CLAIMS MANUAL

This manual was prepared to document all procedures related to claims, as well as to show forms needed in processing each submitted claims.

I. DEFINITION OF TERMS

1. **MICRO-INSURANCE** - Insurance products that offer coverage to low-income households. A micro-insurance plan provides protection to individuals who have little savings and is tailored specifically for lower valued assets and compensation for illness, injury or death.
2. **CLAIMS -** A formal request to an insurance company asking for a payment based on the terms of the insurance policy. Insurance claims are reviewed by the company for their validity and then paid out to the insured or requesting party (on behalf of the insured) once approved.
3. **Accident** - An unforeseen, unintended event.
4. **Accidental death benefits** - If a life insurance policy includes an accidental death benefit, the cause of death will be examined to determine whether the insured´s death meets the policy´s definition of accidental
5. **Application** - A form to be filled out with personal information that an insurance company will use to decide whether to issue a policy and how much to charge.
6. **Assured** - refers to the person for whose benefit the insurance is granted.
7. **Beneficiary** - The person, people, or entity designated to receive the death benefits from a life insurance policy or annuity contract.
8. **Certificates of coverage -** Printed materials showing members of a group the benefits of the plans as provided by the group master policy
9. **Claimant** - A person who makes an insurance claim.
10. **Complaint** - A written communication primarily expressing a grievance against an insurance company or agent.
11. **Contestable period** - A defined period of time within which a life insurance company may deny payment of a claim or determine valid cause of non-coverage because of suicide or a material misrepresentation on an application.
12. **Contract** - In most cases, an insurance policy. A policy is considered to be a contract between the insurance company and the policyholder.
13. **Credit life insurance** - This is a special type of coverage between an insurance company and a creditor usually designed to pay off a loan or charge account balance if the policyholder dies.
14. **Death benefit** - Amount paid to the beneficiary upon the death of the insured.

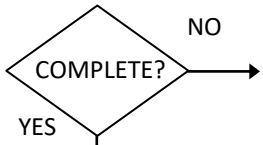
15. **Effective date** - The date on which an insurance policy becomes effective.
16. **Eligible member/employee –** A member or employee who meets the eligibility requirements for coverage in a group plan.
17. **Exclusions or limitations -** Provisions that exclude or limit coverage of certain named diseases, medical conditions, or services, as well as some sicknesses or accidents that occur under specified circumstances.
18. **Expiration date** - The date on which an insurance policy expires.
19. **Grace period** - The time, during which a policy remains in force after the premium is due but not paid. The policy lapses as of the day the premium was originally due unless the premium is paid on or before the end of the 60 days, after the due date.
20. **Group life insurance** - This type of life insurance provides coverage to a group of people under one contract. Most group contracts are sold to businesses that want to provide life insurance for their employees or members. Group life insurance can also be sold to associations to cover their members and to lending institutions to cover the amounts of their debtor loans. Most group policies are for term insurance. Generally, the business will be issued a master policy and each person in the group will receive a certificate of coverage.
21. **Incontestability** - A provision that places a time limit on a life insurance company´s right to deny payment of a claim because of suicide or a material misrepresentation on ones application.
22. **Insured** - The individual person covered by an insurance policy.
23. **Insurer** - The insurance company.
24. **Irrevocable beneficiary** - A named beneficiary whose rights to life insurance policy proceeds are vested and whose rights cannot be canceled by the policy owner unless the beneficiary consents.
25. **Lapse** - The termination of an insurance policy because a renewal premium is not paid by the end of the grace period.
26. **Loss** - The amount an insurance company pays on a claim.
27. **Policy** - The contract issued by the insurance company to the insured.
28. **Policy period** - The period a policy is in force, from the beginning or effective date to the expiration date.
29. **Premium** - The amount paid by an insured to an insurance company to obtain or maintain an insurance policy.
30. **Reinstatement** - The process by which a life insurance company puts a policy back in force after it lapsed because of nonpayment of renewal premiums.
31. **Renewal** - Continuation of a policy after its expiration date.

