AXA Affin General Insurance Berhad (23820-W)
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71 Jalan Raja Chulan 50200 Kuala Lumpur
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POLICY

Smart*Business*
Major Critical Illness Plan

Introduction

This policy sets out the terms and conditions of your Major Critical Illness plan with us and must be read together with any supplementary documentation we provide to you from time to time (e.g. your policy schedule, certificate of insurance and any endorsements). If you require further clarification, please do not hesitate to call us at: 03-2170 8282

Take a few moments to refresh your memory about your AXA Major Critical Illness plan then relax and look forward to the highest standards of service from AXA. You can be rest assured that, whatever the coming year brings, we'll be there to support you.

Do keep this policy and any other accompanying schedules/endorsements in a safe place as they are legal documents.

At AXA we are always aware that behind every claim there is a person who needs help and assistance. It is our role to assist you, wherever possible, within the terms and limits of your AXA Major Critical Illness plan. Please also see Page 7 for details of our AXA Office.

Persons eligible

Please note that the AXA Major Critical Illness plan is not available on a stand-alone basis and can only be extended from a **Smart***Business* policy.

Insured person eligible to be covered under this **policy** must be aged between eighteen (18) and sixty (60) years (age at the next birthday) at the time of application. This **policy** can be renewed up to age seventy (70) (age at the next birthday) subject to **you** paying the applicable premium.

This **policy** provides cover only if the **insured person** is a resident of Malaysia. By resident of Malaysia **we** mean Malaysian Citizens and Permanent Residents (holders of re-entry permits), holders of Employment Pass, Work Permit, Student Pass or Dependant's pass.

Further conditions concerning cover

(a) If an **insured person** is confined in a **hospital** on the date when his/her **policy** would otherwise become effective, such **policy** will not become effective until the date following discharge from **hospital.**

(b) This **policy** would terminate once a claim under 'AXA Major Critical Illness' benefit below is paid out.

(c) **Insured Person** must be an employee of the Policyholder or an immediate family of the said employee.

What you're covered for

The benefits below are payable on a specified-sum basis, without reference to actual charges incurred, if any. The amount payable is on a one-time basis, as provided in the **policy schedule**.

Please refer to the **policy schedule** for further information on the availability and benefit levels of your **plan**.

Major Critical Illness Benefit
We will pay the amount shown in your **plan**, in one lump sum, upon the **insured person** being diagnosed with **Major Critical Illness** by a **medical practitioner**. This benefit is payable only once in the **insured person's lifetime** and up to the limits shown in the benefit schedule, irrespective of the number of illnesses **diagnosed**.

Major Critical Illness shall mean any of the 8 illnesses specified below and excludes all other illnesses.

(1) Cancer – of specified severity and does not cover very early cancers
Any malignant tumour positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukemia, lymphoma and sarcoma.

For the above definition, the following are not covered:

(i) All cancers which are histologically classified as any of the following:
- pre-malignant
- non-invasive
- carcinoma in situ
- having borderline malignancy
- having malignant potential

(ii) All tumours of the prostate histologically classified as T1N0M0 (TNM classification)

(iii) All tumours of the thyroid histologically classified as T1N0M0 (TNM classification)

(iv) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM classification)

(v) Chronic Lymphocytic Leukemia less than RAI Stage 3

(vi) All cancers in the presence of HIV

(vii) Any skin cancer other than malignant melanoma.

(2) Coronary Artery By-Pass Surgery
Refers to the actual undergoing of open-chest surgery to correct or treat Coronary Artery Disease (CAD) by way of Coronary Artery By-Pass Grafting.

For the above definition, the following are not covered:

(i) Angioplasty;

(ii) Other intra-arterial or catheter based techniques;

(iii) Keyhole procedures;

(iv) Laser procedures.

(3) Kidney Failure – requiring dialysis or kidney transplant
End stage kidney failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular dialysis is initiated or kidney transplantation is carried out.

