.

If the Covered Person needs to have Medical Treatment in a Hospital outside the Company's network, the Covered Person must check with the Company to ensure his or her entitlement to the coverage according to the conditions of the Policy, and must receive the Company's written confirmation, before receiving the Medical Treatment. If no confirmation is received from the Company, the Policyholder or the Covered Person must immediately contact the Company.

If the Medical Treatment is an Emergency and the Covered Person is thereby unable to contact and seek approval for the expenses from the Company, the Policyholder, the Insured, the Covered Person, the Insured's or the Covered Person's representative, or another person who can report the claim must contact and seek approval for those expenses from the Company as soon as it is practical so that the Hospital will promptly contact the Company. In addition, the Insured or the Covered Person must present his or her membership card and/or citizen identification card and/or any identification evidence to the Hospital at the time of admission.

18. **Submission of evidence to claim for benefits under the Policy**

To claim for the benefits under this Policy, the Policyholder, or the Covered Person, or his or her representative, as the case may be, must submit the following evidence to the Company at his or her own expense:

1. a form of claim for Medical Treatment or other benefits as prescribed by the Company,
2. an original medical certificate or medical report that specifies the significant symptoms, the diagnosis results, and the treatments, and
3. the original and copy of receipt listing expenses.

The foregoing evidence must be submitted within 30 days from the date of discharge from

a Hospital or medical center, or the date of treatment at a clinic. The receipt must be an original. The Company will return the original receipt, bearing the certification of the amount paid, to the Covered Person for use in a claim for a shortfall amount from another insurer. If the Covered Person is already compensated by government welfare or any other welfare, or other insurance, the Covered Person may submit a copy of the receipt bearing the certification of any amount paid by the government welfare or other agency in order to claim the shortfall amount from the Company.

Failure to submit the evidence within the prescribed time will be without prejudice to the right of claim, if it can be proven that the failure is justified and the evidence is submitted as soon as is practical.

19. **Payment of benefits**

The Company will pay the benefits and Reasonable and Customary Charges to the Policyholder or a Covered Person within 15 days from the date on which correct and complete evidence of damage is received by the Company. If the Covered Person dies, the Company will pay them to his or her beneficiaries.

If there are reasonable grounds for suspecting that a claim for benefits under the Policy is not made in accordance with the insuring agreements hereunder, the Company may extend the payment period as necessary, but to no more than 90 days from the date of its receipt of complete evidence of damage.

Benefits under this Policy will be paid in Thai currency. If the claimed compensation is in a foreign currency, the Company will pay benefits based on the exchange rate announced by the Bank of Thailand on the date specified in the receipt.

If the Company is unable to completely pay the benefits within the stipulated time, the Company is liable to pay interest at 15 percent per annum on an amount payable by it, as from the due date of payment thereof.

If the Policyholder or the Covered Person claims the benefits in a dishonest manner or in violation of the insuring agreements and/or attachments to this Policy, the Company will not pay them. If the Company has paid the benefits before that dishonesty or violation is discovered by it, the Company may demand that the benefits so paid be returned by the Policyholder, or the Covered Person, or his or her beneficiaries. The Company may also exercise its right as specified in clause 2, breach of the insurance agreement.

20. **Claim procedure**

The Policyholder or the Covered Person must report to the Company each claim that, in the knowledge of the Policyholder or the Covered Person, can be exercised against any third party, company, or entity.

20.1 If a claim can be exercised under another insurance policy, the Company will contribute to the payment of compensation no more than the ratable proportion of coverage under this Policy.

20.2 If a claim for compensation is exercised as a result of an act by a third party, the Company will pay benefits as specified in the schedule (or according to the ratable proportion of coverage under this Policy, if a claim can also be exercised under another policy). Furthermore, the Company has the right to exercise a claim, or file a lawsuit, against any party for its indemnification in the interest of the Company on behalf of the Policyholder or the Covered Person. In this regard:

20.2.1 the Policyholder or the Covered Person must report the Injury or Illness caused by a third party to the Company as soon as is practical, and the Company will send a form to the Policyholder or the Covered Person to declare the details, or

20.2.2 if the Policyholder or the Covered Person has not claimed compensation from any party, the Policyholder or the Covered Person must cooperate with the Company to enable the Company to recover the compensation advanced by it according to the benefits specified in the Policy, or

20.2.3 if the Policyholder or the Covered Person fails to reimburse expenses for Medical Treatment, including interest claimed from any party, to the Company, the Company, either through its employee, its agent or broker, or an outsourced agent engaged by it, has the right to recover these expenses from the Policyholder or the Covered Person.

21. **Condition precedent**

The Company may deny its liability under this insurance agreement, unless the Policyholder, the Insured, the Covered Persons, or their beneficiaries or representatives, fully observe and comply with the insurance agreement and the conditions of this Policy.

22. **Change of benefits and coverage**

The Policyholder and the Covered Persons may increase the benefits and coverage at the renewal of the Policy, provided a written notice of that change is given by the Policyholder to the Company, and the Company agrees to underwrite the insurance so changed.

The Policyholder and the Covered Persons must declare any Medical Conditions to the Company when requesting an increase of the benefits. If the Policyholder and the Covered Persons know of, or sustains, any Injury or Illness before the increase of the benefits and coverage, the Maximum Limit of benefits to be reimbursed for Medical Treatment of that Injury or Illness sustained before the increase will not exceed the original Maximum Limit before the increase.

23. **Addition or removal of Covered Persons during a Policy Year**

If the Policyholder wishes to add or remove Covered Persons during a Policy Year, the Covered Person may do so immediately by completing an insurance application as required by the Company, and submit it to the Company.

The Insured may add a newborn baby as a Covered Person under this Policy within 30 days from the date of the birth, provided that the benefits and coverage of the mother who is a Covered Person under this Policy remain in effect.

If the mother of a baby is not covered under this Policy, the coverage for the baby can be obtained when the baby is discharged from hospital.

Addition or removal of the Covered Persons will be effective when written notice of that addition or removal is given by the Policyholder to the Company, and the Company agrees thereto with the premium proportionately adjusted.

