FWD insurance

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Policy Document

Quick Reference

About this policy	1
Your benefits at a glance	3
What you are covered for	5
Major critical illness benefit	5
Minor critical illness benefit	7
Death benefit	8
Surrender benefit	8
Healthy life benefit	8
Waiver of premium benefit	8
Claiming this benefit	9
Taking unpaid loans or premiums from benefit payments	9
Benefit limit	9
What we do not cover	10
When this policy starts and ends	12
When this policy starts	12
Canceling this policy	12
When this policy ends	12
Making changes to this policy	12
Reinstating this policy	13
The main people under this policy	14
Policy owner (you)	14
Changing the policy owner	14
Using your policy as collateral	14
Insured person	15
Beneficiaries	15
Premiums and loans	18
When you need to pay your premiums	18
What happens when you do not pay your premiums	18
Policy loan	19

Keeping it legal 20
Contract and governing law 20
We rely on your information 20
Incorrect age or gender Contestability 20
Time limit on legal action 20
Payments under your policy 21
Payments are not adjusted for inflation or deflation 21

Medical definitions for major critical illness 22

Medical definitions for minor critical illness 30

Important words and phrases 33

Table of cash values 35

About this policy

Thank you for choosing FWD. We're pleased to be protecting you, so you can focus on living life to the fullest.

Easy to read

We're here to change the way you feel about insurance–starting with this document. We've made it easy to read, so you can understand your benefits and what you are covered for.

⚠ **We highlight important information like this. Read these carefully.**

Words with special meaning

Some words in this policy have special meaning. We show those meanings on page 33 Important words and phrases. Please refer to this section when you need to.

90-day no-claim period	Cancer-free for five years	Minor critical illness
Accident	Cash value	Medical practitioner
Activities of daily living	Major critical illness	Pre-existing condition
Benefit amount		

What makes up your policy

This insurance policy is made up of the documents listed below. We will provide them to you in electronic form. You may also request for a paper version to be provided to you.

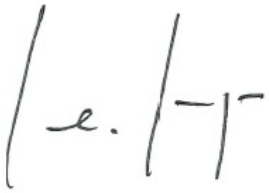
- This policy document.
- The policy data page.
- The application form and any documents you provided with it.
- Any policy endorsement.
- The rewards terms and conditions.

⚠ **A policy endorsement is the document we provide to tell you about any official change to your policy.**

Questions?

Please call our Customer Connect Hotline at +632 8888 8388. We are here for you 24/7.

For and on behalf of FWD Life Insurance Philippines,



Lee Longa
Chief Financial Officer and Treasurer

Set for Health

This policy pays a lump sum if the insured person is diagnosed with a major or minor critical illness.

Your benefits at a glance

Major critical illness

Details on page 5

We pay 100% of the benefit amount if the insured person is diagnosed with a major critical illness.

PLUS

We pay 100% of the benefit amount if the insured person is diagnosed with a second major critical illness. The diagnosed condition must be from a group that is different to the first major critical illness.

PLUS

We pay 100% of the benefit amount if the insured person is diagnosed with a third major critical illness. The diagnosed condition must be from a group that is different to the previous major critical illnesses.

Minor critical illness

Details on page 7

We pay 20% of the benefit amount if the insured person suffers a minor critical illness.

Death benefit

Details on page 8

We pay 100% of the benefit amount if the insured person dies.

or

Surrender benefit

Details on page 8

We pay the cash value (if any) if you request that we end this policy before its expiry date.

The amount of cash value is shown in page 35 Table of cash values

This policy ends upon payment of the benefit.

Health Life Benefit

We believe that those who live a healthy life should be rewarded. 100% RETURN OF TOTAL PREMIUMS is given if the insured person does not suffer any of the eligible major critical illnesses until the policy expiry date.

Waiver of Premium

We pay all future premiums from the date the insured person is diagnosed with a major critical illness.

This is a simplified diagram. For more important details see page 5 What you're covered for.

This is a protection product

This **Set for Health** policy is a protection product and does not contain any savings or investment components. This policy provides critical illness benefit or death benefit or surrender benefit (if this policy has a cash value).

What you are covered for

In this section, we explain what benefits you are covered for, and any conditions that apply to those benefits. General exclusions also apply – see page 10 What we do not cover.

Summary of your policy benefits

⚠ **You can claim the following benefits while the policy is active.**

Major critical illness

We pay 100% of the benefit amount if the insured person is diagnosed with a major critical illness shown in the table below Major critical illnesses covered. We will pay this benefit if all of the following conditions are met:

- the major critical illness first occurs, is first diagnosed or, symptoms leading to the diagnosis of the major critical illness are first experienced by the insured person after the 90-day no-claim period; and
- the insured person survives at least 14 days after the diagnosis of the major critical illness.