(4) End Stage Liver Failure
End stage liver failure as evidenced by all of the following:

(i) Permanent jaundice;

(ii) Ascites (excessive fluid in peritoneal cavity); and,

(iii) Hepatic encephalopathy.

Liver failure secondary to alcohol or drug abuse is not covered.

(5) End Stage Lung Disease
End stage lung disease causing chronic respiratory failure. All of the following criteria must be met:

(i) The need for regular oxygen treatment on a permanent basis;

(ii) Permanent impairment of lung function with a consistent Forced Expiratory Volume (FEV) of less than 1 liter during the first second;

(iii) Shortness of breath at rest; and

(iv) Baseline Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less.

(6) Heart Attack – of specified severity
Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

(i) A history of typical chest pain;

(ii) New characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block and

(iii) Elevation of the cardiac biomarkers, inclusive of CPK-MB above the generally accepted normal laboratory levels or Troponins recorded at the following levels or higher:
– Cardiac Troponin T or Cardiac Troponin I > / = 0.5 ng/ml

The evidence must show the occurrence of a definite acute myocardial infarction which should be confirmed by a cardiologist or physician.
For the above definition, the following are not covered:

(i) Occurrence of an acute coronary syndrome including but not limited to unstable angina.

(ii) A rise in cardiac biomarkers resulting from a percutaneous procedure for coronary artery disease.

(7) Parkinson's Disease – resulting in permanent inability to perform Activities of Daily Living
A definite diagnosis of Parkinson's Disease by a neurologist where all the following conditions are met:

(i) Cannot be controlled with medication;

(ii) Shows signs of progressive impairment; and

(iii) Confirmation of the permanent inability of the Life Assured to perform without assistance three (3) or more of the Activities of Daily Living.

Only idiopathic Parkinson's disease is covered. Drug-induced or toxic causes of Parkinsonism are not covered.

(8) Stroke – resulting in permanent neurological deficit with persisting clinical symptoms
Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolization from an extra cranial source resulting in permanent neurological deficit with persisting clinical symptoms. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a neurologist. A minimum Assessment Period of three (3) months applies.
For the above definition, the following are not covered:

(i) Transient ischemic attacks

(ii) Cerebral symptoms due to migraine

(iii) Traumatic injury to brain tissue or blood vessels

(iv) Vascular disease affecting the eye or optic nerve or vestibular functions.

Benefit Schedule

	Basic Cover	**Double Cover**
Upon diagnosis of **Major Critical Illness**	RM25,000	RM50,000

Important information about your plan

Our policy on changing your level of cover or moving to another plan

We reserve the right to refuse any request to upgrade or amend a cover. In the event that we do accept a request for an upgrade we may restrict cover for conditions existing at the time of the upgrade to the level of benefits enjoyed under the original policy. In any event, final acceptance of any amendment by us and particularly the application of upgraded benefits will only be made at the next renewal following such a request. Neither amendments nor upgrades can be made during the policy year. Any condition known or should be reasonably known about at the time of an amendment or upgrade must be advised to us before the policy amendment takes effect.

What happens if you wish to cancel your policy

You have a free-look period of fifteen (15) business days from the date that you receive this policy to review it. You are deemed to have received the policy within three (3) days after we have dispatched it. If you decide that this policy does not suit your needs, you may request to cancel it by giving us clear, written instructions and returning the policy documents to us within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you, in full less deduction of expenses incurred by us for the issuance of the policy. This free-look period shall not apply to policy renewals.

In addition, you may cancel your policy at any time by giving us notice in writing and provided that no claims have been made during the current policy year, you are entitled for a refund of premium as follows:

Period Not Exceeding	Refund of Annual Premium
15 days (for renewal only)	90%
1 month	80%
2 months	70%
3 months	60%
4 months	50%
5 months	40%
6 months	30%
7 months	25%
8 months	20%
9 months	15%
10 months	10%
11 months	5%
Exceeding 11 months	No refund

Please also note that no claim of any kind will be considered after notification by you to us of any cancellation.