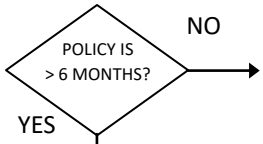
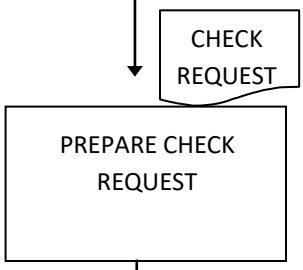
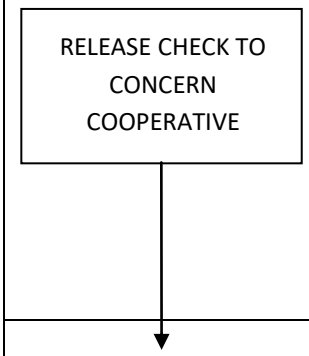
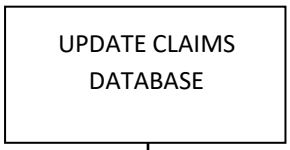
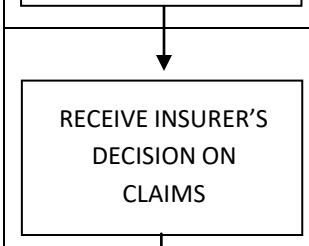
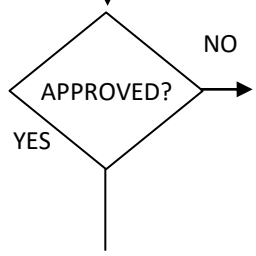
II. NATCCO MBAI CLAIMS PROCESS FLOW

DAMAYAN

PROCESS NAME	**CLAIMS ADMINISTRATION FOR DAMAYAN (FAMILY YEARLY RENEWABLE PLAN - FYRP)**
PROCESS OWNER	**CLAIMS ASSOCIATE**
PREPARED BY	**MINES TEJADA – GM, NATCCO- MBAI**
DATE	**May 8, 2015**
VERSION#	**1**

PROCESS FLOW	PROCESS DESCRIPTION	REQUIREMENTS/ RULES/ DEADLINES	STAFF RESPONSIBLE
START			
RECEIVE CLAIMS APPLICATION	1. Receive claims application from MICOOP and direct Cooperative Partners. 2. Log new transaction in the "Claims database".	a. MICOOP/Direct Coop does the initial screening of application form and required documents.	Claims Associate (Jennifer Estocada)
VALIDATE COVERAGE	3. Validate if policy owner is included in NATCCO_MBAI list of official enrollees.	a. Validate using NATCCO_MBAI database of enrollees b. **Turn-around time** b.1 Application received from 8:30am-12:00nn: **up to 6:00pm of the same day** b.2 Application received from 1:00pm-6:00pm: **up to 12:00nn of the following work day**.	Claims Associate (Jennifer Estocada)
POLICY OWNER COVERED? NO / YES	4. Return the application form to MICOOP or direct Cooperative Partner and inform that it is not insured with NATCCO_MBAI.	a. Record return of documents, and keep the receiving copy.	Claims Associate (Jennifer Estocada)
VERIFY DOCUMENTS	5. Check all documents submitted. (See attached checklist)	a. **Turn-around time** a.1 Application received from	Claims Associate (Jennifer Estocada)

	6. Ensure 100% submission of requirements, as well as validity of documents.	8:30am-12:00nn**: up to 6:00pm of the same day** a.2 Application received from 1:00pm-6:00pm: **up to 12:00nn of the following work day** b. For the complete list of requirements, refer to the "Claim Form".	
	7. Return application form to MICOOP and inform them of the list of lacking requirement(s). Ask them to re-submit the claims application form once completed. 8. For direct Cooperative Partner, inform them, through email, on the list of lacking requirement(s), and ask them to submit those immediately. Keep the file and note that it is still with lacking requirements.	a. Return application form within the same day of documents validation, and file the receiving copy.	Claims Associate (Jennifer Estocada) MICOOP Posting Clerk (Yani Yugo)
SUBMIT DOCUMENTS TO REINSURER	9. Forward all documents to reinsurer. 10. Record the forwarded claims in the database.	a. Photocopy all documents and keep these as MBAI file. b. Forward the submitted documents to concern insurer, with covering memo stating the summary of claims. - Ask the reinsurer to send their messenger to pick-up the claims documents from MBAI office. - Ensure that the receiving copy is properly signed, with printed full name and date is also indicated.	Claims Associate (Jennifer Estocada)

