Allianz Insurance Lanka Ltd.
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ALLIANZ GLOBAL HEALTHCARE POLICY

CONTENTS

PREAMBLE

Whereas the insured named in the Schedule being desirous of insuring in the manner, hereinafter mentioned as ALLIANZ INSURANCE LANKA LTD (hereinafter called the company) the persons named in the schedule as the lives insured (hereinafter individually referred to as "Insured", whose Agent the insured shall be deemed to be for the purpose of this policy), has by a Proposal and Declaration which together with any other statement in writing relating to this insurance made by the Insured shall be the basis of this contract and be deemed to be incorporated herein, and as the insured has paid to or agreed to pay to the company the required premium as the consideration for this insurance, this Policy witnesses that if during the period of insurance any Insured shall contract sickness, which is contracted and begins after this policy has been in force for not less than thirty (30) days or sustain accidental bodily injury, after the policy has been in force, which injury or sickness shall necessitate medical and surgical treatment as hereinafter defined, the company will be subject to the terms, limits, provisions, exceptions and conditions of or endorsed on this policy pay to the insured and indemnify in respect of any of the various expenses listed in the following table of benefits, which are recommended and approved by a Physician / Specialist.

Anura Perera
Chief Underwriting Officer

Table of Benefits

Table of benefit show the eligible benefits according to the different plans offered under this Policy. These benefits unless otherwise stated are expressed per Year, per Insured Person and subject to contractual limits.

ALLIANZ GLOBAL HEALTHCARE BENEFIT TABLE

Benefit Description	Classic Plan	Gold Plan
Geographical coverage	Singapore, Malaysia, Thailand, Sri Lanka & India	Worldwide excluding USA/Canada
Overall maximum benefits	**USD 800,000**	**USD 1,000,000**
In-Hospital accommodation	Standard Private Room	Standard Private Room
In-Hospital Surgery, Treatment Facilities and Services	In full	In full
Cancer Treatment (Inpatient and Outpatient)	In full	In full
Kidney Dialysis (Inpatient and Outpatient)	In full	In full
Prescription Drugs and Material	In full	In full
Physician, Surgeon and Anesthetist Fees	In full	In full
Surgical Appliances and Prostheses	In full	In full
Physiotherapy Treatment (Inpatient Only)	In full	In full
Psychiatric Treatment (Inpatient Only) Sublimit Per Year	USD 5,000	USD 10,000
Day Surgery	In full	In full
Casualty Ward Accident and Emergency Services	In full	In full
Local Ambulance Services	In full	In full
Accidental Dental Treatment	In full	In full
Pre-Hospital Specialist and Diagnostic Services - Up to 60 days	In full	In full
Post Hospital Follow-Up Treatment - Up to 90 days	In full	In full
COVID - 19 Cover	In full	In full
Government Hospitalization Cover		
Daily Hospital Cash Per Night For Non-Paying Patient (Up To Max 30 Days For Hospitalisation)	USD 200 Per Day	USD 200 Per Day
Emergency medical evacuation and repatriation cover overseas		
Medical Evacuation and Repatriation	In full	In full
Repatriation Of Mortal Remains	In full	In full
Compassionate Travel (Cost of Economy Air Ticket and Accommodation, Subject to Approval)	In full	In full
Cost of Economy Air Tickets for Insured Patient Due To Repatriation Per Travel	USD 1,000	USD 1,200
Maternity (Waiting period 12 months)		
Cost of Normal Delivery and Medical Recommended Caesarean/Forceps Delivery Per Policy Year	Nil	USD 1,000

Other Benefits		
Hospital accommodation for accompanying parent (for insured child below age 18)	In full	In full
Home nursing care following discharge from hospital (up to max 24 weeks per policy year)	Nil	In full
Organ Transplant Operation costs for kidney, heart, liver, lung and bone marrow transplants (Excluding costs of obtaining donor agencies per policy year)	USD 200,000	In full
Test prescribe by a Physician (Outpatient benefit) PET, CT and MRI scans provided by or prescribed by a physician per policy year	USD 1,500	USD 2,500

Compulsory Co - Payment for Overseas Treatments	Co – Payment (Excess)
Insured above the age of 60 years	10%
Insured above the age of 70 years	20%

COVERAGE

1. *HOSPITAL AND RELATED SERVICE*

Hospital Treatment and Services

All necessary medical and surgical treatments and services provided on the order of a physician to the insured person when admitted as a registered in-patient to a hospital.

Cover includes hospital accommodation (the cost of a standard private class single-bed airconditioned room), meal charges, general nursing services, diagnostic, laboratory or other medically necessary facilities and services, physician's / surgeon's / anaesthetist's or physiotherapist's fees, operating theatre charges, intensive care unit charges, specialist consultation or visits and all drug, dressings or medications prescribed by the treating physician for in-hospital use. We do not pay for the costs of non-medical goods or services such as telephone, television and newspapers.

Cancer Treatment

Charges for treatment of an insured person for cancer irrespective of whether such treatment is received as a registered in-patient or as an outpatient at a registered cancer treatment centre.