When the terms of your policy might change

We have the right to cancel or change all or any part of your policy from any renewal date to reflect any past or foreseeable changes in medical practice or procedures and the type and frequency of claims made generally by all insured persons covered under the same plan as you. The purpose of such changes will be to seek, as far as possible, to maintain substantially the same level and type of cover in place while ensuring that the plan remains affordable. We will give you thirty (30) days prior notice of the changes and will send details of them by ordinary post to the address we have for you on our records.

We may also change premiums if costs, taxation, regulations or benefit changes make this necessary. In the event that we are required by law to make a change during the policy year, for example if a new tax is introduced, we will be obliged to do so before the next renewal date.

We do reserve the right to vary underwriting terms to your policy or terminate the policy at any time if a medical condition that should reasonably have been declared, at policy inception, comes to our attention.

What this policy means

In the following section **you** will find detailed definitions, terms and exclusions forming part of the contract between **you** and **us**. Please read them carefully and ask **us** if there is anything that **you** do not understand.

1. Definitions

Some words and phrases have special meanings. These meanings are set out below. When **we** use these terms they are in bold print.

1.1 **diagnosis** – the act or process of identifying or determining the nature and cause of a **medical condition/disability** through evaluation of patient's medical history, physical examination, x-ray or other means of diagnosis such as laboratory tests and tissue analysis.

1.2 **family member** – shall include parents, step parents, spouse, siblings, children, step children and in-laws.

1.3 **hospital** – shall mean an establishment duly constituted and registered as a hospital for the care and **treatment** of sick and injured persons as paying bed-patients, and which:

(a) has facilities for **diagnosis** and major surgery,

(b) provides twenty-four (24) hour a day nursing services by registered and graduate nurses,

(c) is under the supervision of a **medical practitioner**, and

(d) is not primarily a clinic; a place for alcoholics or drug addicts; a nursing, rest or convalescent home or a home for the aged or similar establishment.

1.4 **lifetime** – the period in which the **insured person** is alive. This does not refer to the duration of the **policy**.

1.5 **medical condition/disability** – any disease, illness or injury excluding psychiatric illness.

1.6 **medical practitioner** – shall mean a person qualified and licensed by the relevant licensing authority to practise western medicine and who, in rendering such treatment, is practising within the scope of his licensing and training in the geographical area of practice, but excluding a **medical practitioner** who is the **insured person** or the **insured person's family member**.

1.7 **insured person** – shall mean the person described in the certificate of insurance as the person covered under this **policy** who must be an employee of a policyholder or a spouse or an unmarried child of the employee.

1.8 **plan** – any AXA Major Critical Illness plan.

1.9 **policy** – the insurance contract between **you** and **us**. Its full terms are set out in the latest versions of the following documents as sent to **you** from time to time:

- these terms and the **policy schedule** setting out the cover under your **plan**.
- your **policy schedule**, **our** letter of acceptance and/or endorsements

Changes to these terms must be confirmed in writing and **we** will write to **you** to confirm any changes, undertakings or promises that **we** make.

1.10 **policy schedule** – the schedule which sets out the details and benefits of the cover provided under your **plan**.

1.11 **policyholder/you** – shall mean a corporate body to whom the **policy** has been issued in respect of cover for the **insured person**.

1.12 **pre-existing condition –** shall mean **medical condition/disability** for which:

- the **insured person** had received or is receiving **treatment**;
- medical advice, **diagnosis**, care or **treatment** has been recommended to the **insured person**;
- clear and distinct symptoms are or were evident; or
- its existence would have been apparent to a reasonable person in the circumstances;

excluding heart related ailment, hypertension, cholesterol or chest pain without hospitalisation prior to policy inception. Hospitalisation include day care admission for the purpose of diagnosis and/or treatment.