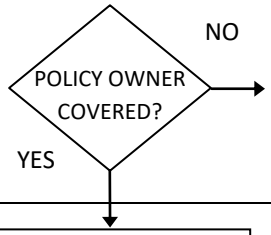
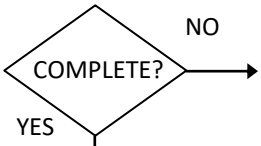
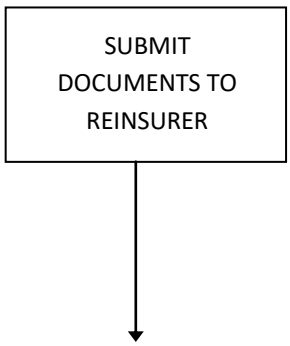
	11. If policy is within MBAI's contestability period, which is 6 months, wait for reinsurer's decision on claim.		
	12. If policy is beyond contestability period, MBAI will advance release the benefit amount to the beneficiary. 13. Prepare cheque request. 14. Forward to Accounting Staff.		Claims Associate (Jennifer Estocada) Accounting Staff (Jemilyn Antipuesto)
	15. Upon receipt of check from Accounting staff, release the cheque to concern cooperative via bank deposit. 16. Record cheque details in the claims database. 17. Inform cooperative of the deposited /released cheque.	a. Release check within the same day of receipt from Accounting staff. b. Forward original bank's validation receipt to Accounting staff. Keep the photocopy in the claims file.	Claims Staff (Jennifer Estocada) Accounting Staff (Jemilyn Antipuesto)
	18. Update claims database and indicate if claims is approved or denied.		
	19. Receive insurer's decision on submitted claims.	a. Average turn-around time: 2 weeks from submission date	Claims Associate (Jennifer Estocada)
	20. Generate and send denial letter for MICOOP/Direct Cooperative. 21. File all related-documents.	a. Using MBAI letterhead, generate the letter. Use the insurer's decision/explanation as reference.	Claims Associate (Jennifer Estocada)

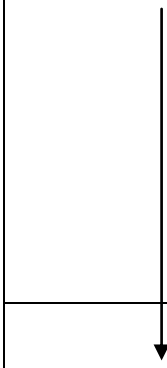
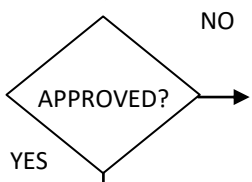
UPDATE CLAIMS DATABASE	22. Forward check to Accounting Staff to records payment and 23. deposit to MBAI bank account. 24. Update claims database and indicate if claims is approved or denied.		
END			

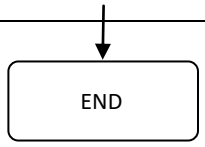
LGP

PROCESS NAME	**CLAIMS ADMINISTRATION FOR LOAN GUARANTEE PLAN (LGP)**
PROCESS OWNER	**CLAIMS ASSOCIATE**
PREPARED BY	**MINES TEJADA – GM, NATCCO- MBAI**
DATE	**April 29, 2015**
VERSION#	**1**

PROCESS FLOW	PROCESS DESCRIPTION	REQUIREMENTS/ RULES/ DEADLINES	STAFF RESPONSIBLE
START			
RECEIVE CLAIMS APPLICATION	25. Receive claims application from MICOOP and direct Cooperative Partners. 26. Log new transaction in the "Claims database".	b. MICOOP does the initial screening of application form and required documents.	Claims Associate (Jennifer Estocada)
VALIDATE COVERAGE	27. Validate if policy owner is included in NATCCO_MBAI list of official enrollees.	c. Validate using NATCCO_MBAI database of enrollees d. **Turn-around time** b.1 Application received from 8:30am-12:00nn: **up to 6:00pm of the same day** b.2 Application received from 1:00pm-6:00pm: **up to 12:00nn of the following work day.**	Claims Associate (Jennifer Estocada)