Kidney Dialysis Treatment

Charges for treatment of an insured person for kidney dialysis irrespective of whether such treatment is received as a registered in-patient or as an outpatient at a legally registered dialysis centre.

Physiotherapy Treatment

Charges for physiotherapy treatment which is received as a registered in-patient at a hospital. -

Psychiatric Treatment

We will pay for the costs of psychiatric treatment received as an in-patient in a psychiatric unit of a hospital after the insured person has been insured under this policy for a continuous period of 10 months. All treatment must be administered under the direct control of a registered psychiatrist.

Day Surgery

The cover provided by the hospital treatment and services is extended to include day surgery. Day surgery means all surgical procedures and related treatment provided on the order of a physician to the insured person at a hospital. We do not pay for non-surgical procedures and related treatment.

Casualty Ward Accident and Emergency Services

Services provided to the insured person as an out-patient in a hospital casualty ward immediately following an emergency medical illness or accident.

Pre-Hospital Specialist and Diagnostic Services

Charges by specialist and laboratory, X-ray or other medically necessary diagnostic procedures recommended by a physician and carried out within 60 days of recommendation result in the insured person being admitted as a registered in-patient to a hospital for the treatment of the specific medical condition diagnosed, provided that such medical condition is covered by the policy.

Post Hospital Follow-Up Treatment

The medically necessary follow up treatment recommended by a physician to be rendered for up to 90 days from the insured person's discharge from the hospital for any one illness or disability. Cover is restricted to follow-up treatment of the specific medical condition for which the insured person was subjected at the hospital.

Local Ambulance Services

Cover extends to include local transportation of the insured person between airports and/or home and/or hospitals by taxi or other suitable modes of transport for the purpose of receiving hospital treatment covered by the policy. For the purpose of this clause, "local" means within the country in which the insured person is in when he requires the service.

Accidental Dental Treatment

Dental treatment required to restore or replace sound natural teeth lost or damaged in an accident for which the treatment was received within 14 days following the accident.

Daily Hospital Cash

For a non-paying in patient, where the treatment received is free of charge and covered within the terms of this policy, daily hospital cash benefits up to the sub-limits stated in the benefits schedule for a maximum of 30 days per disability shall be paid.

2. *ORGAN TRANSPLANTATION*

The cost of operation for the transplantation of the kidneys, heart, liver, lungs or bone marrow where the insured person is the recipient shall be paid. We do not pay for the costs of acquiring the organ or expenses incurred by the donor. No other type of benefits insured by the policy provides cover in connection with organ transplantation.

3. *EMERGENCY MEDICAL EVACUATION AND REPATRIATION*

This benefit applies while you are travelling:

a) Within the home country but excluding war zones and countries where the prevailing conditions render evacuation impracticable.

The company and its medial advisers reserve the absolute right to decide whether the insured person's medical condition is sufficiently serious to warrant emergency medical evacuation and/or repatriation. The company or its medical advisers shall also decide where and how the insured person shall be evacuated after considering all facts and circumstances of which the company is aware at the relevant time.

A) *Emergency Medical Evacuation and Assistance*

The cover under this benefits clause 3A is defined as;

i. Emergency Medical Evacuation

We will only pay for evacuation or repatriation arrangements provided that it is prior approved and authorized by our 24-hour emergency assistance centre.

We will pay in full, the cost of transportation for the insured person to be evacuated for in-patient treatment,

a) only if the treatment is covered under the policy.

b) is recommended by the doctor concerned.

c) is not available locally

This must be approved in advance by the 24-hour emergency assistance centre. The insured person must provide us with any information or proof that we may reasonably ask to support the request.

We will only pay for the evacuation of the person requiring the treatment to the nearest place where the treatment is available. Please note that the nearest country may not be your home country.

ii. Compassionate travel

We will only pay the expenses, up to the cost of one economy class return airfare and all ancillary charges including accommodation, for a family member to join an insured person who becomes seriously ill while travelling alone outside the home country, as long as;

a) the insured person has been or will be hospitalized in a hospital for a period of more than 7 days with our prior approval.

b) we or our medical advisers consider it necessary on medical grounds and/or to avoid the need for medical evacuation.

iii. Return of Minor Children

The expenses, up to the cost of economy class one-way airfares and usual ancillary charges, to return children who are left unattended to the home country as a result of the accompanying adult insured person's accident., illness, death, hospitalization or medical evacuation covered by the policy.

iv. Dispatch of Medicines

The expenses incurred on the order of the company or its medical advisers to replace essential medical commodities for an insured person travelling outside the home country in circumstances where such commodities have been lost or stolen and no suitable replacements of substitutes are available locally.

B) Repatriation

The cover under this benefits clause 3B is defined as;

i. Repatriation, Travel or Accommodation Expenses

We will pay the expenses necessarily and unavoidably incurred in returning the insured person to the home country following emergency medical evacuation provided that such additional costs are medically necessary and approved in advance by us or our medical advisers. We will also pay reasonable transportation costs for one other person to travel or remain with the insured person during evacuation only if it is considered necessary for medical reasons. We only pay for one repatriation per illness or injury.

ii. Repatriation or Local burial of mortal remains

We will pay the expenses of preparation and air transportation of the mortal remains of an insured person from the place of death to the home country, or the preparation and local burial of the mortal remains of an insured person who dies outside the home country. Within the stipulated policy limit for the benefits, cover includes the cost of a single, economy class airfare for one family member accompanying the body back to the home country.
For the purpose of this clause "Local" means within the country where the insured person died.

