MEDICAL INSURANCE POLICY

INDIVIDUAL/FAMILY

Name of the Participant	**:**
Policy No	**:**
Policy Period	**:**
DHA / DOH No	**:**

Terms and Conditions

Whereas the insured (herein after called the **Participant**) has made to Methaq Takaful Insurance **Company** (herein after called the **Company**) a written proposal and declaration together with any information or particulars from time to time supplied to the **Company** by the **Participant** in accordance with Benefits Schedule (otherwise referred to as Table of Benefits) shall be the basis of this contract and be considered as incorporated herein,

It is hereby agreed that in consideration of the payment of the first contribution (hereinafter called "contribution") and on condition that the subsequent contributions are paid in accordance with the provisions of the **Policy**, the **Company** agrees to provide the cover as described in the Benefits Schedule or in any Endorsements attached hereto, subject to the conditions and provisions stated hereto and/or endorsed and signed for and/or behalf of the **Company.**

Both Parties herein sign on this_____ of _____ 2020.

Company

Signed on this_____ of _____ 2020

Participant

Signed on this_____ of _____ 2020

SECTION 1 – DEFINITIONS

DEFINITIONS

In this **Policy** all words and expressions signifying the singular shall include the plural and vice versa. Words and expressions implying the masculine gender shall include the feminine

1. **"Accident"** = An unexpected, unforeseen and involuntary external event resulting in injury occurring whilst the **Policy** is in force.
2. "**Accommodation Charges**" **-** Charges made by a hospital for In Patient or Day-Care treatment including charges for beds, routine nursing and care services, housekeeping, room and meal charges, drugs, dressings and medication. This does not include charges for visitors' expenses for beds, meals, drinks or any other charges.
3. "**Access Card**" - A Personalized card issued in the name of each **Insured person,** facilitating his/her access to the Healthcare services covered under this **Policy** and provided by the Network.
4. "**Acute"** - A **Medical Condition** which is brief has a definite end point and which the **Company,** on **Advice** or **General Advice** determines/ responds to and can be cured by **Treatment.**
5. **"'Advice "** - Any consultation from a **Medical Practitioner** or **Specialist** including the issue of any prescriptions or repeat prescriptions.
6. "**Appliances**" - Devices and equipment when used as an integral part of a medical procedure administered by a **Medical Practitioner** or **Specialist.**
7. "**Assistance**" – 24 hour medical call centre, staffed with a team of Medical and Claims administrative specialists working for **Third Party Administrator** to support and monitor the proper application of the Insurance **Policy**. **Third Party Administrator** provides Beneficiaries and Providers with medical and procedural guidance and information through telephone inquiries; advises claims and Insured Persons eligibility; carries out pre-approval reviews; provides appropriate authorizations; takes decision in the name and on behalf of the

Company as to whether or not grant access to the specific healthcare service under consideration and evaluates submitted claims in order to approve payment.

8. "**Assistance Company**" – means any provider of stabilization and evacuation services, approved and appointed by the **Company**, for purposes of providing Emergency Evacuation to Beneficiaries.
9. **"Benefits "**– The coverage provided by this **Policy** and any extensions or restrictions shown in the **Policy Schedule** or in any endorsements (if applicable).
10. **"Chronic Conditions"** A chronic condition is a human health condition or disease that is persistent or otherwise long-lasting in its effects or a disease that comes with time. The term chronic is often applied when the course of the disease lasts for more than three months.
11. "**Coinsurance**" **-** That portion of a claim, on a prior mutually agreed basis and in accordance with pre-defined percentages, borne by the **Insured person,** and detailed in the **Benefits.**
12. "**Commencement Date**" **-** The date shown on the **Policy Schedule** on which cover under this **Policy** commences. For the purpose of this **Policy** the time of the start of cover will be 00:01am on the date shown on the **Policy Schedule.**
13. "**Contract**" - means the contractual obligation arising between the **Company** and the **Participant** in respect of the provision of services in terms of this **Policy**.
14. "**Congenital Anomaly**" - Intrauterine development of an organ or structure that is abnormal with reference to form, structure or position.
15. **"Congenital Abnormality" -** A condition existing at or from birth which constitutes a significant deviation from the common form or normal and for the purposes of this Policy will include visible and latent structural deviations as well as chromosomal abnormalities
16. "**Country of Nationality**" - For the purpose of this **Policy** this will be the country for which the **Insured Person** holds a passport.
17. **"Cover" -** means the time during the Period of Insurance where the **Company** is liable in terms of this Policy for eligible medical costs incurred.
18. "**Country of Residence" -** The country in which Insured Person has **his/her** habitual residence (residing for a period of **not less** than six months per **Period of**

Cover) at the time this **Policy** is first taken out or at each subsequent **Renewal Date.**

19. "Date **of Entry**" - The date shown on the **Policy Schedule or Endorsement** on which an **Insured Person** was included under the **Policy**
20. "**Date of Service"** - means:
    a. In the case of a consultation, visit or treatment, the dates on which each of these Services took place, whether for the same illness or not;
    b. In the case of an operation or procedure, the date on which such a Service was performed;
    c. In the event of hospitalization, the dates falling within and including the dates of each admission and discharge from such hospital, where these dates relate to in-hospital Services received;
    d. In the case of any other Service, the date on which such Service was rendered or the date on which a **Participant** received treatment that is covered in terms of this **Policy.**
    e. In the event that **the Insured Person's** cover lapses because of non-payment of renewal contribution during the **Insured Person's** hospital stay for Emergency treatment, the full in-hospital cost of the single medical event leading to hospital admission before lapse of the **Insured Person's** cover shall be covered by this **Policy** irrespective of the fact that some of the in-hospital costs pertaining to the event are incurred after the effective termination date of cover. This provision shall only be applicable to

       Emergency in-hospital services and shall not extend to stabilization, evacuation, non-emergency, elective or any other medical care.

21. **"Day-Patient"** - **Treatment** in a **Hospital** where the **Insured Person** is admitted to a **Hospital** bed but does not stay overnight.
22. "**Dental Practitioner**" - A person who is licensed by the relevant licensing authority to practice dentistry in the country where the dental **Treatment** is given.
23. "**Drugs and Dressings**" - Drugs, medicines and dressings prescribed by a **Medical Practitioner** or **Specialist.**
24. **"Dependant**s" - A spouse or adult partner and/ or unmarried children who are not more than 18 years old and residing with the **Participant,** or 23 years old if in full-time education or un-married at the date of joining or at any annual **Renewal Date.** All **Dependants** must be named as **Insured Persons** in the **Policy Schedule.**

