6. If a Covered Person dies abroad, the Company will pay the cost of taking the body back to the Principal Country of Residence, or Home Country.

7. a. The Company will not be liable for any failure to provide the Service or for any delays in providing it unless the failure or delay is caused by the Company's negligence (including that of the international assistance company the Company has appointed to act for the Company) or of agents appointed by either.
   b. The Company will not be liable for failure or delay in providing the Service:
      7.1.1. if, by law, the Service cannot be provided in the country in which it is needed; or
      7.1.2. if the failure or delay is caused by any reason beyond the Company's control including but not limited to strikes, flight conditions and/or visa restrictions.
      7.1.3. The Company is not liable for Injury or death caused to the Covered Person while he or she is being moved unless it is caused by the Company's negligence or the negligence of anyone acting on the Company's behalf.

8. Benefits for any Treatment received by the Covered Person following repatriation or evacuation will be paid as set out in terms and condition of the insured's Plan.

How the service works:

When the Covered Person is away from his/her Principal Country of Residence

- In the event of Covered Person suffering sudden illness or Injury whilst away from his/her Principal Country of Residence and requiring immediate in-patient Treatment, the Covered Person should contact the Emergency Control Centre.
- The Emergency Control Centre will assess the situation and advise if evacuation of the Covered Person is appropriate.
- If the Emergency Control Centre advises that evacuation of the Covered Person is appropriate, they will make all the arrangements to get the Covered Person to the nearest place where appropriate services are available and where he/she will be treated in accordance with the benefits of his/her Plan.
- If the Covered Person is under eighteen (18) years of age, or in other cases where the Emergency Control Centre consider that the Covered Person's Medical Condition makes it appropriate, another person over the age of eighteen (18) years may accompany the Covered Person while they are being moved.

When the Covered Person is in his/her Principal Country of Residence

- In the event of the Covered Person requiring in-patient Treatment which is not available within his/her Principal Country of Residence, the Covered Person should contact the Emergency Control Centre.
- The Emergency Control Centre will assess the situation and decide if it is necessary to evacuate the Covered Person to another Hospital where the necessary services are available.
- If the Emergency Control Centre considers it is necessary to evacuate the Covered Person, it will make all the arrangements to get the Covered Person to a suitable place for the Treatment to take place. This may be in another country.
- Once evacuated the Covered Person will be treated in accordance with the benefits of their Plan.
- If the Covered Person is under eighteen (18) years of age, or in other cases where the Emergency Control Centre considers that the Covered Person's Medical Condition makes it appropriate, another person over the age of eighteen (18) years may accompany the Covered Person while they are being moved.

If a Covered Person should die while away from his/her Principal Country of Residence

- The family of the Covered Person should contact the Emergency Control Centre who will arrange for the body of the deceased to be taken back to the Principal Country of Residence, or Home Country.

Important

All cases must be assessed by the Emergency Control Centre, be deemed necessary for evacuation and/or repatriation, and all arrangements must be made by the Emergency Control Centre in order to ensure that related costs are covered by the Service.

If the Covered Person makes his/her own arrangements, its costs will not be covered. Entitlement to the Service does not mean that the Covered Person's Treatment following evacuation or repatriation will be eligible for benefit. Any such Treatment will be subject to the terms and conditions of your Plan.

The exclusions in the Policy do not apply to the Service but will apply to any Treatment received following repatriation to the Principal Country of Residence, or any country to which the Covered Person has been evacuated.

If the Service is needed you must contact the emergency control centre so that immediate help or advice can be given over the phone. Arrangements may then be made for an Appointed Doctor to make all necessary enquiries

and arrange to move them if necessary. If an Appointed Doctor thinks it is necessary then the Service will be carried out under medical supervision.

Exclusions:
The Service is not available to cover the following:

a. any Medical Condition which does not need immediate in-patient Hospital Treatment or which does not prevent the Covered Person from continuing to travel or to work.
b. the Covered Person's participation in base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 meters, trekking to a height of over 2,500 meters, bungee jumping, canyoning, hangliding, paragliding or microlighting, parachuting, potholing, skiing off-piste or any other winter sports activity carried out off-piste.
c. if the Covered Person needs to be moved from a ship, oil-rig platform or similar off-shore location.
d. any costs that the Company does not approve beforehand.
e. if the Company has not been told about the Accident or illness for which the Service is needed within 30 days of its happening.
f. at the time of travel the Covered Person is travelling to a country or area that the Ministry of Foreign Affairs, Thailand lists as a place which, for any reason, it advises against.