C) *Emergency Medical Advice and Assistance*

In emergencies, the insured person may call our 24 hour emergency assistance centre. at any time for medical advice and evaluation from the attending coordinator or doctor in order to locate suitable medical services anywhere in the world or to provide referral to physician or hospitals for personal assessment and/or treatment as medically appropriate. The insured person must understand and agree that such telephone conversations mentioned above cannot establish a diagnosis and must be considered as an advice only.

The emergency assistance center will as far as it is reasonably possible facilitate necessary hospital admission by confirming the extent of insurance cover, monitoring claim procedures and issuing appropriate guarantees in accordance with the payment guarantee condition of this policy.

D) *International Travel Assistant Services*

While the insured person is travelling, the 24-hour emergency assistance centre, can provide the following administrative assistance and services.

- Pre-trip information
- Services -Embassy referral
- Weather and exchange rate information assistance
- Emergency message transmission assistance
- Arrangement of hotel accommodation in case of an emergency
- Interpreter referral
- Lost luggage assistance
- Lost passport assistance

Please note that any third-party fees of charges reasonably and properly incurred by the company in the delivery of these services must be borne entirely by the insured person.

4. *MATERNITY BENEFIT*

We will pay for the medical expenses up to the sub limit stated in the schedule, provided that the insured person being covered under the plan for a minimum period of 12 months before incurring medical expenses.

Medical expenses include ante-natal care such ultrasound scans, hospital charges, obstetrician's and midwife's fees for childbirth, post-natal care required by the mother immediately following childbirth, secondary conditions brought about by pregnancy such as backache, high blood pressure, vaginal bleeding, nausea and vomiting.

Cover provided under this benefit is further extended to include,

a) charges for surgery and related medical care for caesarean section which is non-elective and the need for the surgery has to be certified by a physician in writing that a natural delivery will

endanger the life of the insured person and/or her child(ren).

b) charges for surgery and related care for the treatment for extra-uterine pregnancy or complication requiring intra- abdominal surgery after necessary termination of pregnancy for medical reasons.

c) charges for other necessary care which is provided during hospitalization for pernicious vomiting in pregnancy, toxaemia with convulsion or spontaneous abortion.

d) miscarriage, ectopic pregnancy and stillbirth.

No other type of benefit insured by the policy (except for emergency medical evacuation services) provides any cover for expenses incurred in connection with maternity or childbirth.

5. *OTHER BENEFITS*

Hospital Accommodation for Accompanying Parent of Insured Child

Accommodation charges incurred by one parent sharing the hospital room of an insured child under 18 years old, where the latter is treated for illness or injury at a hospital, as an in-patient for a period on the recommendation in writing by the treating physician.

Home Nursing Following Hospitalization

Following discharge from hospital, cost of a full time or part-time services of a state registered or government-licensed nurse in the insured person's home as long as all of the following apply;

a) Continuous treatment of the specific medical condition for which the insured person was hospitalized has to be recommended by a physician.

b) It is essential for medical as distinct from domestic reasons.

Cover is limited to a maximum period of 24 weeks for any one claim or event in any one policy year.

Test Prescribe by A Physician (Outpatient Benefit)

The Company will pay for the costs of Computerized Tomography (CT), Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET), provided by or prescribed by a physician to diagnose or assess the Insured Person's Medical Condition.

KEY DEFINITIONS

The following words or terms will have the meaning described below wherever they appear in this Policy, and reference to the singular will include the plural wherever the context so permits:

The company, we, our, us

Means Allianz Insurance Lanka Ltd

You, Your

Means the insured

Family Member

Means an Insured Person's legal spouse; children; parents; legal guardian, step-parents; who reside in Sri Lanka.

Accident

Means bodily injury caused solely by violent, accidental, external and visible means and not by sickness, disease or gradual physical or mental process.

Co-Payment (Excess)

Means the amount stated in the schedule of Benefits, which will be borne by the Insured in respect of each and every claim made under this policy. You may buy-back the cover with a payment of an additional premium.

Application Form

Means the forms you signed to apply for this policy from us, including any written statement, representation or document given to the company which contains information we relied on this policy.

Domicile

Domicile is a place you state as your permanent home, as set out in the application/proposal form and you are bound by the laws, benefits and taxes that apply to you.

Approved Hospitals

Means a hospital approved by the company to provide treatment for which a benefit may be payable under the policy.

Area of Cover

Means the countries in which the insured person will be covered as per the geographical coverage specified in the selected plan.

Due Date

Means the date of commencement or renewal of cover as shown on the schedule or the date on which any subsequent, annual payment or premium falls due.

Emergency medical complaint

Means a medical condition resulting from an accident or any sudden beginning or worsening of a

severe illness that,

a) presents an immediate and serious threat to the insured person's health and
b) requires immediate medical attention by a physician.