25. **"Emergency"** - A medical emergency is the sudden, unexpected onset of a health condition that needs immediate medical or surgical treatment. Failure to provide this treatment would place the **Participant's** life at risk or result in serious impairment or dysfunction of an organ or body part
26. "**Emergency Evacuation**" means the pre-authorized transportation (by road and / or air ambulance) of the **Participant** who has suffered an Emergency, from the country of occurrence to a medical facility determined by the Assistance **Company** in accordance with the **Benefits**, and subject to the authorization by the **Company.**
27. "**Emergency Transportation**" - means a method of transportation that is equipped for the emergency treatment of **Insured Persons**
28. **"Emergency Dental Treatment" -** Dental treatment which is required within 48 hours following accidental damage to sound natural teeth for the initial relief of pain, and any treatment necessary to preserve the dental structure
29. "**Evacuation"** - Costs incurred in moving an **Insured Person** from the place of incident to the nearest appropriate medical facility, as determined by the attending **Medical Practitioner** or **Specialist** in conjunction with the Third Party Administrator.
30. "**Excess**"- The amount payable by an **Insured Person** in respect of expenses incurred before any **Benefits** are paid under the **Policy.**
31. **"Excluded Activities**" includes but is not limited to mountaineering or rock or cliff climbing necessitating the use of ropes or guides, water activities including aqualung diving and scuba diving, hang-gliding, polo, water ski-jumping and tricks, boxing, pot-holing, power boating, wrestling, racing, yachting beyond 5 kilometer off the coast line, motor competition, show jumping, sky diving, aeronautical activities such as parachuting, bungee jumping and such like activities or persuits.
32. "**Expatriate" -** Any persons living or working outside of the country for which they hold a passport for a period in **Excess** of 6 months per **Period of Cover.**
33. "**Free Access"** - The medical providers where **Insured Persons** are able to obtain medical **Treatment** for valid **Medical Conditions** and where the expenses will be settled directly by the **Company. Insured Persons** are still responsible for any **Co-insurance** or
34. **Excess** applicable to the **Policy** which must be settled directly to the medical providers at the time of **treatment.**
35. "**General Advice**" - **Advice** from the relevant professional body as to establish medical practice and/ or the established medical opinion in relation to any **Medical Condition** or **Treatment.**
36. "**Geographic Area**"- The **Geographic Area** which will apply to the **Participant** will be shown in the **Benefits.**
37. **"Hereditary**"- Transmitted from parents to offspring.
38. **"Home Nursing" -** Skilled nursing services given by a registered nurse at home immediately after an In-Patient or **Daycare** Treatment.
39. **Hospitalization**" - means admission as an in-patient at the instruction of and under the supervision of a Medical Practitioner for a period, to a facility which meets the

40. following standards:
    a. It is lawfully operated;

b. Has diagnostic and therapeutic facilities for surgical and medical diagnosis treatment and care of sick persons by or under the supervision of a staff of Medical Practitioners;
c. Provides nursing service supervised by registered nurses or nurses with equivalent qualifications;
d. Is not other than incidentally either a mental institution or a convalescent home;
e. Is not a place of rest for the aged;
f. Is not a rehabilitation centre involved with the treatment of substance abuse;
g. Is not or a health hydro or natural cure clinic or similar establishment;
h. Is not an institution providing long-term care for the blind, deaf, dumb or handicapped persons.

41. "**Incident**" - means any one accident or illness that causes the **Participant** to undergo medically necessary treatment under this Policy

42. "**In-patient**" - An **Insured Person** who stays in a **Hospital** bed and is admitted for one or more nights solely to receive **Treatment**.

43. "**Insured Person**" - An individual entering into a contract of insurance or eligible employees (and their eligible dependants) of a Corporate/Government entity who are covered under the Policy.

44. **"Maternity"**- Hospital Confinement for Normal or Cesarean Delivery, Medically Necessary abortion or miscarriage and/ or any complications arising there from, ante – and post natal treatment as Medically Necessary.

45. "**Medical Condition**" - Means a disease, illness or injury, including that attributable to or caused by starvation, thirst or exposure as a result of an accidental occurrence that in the Company's opinion is deemed curable. The benefits provided by the **Policy** will cover these conditions in terms of clinical protocols, unless otherwise excluded.

46. "**Medical Director**" means the Medical Practitioner appointed by the **Company** to authorize benefits in accordance with the Policy.

47. "**Medical expenses**" mean all eligible medical costs at Reasonable and Customary charges as determined by the Company incurred in respect of the benefits provided for according to the Benefits and Benefit Schedule

48. "**Medically Necessary**"- A medical service or Treatment which in the opinion of a qualified Medical Practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted or postponed without adversely affecting the **Insured persons** condition or the quality of medical care rendered.

49. "**Medical Practitioner**"- A person who has attained primary degrees in medicine or surgery by attending a Medical School recognized by the World Health Organization and who is licensed by the relevant authority to practice medicine in the country where the **Treatment** is given.

50. "**THIRD PARTY ADMINISTRATOR / THIRD PARTY ADMINISTRATOR Claims Center**" - THIRD PARTY ADMINISTRATOR is a Third Party Administration Company and appointed to act in the name and on behalf of the **Company** in administering this Insurance **Policy** in part. Among other management services, THIRD PARTY ADMINISTRATOR interfaces with the **Insured person** through a **THIRD PARTY ADMINISTRATOR Claims Center** (referred to hereinafter as **THIRD PARTY ADMINISTRATOR**) and the **Assistance** Company.

51. "**Network**" -_Providers forming the **THIRD PARTY ADMINISTRATOR** Network(s) through a special and formal contractual arrangement whereby they agree to avail the **Insured Person**, usually on his Access Card presentation, with access on a direct billing basis to their healthcare services in conformity with the terms of this Insurance **Policy** and as set forth in the **Policy Schedule** and in the **Insured Person** User's Handbook.

52. **"Option"** shall mean the pre-defined benefit composition as selected by the **Participant** at the start of each Benefit year as a sub-set of benefits as published from time to time as specified in the Benefit Schedule (Annexure A)

53. "**Out-patient**" - An **Insured Person** who receives **Treatment** at a recognized medical facility, but is not admitted to a **Hospital** bed as an **In-patient** or **Day-Patient.**

54. "**Palliative Treatment**" - Any **Treatment** given in an independent Medical Practitioners opinion for the purpose of offering temporary relief of symptoms but not as to cure the **Medical Condition** causing the symptoms.
55. "**Period of Cover**"- The **Period of Cover** set out in the **Policy Schedule.** This will be a 12-month period starting from the **Commencement Date** or **Renewal Date.**
56. **"Physiotherapist**" - A person who is registered as a **Physiotherapist** and licensed to practice in the country in which **Treatment** is being given.
57. **"Plan" -** Any of the private medical expenses insurance schemes provided by the **Company**
58. **"Policy**"- The contract of insurance between the **Company** and the **Participant** providing cover as detailed in this **Policy** documents. The Application Form and **Policy Schedule** form part of the contract and must be read together with this **Policy** document.
59. **"Participant**" - The person or **company** named as **Participant** in the **Policy Schedule**
60. "**Policy Schedule**" - The Schedule giving details of the **Participant** and the **Insured Persons, Policy** details and endorsements (if applicable).
61. "**Premature Birth**" - A birth that takes place before 37 weeks of gestation has passed counting from the first day of the last menstrual period (LMP).
62. "**Pre – Existing Condition**" - Any health condition known or in the Company's opinion ought to have been known to the **Insured Person** and/or to the **Participant** which exhibited symptoms or was a consequence of injury or illness for which Medical, Surgical, and/or Pharmaceutical treatment, Medical diagnosis or advice was provided prior to the **Insured Person** first Enrolment Date under the **Policy.**
63. "**Preferred Service Provider**" shall mean a Service Provider that has been **contractually appointed by the Company. The Company reserves the right to refer an Insured Person** to a **Preferred Service Provider**
64. "**Contribution**" means the minimum amount, specified in the Schedule, payable in respect of a **Participant** under this Policy for benefits subscribed to in respect of the **Participant's** Period of Insurance.