	28. Return the application form to MICOOP or direct Cooperative Partner and inform that it is not insured with NATCCO_MBAI.	b. Record return of documents, and keep the receiving copy.	Claims Associate (Jennifer Estocada)
	29. Check all documents submitted. (See attached checklist) 30. Ensure 100% submission of requirements, as well as validity of documents.	c. **Turn-around time** a.1 Application received from 8:30am-12:00nn: **up to 6:00pm of the same day** a.2 Application received from 1:00pm-6:00pm: **up to 12:00nn of the following work day** d. For the complete list of requirements, refer to the "Claim Form".	Claims Associate (Jennifer Estocada)
	31. Return application form to MICOOP and inform them of the list of lacking requirement(s). Ask them to re-submit the claims application form once completed. 32. For direct Cooperative Partner, inform them, through email, on the list of lacking requirement(s), and ask them to submit those immediately. Keep the file and note that it is still with lacking requirements.	b. Return application form within the same day of documents validation, and file the receiving copy.	Claims Associate (Jennifer Estocada) MICOOP Posting Clerk (Yani Yugo)
	33. Forward all documents to reinsurer. 34. Record the forwarded claims in the database.	c. Photocopy all documents and keep these as MBAI file. d. Forward the submitted documents to concern insurer, with covering memo stating the summary of claims. - Ask the reinsurer to send their messenger to	Claims Associate (Jennifer Estocada)

		pick-up the claims documents from MBAI office. - Ensure that the receiving copy is properly signed, with printed full name and date is also indicated.	
RECEIVE INSURER'S DECISION ON CLAIMS	35. Receive insurer's decision on submitted claims.	b. Average turn-around time: 2 weeks from submission date	Claims Associate (Jennifer Estocada)
	36. Generate and send denial letter for MICOOP/Direct Cooperative. 37. File all related-documents.	b. Using MBAI letterhead, generate the letter. Use the insurer's decision/explanation as reference.	Claims Associate (Jennifer Estocada)
CHECK REQUEST PREPARE CHECK REQUEST	38. Prepare check request and forward to Accounting Staff.	a. Turn-around time Insurer's decision that is/are received from 8:30am-12:00nn: up to 6:00pm of the same day b. Insurer's decision that is/are received from 1:00pm-6:00pm: up to 12:00nn of the following work day	Claims Associate (Jennifer Estocada) Accounting Staff (Jemilyn Antipuesto)
RELEASE CHECK TO CONCERNED COOPERATIVE	39. Upon receipt of check from Accounting staff, release the check to concern cooperative via bank deposit. 40. Record check details in the claims database. 41. Inform cooperative of the deposited /released check.	c. Release check within the same day of receipt from Accounting staff. d. Forward original bank's validation receipt to Accounting staff. Keep the photocopy in the claims file.	Claims Staff (Jennifer Estocada)
UPDATE CLAIMS DATABASE	42. Update claims database and indicate if claims is approved or denied.		

III. NATCCO MBAI: CLAIMS PROVISIONS AS SPECIFIED IN RULES AND REGULATIONS OF THE MUTUAL AID SYSTEM (MAS)

V. CLAIMS

BENEFICIARIES. *A member shall have the right to designate anybody, not disqualified by law, as his beneficiary or beneficiaries, and may at anytime, designate new beneficiary or beneficiaries by filing a properly completed written request on a form satisfactory to the Association. Such change shall take effect only when recorded in writing by the Association at its Home Office but without prejudice to the Association on any payment made before receipt of such notice.*

The death benefit shall be payable to the Member's designated beneficiary or beneficiaries, if surviving; or if there be no beneficiaries designated or surviving at the death of the Member, to the surviving class of the following classes of successive preference beneficiaries:

the member's:

a. *widow or widower*
b. *surviving children born or legally adopted by the member*
c. *surviving parents*
d. *surviving brothers and sisters*
e. *executors and administrators*

Surviving beneficiaries in the same beneficiary classification share equally in the death benefit proceeds for that beneficiary classification, unless otherwise specified.

FILING OF CLAIM. *A claim for death benefit shall be filed with the Association's office within six (6) months after death of Member or in case of accidental death, within thirty (30) days from the date of accident causing death, or as soon thereafter as is reasonably possible. Failure to comply within the time provided shall not invalidate nor reduce if it was given as was reasonably possible.*

The claim should be accompanied with the appropriate proofs in accordance with the prevailing guidelines of the Association and the Insurance Commission.