1.13 **treatment** – a surgical procedure or medical procedure carried out by a **medical practitioner**.

1.14 **we/us/our** – AXA Affin General Insurance Berhad, being the AXA company issuing your **policy.**

1.15 **year** – twelve calendar months from when your **policy** began or was last renewed unless **we** have agreed otherwise.

1.16 **irreversible** – means cannot be reasonably improved upon by medical treatment and/or surgical procedures consistent with the current standard of the medical services available in Malaysia.

1.17 **permanent** – means expected to last throughout the lifetime of the Life Assured.

1.18 **permanent neurological deficit with persisting clinical symptoms** – means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Life Assured. Symptoms that are covered include numbness, paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

1.19 **activities of daily living** (ADL) are as follows:

- **transfer** – getting in and out of a chair without requiring physical assistance.
- **mobility** – the ability to move from room to room without requiring any physical assistance.
- **continence –** the ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
- **dressing** – putting on and taking off all necessary items of clothing without requiring assistance of another person.
- **bathing/washing** – the ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.
- **Eating** – all tasks of getting food into body once it has been prepared.

1.20 **assessment period** – means the period during which the insurer will assess a condition before deciding whether or not the condition qualifies as being permanent. The assessment period will be for the minimum period time frame stated in the relevant definition and will not be longer than twelve (12) months (provided all required evidence has been submitted).

2. What we pay for

2.1 This **policy** provides the **policyholder** or **insured person** a lump sum payment upon **diagnosis** of **Major Critical Illness**. However, **we** will only pay claims when they are related to:

(a) benefits listed in your **policy schedule** subject to the limits shown there; and

(b) **diagnosis** during a period for which the premium has been paid.

3. What we do not pay for (exclusions and limitations)

3.1 **We** do not pay for claims related to:

(a) Any **Major Critical Illness** directly or indirectly caused by any **pre-existing condition**;

(b) **Major Critical Illness** (except for Heart Attack, Coronary Artery Disease Requiring Surgery, or Cancer) for which the **insured person** gets medical advice, has symptoms, or tests, or received any medication or **treatment** within thirty (30) days from the date the **insured person** was first covered under this **policy**;

(c) Heart Attack, Coronary Artery Disease Requiring Surgery, or Cancer for which the **insured person** gets medical advice, has symptoms, or tests, or received any medication or **treatment** within sixty (60) days from the date the **insured person** was first covered under this **policy**;

(d) **Major Critical Illness** which is diagnosed and the **insured person** lives for a period of less than fourteen (14) days after the **diagnosis**;

(e) **Major Critical Illness** for which the **insured person** is claiming if the **insured person** has been diagnosed with the same **Major Critical Illness** before the date such **insured person** was first covered under this **policy**;

(f) **Major Critical Illness** diagnosed:

(i) in the presence of Human Immunodeficiency Virus (HIV); or

(ii) arising directly or indirectly out of or in connection with any congenital condition which manifested itself before the **insured person**'s 6th birthday ;or

(iii) arising under the influence of any drug unless it was prescribed by a **medical practitioner** and taken in accordance with the **medical practitioner's** advice; or

(iv) arising from or is a complication of infection with a venereal disease; or

(v) from or is a complication of birth control, sterilisation, infertility or treatment thereof, pregnancy, childbirth, caesarean, miscarriage or abortion.

(g) A **diagnosis** made by a **medical practitioner** who is an **insured person** or a member of the **insured person's** family;

(h) **Major Critical Illness** caused as a result of nuclear contamination, biological contamination or chemical contamination.

3.2 **We** will not pay benefits for claims for which **we** have not received a properly completed claim form and all documents required by **us** to process your claim within ninety (90) days of the **diagnosis** made by your **medical practitioner** or date of discharge from the **hospital**.