65. "**Qualified Nurse**" A qualified resident or daily nurse whose name is currently on any register or roll of nurses, maintained by any Statutory Nursing Registration Body within the country in which they are resident.
66. "**Reasonable & Customary Charges**" The average amount charged in the country of treatment and the policy designated grade of hospitals network in respect of valid services or **Treatment** costs, as determined and substantiated by an independent Third Party Administrator.
67. "**Related Condition**" - Any injuries, illnesses or diseases are **Related Conditions** if the **Company,** on **Advice** or **General Advice,** determines that one is a result of the other or if each is a result of the same injury, illness or disease.
68. "**Renewal Date**" - The annual anniversary of the **Commencement Date.**
69. "**Service**" - means reasonable and appropriate healthcare treatment performed on an **Insured Person** by a Medical Practitioner with the objective of:
    a. examination of the **Insured Person**, or
    b. medical investigation, diagnosis, treatment (including surgery) or prevention of a physical defect, illness or deficiency deemed by the **Company** to be covered by the **Policy**, or
    c. advising the **Insured Person** about a physical defect, illness or deficiency deemed by the **Company** to be covered by the **Policy**, or
    d. prescribing medicine, supplying medicine for any physical defect, illness or deficiency deemed by the **Company** to be covered by the **Policy**, or
    e. Supplying appliances or apparatus for such physical defect, illness or deficiency deemed by the **Company** to be covered by the **Policy**.

"**Service"** also includes:

    f. supplying accommodation in an institution established or registered in terms of any law as a hospital or an institution, approved by the **Company** , where nursing is practiced, or

    g. Supplying accommodation in any other institution where surgical or other medical activities are performed provided such accommodation is necessitated

by a physical defect, illness or deficiency deemed by the **Company** to be covered by the **Policy**.

70. **"Service Provider" -** shall mean a Physician, Medical Advisor, Medical Practitioner, Hospital or Clinic, Step-down facility, Emergency Transportation provider.
71. **"Step-Down Facility" -** means an institution registered to provide post-operative care
72. **"Specialist' -** A registered **Medical Practitioner** who-

    a. has at any time held a substantive consultant appointment in that specialty in a Hospital.

    b. has at any time held a substantive consultant appointment which the **Company** on **Advice** or **General Advice** accept as being of equivalent professional status, or

    c. is recognized as such by the statutory bodies of the relevant country.

73. **"Summary of the Policy"** - shall mean all the specific terms and conditions relating to a **Participant** supplied at the **Commencement Date**.
74. "**Terminal Condition**" - A **Medical Condition** or **Related Condition** which the **Company,** on **Advice** or **General Advice,** determines does not respond to or cannot be cured by **Treatment.**
75. **"Termination Date" -** means the date at which the Period of Insurance ends.
76. "**The Perils" -** means the incident or event, which leads to a loss or damage within the terms, condition, and limitation of the Policy and renders entitlement for compensation.
77. "**Treatment**" - Any medically necessary surgical or medical procedure carried out by or medication prescribed by a medical practitioner with the sole intention to cure a medical condition, including diagnostic procedures, consultations and investigations needed to establish a diagnosis, In-Patient treatment/Hospitalization, **Day-Care** treatment and Out-Patient treatment. Surgical, medical or other procedures the sole purpose of which is the cure or relief of a **Medical Condition.**
78. T**TO" ("to take out")** - means prescription medicine dispensed to an **Insured Person** on discharge from hospital for use by the **Insured Person** to treat the condition for which

the **Insured Person** was hospitalized and in this instance limited to a supply deemed appropriate as per the benefit stipulated in the **Benefit Schedule**.

79. **"Underwriting"** - refers to the assessment of risk presented by **a Participant** for Cover.

80. **"Waiting Period"** - means a period specified in the **Policy** and calculated from the **Commencement Date**. During this period, no claims shall be payable in respect of those benefits to which the Waiting Period relates.

Note: - Where an **Insured Person** receives Treatment for a Medical Condition that is not covered within the terms of the **Policy**, **Participant** remains liable for the costs of such **Treatment,** which must be settled in full upon request. Failure to settle such outstanding costs within 30 days of request shall entitle the **Company** and **THIRD PARTY ADMINISTRATOR** to withhold further claims from **Insured Person** under this **Policy**.

SECTION II – ADDITIONS / DELETIONS

ADDITION OF INSURED PERSONS

1. General Rule: -

The **Participant** may request the **Company**, by completing and signing a Request Form, accompanied with supporting documents for the addition of new **Insured Persons** such as new employees, newly wedded spouse or newborn children or newly adopted children of an already enrolled employee on a compulsory basis. The **Company** shall accept the request of the **Participant** subject to the **Participant's** In-house rules.

On application for Cover, an applicant may be required at his own expense to submit evidence of his good health and in addition thereto or in place thereof such an applicant may be required to undergo a medical examination at a Service Provider nominated by the **Company**

The **Company** shall be entitled to decline or to accept a person as a **Participant** where such person cannot, or does not furnish evidence of his good health.

Every **Participant** shall, in respect of himself supply the **Company** with such information and evidence as the **Company** may from time to time require.

Cover shall only become effective from the **Commencement Date**, notwithstanding that the fees may have been received by the **Company**, or any Agent acting on behalf of the **Company**, for Cover on the Policy, pending consideration of and underwriting of the application of a potential **Participant**. Upon consideration of the application and subject to the acceptance by the **Participant** of the underwriting conditions, the **Company** shall receive payment of the Contribution or subsequent contributions. Under no circumstances shall Cover commence until the payment of the Contribution or

subsequent contributions and until such time as the receipt of contributions has been cleared by the **Company**'s bankers and a receipt issued to the applicant.

Cover and payment of contributions shall only be effective and deemed to be communicated to or paid over to the **Company** when such communication and/or payment is made to the **Company.**

There will be no backdating of Cover

.

The **Company** reserves the right to reconsider terms and conditions of Cover of the Policy should a **Participant** change his employment status, marital status and / or there occurs a life changing event where such a change may influence the underwriting assessment of his Cover.

The **Company** shall not assume any responsibility towards a **Participant** or prospective **Participant** in relation to the acts or omissions of a duly appointed Agent other than those acts or omissions performed by the Agent in accordance with the specific terms and conditions of the contractual obligations existing between the Agent and the **Company**.

2. Eligibility: -

2.1 Employees/Investor- This insurance is available only to United Arab Emirates Nationals and persons holding a valid current full residence status visa for the United Arab Emirates and

who are ordinarily resident in the United Arab Emirates. Only employees aged under 65 currently in active service of the employer and their Dependants are eligible.(not applicable for Dubai and Abu Dhabi visa holders)

2.2 Dependants - For the purpose of this plan, dependants who are eligible for coverage are full time employee's Spouse and their unmarried Children from the date of birth up to 18 years of age residing in the Area of Residence. In addition, if the children are unmarried, full time students (proof will be needed) and dependent upon you for support, they will continue to be eligible up to the age of 23 years. Newly born children shall be eligible for insurance as per regulator guidelines.