24. **Pre-existing Condition**

The Company will not pay benefits under this Policy for any Chronic disease, Injury, or Illness (including any complication) not yet fully cured before the date this Policy first comes into effect, unless:

24.1 the Covered Person has declared that condition to the Company, and the Company agrees in writing to accept that condition when the Company accepts the insurance application without excluding the coverage,

24.2 this Policy has been in effect for a continuous period of at least three years, and the Chronic disease, Injury, or Illness (including any complication) has not appeared, or has not been treated, or diagnosed by a Physician, or no consultation or advice has been sought from a Physician during five years before the date this Policy first comes into effect, which would have been sufficiently crucial for an ordinary person to seek diagnosis, care, or Medical Treatment by a

Physician, or for a Physician to provide diagnosis, care, or Medical Treatment.

25. **Change of Occupation**

If the Insured change his occupation, he will need to inform the Company. If the occupation is a declined risk, the Company will terminate the Policy and refund the premium to the Insured on a pro-rata basis as from the date of receiving such evidence of change. However, if there was a previous claim done within the Policy Year, no refund of premium will be provided.

Section 3: General Exclusions

This insurance does not cover any expenses arising from Medical Treatment, or damage arising from an Injury or Illness (including any complication), symptom, or irregularity, caused by:

1. a Pre-existing Conditions as defined, including any treatment and complication arising from the Pre-existing Condition, and its Associated Medical Conditions unless allowed for by the benefits table and accepted by the Company in writing;
2. Congenital disorders or congenital malformations or genetic disorders or developmental anomalies unless this Insurance Policy has been effective for not less than one year (1 year) and the symptom has become apparent after the Insured attain the age of 16 years.
3. treatment of physiological and/or all types of neurological development, cognitive development, developmental milestones, learning development problems or disorders, speech delays, educational problems, behavioural problems, physical development including assessment or grading of such problems
4. any beautification treatment or cosmetic Surgery, or treatment of skin problems, acne, blemish, freckle, dandruff, hair loss, weight control, liposuction or removal of fat deposits, or elective Surgery, except for reconstructive Surgery due to a covered Accident with the Company's written consent,
5. pregnancy, child birth, abortion, surrogacy (whether the Covered Person is acting as a surrogate or an intended parent), miscarriage (except due to an Accident), birth control, treatment of infertility or to promote conception (including medical investigation), sterilization or sterilization reversal, varicocele, impotence, or consequences thereof, circumcision, except due to Medical Necessity or as specified otherwise in this Policy,
6. Human Immunodeficiency Virus (HIV) infection, acquired immune deficiency syndrome (AIDS), venereal diseases, or sexually transmitted diseases,
7. treatment, prevention or the usage of drugs or substances for anti-ageing or giving of replacement hormone during climacteric or menopause, corporal imbecility in a female or male, treatment of sexual disorder, gender confirmation or transgender Surgery,
8. routine medical examinations, requests for admission to a Hospital or medical center, or requests for Surgery, convalescence, rehabilitation or rest cures, diagnosis for any cause not directly related to the admission in the Hospital, medical center, or clinic, except as specified otherwise in this Policy,
9. checks and treatment for abnormality of vision, Lasik, expenses for a vision-aid device or for treatment of abnormality of vision, except as specified otherwise in this Policy,
10. treatment or Surgery related to teeth or gums, dentures, crowns, root canal treatment fillings, orthodontics, polishing, extraction, or root implants except as necessary due to accidental Injury (excluding dentures, crowning, and root canal treatment or root implants), except as specified otherwise in this Policy,
11. treatment or therapy for drug addiction, smoking, alcoholism, or use of psychoactive substances,
12. treatment of symptoms or diseases related to mental disorders, psychiatric diseases, behavioral or personality disorders, including attention deficit disorder, autism, stress, eating disorders, or anxiety, except as specified otherwise in this Policy;
13. a treatment that is in a trial stage**,** that has not been established as being effective or which is Experimental or pioneering medical or any surgical techniques and medical devices not approved by the relevant authorities, government regulatory board, or the clinical trials for medicinal

products which the Covered Person chooses to receive even though usual, customary, and Conventional treatment for the condition is available. However, the Company will pay if, before the treatment begins, it is established that the treatment is recognized as appropriate by an authoritative medical body and the Company has agreed in writing, with the Physician, what the fees will be. For established treatment, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies

14. the use of a drug or any off-label drug which has not been established as being effective or has not been approved by Food and Drug Administration (FDA), or which is Experimental or within clinical trials, unless with the pre-approval in writing by the Company.

15. Robotic surgery except for prostatectomy, partial nephrectomy and pyeloplasty using the Da Vinci Robot.

16. treatment for all types of sleep disorder including sleep apnoea, sleep study test or snoring,

17. any inoculations or vaccinations (excluding rabies vaccination after an animal attack and tetanus vaccination after an Injury), except as specified otherwise in this Policy,

18. Treatment offering temporary relief of symptoms rather than dealing, when it is reasonable to do so, with the underlying condition, the prescription of medicine that does not immediately respond to or treat the Injury or Illness, or the diagnosis of Injury or Illness, or the treatment or diagnosis for cause that is not a Medical Necessity or in accordance with the Medical Standards, or is not directly related to the admission in the Hospital, medical center, or clinic,

19. a treatment by an approach that is not a modern approach, including an alternative medical approach, except as specified otherwise in this Policy,

20. expenses arising from Medical Treatment that a Covered Person, who is a Physician prescribes for himself or herself, including expenses arising from Medical Treatment by a Physician who is the Covered Person's employee, employer, business partners, or any person related by blood, marriage, or adoption to the Insured or Covered Person,

21. suicide, attempted suicide, self-inflicted Injury, or attempted self-inflicted Injury, whether by oneself or with the assistance of someone else, and while sane or insane, including an Accident caused by consumption or injection of a drug or poisonous substance, or drug overdose,

22. an Injury caused by the action of the Covered Person while under the influence of alcohol, addictive substances, or harmful narcotics to the extent of being unable to control one's mind. The term under the influence of alcohol means a blood alcohol level of 150 milligrams percent or more, according to the results of a blood test,

23. an Injury arising while the Covered Person is engaging in a brawl or fight, or taking part in inciting a brawl or fight,

24. an Injury arising while the Covered Person is committing an indictable felony, or is being arrested or is avoiding arrest,

25. any costs incurred as a result of any amateur or professional sports, engaging in, competing in or training for any sport for which the Covered Person receives a salary or monetary reimbursement, including grants or sponsorship (unless the Covered Person receives travel costs only).