If the first major critical illness benefit described above has been paid, we will pay a second, and a third major critical illness benefit where appropriate. Each benefit will be equal to 100% of the benefit amount. We will only pay the benefit if all of the following conditions are met:

- the insured person is diagnosed with a major critical illness;
- the insured person has not previously been diagnosed with and received a major critical illness benefit due to:
  - loss of independent existence; or
  - terminal illness
- the second or third major critical illness is diagnosed at least one year after the diagnosis of the most recent major critical illness where a benefit is claimed;
- each major critical illness benefit claimed belongs to a different group shown in the table below Major critical illnesses covered. In the case of group one (cancer), you can claim up to two major critical illness benefits provided that the insured person is cancer-free for five years prior to the diagnosis of the second cancer; and
- the insured survives at least 14 days after the diagnosis of a major critical illness.

⚠ **We do not pay any major critical illness benefit if signs of a condition become apparent to the insured person within the 90-day no-claim period even if the condition is diagnosed on or after this period by a medical practitioner.**

⚠ **We do not pay any major critical illness benefit if the claim arises from a pre-existing condition.**

Major critical illnesses covered

Group 1: Cancers	1. Late-stage cancers	
Group 2: Major organ failure	2. Aplastic anemia 3. Chronic liver disease 4. Chronic lung disease 5. Chronic recurrent pancreatitis 6. Crohn's disease 7. Fulminant viral hepatitis 8. Loss of hearing (deafness) 9. Loss of sight (blindness)	10. Major organ and bone marrow transplant 11. Medullary cystic disease 12. Progressive scleroderma 13. Renal failure 14. Terminal illness 15. Ulcerative colitis
Group 3: Heart and blood vessels	16. Cardiomyopathy 17. Coronary artery disease 18. Heart attack (myocardial infarction)	19. Heart valve surgery 20. Primarypulmonary arterial hypertension 21. Surgery to aorta
Group 4: Neuro-muscular related	22. Alzheimer's disease 23. Apallic syndrome 24. Benign brain tumor 25. Cerebral aneurism requiring surgery 26. Coma 27. Loss of independent existence	28. Motor neurone disease 29. Multiple sclerosis 30. Muscular dystrophy 31. Paralysis 32. Parkinson'sdisea 33. Stroke
Group 5: Others	34. Bacterial meningitis 35. Encephalitis 36. HIV/AIDS due to blood transfusion 37. Loss of limbs 38. Loss of speech	39. Major burns 40. Major head trauma with severe brain 41. damage 42. Occupationally-acquired HIV/AIDS 43. Severerheumatoid arthritis

We pay 20% of the benefit amount if the insured person is diagnosed with a minor critical illness shown in the table below Minor critical illnesses covered. We will not pay more than Php 500,000 for this benefit across all policies we issue for the insured person. We will pay this benefit if all of the following conditions are met:

- the minor critical illness first occurs, is first diagnosed or, symptoms leading to the diagnosis of the minor critical illness are first experienced by the insured person after the 90-day no-claim period;
- the minor critical illness is first diagnosed at least one year after the date of diagnosis of the most recent major critical illness where a benefit was paid; and
- the insured person survives at least 14 days after the diagnosis of the minor critical illness.

⚠ **You can only claim for the minor critical illness benefit once.**

⚠ **We do not pay any minor critical illness benefit if signs of a condition become apparent to the insured person within the 90-day no-claim period even if the condition is diagnosed on or after this period by a medical practitioner.**

⚠ **We do not pay any minor critical illness benefit if the claim arises from a pre-existing condition.**

Minor critical illnesses covered

1. Accidental fracture of spinal column
2. Angioplasty and other invasive treatments for coronary artery disease
3. Diabetic retinopathy
4. Early-stage cancer
5. Loss of one limb
6. Loss of one lung
7. Removal of one kidney
8. Severe osteoporosis
9. Surgical removal of pituitary tumor

We pay 100% of the benefit amount if the insured person dies.

We pay the cash value of this policy as stated in page 35 Table of cash values, if you request that we end this policy before its expiry date.

You cannot reinstate this policy after you receive the surrender benefit.

We pay 100% of the total premiums paid if this policy is active until the expiry date and no major critical illness benefit has been paid.

We pay all future premiums from the date the insured person is diagnosed with a major critical illness.

Claiming this benefit

Claiming this benefit

To claim for this benefit, we need to receive signed claim documents and any other information that we need. We will not be able to process your claim until we receive this information and your signed claim documents.

We are not responsible for any of the costs of filing any forms or getting any documents or reports.

What you need to do

You must make every effort to send your claim to us within 90 days of the insured person's death or diagnosis of a critical illness as it is difficult to assess claims after this period. Your claim will not be declined or reduced if there were good reasons why you could not send us your claim on time.

When the unexpected happens, we're here to help. Just call our 24/7 Customer Connect Hotline on **+632 8888 8388** and we'll help you with your claim.

What we will do

We will assess your claim, and if it is valid, we will pay the benefits less any outstanding loans and any unpaid premiums

Taking unpaid loans or premiums from benefit payments

If there are any unpaid policy loans (including interest on those loans) or premiums, we will deduct these amounts from the benefit payment when we pay it. Your outstanding loan would be the total of the unpaid policy loans and any interest on the policy loans.

Benefit limit

If the insured person suffers a major or minor critical Illness as a direct result of participation in any dangerous sports or hobbies such as racing on wheels, glider flying, or sailing, the total amount payable from this policy and all other insurance policies that we issue for the insured person is subject to a limit of Php 10,000,000.