2.2.1 Dependants may be added or removed during the Period of Insurance subject to supporting documents.

2.2.2 Acceptance of newly born/adopted children is subject to written notification and receipt of contribution within 30 days of birth/adoption.

2.3 The removal of an **Insured Person** will be accepted on receipt of written notification from the **Participant.** Cover will cease at point of acceptance by the **Company.**

2.4 There will be no refund in contribution in respect of the removed **Insured Persons if illegible claim has been incurred.**

3. Effective Date: -

3.1 Employees /Investor

Insured Persons - Full time employees will be covered on the date officially start at work.

3.1 Dependents

Insured Persons - The coverage for your dependents shall start: -

1.) On the date the Employee coverage starts (applicable for SME) .
2.) On the day the Employee first acquire such dependant, from the date of birth or from date of marriage, whichever is later.

The Policy allows **10 days** from date of eligibility to enroll the New Employees and dependants. If applied after **10 days**, evidence of good health, satisfactory to the **Company** is required at your expense (applicable only for SME).

4. Contribution: -

The Contribution relating to any approved addition shall be calculated on a pro-rata basis however any addition request received two months prior to the policy expiry is entitled for minimum three months premium payment.

5. Recovery: -

The **Company** will be compensated by the **Participant** for all Claims made:

- For **Excess** amounts,
- In excess of the individual's Benefit limits,
- For **Insured Person** not obtaining pre-authorization for **Hospitalization**,
- For **Insured Person** use of non **Network** medical providers,
- For excluded Treatments,
- By individuals who are not eligible for cover,
- By the **Participant** during any period when contributions are in arrears,
- In respect of fraudulent use of Insured Persons Cards

DELETION OF INSURED PERSONS

1. General Rules: -

The **Participant** has the right to request the **Company**, by completing and signing a Request Form such as deceased or terminated with supporting documents.

2. Termination of Membership: -

Insured Persons shall automatically terminate: -

1.) If employment is terminated.

2.) If the plan terminates.

3.) When attain 65 years (not applicable for DHA/DOH).

3. Supporting Documents: -

Submission by the **Participant** of supporting documents, relating to deletion requests, which are satisfactory to the **Company**, is a pre-requisite for deletion validation. Among the documents required are the Access Cards of the particular Beneficiaries.

4. Deletion Date: -

The Deletion Date of any approved deletion is the day following the date of death or termination of the Employee provided request for deletion is made promptly and Access Card returned to the **Company**. Otherwise, the Deletion Date is the date on which the Access Card is returned to the **Company**. For the Insured dependants, the **Company** shall accept deletion on the date of receiving the Access Card.

5. Liability: -

The **Participant** shall be the sole and fully liable party towards the Provider(s) and/or THIRD PARTY ADMINISTRATOR in relation with any expenses incurred by the deleted Beneficiaries as from the Deletion Date.

To this effect the **Participant** should make sure that the Access Card of the **Insured Person** to be deleted has been withdrawn from the **Insured Person** and sent back to the **Company** prior to or on the Deletion Date.

6. Contribution: -

The Contribution refund relating to the cancellation of this policy is on short period Contribution. Rates for short period less than one year and for cancelled and not replaced policies are as follows:

30 days	25 Percent
60 days	37.5 Percent
90 days	50 Percent
120 days	62.5 Percent
150 days	75 Percent
180 days	87.5 Percent
210 days	100 Percent

SECTION III – GENERAL CONDITIONS

GENERAL CONDITIONS

1. Subrogation Clause: -

   If the **Company** pay benefits under this **Policy** for covered expenses incurred and it is found that **Participant** were repaid for all or some of those expenses by another source the **Company** will have the right to a refund from **Participant.** Where necessary the **Company** retains the right to deduct such refund from any impending or future claim settlements or to cancel the **Policy** void ab initio, without a refund of contribution.

   Other than with the **Company** written consent the **Participant** have no entitlement to admit liability for any eventually or give promise of any undertaking which is binding upon the **Participant** and/or **Dependants** and/or any other person named in the **Policy.**

2. Family Dependent Cover: -

   The Employees and their Dependants (if applicable) are required to be covered under the same **Policy** with identical cover.

3. Acceptance Clause: -

   Company maintains the right to ask the **Participant** to provide proof of age and/ or state of health of any person included in the application.

   Company reserves the right to apply additional endorsements, exclusions or contribution increases to reflect any circumstances the **Participant** advice in the Application Form or declared to the **Company** as a material fact.

4. Compliance with Policy Terms: -

Company shall not be liable under this **Policy** in the event of any failure by an **Insured Person** to comply with its terms and conditions, except where the circumstances of any claim are unconnected with such failure and no fraud is involved.

5. Change of Risk: -

The **Participant** must inform **the Company** as soon as reasonably possible of any material changes relating to any **Insured Person** which the Company may deem as ought reasonably to have been made aware of or affect information given in connection with the application for cover under this **Policy. Company** reserves the right to alter the **Policy** terms or cancel cover for an **Insured Person** following a change of risk to the extent permissible by the laws of **Insured Person Country of Residence.**

6. Policy Duration and Contributions -

a. The **Policy** is for one year and is renewable for successive one-year period, subject to new terms at the time of each **Renewal Date** and to payment of the contribution.
b. The contribution payable may be changed by the **Company** from time to time. If the **Participant** moves into a higher age band, the contribution will increase at the next **Renewal Date**. However, this **Policy** will not be subject to any alteration in contribution rates generally introduced until the next **Renewal Date**.
c. All contributions are payable in advance of any cover under this **Policy** being provided.
d. **The Policy** is an annual contract and **Participant** is responsible for the whole year's contribution even if the C**ompany** have agreed that **Participant** may pay by installments.

7. Break in Cover: -

Where there is a break in cover, for whatever reason, **Company** reserves the right to reapply Exclusion 1 in respect of Pre-Existing **Medical Conditions**.

8. Alterations: -

a. **Company** may alter the terms and Conditions of this **Policy** at any **Renewal Date**. **Company** will give the **Participant** reasonable notice of such alterations and will send details of such alterations to the last known address of the **Participant**. However, the alterations will take effect even if the **Participant** do not receive them for any reason.

b. No alteration or amendment to the **Policy** terms will be valid unless it is in writing from the **Company**.

9. Waiver: -

Waiver by the **Company** in any instance of any term or condition of this **Policy** will not prevent the **Company** from relying on such term or condition in other instances.

10. Cancellation: -

This policy can be cancelled by the company with 30 days notice of the cancellation. Additionally, In the event of any non-payment of contribution, the **Company** shall be entitled to cancel this **Policy** automatically. **Company** may at own discretion reinstate the cover if the contribution is subsequently paid.