26. an Injury sustained from playing professional sport or from taking part in dangerous sports or activities including but not limited to:

- racing of any kind (except foot racing),
- horse racing

- skiing of any kind including jet skiing
- base jumping, cliff diving,
- flying in an unlicensed aircraft,
- martial arts, boxing, free climbing, bouldering
- mountaineering with or without ropes,
- scuba diving to a depth of more than 10 meters, or to a depth of more than 30 metres if the Covered Person hold an appropriate diving qualification or the Covered Person is being instructed by an appropriately qualified diving instructor, for example an instructor recognised by PADI (Professional Association of Diving Instructors),
- any activity at a height of over 5,000 metres above sea level,
- trekking or mountain climbing to a height of over 2,500 meters above sea level,
- bungee jumping,
- Hangliding, wingsuit jumping
- paragliding or micro lighting,
- parachuting,
- potholing,
- any other winter sports activity carried out off piste.

27. an Injury arising while the Covered Person is embarking on or disembarking from, or traveling in, an aircraft not registered for carrying passengers and operated as a commercial aircraft,
28. an Injury arising while the Covered Person is piloting or acting as a crew member in any aircraft,
29. an Injury arising while the Covered Person serves as a soldier, policeman or policewoman, or a volunteer, and engages in war or crime suppression,
30. war, invasion, acts of foreign enemies, warlike operations (whether declared or not), civil war, which means a war fought by people living in the same country, uprising, insurrection, Terrorism Act, riot, strike, civil commotion, revolution, coup d'etat, proclamation of martial law, or any events that result in the proclamation or maintenance of martial law or criminal or illegal acts,
31. radiation or radioactivity from any nuclear fuel or nuclear refuse arising from the combustion of nuclear fuel or any process of self-sustaining nuclear fission or fusion, radioactive explosion, or any nuclear component or harmful substance that may cause an explosion in a nuclear process,
32. all kinds of orthotics and prostheses, such as a walking stick, eyeglasses, lenses, hearing aids, speech devices, heart pacemakers, medical devices and durable medical supplies, respirators, oxygen machines, vital sign monitors (pulse, blood pressure, body temperature), support aids, wheelchairs, prosthetic parts, i.e. artificial limbs and artificial eyes, except heart valves, skull or hip prostheses, and knee prostheses,
33. cosmetic products or toiletries such as, but not limited to shampoos, soaps, tooth-pastes, mouthwash, lotions, moisturizers, cleanser, shower gels, regardless whether Medically Necessary or prescribed by a Physician or acknowledged as having therapeutic effects; contraceptives, proprietary headache and cold cures, artificial tear drop/ gel, vitamins or minerals which may be bought over the counter, products classified as organic substances, vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary consultations and supplements, including, personal items such as but not limited to, telephone charges.
34. a treatment during 90 days after birth, for a child born from unnatural pregnancy or pregnancy by artificial insemination or any child conceived by assisted conception/ assisted pregnancy,
35. expenses arising while premium payments under the Policy have not yet been received,

36. treatment in a health hydro, spa, or nature cure clinic,
37. rehabilitation as an inpatient for a period in excess of 28 days,
38. cryopreservation, expenses for harvesting, acquiring and preserving organs or storage of stem cells as a preventive measure against possible disease/illness/injury; or any implantation or re-implantation of living cells or living tissue, whether autologous or provided by a donor unless this has been pre-approved and agreed by the Company in writing,
39. Medical Treatment received Outside the Area of Cover unless specified otherwise in this Policy, including travel against medical advice even if it is within the Area of Cover,
40. hormone replacement therapy unless there is a medical indication, excluding treatment of physical symptom. The Company will pay the cost of hormone implants or patches (excluding hormone tablets)
41. any natural catastrophic event, earthquakes, flood, volcanic eruption, landslide and other natural hazards or disasters or any similar event
42. microbial studies or genetic testing, including any counselling made necessary following the tests, even when those tests are undertaken to establish whether or not the Covered Person may be genetically disposed to the development of a medical condition in the future.
43. Treatment whilst staying in a hospital for more than ninety (90) continuous days for permanent neurological damage or if member is in a persistent vegetative state. Persistent vegetative state is defined as the condition of profound no responsiveness, with no sign of awareness or consciousness or a functioning mind, even if the person can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name, or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery.
44. artificial life maintenance including life support machine use, other than any benefit the Covered Person may be eligible for cover such as Hospice and Palliative care;
45. Treatment required as a result of negligence or malpractice. The Covered Person must take all reasonable steps to recover the loss from the third party or third-party insurer.
46. any treatment needed as a result of work related accident or injury where the cost of such treatment is recoverable under a Workman's Compensation policy or similar cover required by Government Act prevailing in the country where the work-related accident or injury took place or elsewhere at the time of injury or accident.
47. Treatment received in any sanctioned countries and any country with whom at the date of commencement of Treatment, the insurer or reinsurer has prohibited trade to the extent that payments are illegal under the applicable law.

Section 4: Insuring Agreement

While this Policy is in effect, subject to the conditions of the insuring agreements under this Policy, if a Covered Person sustains an Injury from an Accident or an Illness after the expiration of the waiting period causing him or her to receive Medical Treatment, the Company will compensate for the Reasonable and Customary Charges incurred thereby, in accordance with Medical Necessity and Medical Standards, as actually paid, but no more than the Maximum Limit as specified in the schedule for the insuring agreements set out below.

Insuring Agreement
Hospitalization and Surgery

Additional Definitions

Intensive Care Unit	means	a section within a Hospital that is designated as an Intensive Care Unit, and is maintained on a 24-hour basis for treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.
Surgical Operation	means	a Surgery arising during the treatment, which is not excluded under this Policy.
Minor Surgery	means	the use by a Covered Person of a medical facility for performance of a Minor Surgery planned in advance, but excluding an overnight stay in a Hospital according to the foregoing definition of an Inpatient.
Organ Transplantation	means	the transplantation of bone marrow, heart, lung, liver, pancreas, or kidney.
Day Surgery	means	a Major Surgery or procedure in lieu of Major Surgery or use of special treatment tool which can replace Major Surgery without the need of hospitalization as an Inpatient at the Hospital or Health Facility.
Daycare treatment	means	eligible Treatment at a hospital or day-care unit where the Covered Person needs a medically supervised recovery but does not occupy a bed overnight.

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident or an Illness to the extent that he or she needs to visit a Physician and, as diagnosed and advised by the Physician, must be treated in a Hospital as an Inpatient, or must receive Surgery as an outpatient without the need to stay overnight in the Hospital, the Company agrees to pay the benefits according to the expenses actually incurred, but not exceeding the Maximum Limit of benefits specified in the schedule, whichever is less.