***PAYMENT OF CLAIM**. Claims shall be paid within ten (10) working days from receipt of complete documents. The Association shall establish procedures and guidelines to deliver the benefit payments, in full or in part, earlier than the period stated above to enable the family or beneficiaries of the Member to meet urgent burial needs.*

IV. CLAIMS PROCESSOR'S CHECKLIST – see attachment

V. LIST OF CRITICAL ILLNESSES

1. Heart Attack

The death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply and being evidenced by:

(a) A history of typical prolonged chest pain; and

(b) New electrocardiographic changes resulting from this occurrence; and

(c) Elevation of the cardiac enzyme (CPK-MB) above the generally accepted laboratory levels of normal.

Diagnosis based on the elevation of Troponin-T test alone shall not be considered diagnostic of a heart attack.

Angina is specifically excluded.

2. Stroke

Defined as a cerebrovascular accident or incident producing neurological sequelae of a permanent nature, having lasted not less than six months. Infarction of brain tissue, hemorrhage and embolisation from an extra-cranial source are included. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a Consultant Neurologist.

Specifically excluded are cerebral symptoms due to transient ischaemic attacks, any reversible ischaemic neurological deficit, vertebrobasilar ischaemia, cerebral symptoms due to migraine, cerebral injury resulting from trauma or hypoxia and vascular disease affecting the eye or optic nerve or vestibular functions.

3. Coronary Artery Disease Requiring Surgery

Refers to the actual undergoing of coronary artery by-pass surgery by way of thoracotomy to correct or treat coronary artery disease but not including angioplasty, other intra-arterial, keyhole or laser procedures.

4. Cancer

Cancer is defined as the uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist treatment or surgery (excluding endoscopic procedures alone) is considered necessary. The cancer must be confirmed by histological evidence of malignancy.

The following conditions are excluded:-

(a) Carcinoma in situ including of the cervix

(b) Ductal Carcinoma in situ of the breast

(c) Papillary Carcinoma of the bladder and Stage 1 Prostate Cancer

(d) All skin cancers except malignant melanoma

(e) Stage I Hodgkin's disease

(f) Tumors manifesting as complications of Acquired Immune Deficiency Syndrome.

5. Kidney Failure

End stage kidney failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated or renal transplantation carried out.

6. Fulminant Viral Hepatitis

This is defined as a sub massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure.

The diagnostic criteria to be met are:

(a) A rapidly decreasing liver size as confirmed by abdominal ultrasound; and

(b) Necrosis involving entire lobules, leaving only a collapsed reticular framework; and

(c) Rapidly deteriorating liver functions tests; and

(d) Deepening jaundice.

Hepatitis B infection or carrier status alone does not meet the diagnostic criteria.

7. Major Organ Transplant

The actual undergoing of a transplant as a recipient of one of the following human organs:

(a) Kidney

(b) Lung(s)

(c) Liver

(d) Heart

(e) Bone marrow

8. Paralysis / Paraplegia

The complete and permanent loss of use of both arms or both legs, or one arm and one leg, through paralysis caused by illness or injury persisting for at least six (6) months from the date of trauma or illness.

9. Multiple Sclerosis

Unequivocal diagnosis by a Consultant Neurologist confirming the following combination, which has persisted for at least a continuous period of six (6) months:

(a) Symptoms referable to tracts (white matter) involving the optic nerves, brain stem and spinal cord, producing well-defined neurological deficits; and

(b) A multiplicity or discrete lesions; and

(c) A well-documented history of exacerbation and remissions of said symptoms / neurological deficits.

10. Primary Pulmonary Arterial Hypertension

Means primary pulmonary hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterization, resulting in permanent irreversible physical

impairment to the degree of at least Class 3 of the New York Heart Association Classification of cardiac impairment, and resulting in the Life Assured being unable to perform his/her usual occupation.

11. Blindness

The total, permanent and irrecoverable loss of the sight of both eyes. Certification by an ophthalmologist is necessary.