3.3 **We** will not allow **insured persons** to upgrade their level of cover except at each **policy** anniversary and only then when requested, in writing, to do so. Acceptance by **us** of such an upgrade must be confirmed in writing by **us** before the upgrade can become effective.

3.4 During the first twelve (12) months following the effective date of upgrade, **we** will not pay upgraded benefit levels relating to **diagnosis** of any **medical condition** which was made prior or at the time of the upgrade. Benefits for such a **medical condition** will be restricted to the level of cover that would have been applicable to such a **medical condition** prior to the upgrade.

4. Making Claims

4.1 Before **we** can consider a claim please ensure that:

- **you** send to **us** a completed claim form, filled in and signed by **you** and the medical practitioner as soon as **you** can and no later than ninety (90) days from the date of **diagnosis** made by your **medical practitioner** or date of discharge from the **hospital**; and
- **we** receive copy of completed medical report, bill, Histopathological Examination Report , Biopsy Report and other related diagnostic report; and
- **you** promptly give **us** all the information **we** have requested.

4.2 In the event of suspicion of fraud or dishonesty, **we** can appoint and pay for an independent **medical practitioner** and/or investigator to advise **us** on the medical issues relating to any claim. If required by **us** the independent **medical practitioner** will also medically examine the **insured person** making the claim and provide **us** with a report. The **insured person** must co-operate with the independent **medical practitioner** and/or investigator otherwise **we** have the right to refuse payment of the claim.

4.3 If **you** make a claim which is in any way dishonest:

- **we** will not pay any benefits for that claim; and
- if **we** have already paid benefits for that claim before **we** discovered the dishonesty **we** can recover those benefits from **you**; and
- **we** can take any of the actions listed in 7.9.

4.4 **You** can visit our website at www.axa.com.my to obtain a printable claim form if **you** need one or call **us** at the number shown on page 7 of this policy.

4.5 Completed claims form to be sent to:
AXA Affin General Insurance Berhad
Ground Floor, Wisma Boustead, 71 Jalan Raja Chulan, 50200 Kuala Lumpur, Malaysia
or
to your local AXA branch in Malaysia.

5. Joining and renewing

5.1 **We** will advise **you** in writing the date your **policy** starts and any special terms which apply to it.

5.2 Your **policy** is valid for a period of one **year** unless **we** have agreed otherwise. At the expiry of your **policy** (**policy** anniversary), provided the **plan you** are on is still available and your **Smar*tBusiness*** policy is renewed, **you** can renew your AXA Major Critical Illness plan on the terms and conditions applicable at that time. **You** will be bound by those terms. However, **we** reserve the right to refuse to accept **you** as a customer or to renew your **policy** at any **policy** anniversary for reasons shown in 7.4 and 7.9.

5.3 It shall not be incumbent on **us** to give notice that any premium for renewal is due and such premium shall be deemed to be due on which the **policy** expires and must be paid within thirty (30) days thereafter. However, during the thirty (30) days, **we** shall remain liable thereunder if by the last of such date the premium is actually paid.

6. Conditions

6.1 The due observance and the fulfillment of the terms, provisions and conditions of this **policy** by the **policyholder/insured person** and in so far as they relate to anything to be done or complied with by the **policyholder/insured person** shall be conditions precedent to any liability of **ours**.

6.2 **You** must ensure that all information given to **us** pertaining to yourself, your health condition and/or medical history are true, accurate and complete, failing which **we** have a right to terminate the **policy** or apply different terms of cover.

6.3 If the proposal or declaration of the **insured person** is untrue in any respect or if any material fact affecting the risk be incorrectly stated herein or omitted therefrom, or if this insurance, or any renewal thereof shall have been obtained through any misstatement, misrepresentation or suppression of information, or if any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support thereof, then in any of these cases, this **policy** shall be void.

6.4 (a) **Insured person's** age at the next birthday will be used for the purpose of determining premiums payable.