For treatment that is not an emergency Medical Treatment, the Covered Person should check his or her entitlement to the coverage according to the conditions of the Policy with the Company before having treatment as an Inpatient, or a Surgery as an outpatient without the need to stay overnight in the Hospital. The Company will issue a written confirmation of the Reasonable and Customary Charges to the Hospital, with the details as specified below.

1. Room and board for a normal room and an Intensive Care Unit

Expenses for a single room with the lowest room rate, including meals and general nursing services, as well as expenses arising during the treatment in an Intensive Care Unit of the Hospital.

2. Miscellaneous expenses during the treatment in the Hospital, which includes:

2.1 medication and parenteral nutrition

2.2 blood transfusion services and blood components

2.3 ambulance service for medical emergency

2.4 laboratory tests, pathology, radiological test, other special diagnostics, and Physician's reading fees

2.5 medical equipment:

- medical tools and equipment outside the operating room
- medical consumables (medical supplies 1) and
- medical equipment or supplies that go inside the patient's body (medical supplies 3), except a defibrillator or pacemaker

2.6 physical therapy / occupational therapy:

physical therapy, occupational therapy, rehabilitation physician, or Physiotherapist, and essential facilities and equipment according to Medical Necessity, provided that the therapies are directly related and correlated the Injury or Illness

2.7 operating room and equipment:

operating room, operating equipment, facilities for anesthesia, observation room after Surgery, and staff in the operating room

2.8 anesthetists / anesthetic nurses:

physicians and nurses who perform anesthesia

2.9 surgical consultation fees where no Surgery is performed: Surgical consultation fees based on the actual amount

2.10 take home drugs:

take home drugs according to Medical Necessity and actual amount paid after the date of discharging from a Hospital or medical center and

2.11 emergency Medical Treatment:

expenses for emergency Medical Treatment due to an Injury within 24 hours after an Accident, after the first date of Medical Treatment for a Single Injury or Illness, not exceeding the actual amount paid.

3. Daycare treatment or procedures (not involving admission to a Hospital or medical clinic as an Inpatient)

4. Physician's bedside visit fees

Fees for Physician's daily bedside visits while the Covered Person is treated in a Hospital as an Inpatient.

5. Surgeon's fees

Fees for a Surgery performed by a surgeon, including surgeon's bedside visits and care after the Surgery.

6. Pre and Post-hospitalization Benefit

The Company will pay up to the benefit limit or Maximum Limit as specified in the schedule for consultation, prescribed investigations and essential medications by a Physician received as an Out-patient within 90 days prior to a hospitalization, where such hospitalization is eligible for cover under Covered Person’s Plan and where the need for such hospitalization has arisen as a direct result of the medical examination and investigation findings drawn from that consultation.

The Company will pay for follow-up Out-patient consultation and Medical Treatment following an eligible In-patient treatment or daycare surgery when such consultation is carried out by the in-patient treating Physician or a referred Physician and provided such consultation or treatment occurs within 90 days immediately following the date of discharge from hospital for which the member was confined as an in-patient or the date of the daycare surgery.

The maximum number of specialist consultations under this benefit shall not exceed the number of visits specified in the schedule per inpatient treatment, and shall be subject to the maximum benefit limit per Covered Persons as stated in the schedule.

<u>Exclusions</u> (applies to "Hospitalization and Surgery" Insuring Agreement)

This Policy does not cover benefits for any claims directly or indirectly arising from:

1. special nurse care, unless with the written consent of the Company and in accordance with the Medical Standards.

Insuring Agreement
Medical Treatment without Hospital Confinement (outpatient treatment)

Insuring Agreement

While this Policy is in effect and provided the benefits are available in the selected plan, if a Covered Person sustains an Injury from an Accident or an Illness that necessitates treatment by a Physician, the Company agrees to pay the benefits for Medical Treatment as an Outpatient to the Covered Person according to the actual amount or the benefit limit per year or per visit, but not exceeding the Maximum Limit according to the entitlement as specified in the schedule, whichever is less. This coverage includes the following.

1. Physician's fees

1.1 The Company will pay the benefits for Medical Treatment as an Outpatient to the Covered Person who is treated by a Physician as a result of a Single Injury or Illness, but no more than the actual amount paid or the Maximum Limit specified in the schedule, as well as for the diagnosis by a Physician in order to obtain a second opinion. However, the Covered Person must obtain the prior consent of the Company for each of the diagnoses to be sought for the purpose of obtaining opinions from subsequent Physicians.

1.2 Fees for other examinations and tests, such as a laboratory test, x-ray, or ultrasound.

1.3 Outpatient medication, provided that the cost of medicines prescribed for a period in excess of 30 days requires the prior consent of the Company.

2. Computerized tomography, such as magnetic resonance imaging (MRI), positron emission tomography (PET), or gait scan, provided that the service is received as an Outpatient.

3. Radiotherapy or chemotherapy received as an Outpatient under the supervision of a Physician.

Exclusions (appies to "Medical Treatment without Hospital Confinement (outpatient treatment)" Insuring Agreement)

This Policy does not cover any claims directly or indirectly from:

1. **Physical Therapy**
2. **Kidney Dialysis**
3. **Alternative Medicine**

Insuring Agreement
Loss of Life, Dismemberment, Loss of Sight, Loss of Hearing, Loss of Speech, or Permanent Disability from Accident (P.A.2)

Additional Definitions

Dismemberment	means	amputation of limb from the wrist or ankle, including the total loss of function of that part which, according to a clear medical indication, will be incapable of functioning again.
Loss of Sight	means	complete, permanently incurable, blindness.
Total Permanent Disability	means	disability to the extent of being unable to perform the normal duty in the Insured's regular occupation or any other occupation totally and permanently and such permanent disability prevent the Covered Person to perform 3 or more activities of daily living by himself/herself. Activities of Daily Living (ADL) means the ability to perform 6 types of daily self-care activities which is a term used in healthcare to assess the patient. The Activities of Daily Living consist of (1) The ability to move from chair to bed and vice versa without the help another person or equipment. (2) The ability to move from one room to another without the help of another person or equipment. (3) The ability to put on and take off clothes without the help of another person or equipment. (4) The ability to wash body in a bath or shower including the ability to get to and from the bathroom without the help of another person or equipment. (5) The ability to feed oneself without the help of another person or equipment. (6) The ability to get to and from the toilet, using it appropriately, and cleaning oneself without the help of another person or equipment.
Partial Permanent Disability	means	a disability that renders a permanent inability to perform any regular duties of one's own occupation, but does not prevent the engagement in other work for remuneration.