The **Company** may at any time terminate an **Insured Persons** cover if he/she or the **Participant** at any time has;

a. Misled the **Company** by misstatement.

b. Did not inform the **Company** of material information which the **Company** may reasonably deem ought to have been made aware of.

c. Knowingly claimed **Benefits** for any purpose other than as are provided for under this **Policy**.

d. Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the **Company** detriment.

e. Otherwise failed to observe the terms and conditions of this **Policy** or failed to act with utmost good faith.

f. If in the **Company's** opinion a **Participant** is abusing the benefits of the Policy, which abuse shall include but not be limited to the failure to comply with the terms and conditions of the **Policy** and/or the failure by a **Participant** to make a full disclosure on application of Cover to the **Company** of an existing medical condition.

g. A **Participant** shall refund to the **Company** any sum which, but for the abuse of the privilege of the Policy, would not have been dispersed on his behalf.

h. The use of a Policy document / card by a person other a **Participant** shall, where such use occurs with the knowledge of such **Participant**, be construed as an abuse of the privileges of the Policy. In the event that the **Company** has incurred costs or liability as a result of such abuse the **Company** shall be entitled to use whatever remedy is available to it at law to recover such costs from the **Participant.** Once the element of fraud has been proven by the **Company**, a certificate issued by the auditors of the Policy as to the amount of the loss suffered by the **Company** will be construed as prima facie evidence of such loss. The onus will then rest on the **Participant** to prove the incorrectness of the amount reflected on the certificate.

i. In the event of the failure by the **Participant** to renew the Policy and pay the relevant contributions, Cover on the Policy shall automatically terminate.

11. Other Insurance: -

If there is any other insurance covering any of the same **Benefits**, the **Participant** must disclose or ensure that the relevant **Insured Person** discloses the same to the **Company** and the **Company** shall not be liable to pay or contribute more than the **Company** ratable proportion.

12. Fraudulent/Unfounded Claims: -

If any claim under this **Policy** is in any respect fraudulent or unfounded, all **Benefits** paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable. In addition all cover in respect of the **Participant/Insured Person** shall be cancelled / void ab initio, without refund of contributions.

13. Liability: -

The **Company's** liability shall cease immediately upon termination of the **Policy** for whatever reason, including without limitation non-renewal and non-payment of contribution

14. Third Parties: -

The only parties to this contract are the **Participant** and the **Company**. No other person, including any **Insured Person**, has any right under this Contract to enforce this Policy or any part of it.

15. Disputes: -

The decision of the **THIRD PARTY ADMINISTRATOR**, duly appointed by the **Company,** shall be prima facie proof of any of the following facts:

a. The nature of any **Medical condition**;
b. The nature of any service required to deal with a **Medical condition**;
c. The level, type and duration of the service appropriate to any **Medical condition;**
d. Whether the place of treatment facility is appropriate to any particular **Medical condition;**
e. The occurrence (or otherwise) of any abuse of privilege.

16. Arbitration Clause: -

16.1 General Differences:

If any difference or dispute of any kind whatsoever shall arise between the **Participant** and the **Company** under this **Policy** shall be referred to the decision of an arbitrator to be appointed in writing by the parties. If the parties cannot agree upon a single arbitrator, then the matter should be referred for review by two arbitrators, one to be

appointed in writing by each of the parties. Should the two arbitrators fail to agree, then an independent umpire should be appointed in writing by the arbitrators. The umpire shall sit with the arbitrators and preside at their meetings and the making of an award shall be a condition precedent to any right of action against the **Company**.

If the **Company** disclaims liability to the **Participant** or **Insured Persons** or, his/her legal personal representatives or any claimant, for any claim hereunder, and such claim is not within 12 calendar months from the date of such disclaimer referred to arbitration under the provisions herein contained, then the claim shall be deemed for all purposes to have been abandoned and shall thereafter not be recoverable hereunder.

16.2 Medically Necessary Procedure: -

In case of a difference between the **THIRD PARTY ADMINISTRATOR**, acting as an independent administrator, and the attending Physician concerning the qualification of a service or Treatment as Medically Necessary, the parties can call for the arbitration of a Medical Committee, which will take the final decision. The Medical Committee shall be composed of three Insured Persons - the attending Physician, the THIRD PARTY ADMINISTRATOR Physician and a third independent Physician agreed upon by the first two.

The Committee will meet in neutral territory, and its decision will be taken by majority vote. This decision will be reported in duplicate documents, one for each party, and must be signed by all the Physicians. If any of the Physicians refuses to sign the documents, this refusal should be reported in the documents. **Both parties** undertake to accept the decision of this Medical Committee as final and binding.

17. Jurisdiction and Change Of Law: -

This **Policy** is subject to and shall be construed in accordance with the Law of U. A. E. and Shariah.

If following to an amendment of the applicable law, which has come into force after the Effective Date of this **Insurance Policy**, a conflict has arisen with the conditions of this **Insurance Policy,** the **Company** may at its option, re-negotiate the conditions of this **Insurance Policy** from the date such amendment of the law becomes effective.

18. Currency: -

All monetary amounts specified in this **Policy** are expressed in the currency Dirham's, referred to herein as U. A. E. Dirham's.

19. Duties: -

Any levies on the Insurance Policy, tax or stamp duty shall be borne exclusively by the **Participant.**

20. Policy To Take Precedence: -

The provisions contained in the **Policy**, and any amendments thereto which may have been implemented, shall take precedence over all other documentation relating to the provision of the benefit in terms of this **Policy** and to the extent that the terms and conditions of this document are in conflict with or inconsistent with the terms and conditions of any agreement entered into between the **Company** and any other entity which provides any benefit in accordance with this **Policy**, as well as the promotional and sales literature distributed in connection with the provision of the benefits of the **Company**, the provisions of this document shall prevail.

21. Indemnity: -

21.1 No **Participant** or **Insured Person** shall have any claim against the **Company**, it's administrators, their directors, employees, assignees, agents, officers, or sub-contractors, for any loss or damage of whatsoever nature and howsoever arising including loss or damage due to gross negligence or any wrongful act or omission by the **Company**, its administrators, their directors, employees, assignees, agents,

officers or sub-contractors and/or any of its authorized agents, including, but not limited to, loss or damage arising out of accommodation, transportation, recreational activity, hospitalization or medical treatment.

21.2 Summary of Policy: Each **Participant** is entitled to the Summary of the **Policy**. The full **Policy** document shall be made available to a **Participant** upon request. This document contains all the **Policy** provisions applicable to the **Policy** and shall not be open to any other interpretation other than that which is in accordance with this document

22. Health Information: -

The **Participant**/**Insured Persons** irrevocably authorizes any doctor or other person who may have, or may acquire any information concerning his health, to disclose such information to the **Company** and or a third party contracted to manage the benefits of the **Policy** on behalf of the **Company**. This authorization extends to the Preferred Service Providers. The **Company** and all Preferred Service Providers undertake to keep the information confidential and not to disclose the information to unauthorized third parties without the prior written authorization by the **Participant**/ **Insured Persons**. This authority shall remain in force for a period of not less than twelve months following the expiry date of his Cover with the **Company**.

23. Non Disclosure: -

A claim will not be admitted unless all the material, risk-related information was fully disclosed to the **Company** before the issue date of this **Policy**. In order for a claim to be assessed, the **Policy** must have been in force on the **Date of Service**

24. Renewals: -

23.1. The renewal contribution will be based on the number of Insured Persons and Dependants, the ages of the **Insured Person** and **Dependants**, the option selected and other material facts disclosable by the **Participant** and **Insured Person**.