12. Heart Valve Replacement

The actual undergoing of open-chest surgery to replace or repair cardiac valves as a consequence of heart valve defects or abnormalities that have occurred after the date of issue or date of reinstatement of this contract.

Repair, via valvotomy, intra-arterial procedure, key-hole surgery or similar techniques are specifically excluded.

13. Loss Of Hearing / Deafness

Total, permanent and irreversible loss of hearing in both ears as a result of disease or accident. Medical evidence in the form of an audiometry and sound-threshold test must be provided.

14. Surgery To Aorta

The actual undergoing of surgery via a thoracotomy or laprotomy to repair or correct an aortic aneurysm, an obstruction of the aorta or a coarctation of the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

15. Loss of Speech

Total and irrecoverable loss of the ability to speak for a continuous period of 12 months. Medical evidence to confirm injury or illness to the vocal cords to support this disability must be supplied by an appropriate (Ear, Nose, Throat) specialist.

All psychiatric related causes are excluded.

16. Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders

Deterioration or loss of intellectual capacity or abnormal behavior as evidenced by the clinical state and accepted standardized questionnaires or tests arising from Alzheimer's Disease or irreversible organic degenerative brain disorders excluding neurosis, psychiatric illness, and any drug or alcohol related organic disorder, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Life Assured. The diagnosis must be clinically confirmed by an appropriate consultant.

17. Major Burns

Third degree burns covering at least twenty percent (20%) of the Life Assured's body surface area as measured by "The Rule of 9" • of the Lund & Browder Body Surface Chart.

18. Coma

A state of unconsciousness with no reaction or response to external stimuli or internal needs, persisting continuously for at least 96 hours, requiring the use of life support systems and resulting in a neurological deficit, lasting more than 30 days. Confirmation by a Consultant Neurologist must be present.

Coma resulting directly from self-inflicted injury, alcohol or drug misuse is excluded.

19. Terminal Illness

The Life Assured must be suffering from a condition, which in the opinion of an appropriate Medical Practitioner is highly likely to lead to death within 12 months. The Life Assured must no longer be receiving active treatment other than that for pain relief.

20. Motor Neurone Disease

Motor neurone disease of unknown aetiology is characterized by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. These include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis.

Diagnosis must be confirmed by a Consultant Neurologist.

21. AIDS Due To Blood Transfusion

The Life Assured being infected by HIV virus or AIDS provided that:

(a) the infection is due to blood transfusion received in Malaysia or Singapore after the commencement of the Policy; and

(b) the Life Assured is not a haemophiliac; and

(c) the Life Assured is not a member of any high risk groups such as but not limited to homosexuals, intravenous drug users or sex workers.

Notification and proof of incident will be required via a statement from a statutory Health Authority that the infection is medically acquired.

22. Parkinson's Disease

Unequivocal diagnosis of Parkinson's Disease by a Consultant Neurologist where the condition:

(a) Cannot be controlled with medication; and

(b) Shows signs of progressive impairment; and

(c) Activities of Daily Living assessment confirm the 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 excluded.

23. Chronic Liver Disease

End stage liver failure evidenced by permanent jaundice, ascites, encephalopathy and portal hypertension.

Wernicke's encephalopathy and liver failure secondary to alcohol or drug misuse is excluded.

24. Chronic Lung Disease

End stage respiratory failure including chronic interstitial lung disease.

The following criteria must be met:

(a) Requiring permanent oxygen therapy as a result of a consistent FEV1 test value of less than one liter.

(Forced Expiratory Volume during the first second of a forced exhalation); and

(b) Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less; and

(c) Dyspnoea at rest.

25. Major Head Trauma

Physical head injury causing significant permanent functional impairment lasting for a minimum period of three (3) months from the date of the trauma or injury. The resultant permanent

functional impairment is to be verified by a Consultant Neurologist and duly concurred by the Company's Medical Officer and must result in an inability to perform at least three (3) of the Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent", shall mean beyond the hope of recovery with current medical knowledge and technology.