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident, causing him or her to die, or to suffer Dismemberment, Loss of Sight, loss of hearing, loss of speech, or Total Permanent Disability within 180 days from the date of the Accident, or if the Injury sustained by the Covered Person necessitates his or her continuous treatment as an inpatient in a Hospital and the Covered Person dies as a result of that Injury at any time, the Company will pay compensation as follows:

1.	100% of the sum insured	For loss of life
2.	100% of the sum insured	For Total Permanent Disability that continues for not less than 12 months after the Accident, or with a medical indication that the Covered Person will become a totally and permanently disabled person.
3.	100% of the sum insured	For the loss of both hands at or above the wrists, or the loss of both feet at or above the ankles, or the Loss of Sight of both eyes.
4.	100% of the sum insured	For the loss of one hand at or above the wrist and the loss of one foot at or above the ankle.
5.	100% of the sum insured	For the loss of one hand at or above the wrist and the Loss of Sight of one eye.
6.	100% of the sum insured	For the loss of one foot at or above the ankle and the Loss of Sight of one eye.
7.	60% of the sum insured	For the loss of one hand at or above the wrist.
8.	60% of the sum insured	For the loss of one foot at or above the ankle.
9.	60% of the sum insured	For the loss of sight of one eye.
10.	50% of the sum insured	For the loss of hearing in both ears or the loss of speech.
11.	15% of the sum insured	For the loss of hearing in one ear.
12.	25% of the sum insured	For the loss of a thumb (both phalanges).
13.	10% of the sum insured	For the loss of a thumb (one phalanx).
14.	10% of the sum insured	For the loss of an index finger (three phalanges).
15.	8% of the sum insured	For the loss of an index finger (two phalanges).
16.	4% of the sum insured	For the loss of an index finger (one phalanx).
17.	5% of the sum insured	For the loss of any finger (at least two phalanges) other than a thumb or an index finger.
18.	5% of the sum insured	For the loss of a big toe.
19.	1% of the sum insured	For the loss of any one toe (at least one phalanx) other than a big toe.

The Company will compensate for only one item of loss with the highest amount of compensation. In the case of a total permanent loss of a finger or toe under items 12 to 19, for which no compensation under items 1 to 9 is claimable, the Company will compensate for the respective items of the actual loss, provided that the aggregate amount of compensation will not exceed the insured sum as specified in the schedule.

In the case of a Partial Permanent Disability, other than the loss of taste or smell, for which no compensation as specified under items 2 to 19 is claimable, the Company will pay compensation according to the opinion of the Company's Physician, but no more than 50 percent of the insured sum specified in the schedule.

Throughout the insurance period, the aggregate amount of compensation paid by the Company for the consequences covered hereunder will not exceed the sum specified in the schedule. If the amount of compensation paid by the Company under this coverage agreement has not yet reached the full amount of the insured sum, the Company will provide coverage hereunder until the expiration of the insurance period, in accordance with the balance of the insured sum.

Claim for benefits for loss of life

The Policyholder or Insured, at their own expense, must submit the following evidence to the Company within 30 days from the death of the Covered Person:

1. a claim form as prescribed by the Company
2. a death certificate
3. a copy of the post-mortem report certified by the police officer in charge of the case or the agency issuing the report
4. a copy of the daily case report certified by the police officer in charge of the case
5. copies of the Covered Person's citizen identification card and house registration indicating the "deceased" status of the Covered Person and
6. copies of the beneficiary's citizen identification card and house registration.

Claim for Benefits for Total Permanent Disability, Dismemberment, Loss of Sight, loss of hearing, or loss of speech

The Covered Person, at his or her own expense, must submit the following evidence to the Company within 30 days after the date of a Physician's diagnosis that the Covered Person has suffered a Total Permanent Disability or Dismemberment:

1. a claim form as prescribed by the Company and
2. a medical report that confirms the Total Permanent Disability, Dismemberment, Loss of Sight, loss of hearing, or loss of speech.

Failure to submit the evidence within the prescribed time will be without prejudice to the right of claim, if it can be proven that the failure is justified and the evidence is submitted as soon as practical.

Section 5: Endorsement

While this Policy is in force and subject to general terms and conditions under the additional endorsement(s) attached to the Policy, if the Covered Person sustains injury from an Accident or Illness after the waiting period, which requires Medical Treatment, the Company will pay for the Customary and Reasonable Medical Charges, within the Medical Standards up to the actual expenses but not exceeding the Maximum Limit per Policy Year as stated in the schedule in respect of the additional endorsement, as follows:

Endorsement
Cremation or Funeral Expenses in case loss of life due to Injury or Illness

Additional Definitions:

Cremation or Funeral expenses	means	Related funeral expenses including coin, burial or cremation and other necessary expenses thereof. The Company will pay the beneficiary following the death of the Covered Person from injury or illness.

Coverage:

It is hereby agreed that during the effective period as stated in this endorsement while this Policy is in force and after the waiting period, this Policy is extended to provide cremation or funeral expenses in case loss of life due to injury or illness while this endorsement is in force. The Company will pay Cremation or Funeral expenses for funeral expenses or incurred expenses related to funeral ceremonies to the beneficiary subject to the sum insured as stated in the Policy Schedule provided that it is the actual expenses incurred and is currently reasonable and customary.

Additional Conditions (applies to "Cremation or Funeral Expenses in case loss of life due to injury or illness" Endorsement)

1. This endorsement has a waiting period of 180 (a hundred and eighty) days after the first inception date of this endorsement, if the Covered Person shall die due to illness within 180 (a hundred and eighty) days as from the first inception date of this endorsement, there will be no benefit for funeral expenses or incurred expenses related to funeral ceremonies under this endorsement but the Company will refund all premium applicable to this endorsement, with no deduction of expenditure, to the beneficiary.
2. If the Insured renews this endorsement within 30 (thirty) days from the expiry date, the Covered Person will be continuously covered for funeral expenses or incurred expenses related to funeral ceremonies in case of death. But if the Insured renews this endorsement after 30 (thirty) days from the expiry date, the counting of waiting period will be re-started in respect of the cremation or funeral expenses in case loss of life due to injury or illness extension if the Covered Person shall die due to illness.