(b) If the age, gender or smoker indication of the **insured person** has been misstated and the premium paid as a result thereof is insufficient, any claim payable under this **policy** shall be prorated based on the ratio of the actual premium paid to the correct premium which should have been charged. Any excess premium, which may have been paid as a result of such misstatement of age, shall be refunded without interest.

If at the correct age the **insured person** would not have been eligible for cover under this **policy**, no benefit shall be payable.

6.5 Premium must be paid on or before the due date, based on the amount advised by **us**.

6.6 Premium rates are not guaranteed and the premium payable at renewal shall be determined at each renewal based on the age of the **insured person** at the next birthday, the premium rates then in effect, and any other factors which may materially affect the risks insured.

6.7 All correspondence pertaining to the **policy** will be sent to your address hence **you** need to advise **us** in writing of any change of address.

7. General

7.1 This **policy** is subject to and governed by the Malaysian laws and the parties hereby submit to the jurisdiction of the courts of Malaysia.

7.2 This **policy** shall become effective as of the date stated in the **policy schedule**. The **policy** anniversary shall be one **year** after the effective date and annually thereafter. The premium rate is not guaranteed. On each such anniversary, this **policy** is renewable at the premium rates in effect at that time as notified by **us**. **We** will give **you** at least thirty (30) days written notice in the event of premium revision. Renewability is at **our** option and is not guaranteed.

7.3 An **insured person** shall not be covered under more than one AXA Major Critical Illness plan with **us**. In the event an **insured person** is covered under more than one **plan**, **we** will consider that **insured person** to be insured under the **policy** which provides the highest benefit. When the benefit under each of such policies is identical, **we** will consider that **insured person** to be insured under the policy first issued.

7.4 Subject to the other terms of this **policy**, cover under this **policy** shall also automatically terminate on the earliest occurrence of any of the following events:

(i) **policy** lapsing due to non-payment of premium

(ii) when **insured person** reaches seventy (70) years of age (next birthday)

(iii) the date the **policy** is terminated whether by cancellation, death of **insured person** or for any reason whatsoever;

(iv) any benefit under 'Major Critical Illness' is paid out under this **policy**;

(v) upon cancellation or termination of the **policyholder's** coverage under the **Smart***Business* policy; or

(vi) **we** withdraw this **policy / plan** from the market.

7.5 **We** can change all or any part of the **policy** including the **policy schedule** or these terms for the reasons shown in **our policy**, and the changes will only apply to **you** when **you** renew unless **we** are obliged by law to apply any change with immediate effect. **We** will give **you** thirty (30) days prior notice of the details of changes. The changes will take effect from the next renewal or as required by law, whichever is earlier.

7.6 Unless otherwise expressly provided for by endorsement in the **policy**, **we** shall be entitled to treat **you** as the absolute owner of the **policy**. **We** shall not be bound to recognise any equitable or other claim to or interest in the **policy**, and the receipt of the **policy** or a benefit by **you** (or by your legal or authorised representative) alone shall be an effective discharge of all obligations and liabilities of **ours**.

7.7 Any change, approval, or other statement relating to your **policy** must be confirmed, in writing, by **us**. **We** are not bound by any verbal commitment not confirmed by **us** in writing.

7.8 **We** do not pay for administration costs or reports of any kind.

7.9 In the event of any dishonesty or fraud in procurement of this **policy** or in deriving any benefits, **we** can, at our sole and absolute discretion,:

- refuse to make any payment; and
- refuse to renew your **policy**; or
- impose different terms to any cover **we** are prepared to provide; or
- end your **policy** and all cover under it immediately.

7.10 All differences arising out of this **policy** shall be referred to an Arbitrator who shall be appointed in writing by the parties in difference. In the event they are unable to agree on who is to be the Arbitrator within one (1) month of being required in writing to do so then both parties shall be entitled to appoint an Arbitrator each who shall proceed to hear the differences together with an Umpire to be appointed by both Arbitrators. However this is provided that any disclaimer of liability by **us** for any claim hereunder must be referred to an Arbitrator within twelve (12) calendar months from date of such disclaimer.