Home country

This is the country where you are permanently residing and the country to which you will return to if you wish to make a claim for repatriation.

The home country of your dependents will be deemed to be the same home country of the insured person.

Home country cover

Means insurance cover provided by the insured person's home country.

Hospital

Means an institution which is legally licensed as a medical or surgical hospital in the country in which it is located. It must be under the constant supervision of a physician. This does not include any entity which is primarily a place for alcoholics or drug addicts, a nursing, rest or convalescent home for the aged or any other similar establishment.

In-patient

Means a person admitted to hospital for treatment and for which the hospital makes a daily room and board charge. It also includes admission of any duration for the purpose of surgery and any preparation and procedure in connection with the surgery without incurring in any room and board charge.

Insured

Means the policy holder named as insured in the policy schedule.

Insured Person

Means an individual or his dependent whose name is included on an application form for the policy and in respect of whom the cover has been confirmed in writing by us.

Physician

Means a person who is legally qualified in medical practice following attendance at a recognized medical school, to provide medical treatment and licensed by the competent medical authorities of the country in which treatment is provided but who should not be the insured person or a relative, sibling, spouse, child, parent of the insured person.

Policy Year

Means a period of 12 months starting from original inception (Start) date for this policy and each consecutive 12 months period for which this policy is renewed.

Pre-Existing Conditions

Means any injury, illness, condition of symptom

a) for which treatment, or medication, or advise, or diagnosis, has been sought or received or was foreseeable by you or insured person prior to the commencement of the policy.

Or

b) which originated or was known to exist by you or the insured person prior to the commencement of the policy whether or not treatment, or medication, or advise, or diagnosis was sought or received.

Reasonable and customary charges

Means charges for medical care which we or our medical advisers consider to be reasonable and customary if they are within general level of charges being made by other care providers of similar standing in the locality where the charges are incurred when giving like or comparable treatment, services or supplies to an individual of the same gender of comparable age for a similar disease or injury.

Schedule

The schedule to this policy headed "Policy schedule" which sets out key terms like the name of the policyholder, the insured persons, the benefits and the policy limits.

Serious Medical Condition

Means, for the purpose of interpreting emergency medical evacuation cover, a condition which in the option of the company or it's authorized representatives constitutes a serious or life- threatening medical emergency requiring immediate evacuation to obtain urgent remedial treatment in order to avoid death or serious impairment to an insured person's immediate or long term health prospects. Unless agreed otherwise by the company it does not mean any circumstances in which the insured person is capable of travelling without a medical escort. The seriousness of the medical condition will be judged within the context of the inured person's geographical location and the local availability of appropriate medical care or facilities.

Specialist

Means qualified and licensed physician, possessing the necessary additional qualification and expertise to practice as a recognized specialist of diagnostic techniques, treatment and prevention, in a particular field of medicine like psychiatry, neurology, pediatrics, endocrinology, obstetrics, gynaecology, dermatology, etc.

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Waiting period

Means the period(s) of time (specified in the schedule) from the original inception (start) date of the policy during which this policy does not cover any treatment made necessary by any cause.

Premium

The insurance premium of the cover is determined by two factors, i.e. the age of the insured and claims under the cover. The premium is subject to annual increase of premium on age based technical pricing and on recurring claims of the insured (claim loading).

CONDITIONS

It is important part of our contract that you observe the following general conditions.

1. *Eligibility*

Unless agreed otherwise in writing by the company, the maximum age for first enrolment in the policy is 60 years and cover shall continue thereafter unless otherwise, the policy is cancelled or discontinued.

Newly born children at least 15 days or after discharge from the hospital where birth took place, whichever is later shall be eligible for insurance.

Applicants who are not eligible may not be enrolled in the policy, and no cover is in force until confirmed by the issue of a policy by the company.

2. *Geographical scope*

2.1 Area Of Cover

This policy covers you in the area of cover as stated in the policy schedule on a twenty-four (24) hour basis.

2.2 Home Country Cover

This policy covers the insured person domiciled in Sri Lanka

3. *Co-ordinating of benefits*

The policy will only provide compensation on a proportionate basis if the insured person has any other insurance in force or it entitled to indemnity from any other source in respect on the same accident, illness, death or expense.

4. *Co-operation*

We will have no liability under this policy unless the insured person or his/her representative complies with all of the followings;

a) Co-operate fully with us and our medical advisers and

b) Fully and faithfully disclose all material facts and matters which the insured person knows or ought to know and

c) Upon our request sign any document to empower the company to obtain relevant information at the insured person's expense, from any doctor or hospital or other source.

5. *Material changes*

We must be informed immediately in writing of any material change of information or circumstances whether relating to occupation, business or sporting activity affecting you or any insured person. We reserve the right either to continue cover for the insured person on terms and condition we consider appropriate because of the material change in information or circumstances or to decline to continue cover under this policy.

6. *Renewal*

Your coverage will be renewed for the next insurance year by payment of the renewal premium before the due date provided the company invites for renewal. Insured shall be notified by the company 30days prior to the expiry of the policy in the event the company will not be inviting for renewal.