23.2 The **Company** will notify the **Participant** of the renewal process and updated benefits and contribution and at least four (4) weeks prior to the Renewal Date.

SECTION V – CLAIMS PROCEDURES AND SETTLEMENT

Claims Procedures and Settlement

A Personalized Access Card to be in the name of each **Insured Person** facilitating his/her access to any of **THIRD PARTY ADMINISTRATOR** participating Network Providers with no cash payment being required except when the **Insured Person** has a deductible excess or

co-participation to settle. The **Insured Person** is always requested to carry his/her **Access Card** together with a proper Identification document to be presented to Providers whenever medical treatment is needed.

A **Network** Claim is the Eligible Expenses relating to Healthcare services rendered to the **Insured person** on a **Free Access** Basis arranged by **THIRD PARTY ADMINISTRATOR** with the **Network Provider** on Direct Billing to the **Company**. This includes Healthcare services that are provided to the **Insured person** within the Network either by the visiting and/or honorary and/or part-time and/or community physicians and/or healthcare providers; where the THIRD PARTY ADMINISTRATOR contracted Network tariff shall apply.

A Direct Claim, is the Eligible expenses directly settled by the **Insured person** and submitted by the **Participant** to the **Company** for reimbursement. Eligible expenses are inclusive of co-insurance, if applicable.

Out of pocket limit is the maximum aggregate amount of eligible expense the **Insured person** should bear during the Policy year out of co-insurance options.

Treatment Outside territory for In-patient Emergency is provided to the **Insured person** while on a visit (vacation, business travel) not exceeding the period stated in Schedule of Benefits, provided that in the opinion of the **Company** the **Treatment** was not elective and the **Insured**

Person could not have reasonably expected it. Reimbursement will be based on 80% of the reasonable cost incurred in the country of treatment. This coverage is not extended to a plan which has UAE only as the Geographical scope of coverage.

Second Opinion

Coverage of certain Treatment as Network Benefits may require that the **Insured person** consult a second Network Physician prior to the scheduling of the Treatment. The **THIRD PARTY ADMINISTRATOR** will notify **Insured person** that the particular Treatment can only

be obtained subject to a Second Opinion and will inform the **Participant/ Insured Person** of the required procedure for obtaining a Second Opinion.

In case of a difference between the **THIRD PARTY ADMINISTRATOR** physician acting as an independent administrator and the treating physician, concerning the qualification of a Treatment and/ or service as medically necessary and/ or appropriate, the **Company** and/ or **Participant/ Company** Insured Person can call for the Second Opinion, results of which will be final and binding.

1. **In-Hospital Directives**

1.1. **Within Selected Territory**

1.1.1 **Network Claims**

- If the **Insured person** chooses to be admitted in a Network Provider, upon presentation of the **Access Card,** the Network Provider will directly co-ordinate with the **THIRD PARTY ADMINISTRATOR** for the authorization.
- For non-emergency cases, the **Insured person** is requested to check with the Network Provider, prior to the scheduled In-Hospital/Day Care or minor procedure, treatment/admission, if the Network Provider has received the authorization from the **THIRD PARTY ADMINISTRATOR**. The **Insured person** may directly contact the THIRD PARTY ADMINISTRATOR Claims Centre to confirm the authorization.
- For emergency cases, upon receipt of the Hospital notification (THIRD PARTY ADMINISTRATOR Pre – hospitalization Form) from the Network Provider, the **THIRD PARTY ADMINISTRATOR** shall immediately issue the authorization for the eligible In-Hospital treatment.
- Outside U.A.E. the **Insured Person** is requested to CALL THIRD PARTY ADMINISTRATOR UAE at Telephone: +971 2 6940800 and Tele-fax: +971 2 6766227.
- THIRD PARTY ADMINISTRATOR Medical and Claims Professional Staff will be receiving the call and shall provide specialized and necessary assistance for the **Insured Person's** Hospitalization and arrange for the eligible Hospitalization expenses to be billed directly to the **Company**.

- Unlike in U.A.E. where the **Insured Person** can directly approach a Local Network Provider, the International Network Providers require that each and every case be arranged by **THIRD PARTY ADMINISTRATOR** prior to accepting an **Insured Person** on free access basis / direct billing.

  The **Insured Person** is requested to provide the following information:

  1. His Name and **Access Card** Number.
  2. His Telephone , when available.
  3. Name and Telephone when available, of the treating Physician.
  4. Name of the Network Provider.
  5. Hospitalization reasons.
  6. Date and Time of Admission.
  7. Other relevant information which may be required.

- THIRD PARTY ADMINISTRATOR shall fax to the treating doctor the **THIRD PARTY ADMINISTRATOR** Pre-Hospitalization Form, which must be completed by the Doctor and faxed back to THIRD PARTY ADMINISTRATOR.
- Once the medical information has been received by **THIRD PARTY ADMINISTRATOR**, a decision regarding the coverage of the **Insured Person's** case shall be taken and the **Insured Person** shall be informed accordingly.
- For approved cases, **THIRD PARTY ADMINISTRATOR** shall arrange with the Network Provider for the direct billing of eligible In-Hospital charges.
- For declined cases, **THIRD PARTY ADMINISTRATOR** shall issue a Denial Form informing the Network Provider, the **Insured Person**/**Participant** and the **Company** that the admission is rejected and not eligible for coverage.

1.1.2. **Direct Claims/ Non- Network Claims**

THIRD PARTY ADMINISTRATOR must be notified, at least 24 hours before a non-emergency Hospitalization and Prior Approval should be obtained from **THIRD PARTY ADMINISTRATOR** before any In-Hospital services can be rendered to the **Insured Person**. For emergency cases, the **Insured Person**/his next of kin/**Participant** should call the **THIRD PARTY ADMINISTRATOR Claims Centre** as soon as possible or, at the most, 24 hours within admission or prior to discharge date whichever is earlier.

- If the **Insured Person** decides to avail of In-Hospital services in a Non-Network Provider, he/she shall be entitled to reimbursement of all Eligible Expenses up to 80% of incurred cost.
- **For emergency cases**: In accordance with the approved tariff up to 100% of the amount approved by **THIRD PARTY ADMINISTRATOR**.
- **For non-emergency cases**: 80% of incurred costs in a country where a THIRD PARTY ADMINISTRATOR Network exists allowing treatment on free access. 100% of incurred treatment cost if incurred in a country where no **THIRD PARTY ADMINISTRATOR** Network exists.
- If the **Insured Person** **fails** to present his/her **Access Card** to a Network provider he/she shall be entitled to 80% reimbursement of all Eligible Expenses less any deductible excess and/or co-participation calculated at the following rates.
- Reimbursement of Eligible Expenses shall be effected upon submission of the required claims documents and subject to the following conditions:

1.2 Outside Area Cover:-

Claims are not covered **except** in case of Emergency in-hospital services he/ she shall be entitled to reimbursement 100% of all eligible expenses according to terms and conditions of this Policy at **THIRD PARTY ADMINISTRATOR** network customary rates. This coverage is not extended to the local plans. The term **"Emergency"** shall be deemed as defined in Section 1 of this **Policy.**

2 **Out-Of-Hospital Directives**

2.1 **Within UAE**

2.1.1 **Network Claims**

- Upon presentation of the **Access Card** to a Network Provider, the **Insured Person** shall benefit from **Free Access** for Eligible Expenses relating to Out-of-Hospital services prescribed on the Claim Form, except for any deductible/ excess, if applicable, which should be settled by the **Insured Person** directly to the Provider.
- For non-excluded diagnostic tests ordered by the treating Physician on the Claim Form, the **Insured Person**, is entitled to have the tests conducted without THIRD

PARTY ADMINISTRATOR prior approval except for procedures mentioned below/refer to point 3, Pre-Approval for diagnostic/therapeutic procedures.