7.11 No action at law or in equity shall be brought to recover on this **policy** prior to expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this **policy**. If the **insured person** shall fail to supply the requisite proof of loss as stipulated by the terms, provisions and conditions of the **policy**, the **insured person** may, within a grace period of one (1) calendar year from the time that the written proof of loss to be furnished, submit the relevant proof of loss to **us** with cogent reason(s) for the failure to comply with the **policy** terms, provisions and conditions. The acceptance of such proof of loss shall be at the sole and entire discretion of **ours**. After such grace period has expired, **we** will not accept, for any reason whatsoever, such written proof of loss.

7.12 All payments under this **policy** shall be made in Malaysian Ringgit.

if any problems arise…

Our AXA managers are here to help. This must be your first point of contact:

In the unlikely event that your complaint is unresolved, please write to:

Customer Service Department
AXA Affin General Insurance Berhad
Ground Floor, Wisma Boustead, 71 Jalan Raja Chulan, 50200, Kuala Lumpur, Malaysia.

who will investigate the matter independently.

Having received a reply from our Customer Service Department, if you are still not happy with the way in which a complaint has been handled, you must then write to:

The Chief Executive Officer
AXA Affin General Insurance Berhad
Ground Floor, Wisma Boustead, 71 Jalan Raja Chulan, 50200, Kuala Lumpur, Malaysia.

If your complaint arises over a claims issue, you may write to the Ombudsman for Financial Services at the following address:

Ombudsman for Financial Services, Level 14, Main Block, Menara Takaful Malaysia, No. 4, Jalan Sultan Sulaiman, 50000 Kuala Lumpur.
Tel: (603) 2272 2811 Fax: (603) 2272 1577

Submit your complaints/feeback at:
Laman Informasi, Nasihat dan Khidmat (LINK), Bank Negara Malaysia; or call BNMTELELINK at 1-300-88-5465; or fax to 03-2174 1515; or e-mail to bnmtelelink@bnm.gov.my; or send letter to P.O Box 10922, 50929 Kuala Lumpur.

Please note: you can only write to the Bureau when you have gone through the required stages of the complaints procedure set out above.

Please remember to quote policy numbers on all correspondence.

Your customer charter

As a valued customer of AXA you have important rights and entitlements. You are entitled to expect:

Courtesy. Your requirements will always be dealt with promptly, considerately and courteously. No customer query is too trivial to us or too much trouble to sort out.

Helpful advice and guidance. AXA staff will help you, if you have any doubts, in understanding the terms of your contract and any other factors which affect your cover. They will help you to make proper use of your cover should you need to make a claim.

Confidential handling of your personal details and affairs wherever possible. Any detail we require (medical or non-medical) will always be kept confidential. However, we may be required to provide information regarding claims you make or have made in the past or other details you have given us to your sponsor or employer or a government department if they are paying for all or part of this policy or are entitled by law to require this of us. In such instance, no liability will be accepted by us for any outcome resulting from the provision of such information to any of the aforementioned parties. For more details, please refer to our Data Privacy Notice contained in our website.

Advance notification of change in cover. Essential changes to the terms of the cover (including benefits, premiums and your policy) will be notified to you, in writing, thirty (30) days in advance of the date from which the changes take effect.

Professional and efficient service. All requests for assistance and any claims you submit will be considered impartially (without any bias or preference) in accordance with the benefits and policy of your plan.

For further information contact your AXA office, details of which can be found below.

Your AXA office

Customer Service Department
AXA Affin General Insurance Berhad
Ground Floor, Wisma Boustead,
71 Jalan Raja Chulan,
50200, Kuala Lumpur,
Malaysia
Tel: (603) 2170 8282
Fax: (603) 2031 7282
Email: customer.service@axa.com.my
Website: www.axa.com.my