Section 8: Psychiatric Treatment

Insuring Agreement

While this Policy is in force, if the Covered Person sustains Sickness, resulting him/her to require a Psychiatric Treatment, the Company will pay for the Reasonable and Customary cost of psychiatric illness Treatment up to the level shown in the policy schedule. The Insured or Covered Person must contact the Company to obtain a written approval of the Treatment planned and the proposed cost before Treatment begins. The limit shown applies to in-patient, daycare and out-patient Treatment in aggregate.

Section 9: Accidental Damage to Teeth

Insuring Agreement

While this Policy is in force, if the Covered Person sustains Injury from an Accident, resulting him/her to require an immediate Treatment (within seven (7) days) following Accidental damage to natural teeth caused by an external trauma when that Treatment is given by a Medical Practitioner, the Company will pay for the Reasonable and Customary cost of initial Treatment incurred up to the limits stated for this benefit in the policy schedule.

Additional Exclusions applicable to Section 9

The insurance Policy does not cover the cost of follow-up Treatment or Treatment required as a result of consumption of food or drink or any foreign bodies contained in such food or drink.

Section 10: Pre- and Post- natal complications

Insuring Agreement

While this Policy is in force, if the Covered Person has been continuously covered under this insurance Policy for 12 consecutive months and has effected the annual renewal of that Plan for the coming Policy Year, the Company will, subject to the limitations and exclusions of this Policy, pay for the Reasonable and Customary cost of Treatment of both the mother (being the Covered Person) and any unborn child up to the moment of delivery. Thereafter cover will be restricted to eligible Treatment for the mother alone. Any newborn infant may be added as a Covered Person to the mother's Policy and enjoy cover commencing at the time of birth provided the Company is requested to add that infant to the mother's Policy within 30 days from the time of birth and mother is a Covered Person under the Policy at the time of delivery. If the mother is not the Covered Person at the time of delivery a newborn baby may only be added to the father's Policy and be eligible for benefit after final discharge of the child into parental care. This benefit does not cover the costs of delivery of any child whether such delivery is normal, by caesarean section or by any other assisted means.

This benefit will not automatically be upgraded to a higher level of Plan. In the case of an upgrade in cover these benefits will be restricted to the level of the original Plan until the Covered Person has been covered under

the upgraded Plan for a period of not less than 12 consecutive calendar months and has effected the annual renewal of the upgraded Plan.

Section 11: New Born Accommodation

Insuring Agreement

While this Policy is in force, the Company will pay for the child who is less than 16 weeks old to stay in the Hospital with the mother (being the Covered Person) while she is receiving eligible inpatient Treatment at such Hospital. This is paid from the mother's (being the Covered Person) Policy.

Section 12: Vaccination

Insuring Agreement

The Company will pay for the Reasonable and Customary cost of necessary vaccinations up to the limit shown in the policy schedule.

Section 13: Hospice and Palliative Care

Insuring Agreement

While this Policy is in force, if the Covered Person has been continuously covered under this insurance Policy for 12 consecutive months and has effected the annual renewal of that Plan for the coming Policy Year, this benefit becomes available when the Covered Person is admitted to a specialist palliative care centre or hospice, recognized by the Company, following diagnosis, written confirmation (including medical evidence) by a Medical Practitioner that the Covered Person is suffering from a terminal eligible Medical Condition or conditions. The benefit must be pre-authorized, in writing, by the Company in advance of admission. Once the Covered Person is admitted, all costs of care and any Treatment related to the terminal condition and related conditions will be taken from this benefit and may not be claimed from any other benefit applicable to the Covered Person's Plan. Any eligible Medical Conditions not related to the Covered Person's terminal condition will be covered under the Covered Person's normal Plan benefits. The Company reserve the right to determine, on the advice of its medical panel, whether a Medical Condition is or is not related to the terminal Medical Condition.

This benefit is payable, up to the limit shown for the Covered Person's Plan, once in a Covered Person's Lifetime, in aggregate for all such conditions. The Covered Person must maintain the same level of cover throughout the palliative or hospice care admission. This means that, if the period of palliative or hospice care falls across a Policy anniversary, the Covered Person must pay the premium for the subsequent Year or else the benefit will cease at the Policy anniversary. In the event that the costs of the Covered Person's admission reach the limit shown for this benefit, no further benefit will be payable. Once the limit of this benefit is reached no benefit of any kind will be payable in respect of any Medical Condition for which palliative and/or hospice care has been received.