7. *Cancellation*

This insurance may be terminated at any time at the request of the Insured in which case the Company will retain the customary short period rate for the time the Policy has been in force. The insurance may also at any time be terminated at the option of the Company, on notice to that effect being given to the Insured in which case the Company shall be liable to repay on a ratable proportion of the premium for the unexpired term from the date of the cancellation.

When the premium is charged on an annual basis and the insured cancels the policy during the policy year, the company will make a 50% refund of premium if the insured person has been insured for less than 6 months in that policy year. If the insured person has been insured for more than 6 months or a claim has risen in respect of that policy year, no refund will be made.

8. *Termination of insurance*

If the policy is either terminated as provided in clause 7 or is not renewed the covered benefits in respect of any valid claim will continue to be payable for up to a maximum period of 30 days after the policy ends but only if all of the following are satisfied.

a) The claim was reported and accepted by us before the policy ended.

b) The insured person's at the time of the accident or illness giving rise to the claim, was within the area of cover stated in the schedule and

c) The claim only related to covered treatment obtained within the area of cover stated in the schedule.

9. *Misstatement of age*

If the age of any insured person has been misstated and the premium paid as a result is insufficient, any claim payable under this policy shall be pro-rated based on the ratio of the actual premium paid to the correct premium which should have been charged for the entire period of insurance. Any excess

premium that may have been paid as a result of any misstatement of age shall be refunded without interest. If at the correct age an insured person would not have been eligible for the cover under this policy, no benefit shall be payable, and our liability shall be limited to the refund of the total premium paid without interest.

10. *Age*

For the purpose of determining premiums payable, an insured person's age shall be based on his/her age at last birthday.

11. *Fraud*

If any claim shall in any respect be false or fraudulent means or any fraudulent devices are used by the insured person or any dependent or anyone acting on their behalf to obtain benefit under this policy, the policy will be cancelled immediately and all premium paid will be forfeited.

12. *Trust*

We will not recognize or be affected by any notice of trust, charge, or assignment relating to this policy and the insured person's receipt or that of the insured's legal personal representative, shall in all cases effectively discharge our liability.

13. *Applicable Law*

The terms and conditions of this policy will be governed by and construed, determined and enforced in accordance with the laws of the Republic of Sri Lanka.

14. *Legal Personal Representatives*

The terms, exception and conditions of this policy are also applicable to the legal personal representatives of the insured.

15. *Currency*

Payment of all claims and benefits will be made in the currency in which this policy is effected and claims payable in Sri Lanka, will be made in Lankan rupees (LKR). Charges incurred in any other currency shall be payable in US dollars, or currency of the policy on the basis of the exchange rate used by us on the date the claims processed.

16. *Exclusion of Rights under the contracts (Right of Third parties) act*

A person who is not a party to this policy shall have no right under the contracts (right of third party) act (act any subsequent amended or replacement of this act) to enforce any of its terms.

EXCLUSIONS

The following treatment items, conditions, activities and their related or consequential expenses are excluded from the policy and the company will not be liable for them:

a) Pre-existing conditions as defined unless otherwise declared on the application form and expressly confirmed acceptance by us.

b) Epidemic / pandemic conditions or any expenses incurred in relation to those conditions.

c) Routine medical examinations or check-ups, routine eye or ear examinations, vaccinations, medical certificates, examinations for employment or travel, spectacles, contact lenses, cosmetic treatments and plastic surgery, all dental treatment or oral surgery related to teeth (except when such dental benefits are being covered under the policy) rest cure s and services or treatment in any home, spa, hydro-clinic, sanatorium or long term care facility that in a hospital not as defined

d) Tests or treatment related to infertility, contraception, sterilization, impotence, sexual dysfunction, birth defects, congenital illness, hereditary conditions or any abortion performed due to psychological or social reason and consequences thereof.

e) Pregnancy or childbirth except when such benefits are shown in the policy schedule.

f) Any emergency medical evacuation expense.

1. Related to pregnancy or childbirth (Except abnormal pregnancy or vital complication of pregnancy occurring within the first 6 months of pregnancy which endangers the life of the insured person and/or any of her unborn children).

Any evacuation expense related to pregnancy or childbirth or miscarriage after the first 6 months of pregnancy.

g) Prosthesis, corrective devices and medical appliances which are not surgically required; treatment by a family member: and all treatment that is not scientifically recognized by western European or North American standards except as defined and covered under alternative medicine.

h) All costs relating to cornea, muscular, skeletal or human organ or tissue transplant from a donor to a recipient and all expenses directly or indirectly related to organ transplantation (except as defined under the organ transplantation benefit).

i) Treatment of self-inflicted injury, suicide, abuse of alcohol, drug addiction or abuse, sexually transmitted diseases other than Acquired Immune Deficiency Syndrome (AIDS).

j) Treatment which the insured person has elected to receive outside the area of cover except when it is for

an emergency medical complaint.

k) Experimental or pioneering medical and surgical techniques not commonly available which the insured person choose to receive elsewhere in the world even though treatment usually and customarily provided for the medical condition concerned is available within the area of cover of the policy.