Claims and Submission of Proof of Claims for Cremation or Funeral Expenses

The beneficiary must submit the following evidence to the Company within 30 (thirty) days as from the date of the Covered Person's death at the beneficiary's own expenses:

1. a death certificate.
2. a physician's report (in case loss of life due to illness).
3. a copy of autopsy report certified by local police in charge or concerned agency issuing the report (in case loss of life due to injury).
4. a copy of police report certified by local police in charge (in case loss of life due to injury).
5. a copy of the Covered Person's ID card and house registration duly stamped "death" on it.
6. a copy of the beneficiary's ID card and house registration.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede.

All other terms, conditions and exclusions remained unchanged.

Endorsement
Daily Compensation In case of No Claim Compensation

Coverage:

While this Policy is in effect and provided this benefit is available in the selected plan, after the expiration of a waiting period as specified in the Policy, the Company shall pay the daily compensation to the Covered Person covered under the Insurance Policy conditions when the Covered Person is confined for treatment in a Hospital due to illness or injury, provided that the Covered Person has received the state welfare or any other welfare or compensation from other insurance and has not claimed for the compensation from the Company.

1. When the Covered Person has been admitted as an inpatient due to illness or injury, the Company shall pay according to the number of days on which the Covered Person has been admitted as an inpatient but not exceed days and benefits per day as specified in the Policy Schedule

2. When the covered person becomes ill or sustains an injury that, under medical necessity, would normally require inpatient treatment through surgery or medical procedures, but due to advancements in medical technology such treatment can be performed without the need for hospitalization, the Company shall pay a daily compensation benefit for one (1) day for each such surgical or medical procedure, as specified below. This shall be deemed equivalent to the covered person having received inpatient treatment, in accordance with the coverage for daily compensation benefits.

1. Extracorporeal Shock Wave Lithotripsy (ESWL)
2. Coronary Angiogram / Cardiac Catheterization
3. Extra Capsular Cataract Extraction with Intra Ocular Lens
4. Laparoscopic Surgery (all types)
5. Endoscopic Examination (all types)
6. Sinus Operations or Sinus Puncture
7. Excision of Breast Mass
8. Bone Biopsy
9. Amputation of Fingers or Toes
10. Liver Puncture / Liver Aspiration
11. Bone Marrow Aspiration
12. Lumbar Puncture
13. Thoracentesis / Pleuracentesis / Thoracic Aspiration / Thoracic Paracentesis
14. Abdominal Paracentesis / Abdominal Tapping
15. Curettage, Dilatation & Curettage, Fractional Curettage
16. Colposcope, Loop Diathermy
17. Marsupialization of Bartholin's Cyst
18. Gamma Knife Treatment

The Company shall pay Daily Compensation In case of No Claim Compensation benefit under the terms specified above within Hospitalization and Surgery Insuring Agreement benefit. In cases where the covered person undergoes two or more treatments (whether as an inpatient or outpatient) for the same illness or cause, and each treatment occurs within an interval of no more than 90 days, such treatments shall be considered as a single course of treatment.

In any case, the insured person shall not be entitled to claim Daily for hospitalization on the same day for both normal room and intensive care unit.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede.

All other terms, conditions and exclusions remained unchanged.

Endorsement
Emergency Treatment Outside Area of Cover

Coverage:

While this Policy is in effect, the Company will cover charges for Emergency Inpatient Treatment which occur outside the Covered Person's Area of Cover up to the amount shown in the Table of Benefits. The Company will, in consultation with the treating Physician, retain the right to determine what constitutes as an Emergency treatment. The benefit coverage as provided under the specific plan in the schedule pays up to a maximum period of 90 day per trip (inclusive of the treatment days) and within the Maximum Limit which includes Inpatient Treatment required in the event of an Accident, or the sudden illness which presents an immediate threat to the Covered Person's health. Treatment by a Physician must commence within twenty-four (24) hours of the Emergency event.

Once the Company has determined, in conjunction with the treating Physician that the eligible Medical Condition is stabilized or the health status of the Covered Person allows him to travel back into his Area of Cover, the Company will stop paying for Emergency treatment.

The Insured is advised to contact the Company if the Covered Person is moving outside Area of Cover for more than 90 days.

Exclusion (applies to "Emergency Treatment Outside Area of Cover" Endorsement)

This Policy does not cover benefits for any claims directly or indirectly arising from:

1. any curative or follow-up non-emergency Treatment.
2. special nurse care, unless with the written consent of the Company and in accordance with the Medical Standards.
3. any charges which are incurred for social or domestic reasons or for reasons which are not directly connected with the Medical Treatment.
4. When the Covered Person is admitted as an Inpatient if these Medical Treatments are purely for the convenience of the Covered Person or the Physician and can be reasonably rendered in an Outpatient setting.
5. maternity, pregnancy, childbirth or any complications of pregnancy or childbirth.
6. Inpatient Hospice and Palliative Care.
7. Treatment for any Medical Condition if a Covered Person has travelled outside his Area of Cover to get treatment (whether or not that was the only reason) or for any Medical Treatment which was, or may have reasonably been known about, before travel commenced.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede.

All other terms, conditions and exclusions remained unchanged.

Endorsement
Outpatient Kidney Dialysis

Additional Definitions

1. Kidney Dialysis	means	End-Stage Renal Disease with permanent loss of ability of both kidneys to function normally which requires dialysis treatment on a regular basis. The treatment must be under the supervision of a licensed kidney specialist.

Coverage

While this Policy is in force and provided this benefit is available in the selected plan, after the expiration of a waiting period, if the Covered Person has actually incurred expenses for treatments which require the use of equipment or tools for kidney dialysis at a dialysis center in a hospital, clinic or medical center.

The Company will pay for the actual expenses incurred but not exceeding the maximum eligible limit as stated in the Schedule, whichever the lesser.

Exclusions (applies to "Outpatient Kidney Dialysis" Endorsement)
This Policy does not cover any claims directly or indirectly from:
1. Medical treatment is not carried out in a legally registered kidney dialysis center.
2. The service or treatment rendered including pharmaceutical is not related to the illness.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede.

All other terms, conditions and exclusions remained unchanged.

Endorsement
Health Check-Up

Coverage

While this Policy is in effect and provided this benefit is available in the selected plan, the Company will pay a health check-up benefit in a hospital, clinic or medical center according to the actual amount, but not exceeding the benefit limit specified in the schedule.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede.

All other terms, conditions and exclusions remained unchanged.