26. Aplastic Anaemia

Chronic persistent bone marrow failure which results in total aplasia of the bone marrow and requires treatment with at least one of the following:

(a) Regular blood product transfusion

(b) Marrow stimulating agents

(c) Immunosuppressive agents

(d) Bone marrow transplantation

27. Muscular Dystrophy

The diagnosis of muscular dystrophy shall require a confirmation by a Consultant Neurologist of the combination of 3 out of 4 of the following conditions:

(a) Family history of other affected individuals

(b) Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction

(c) Characteristic electromyogram

(d) Clinical suspicion confirmed by muscle biopsy

No benefit will be payable under this Covered Event before the Life Assured had reached the age of 12 years next birthday.

28. Benign Brain Tumor

A life-threatening, non-cancerous tumor in the brain giving rise to characteristic signs of increased intra-cranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment. The presence of the underlying tumor must be confirmed by imaging studies such as CT Scan or MRI.

Cysts, granulomas, malformations in or of the arteries or veins of the brain, haematomas, tumors in the pituitary gland or spine and tumors of the acoustic nerve are excluded.

29. Encephalitis

Defined as severe inflammation of brain substance, resulting in permanent neurological deficit lasting for a minimum period of 30 days and certified by a Consultant Neurologist. The permanent deficit must result in an inability to perform at least three (3) of the Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" • , shall mean beyond the hope of recovery with current medical knowledge and technology.

Encephalitis as a result of HIV infection is excluded.

30. Poliomyelitis

Unequivocal diagnosis by a Consultant Neurologist of infection with the Poliovirus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness. Cases not

involving paralysis will not be eligible for this benefit. Other causes of paralysis (such as Guillain-Barre syndrome) are specifically excluded.

31. Brain Surgery

The actual undergoing of surgery to the brain under general anesthesia during which a craniotomy is performed. Bur Hole and brain surgery as a result of an accident is excluded.

32. Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit lasting for a minimum period of 30 days and resulting in a permanent inability to perform at least three (3) of the Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" • , shall mean beyond the hope of recovery with current medical knowledge and technology.

33. Other Serious Coronary Artery Disease

The narrowing of the lumen of at least three major arteries i.e. Circumflex, Right Coronary Artery (RCA), Left Anterior Descending Artery (LAD), by a minimum of 60 percent or more as proven by coronary arteriography. This benefit is payable regardless of whether or not any form of coronary artery surgery has been performed.

34. Apallic Syndrome

Universal necrosis of the brain cortex, with the brainstem remaining intact. Diagnosis must be confirmed by a Consultant Neurologist and condition must be documented for at least one month.

35. AIDS Cover of Medical Staff

Infection by any Human Immunodeficiency Virus (HIV) only if the Life Assured is a Medical Staff as defined below, and that such infection was considered by the medical authorities involved to be caused by a needlestick/sharp instrument injury or by exposure to blood or bloodstained body fluid which occurred after the commencement of the Policy. The accident must have occurred whilst the Life Assured was following his normal occupational duties and reported in accordance with the established occupational procedures for such accidents. The Life Assured must, within 5 days of the accident have undergone a blood test indicating the absence of HIV or its antibodies but a further blood test performed within 6 months of the accident must indicate the presence of HIV or its antibodies after the commencement of the Policy.

However, the benefit payable will not apply if any medical cure is found for Acquired Immune Deficiency Syndrome or the effects of the HIV virus or a medical treatment is developed which results in the prevention of the occurrence of AIDS.

'Medical Staff' • is defined as Doctors (General Physicians and Specialists), nurses, laboratory technicians, dentists (surgeons and nurses), ambulance workers who are working in the medical centre or hospital or dental clinics/polyclinics in Malaysia.

36. Full Blown AIDS

The clinical manifestation of AIDS (Acquired Immune-deficiency Syndrome) must be supported by the results of a positive HIV (Human Immuno-deficiency Virus) antibody test and a confirmatory Western Blot test. In addition, the Life Assured must have a CD4 cell count of less than two hundred (200) and one or more of the following criteria are met:

(a) Weight loss of more than 10% of body weight over a period of six (6) months or less (wasting syndrome)
(b) Kaposi Sarcoma
(c) Pneumocystic Carinii Pneumonia
(d) Progressive multifocal leukoencephalopathy
(e) Active Tuberculosis
(f) Less than one-thousand (1000) lymphocytes
(g) Malignant Lymphoma

VI. RELATED FORMS – see attachments

VII. RELATED REPORTS – see attachments