l) Second opinion in respect of medical conditions which have already been diagnosed and/or treated at the date such second opinion are obtained unless considered by our medical advisers to be reasonable and necessary having regard to the medical facts and circumstances.

m) Additional fees billed by a referring physician for treatment given after the date on which an insured person has been referred to another physician or specialist.

n) Injury or illness while serving as a full-time member of a police or military unit and treatment resulting from participation in war, riot, civil commodities or any illegal act including resultant imprisonment.

o) Injury or illness sustained while insured person has resided outside the pre-defined area of cover and /or has resided outside Sri Lanka for more than 90 consecutive days during the policy year

p) Outpatient service except as defined under the respective benefits stated in the schedule.

q) Hospital in-patient treatment if the insured person could have been properly treated for the condition as an outpatient.

r) Travel cost in respect of trip made specifically for the purpose of obtaining medical treatment unless in cause of an approved emergency medical evacuation. And all emergency medical evacuation cost which are not approved in advanced by us or our appointed 24-hour emergency assistant center.

s) Hotel or non-hospital accommodation cost to be excepted as provided for in the policy.

t) Rock climbing, mountaineering, pot holing, sky diving, parachuting, hand gliding, parasailing, ballooning, or diving unless the person concern has been duly qualified and certified as diver by an internationally recognized diving organization or unless such person is at the time of happening of the event giving rise to a claim actually receiving diving instruction from a duly qualified and certified diving instructor. Racing of any kind other than that on foot and all professional or inherently dangerous sports unless declared to and accepted by us in writing prior to event giving rise to a claim.

u) Cost of benefits payable under any legislation or corresponding insurance cover relating to occupational death, injury, illness or disease.

v) Cost arising under any legislation which increases the cost of medical treatment and services received by the insured person above charge levels which would be considered reasonable and customary in the absence of such legislation. The cost of medical treatment given by the following parties unless the company agree in writing to meet such costs;

1. arising out of medical facilities provided by the insured person's own medical officer or his employers medical personnel.

2. by a third party under a contract between that third party and the insured person's employer.

w) Cost arising out of any litigation or dispute between the insured person and any medical person or establishment from whom treatment has been sought or given, or any other costs not directly and specifically related to the payment of the medical expenses covered by the policy.

x) Costs or expense of whatever nature directly or indirectly caused by resulting from or on connection with any of the following;

1. Ionizing radiation or contamination by radio activity from any nuclear fuel or from nuclear waste from the combustion of nuclear fuel.

2. The radioactive, toxic, explosive, or other hazardous or contaminating properties of any nuclear installation reactor or other nuclear assembly or nuclear component.

3. Any weapons of war employing atomic or nuclear fission and/or fusion or other like reaction of radioactive force or matter.

y) Treatment for any injury from accident or any disease directly or indirectly attributable to war, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not), civil war, civil commotion assuming the proportions of or amounting to a popular rising, military rising insurrection, conspiracy, military or usurp power, martial law or stage of siege, or any of the event or causes which determine the proclamation or maintenance of martial law or stage of siege, rebellion, mutiny, revolution, confiscation or nationalization, by or under the order of any government or public or local authority or any act of any person acting on behalf of or in connection with any organization with

activities directed towards the overthrow by force of it's government "de jure" or "de facto" or to the influencing of it by terrorism or violence or injury or disease caused by the insured's active participation in riots and/or strikes or similar public disturbances.

CLAIMS HANDLING PROCEDURE

1. Notification of circumstances that may give rise to a claim.

If there are circumstances which will or may give rise to a claim on this policy, you must ensure that the following are adhered:

The 24-hour emergency medical assistance center must be informed immediately. If the insured person may require emergency medical evacuation or repatriation of mortal remains

For all overseas claims

Telephone No: +44 - 203 808 0090
Emails: globalmedical@allianz.lk

For local claims

Telephone No: +94 11 2 303 300
Emails: globalmedical@allianz.lk

Before an insured person begins treatment as a hospital inpatient (except in cases of accent or acute medical emergency), the insured person must notify the 24 hour emergency medical assistance center immediately in writing of the intention to seek such treatment, with full details of the proposed treatment and the names and addresses of the physician and hospital concerned. In case of an accident or acute medical emergency, written notification with reasonably available supportive medical information must be submitted to us within 48 hours of the accident/event.

2. Making a claim

You should complete our claim form and submit it to us before the insured person seeks hospital inpatient treatment or as soon as possible after seeking treatment.

Section A of the claim form should be completed and signed by the insured person or his legal representative.

The claims form can be obtained from
https://www.allianz.lk/content/dam/onemarketing/azlk/wwwallianzlk/alldownloads/global-medical-claim-form.pdf

Telephone No: +94 11 2 303 300

Email: globalmedical@allianz.lk

Section B of the claim form should be completed, signed and rubber stamped by the treating physician.

You should also provide all supporting medical information including original of all documents and bills within 90 days after the hospital treatment begins or as soon after such information is reasonably available. Photocopies of any documents will not be accepted.

You should make new claim form for each separate claim or treatment. Failure to observe the claim conditions, without any reasonable explanation, may invalidate your claim.