Endorsement
Vaccinations

Coverage

While this Policy is in effect and provided this benefit is available in the selected plan, the Company will pay Reasonable and Customary Charges for vaccinations received by the Covered Person, based on Medical Necessity, according to the actual amount, but not exceeding the Maximum Limit specified in the schedule.

Additional Exclusions (applies to "Vaccinations" Endorsement)

This endorsement does not cover benefits for any claims directly or indirectly arising from the cost of Inoculation and Vaccination whilst such medicines or vaccines is still being in a trial phase and / or has not been certified for registration by the Ministry of Public Health.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede.

All other terms, conditions and exclusions remained unchanged.

Endorsement
Dental Care Benefits

Additional Definitions

Dentistry means a practice done to human beings in relation to examination, diagnosis, curing, or treatment of teeth, organs related to teeth, dental organs, intraoral organs, jaw and maxillofacial bone, including surgical or any other procedures for the purpose of curing, restoring, and rehabilitating intraoral organs, jaw and maxillofacial bones, as well as intraoral dental services.

Coverage

While this Policy is in force and provided this benefit is available in the selected plan, this Policy will extend its dental care coverages and benefits.

The Company agrees to pay dental care benefits to the Covered Person for treatment performed by a Dentist as a result of an eligible dental disease, according to the actual expenses necessarily and reasonably incurred and not exceeding the benefit limit specified in the schedule.

This extended coverage covers for treatments below

1. teeth polishing and scaling
2. tooth fillings and restoration
3. oral examination
4. dental x-rays
5. dental extraction
6. root canal treatment
7. bridgework and crowns and
8. treatment of gum disease

Exclusions (applies to "Dental Care Benefits" Endorsement)

This benefit does not cover any claims directly or indirectly arising from:

1. expenses for mouth guards, gum shields, or any dental appliances
2. a treatment by means of burial of any artificial device, including oral preparation before burial of artificial device or before crowning
3. teeth whitening and orthodontics
4. a request for treatment or dental Surgery that is not advised by a Dentist, any medical service not necessary for a treatment, including any treatment or cosmetic Dentistry for beauty only, and not for restoration of normal function of organs or for oral hygiene
5. a treatment by a specialist, that is not a Dentistry performed by a general Dentist
6. wisdom teeth extraction other than the extraction due to a Surgery
7. treatment, repair, or any Dentistry services relating to tooth jewellery
8. Dentistry treatment due to damage or an Injury arising from playing, training, or competing in contact and collision sports, such as boxing, martial arts, rugby, American football, hockey, or lacrosse, unless mouth protection is worn according to the type of the sports or sporting activity
9. expenses for all kinds of orthotics and prostheses, including dentures or any dental prosthetics.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will prevail.

All other terms, conditions and exclusions remained unchanged.

Endorsement
Optical Care Benefits

Additional Definitions

Ophthalmologist means a person (other than the Covered Person, or his or her family member) who is duly registered with the Medical Council, and is licensed to practice the ophthalmology profession in the locality in which the services are provided

Coverage

While this Policy is in force and provided this benefit is available in the selected plan, the foregoing Policy will extend its optical care coverages and benefits.

The Company agrees to pay benefits according to the actual expenses necessarily and reasonably incurred, but not more than the benefit limit specified in the schedule, for an eye examination, visual acuity test, eyeglasses, and corrective spectacle lenses, performed and prescribed by an Ophthalmologist.

Exclusions (applies to "Optical Care Benefits" Endorsement)

This benefit does not cover any claims directly or indirectly arising from:

1. cost of tinted lenses, sunglasses, non-corrective contact lenses, irrespective of whether they are prescribed by an Ophthalmologist or
2. Lasik or any similar treatment.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will prevail.

All other terms, conditions and exclusions remained unchanged

AXA Group Health and Accident Insurance Policy
SME Package

Definitions

1.	**Area of Cover**	means	1. **Thailand** 2. **Asia** means, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, and Vietnam 3. **Worldwide excluding the USA** means, all countries around the world except the USA and its surrounding islands and 4. **Worldwide** means, all countries around the world.
2.	**Outside Area of Cover**	means	the coverage that is provided only for Emergency Medical Treatment not arising during travel undertaken directly for securing Medical Treatment, or that is prepared while a Covered Person travels out of the Area of Cover.
3.	**Emergency**	means	a sudden, serious, and unforeseen acute Medical Condition or injury requiring immediate medical treatment, that without treatment commencing within twenty-four (24) hours of the emergency event could result in death or serious impairment of bodily function.
4.	**Main Country of Residence**	means	the country in which a Covered Person resides for more than 185 days per year, that is specified as his or her address in the Policy.
5.	**Congenital Condition**	means	all kinds of congenital abnormalities, including physical anomalies happening during six months from birth, that are categorized as congenital malformations by the World Health Organization, and deformations or genetic abnormalities, including all kinds of hernia or epilepsy, except epilepsy caused by an Injury after the Covered Person has obtained the insurance.
6.	**Chronic Condition**	means	a Medical Condition or Illness that is persistent and lasting, or continues indefinitely, as diagnosed and concluded by a Physician.
7.	**Medical Standards**	means	the international medical basis or guidelines that give rise to an appropriate course of treatment for a patient, according to Medical Necessity and consistent with conclusions drawn from Injury records, findings, diagnosis results or any other reason.
8.	**Medical Necessity**	means	any eligible Treatment, test, medication, or stay in Hospital or part of a stay in Hospital which: • is not being undertaken for the convenience of the Insured, the treating Physician, Hospital or clinic; and • is required for the diagnosis, direct Treatment and medical management of an eligible Medical Condition suffered by the

			Insured as prescribed by his Physician; and • must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity; and • must conform to the professional Medical Standards widely accepted; and • shall be considered and approved by the Insurer and their medical advisors as the most appropriate, cost effective, Conventional Treatment and not of an Experimental, investigational, research or preventive nature.
9.	**Reasonable and Customary Charges**	means	any medical expenses and/or reasonable costs comparing to those charged to general patients for services provided by a Hospital, or medical center or clinic where a Covered Person is treated. For the avoidance of doubt when comparing treatment, the Company will take into account the complexity of the procedure and the standard of the medical facility where the treatment is received.
10.	**Medical Condition**	means	any disease, Injury, Illness, including mental Illness, that has been diagnosed and concluded by a Physician.
11.	**Pre-existing Condition**	means	any Medical Condition preceding the Policy Commencement Date, or plan upgrade date, whichever date is later: • for which the Covered Person has been diagnosed; or, • for which the Covered Person has sought or received medication, advice, or Treatment, or, • which the Covered Person should reasonably, based on the Company's independent appointed Physician's opinion, have known about, or, • for which the Covered Person have experienced symptoms even if the Covered Person has not consulted a Physician or was not diagnosed before the start of the cover.
12.	**Associated Medical Condition**	means	any symptom, disease, injury, or illness that is: • a medical condition caused by or related to directly or indirectly to a Pre-existing condition; or • a medical condition in which the underlying condition (disease, injury, or illness) is generally known to be same with the underlying disease that cause a Pre-existing condition; or • a risk factor that is generally or directly known to be a medical condition that may cause or is arising from a medical condition that may cause pre-existing condition.