- For non-excluded medicines prescribed by the treating Physician on the Claim Form, the **Insured Person** is entitled to get the required quantity of the prescribed drug/s considered Medically Necessary for the treatment of acute diseases usually for a period of four weeks. Prior approval is required in the event of the prescribed treatment necessitates more than one standard unit of the same medicine, except for antibiotics, antifungal agents and antiparasitic agents where prior approval is required if treatment necessitates more than two standard units.
- For chronic disease related medicines, when covered, the **Insured Person** is entitled to receive the required quantity of the prescribed drug/s up to maximum period of one month with the necessary **THIRD PARTY ADMINISTRATOR** prior approval. If the medicines are

  required for more than one month, the **Insured Person**/Network Provider shall be requested to submit to THIRD PARTY ADMINISTRATOR a medical report issued by the treating Physician including relevant investigation results explaining the **Insured Person's** health condition and its history as well as the recommended treatment plan.
- THIRD PARTY ADMINISTRATOR shall issue a Chronic Claim Form on a monthly, quarterly or until the expiry date of the Insurance Policy depending on the medical condition of the **Insured Person** which may require some modification on the dosage, frequency or the drug itself.
- For non-excluded cases requiring Physiotherapy prescribed by the treating Physician (not physiotherapist), **THIRD PARTY ADMINISTRATOR** pre-approval is required before the service can be rendered to the **Insured Person**.
- For non-excluded Dental treatment prescribed by the treating Physician, Eligible Expenses incurred shall be settled as Direct Claims.

2.1.2 Direct Claims

Upon submission of original medical report(s), bill(s) and receipt(s), an **Insured Person** is entitled to 100% reimbursement of Eligible Expenses if:

i. A Network Provider has refused to provide free access to the **Insured Person**.

ii. Free Access to the Network was suspended and then reinstated after the date of treatment.

iii. Seek Services from a Non-Network Provider is entitled to reimburse a maximum of 80% of the eligible claim amount subject to deductible and/ or co-pay as applicable.

2.1.3 Out-of-Hospital Claims outside U.A.E

The International Plan is restricted to In-Hospital Benefits and applicable only for policies with International coverage. Eligible Out-of-Hospital expenses incurred outside U.A.E. within the territory of In-Hospital coverage shall be settled on reimbursement basis at 100% of eligible claim amount subject to Policy Deductible and/ or co-insurance as applicable.

2.1.4 Insured Persons Residing Outside U.A.E.

Where insurance cover has been granted for any **Insured Persons** residing outside UAE, provided the country loading has been imposed on the Insured Person's contribution, the out-of-hospital expenses will be reimbursed at 100% of eligible claim amount subject to Deductible and/ or co-insurance as applicable.

If **no** country loading is imposed on the **Participant's** contribution, then the **Company** shall reimburse a maximum of 80% of eligible claim subject to any Policy Deductible and/or co-insurance as applicable.

3. Pre-Approval for Diagnostic/Therapeutic Procedures

Notification and authorisation from the **THIRD PARTY ADMINISTRATOR** are required for the following diagnostic/therapeutic in-patient and outpatient procedures prior to treatment.

- Angiography
- Arthogram
- Barium enema
- Barium meal
- Bronchoscopy
- Herpes tests
- Holter monitoring
- Hysterosalphingography
- IVP
- Mammogram

- Colonoscopy
- CMV
- CT-Scan
- Doppler studies
- Echocardiography
- EEG
- EMG
- Endoscopy
- Excretory urography
- FNAC
- Gastroscopy
- MCU
- MRI
- Myelogram
- Oral Cholecystogram
- Pap smear
- Rubella tests
- Sigmoidoscopy
- Stress tests
- Thyroid function tests
- Toxoplasma tests
- Hormonal Tests not related to HRT

Exception:

The procedure has been already implicitly pre-authorised in relevant in-hospital pre-approval process mentioned under points 1.1.1, 1.1.2, and 1.2

4 Required Claims Documentation

For the settlement of Eligible Expenses, the **Insured Person** should submit to the **Company** the following documents within a maximum period of (60) days for claims occurred within and (90) days for claims occurred outside the UAE from date of occurrence:

- THIRD PARTY ADMINISTRATOR Claims Centre authorization for accepted In-Hospital treatment or admission.
- Original itemized receipts and invoices.
- Full and Detailed Medical Report
- Original official results of diagnostic test.
- The treating doctor's prescription of the medicines.

Failure to submit any one of the above documents shall entitle the **Company** to reject the entire claim

5 Modification of Claims Procedures

THIRD PARTY ADMINISTRATOR reserves the right to change and/or modify the claims Procedures and Settlement at any time subject (30) days notice to be given to the **Participant** by the **Company**.

DEFINITION OF THE TERRITORIES

Middle East: Bahrain, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, UAE, Yemen

Arab Countries: Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, KSA, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Somalia, Sudan, Syria, Tunisia, Yemen

Asia: Afghanistan, Armenia, Azerbaijan, Bangladesh, Bhutan, Brunei, Burma(Myanmar), Cambodia, China, Georgia, Hong Kong, India, Indonesia, Japan, Kazakhstan, North Korea, South Korea, Kyrgyzstan, Laos, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Singapore, Srilanka, Taiwan, Tajikistan, Thailand, Turkmenistan, Uzbekistan, Vietnam

Europe: Albania, Austria, Belarus, Belgium, Bosnia, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Greenland, Hungry, Iceland, Ireland, Italy, Kosovo, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malta, Moldova, Netherlands, Norway, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, United Kingdom

Africa: Algeria, Andorra, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Cote D'ivoire, Cote Dlvoire, Djibouti, Egypt, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Madagascar, Mauritius, Morocco, Mozambique, Namibia, Niger, Nigeria, Papua New

Guinea, Rwanda, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia, Zimbabwe

North America: Antigua & Barbuda, Bahamas, Barbados, Belize, Bermuda, Canada, Costa Rica, Cuba, Dominican Republic, Grenada, Guatemala, Haiti, Honduras, Jamaica, Martinique, Mexico, Nicaragua, Panama, Puerto Rico, Salvador, Trinidad, USA

South America: Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, French Guyana, Guyana, Paraguay, Peru, Surinam, Uruguay, Venezuela

Oceania: Australia, Fiji Islands, New Caledonia, New Zealand

Memoranda of Takaful Principles and Conditions

A. Methaq Takaful Insurance **Company** (hereinafter referred to as the "**Company**") acts in compliance with the principles of Islamic Sharia in the field of Takaful insurance as decided by the **Company**'s Sharia Board which shall be applicable to this Policy.