All reimbursement claims will be settled in local currency.

3. Payment guarantees & direct settlements

Subject to an adequate advance notice of a claim as provided in claims condition 1 above is given, we or the 24-hour emergency medical assistance center will give you a confirmation of the extent of insurance benefits, monitor claims procedures, issue (wherever reasonably possible) appropriate payment guarantees and/or arrange direct settlement of the bills rendered by hospitals, physicians or other service providers.

If an adequate advance notice is not given to 24 hour emergency medical assistance centre or us, we will not provide payment guarantee or direct settlement but medical expenses incurred will be reimbursed subsequently.

In the event of any payment made under the payment guarantee or direct settlement which should have been paid by you such as deductibles / excess, such payment should be reimbursed to us within 30 days of being notified.

4. Approved hospitals

The company has made direct billing arrangements with many leading hospital and physicians. Use of other hospitals and physicians will not invalidate a covered claim provided the claim conditions of the policy have been met and furthermore the company's liability shall not exceed the level of charges that would have been made at such approved hospitals for providing similar treatment or services. The company reserves the right to make appropriate reduction to the benefit payable in charges incurred are not considered to be reasonable and customary.

List of locally empaneled hospitals is available on
https://www.allianz.lk/content/dam/onemarketing/azlk/wwwallianzlk/all-hospitals-list/empaneled-hospitals.pdf

24-hour emergency medical assistance center will facilitate payment guarantees and/or arrange direct settlement to overseas hospitals.

You may contact the claims administrator on No: +44 - 203 808 0090 or email for assistance in relation to the empaneled hospitals

Email: globalmedical@allianz.lk

Overseas Treatment

All overseas treatment must be pre-approved by the Claims Administrator of the Company .

5. Proof of claim

Original documentation and receipts together with a fully completed claim form signed by the treating physician must be submitted to the company within the limits defined above and before payment guarantee for inpatient treatment can be made. Photocopies are not acceptable. In the event of a claim being rejected on the pre-existing conditions exclusion, the insured person shall have the right and obligation to produce such medical evidence as the company may reasonably require enabling it to reconsider a claim under the policy.

6. Examinations

The company shall have the right and opportunity through its medical representative to examine the insured person wherever and as often as it may reasonably require within the duration of any claim. In addition, the company shall have the right to require a postmortem examination, where this is not forbidden by law.

7. Claims Settlements

The company shall pay the claims amount due within 60 days of the admission of liability and upon establishment of the identity of the claimant.

GRIEVANCES/COMPLAINTS HANDLING AND DISPUTE RESOLUTION PROCEDURE

1. How to make a complaint

In the event of a customer feels that he/she is dissatisfied with the manner in which they have been served at any of our customer touch points or if our products do not meet their expectation there are many avenues opened to our customers to reach the Complaints Handling Unit and make a complaint.

Following facilities are made available for complaints to be lodged;

(i) By visiting or writing to: The Customer Experience Management Unit at Allianz Insurance Corporate office premises or by visiting any branch office or by visiting to our Customer Care Centre, No 323, Union Place, Colombo 2.

(ii) Direct Telephone contact: Manager – Customer Experience / Complaints Management Unit 0114788796 and 0114788814

(iii) Complaints can be made via 24hrs
• Hotline - General Insurance 0112303300
• Hotline - Life Insurance 0112300400

(iv) Email: email to reach us via info@allianz.lk

(v) Website : customer feedback form available at www.allianz.lk
(vi) Standard notice board displayed at every branches at the front office with the contact numbers/email to reach the Customer Complaints Handling Unit

(vii) Letters addressing to the Complaint officer in-charge as shown below
Manager – Customer Experience
Allianz Insurance Lanka Limited,
Levels 25-27, One Galle Face Tower,
No 1 A, Centre Road, Galle Face, Colombo 02.

1.1.1 Language of preference: Customers could make the complaints in Sinhala, Tamil or English at their convenient and all correspondence with the complainant is followed in the language in which the complaint was made.

1.1.2 Documents and information to be produced along with a complaint by the policy holder/insured:
(i) Name of policy holder
(ii) Policy number/vehicle number/claim number
(iii) Contact details such as telephone no's/email, postal address
(iv) Subject of the complaint
(v) Description of the complaint -in writing preferably (email/letter/fax/social media)
(vi) Documents or evidence supporting the complaints
(vii) Category of the insurance -Life, Motor or Non-Motor

1.2 Complaint Review Process
1.2.1 Registering/Recording of Complaints Every service, related complaints received at ranches/departments/Customer care centre should be forwarded to Manager – Customer Experience via email or via the Complaint Management System. (CMS)

Each complaint is recorded in the Complaint Management System by the Complaints Handling Officers. The system records are maintained with all the necessary information on the complaints, including;

a) Name of policy holder
b) Policy number/vehicle number
c) Contact details/email
d) Description of the complaint
e) Date of receiving the complaint
f) Category of the insurance -Life, Motor or Non Motor
g) Date of acknowledgement
h) Status of the complaint - Resolved/pending/Partially resolved
i) Date of closing the complaint
j) Date of Resolution
k) Description of Resolution

1.2.2 Acknowledgement of complaints
All complaints are recorded in the Complaints Management System within 3 days from the receipt of such complaint. CMS is an in-house developed application enabling to enter and monitor the complaints until the resolution is reached. A reference number for each complaint is provided along with an acknowledgement.