This benefit will not automatically be upgraded to a higher level of Plan. In the case of an upgrade in cover this benefit will be restricted to the level of the original Plan until the Covered Person has been covered under the upgraded Plan for a period of not less than 12 consecutive months and has effected the annual renewal of the upgraded Plan. The waiting period will apply in the event of an upgrade in cover

Section 14: Personal Accident Insurance

Definitions:

Permanent Dismemberment	Refers to the loss of body organ from the wrist joint, the ankle joint, and also the loss of use of that organ, which according to the medical indication, will never be able to function at any time in the future
Loss of sight	Refers to complete blindness, which is permanently incurable.
Total Permanent Disability	Refers to disability to the extent of being unable to perform the normal duty in the Covered Person's regular occupation or any other occupation totally and permanently.
Partial Permanent Disability	Refers to disability to the extent of being unable to perform the normal duty in the Covered Person's regular occupation permanently but being able to perform other work for remuneration.

Insuring Agreement:

While this Policy is in force, if the Covered Person sustains Injury and it causes loss of life, dismemberment, loss of sight, loss of hearing, loss of speech, or permanent disability within 180 days from the date of the Accident or Injury causes the Covered Person to receive continuous medical Treatment as an in-patient in Hospital and loss of life occurs later because of such Injury, the Company shall pay compensation in accordance with the sum insured stated in the policy schedule as follows:

1. 100% of the sum insured for loss of life
2. 100% of the sum insured for permanent disability which continues not less than 12 months after the Accident or if there is any medical indication that the Covered Person suffers permanent disability
3. 100% of the sum insured for loss of both hands from the wrist joint, or both feet from the ankle joint, or loss of sight for both eyes
4. 100% of the sum insured for loss of one hand from the wrist joint and one foot from the ankle joint
5. 100% of the sum insured for loss of one hand from the wrist joint and loss of sight in one eye
6. 100% of the sum insured for loss of one foot from the ankle joint and loss of sight in one eye
7. 60% of the sum insured for loss of one hand from the wrist joint
8. 60% of the sum insured for loss of one foot from the ankle joint
9. 60% of the sum insured for loss of sight in one eye
10. 50% of the sum insured for permanent loss of hearing or speech
11. 15% of the sum insured for permanent loss of hearing in one ear
12. 25% of the sum insured for loss of a thumb (two joints)
13. 10% of the sum insured for loss of a thumb (one joint)
14. 10% of the sum insured for loss of an index finger (three joints)
15. 8% of the sum insured for loss of an index finger (two joints)
16. 4% of the sum insured for loss of an index finger (one joint)
17. 5% of the sum insured for loss of each finger (not less than two joints) other than a thumb and an index finger
18. 5% of the sum insured for loss of a big toe
19. 1% of the sum insured for loss of each toe (not less than on joint) other than a big toe

The Company shall pay only the item of loss with the greatest amount of compensation. In the event of loss of fingers or toes permanently under item 12 to 19 which cannot be claimed under item 1 to 9, the Company will pay combined compensation according to the amount applicable under each loss item but not exceeding the sum insured as stated in the policy schedule.

In the event of partial permanent disability which cannot be claimed under item 2 to 19 and not being loss of use pertinent to a loss of sense of taste or smell, the Company will pay compensation based on the opinion of the Company's appointed physician but not exceeding 50% of the sum insured as stated in the policy schedule.

The Company shall pay the benefit in total not more than sum insured as stated in the policy schedule during the effective period of the Policy. If the total benefit is not fully paid, the Company shall liable only for the remaining sum insured until the expiry date of the Policy.

Claim for compensation in case of death

The beneficiary is required to send the following evidences to the Company within 30 days commencing from the date of death of the Insured / Covered Person at the expense of the beneficiary.

1. Claim Form as prescribed by the Company.
2. Death Certificate
3. Copy of Autopsy Report
4. Copy of Police Report
5. Copies of ID Card and House Registration with the mark as "Death" of the Insured / Covered Person.
6. Copies of ID Card and House Registration of the beneficiary

Claim in case of total permanent disability, dismemberment, loss of sight, loss of hearing, or loss of speech from Accident

The Policyholder or the Insured is required to send the following evidences to the Company within 30 days commencing from the date diagnosed by the physician as total permanent disability or dismemberment at the Policyholder or the Insured's expense.

1. Claim Form as prescribed by the Company.
2. Medical Certificate confirming total permanent disability, dismemberment, loss of sight, loss of hearing, or loss of speech

Failure to submit the documents within such time will not jeopardize the right to claim if sufficient reasons are given.

Remark: the English Language used in this Policy is merely a translation of Thai Version