B. The Takaful Insurance practiced by the **Company** is on cooperative basis whereby a group of individuals (the "**Participants**") seek to indemnify the loss suffered by any **Participant** according to the terms and conditions set forth in this Policy. The **Company** shall compensate the **Participant** out of the collective pooling of the Contribution made by each **Participant** (the "**Takaful Fund**").

C. The **Company** shall manage the Takaful operation for the benefit of the **Participants** as their agent for a fixed agency fees (the "**Wakala Fee**") and shall further invest the Takaful Fund for the benefit of the **Participants** as a 'Mudarib' for a fixed percentage of the realized profits (the "**Mudaraba Percentage**"). The Wakala Fee percentage and the Mudaraba Percentage due to the **Company** is determined in advance and is set out in the Policy Schedule hereto.

D. The net surplus of the Takaful Fund shall be determined after paying/ accounting for:
   (a) the indemnifiable losses of the **Participants**;
   (b) the operating costs of the Takaful Fund;
   (c) deduction in respect of the provision for reserves to protect the **Participants** equity; and

(d) Repayment of any outstanding loans from the Shareholders (the "**Net Surplus**"), Shall be distributed to **Participants** as decided by the Shariah Board and as adopted by the Board of Directors of the **Company**. The Net Surplus shall be considered on the following basis:

(i) In case the underwriting results of all the classes of Insurance business together do not produce a Net Surplus, then all classes will be treated as one fund and there will be no distribution of Net Surplus even for those classes that made a Net Surplus.

(ii) In case the underwriting results of all the classes of Insurance business considered together does produce a Net Surplus, then such Net Surplus will be distributed to the classes which made a Net Surplus in proportion to their contribution to the overall Net Surplus (the "**Distributable Net Surplus**").

E. The **Company** shall distribute from the Net Surplus to the eligible **Participants** as follows:

(a) A **Participant** will not have the right to receive from the Distributable Net Surplus, if he/she has been paid a claim under the Policy, where the claim is equal to or more than his/her Contribution.

(b) Where the claim is less than the Contribution, the **Participant** will be eligible to receive a prorated part of his entitlement after deduction of the claim amount from the Contribution paid. Where the **Participant** has Policies under more than one class of insurance, he/she will only be eligible to receive from the Distributable Net Surplus if the total amount of claims is less than the total Contributions.

(c) Where the amount of Net Surplus to be paid to a **Participant** is less than a minimum amount (as decided by the Sharia Board), this amount shall be paid into the reserves for protection of **Participants** equity.

It is acknowledged and accepted by the **Participant** and the Takaful **Company** that the Policy (including the Schedule and this Memoranda of Takaful Principles and Conditions) is compliant with the principles of Islamic Sharia.

Complaints Process

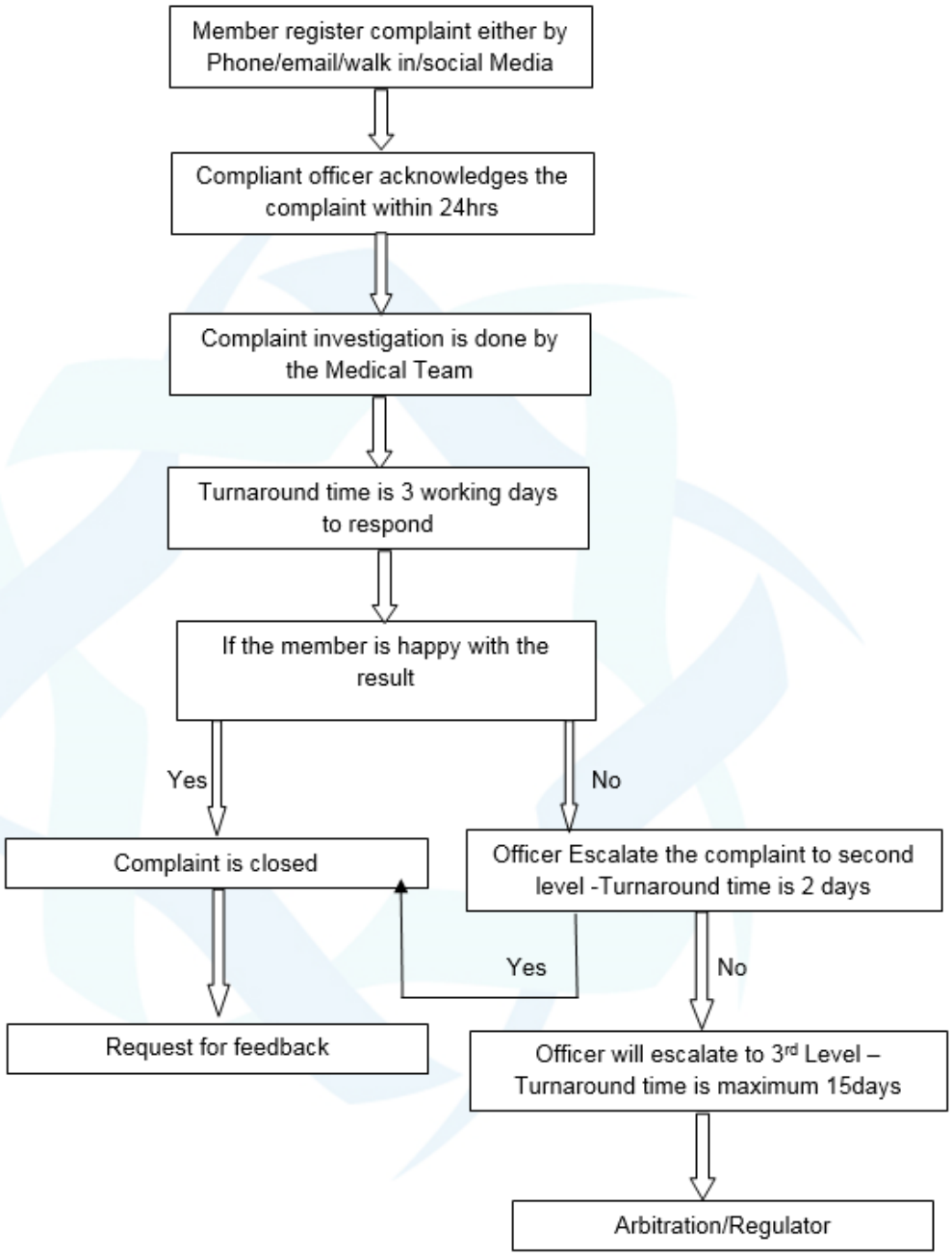
How to file a complaint?

Through Email: medical@methaq.ae or membercare@nextcarehealth.com
Or Log into Methaq.ae under Initiate medical complaint and fill the required details

Requirements (In case complaint is sent by Email) :
Dully Filed up complain form Including your name, Contact number, email address, insurance card number or Emirates ID Number.

***Please refer to the below Complaint Flow Chart**

Complaint Flow Chart:



Contact MTIC for any clarification: Tel : 971 4 2601666 , Emil : medical@methaq.ae