After receiving complaint in writing, acknowledgement shall be sent within 3 working days. The acknowledgement contains the ‘’Reference number’’ and ‘’contact details’’ of the person to be contacted in the event that customer requires to know the status of the complaint.

1.2.3 Analysis of complaints

i. Every incoming complaint is categorized by the nature of the complaint. If the complaints are premium fraud related, misappropriation, wrong selling/mis selling, procedural violation, malpractices, data privacy & information security related, then complaints will be forwarded to the internal investigation unit for further investigations.

ii. Customer Experience Management should also conduct the preliminary investigation in order to find out the facts and to resolve the complaints. However, the respective Department Head or Head of Branch/Regional Sales Manager and Provincial Sales Manager are required to support the Customer Experience Management unit to resolve the complaint within the set timelines.

iii. If Complaint handler views that further inquiry needs to be conducted based on the preliminary findings, the respective head of the department or head of branch should be informed of the same. Accordingly, explanation should be called from the respective employee within (3) working days as per the Complaint Handling Procedure of the Company.

Role of Complaint Handling Unit

a) The complaint shall be addressed to the respective department or operational unit by the Complaints Handling Unit. The status of the complaint should be kept informed and updated to customer.
b) A Complaint Register shall be maintained and updated by Complaints Handling Unit of CRM and by the respective Departments.
c) Complaints Handling Unit should update the Complaint Management System of the outcome. Meantime, HR should take appropriate action based on the findings by the Inquiry and the copy of the decision should be filed in the personal file of the employee/agent.
d) The outcome of the inquiry should be informed to the respective Department head and internal Investigation unit and Legal & Compliance for their information and records.
e) The complaints Register must be orderly maintained at the respective Branch as well.

1.2.4 Timelines in complaints handling and communicating resolution

Activity	Timeline
Recording of Complaints	Within 3 days from the receipt date
Acknowledgement of Complaints	Within 2 days from the receipt date
Resolution for the service related complaints	Within 8 working days
Resolution for the Premium Misappropriation related complaints	28 Days –Subject to availability of the facts and evidences
Communicating the resolution to customer	Within 2 days from the decision taken the facts and evidences
Responding to the appeal	Within 4 weeks from the receipt date

In case an appeal, if the complainant not satisfied with the resolution given, he or she could contact the following officer.

Name	Kasun Yatawara
Designation Head of Market Management	Head of Market Management
Address	Allianz Insurance Lanka Limited, Levels 25-27, One Galle Face Tower, No 1 A, Centre Road, Galle Face, Colombo 02.
Mobile	775144972
Email	info@allianz.lk

Dispute Resolution Mechanisms / Legal Proceedings

In the event the customers are not satisfied with the resolution given by the company, we would advise them to refer their complaint to the either Insurance Ombudsman or Insurance Regulatory Commission of Sri Lanka (IRCSL).
In addition to the above, arbitration clauses are incorporated in non motor and motor policies with regard to determining quantum and/or terms of the policy depending on the policy. Further, Life policies do not have an arbitration clause included.

Office of Insurance Ombudsman
No 143A, Vajira Road,
Colombo 5.

Telephone – +94 11 250 5542 / +94 11 250 5041
Email – info@insuranceombudsman.lk
Website – https://insuranceombudsman.lk/

Director Investigations
Insurance Regulatory Commission of Sri Lanka
Level 11 East Tower, World Trade Center,
Colombo 01.

Telephone – 0112396184-9 / 0112335167
Email – investigation@ircsl.gov.lk / info@ircsl.gov.lk

No action in law or equity shall be brought to recover under the policy until after the expiration of 60 days from the date of which proof of claim has been furnished in accordance with the policy conditions. The parties have agreed that the laws of the Republic of Sri Lank shall apply in the event of any dispute, claim, question, or disagreement arising from or relating to this contact or the breach thereof, the parties shall use their best efforts to settle the issue. They shall consult and negotiate with each other

in good faith, recognizing their mutual interests, and attempt to reach a just and equitable solution satisfactory to both parties through the Company's Complaint Handling Procedure.

Failing which, parties may refer such disputes to a competent court of jurisdiction in Sri Lanka.

GENERAL TERMS

Data Privacy & Protection

The Insurer is strongly committed to conducting its business in full compliance, and in accordance with applicable Data Privacy protection laws and regulations. All privacy related matters are governed by Allianz Privacy Notice which is available on the Insurer's official website https://www.allianz.lk/data-privacy-notice.html. The said privacy notice explains how and what type of personal data will be collected, why it is collected and to whom it is shared or disclosed. Further, the Insurer is committed to keep your Personal Data only so long as necessary to fulfill the purposes for which the data was collected for or to fulfill legal obligations.

Definition:

Personal Data - means any information relating to an individual pre-approved by the Claims Administrator of the Insurance Company

Sanctions Clause

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No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America