General Conditions

Incontestability

The Company will not contest or challenge the validity of this insurance agreement if the Policy has been in effect for a period of two years or more from the date the Policy comes into effect or the date of the Company's approval of additional benefits under this Insurance Agreement, whichever happens later, except in the case of default of premium payment. However, upon the approval of additional benefits, the Company may dispute or object to the incompleteness of this Insurance Policy regarding such additional benefits only.

If the Company becomes aware of any information based upon which the agreement can be nullified, but does not exercise its right of nullification within one month from the date that information is known to the Company, the Company may no longer nullify the validity of the agreement on these grounds.

Governing law

This Policy is governed by, and interpreted in accordance with, the laws of Thailand. The Policyholder and/or the Covered Persons agree that Thai law is the exclusive law for settling all disputes arising from or in connection with this Policy.

Termination of coverage

1. This Policy will automatically terminate upon the occurrence of any of the following events:

1.1 The Policyholder or the Insured fails to pay a premium as specified in clause 6, premium payment and commencement of coverage, of the general conditions.

1.2 On the expiration date of the coverage as specified in the schedule at midnight, Thailand time in the Policy Year when the Insured is 99 years of age.

1.3 On the date either party exercises its right to terminate the Policy according to clause 14, termination of the Policy, of the general conditions.

2. The coverage of each of the Insured will automatically terminate upon the occurrence of any of the following events:

2.1 On the date the Insured retires or resigns. The Company will return the premium to the Policyholder or the Insured after deducting a proportionate amount thereof for the period during which this Policy is in effect. If the Company has paid compensation under the Policy during that Policy Year, no premium will be returned.

2.2 When the Insured dies due to an illness. The Company will return the premium to the Policyholder and/or the beneficiaries after deducting a proportionate amount thereof for the period during which this Policy is in effect, provided no claims was paid out for that Policy Year.

2.3 On the expiration date of the coverage at midnight, Thailand time, as specified in the schedule, provided that the Company has refused renewal of the Policy for the respective Insured by sending a written notice to the Policyholder at least thirty (30) days before the expiration of the Policy, to the last known address or email address.

2.4 On the date of expiration or termination of employment of the Insured. The Company will return the premium to the Policyholder or the Insured after deducting a proportionate amount thereof for the period during which this Policy is in effect. If the Company has paid compensation under the Policy during that Policy Year, no premium will be returned.

3. The coverage of each of the eligible Dependents will automatically terminate upon the occurrence of any of the following events:

3.1 On the anniversary of a Policy Year, when the Dependent ceases to be a Dependent as defined herein.

3.2 When the Dependent dies due to an illness. The Company will return the premium to the Insured or the beneficiaries after deducting a proportionate amount thereof for the period during which this Policy is in effect.

3.3 When the coverage for the Insured comes to an end according to the conditions in clause 2 The Company will return the premium to the Policyholder, or the Insured, or the beneficiaries, after deducting a proportionate amount thereof for the period during which this Policy is in effect. If the Company has paid compensation under the Policy during that Policy Year, no premium will be returned.

3.4 When the Insured ceases to be an Insured as defined herein.

The coverage under each of the insuring agreements and/or attachments will terminate when the compensation paid by the Company reaches the maximum benefit limit specified herein.

Submission of evidence to claim for benefits under the Policy

To claim for the benefits under this Policy, the Policyholder, or the Covered Person, or his or her representative, as the case may be, must submit the following evidence to the Company at his or her own expense:

1. a form of claim for Medical Treatment or other benefits as prescribed by the Company,
2. an original medical certificate or medical report that specifies the significant symptoms, the diagnosis results, and the treatments, and
3. the original and copy of receipt listing expenses.

The foregoing evidence must be submitted within 30 days from the date of discharge from a Hospital or medical center, or the date of treatment at a clinic. The receipt must be an original. The Company will return the original receipt, bearing the certification of the amount paid, to the Covered Person for use in a claim for a shortfall amount from another insurer. If the Covered Person is already compensated by government welfare or any other welfare, or other insurance, the Covered Person may submit a copy of the receipt bearing the certification of any amount paid by the government welfare or other agency in order to claim the shortfall amount from the Company.

Failure to submit the evidence within the prescribed time will be without prejudice to the right of claim, if it can be proven that the failure is justified and the evidence is submitted as soon as is practical.

General Exclusions

Described in this Insurance Policy such as congenital disorders, treatment under trial, fertility and infertility treatment (including investigation and treatment), convalescence or rest for rehabilitation or rest cure, and so on and any exclusions or non-coverage as indicated in each coverage agreement.

Insuring Agreement

1. Hospitalization and Surgery
2. Medical Treatment without Hospital Confinement (outpatient treatment)
3. Loss of Life, Dismemberment, Loss of Sight, Loss of Hearing, Loss of Speech, or Permanent Disability from Accident (PA.2)

Endorsement

1. Cremation or Funeral Expenses in case loss of life due to Injury or Illness
2. Daily Compensation In case of No Claim Compensation
3. Emergency Treatment Outside Area of Cover
4. Outpatient Kidney Dialysis
5. Health Check-Up
6. Vaccinations
7. Dental Care Benefit
8. Optical Care Benefit

Remark

This document only serves as a summary of important information. Full details of general conditions, insuring agreements and exclusions of the Insurance Policy is to follow the Policy Wording for Axa Group Health and Accident Insurance Policy which has been approved by the Office of Insurance Commission (OIC). The Company has the right to select coverages/ endorsement for product packaging.

This document is a summary of essences and some parts of coverage condition and exclusions only

Policy carefully read and understand all details in this Insurance Policy

Contact our Agent / broker

Contact us

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