What we do not cover

This policy has certain exclusions, meaning situations where we will not pay the benefits. We list below the exclusions that apply.

Exclusions that apply to major and minor critical illness benefits

90-day no-claim period	We will not pay any major or minor critical illness benefit: – if the condition was diagnosed; – if the signs or symptoms leading to diagnosis became apparent to the insured person; or – if the signs or symptoms would have been apparent to a reasonable person in the insured person's place within 90 days after the latest of: » the start of coverage; » the date of last reinstatement; or » the date of increase of the benefit amount (for the added benefit amount).
Drugs or alcohol	We will not pay any major or minor critical illness benefit if the claim arises from Alzheimer's disease, late-stage cancer, chronic liver disease, chronic recurrent pancreatitis, coma, or Parkinson's disease due to alcohol or drug abuse: – if the condition was diagnosed; or – if the signs or symptoms leading to diagnosis – became apparent to the insured person within two years after coverage starts, is reinstated, or is increased (for the added benefit amount).
HIV	We will not pay any major or minor critical illness benefit if the claim arises from diagnosis of cancer or encephalitis in the presence of human immunodeficiency virus (HIV) infection.
Loss of independent existence	We will not pay any major or minor critical illness benefit if the claim arises from loss of independent existence due to psychiatric-related causes.
Pre-existing condition	We will not pay any major or minor critical illness benefit if the claim arises from a pre-existing condition. We will only pay the benefit if you have declared the pre-existing condition in your application form and we have included the pre-existing condition in this policy.
Suicide or self-inflicted act	We will not pay any major or minor critical illness benefit if the claim arises from attempted suicide or a deliberate self-inflicted act by the insured person within two years after this policy effective date, last reinstatement date, or date of any increase in the benefit amount (for the added benefit amount).
Unlawful acts	We will not pay any major or minor critical illness benefit if the claim arises from you or the insured person committing any illegal or unlawful act (including terrorist act).

War	We will not pay any major or minor critical illness benefit if the claim arises from war or any act of war (whether declared or not), or any civil or military uprising.

Exclusion that applies to death benefit

Suicide or self- inflicted act	We will not pay the death benefit if the claim arises from attempted suicide or a deliberate self-inflicted act by the insured person while sane within two years after this policy's effective date, last reinstatement date, or date of any increase in the benefit amount (for the increased amount). In this case, we will return the total premiums paid to your beneficiaries after deducting any benefit we have paid. We will pay the benefit if the insured person committed suicide while insane.
Disqualification of beneficiaries due to unlawful acts	If the insured person dies from any of the policy beneficiaries committing any illegal or unlawful act or failure to act, we will not consider those policy beneficiaries to be 'qualified' claimants for any benefit under this policy (including supplementary benefits). We will pay the death benefit to substitute beneficiaries as discussed in page 16 **Substitute beneficiaries**.

When this policy starts and ends

When your policy starts

This policy starts on the effective date shown on the policy data page, unless we tell you that it will start on a different date. You can only claim for this policy after it has started.

Receiving your policy

We will provide you this policy contract in electronic form, and we will consider it delivered to you, 10 days after the effective date. A paper version of this policy is available at your own cost

Canceling this policy

You can cancel this policy by sending us a written request within 15 days after this policy has been delivered to you.

We will provide you this policy contract in electronic form, and we will consider it delivered to you, 10 days after the effective date.

This policy can be accessed by downloading our supercharged 2-in-1 app, Omne by FWD, which allows you to easily manage your insurance policy anytime, anywhere. You can download Omne by FWD at Google Play Store or App Store.

Upon cancellation, we will return all your paid premiums for this policy. No interest will be paid on the refunded amount. If a claim is payable for this policy, we will not refund the premiums.

When this policy ends

Your policy ends on the earliest of the following dates:

- on the date of the insured person's death.
- on the date we approve your request to surrender or cancel this policy;
- on the expiry date of this policy as shown in the policy data page;
- On the date that any outstanding policy loan amounts (including interest) are equal to or greater than the cash value of this policy;
- on the premium due date, if you have not paid your premium for this policy after the 31-day grace period and the cash value is zero.

You can claim a benefit after this policy ends if the minor critical illness, major critical illness, or death happened before this policy ended.

Making changes to this policy

You can ask us to make a change to this policy at any time. Minor changes such as change of contact information can be made through our Customer Connect Hotline at **+632 8888 8388.** We are here for you 24/7.

Changes to your policy coverage such as adjustment to the sum assured, payment frequency, or change in beneficiaries will require you to submit a policy change form.

We will provide a letter documenting the change when we approve the changes.

If you have irrevocable beneficiaries or assignees

You will need written permission from all irrevocable beneficiaries or assignees if you are making a change that will reduce any benefit they can receive under this policy. See page 15 Type of beneficiaries to find out more about irrevocable beneficiaries.

Reinstating your policy

If this policy has changed to reduced paid-up cover

If this policy has been changed to reduced paid-up cover because your premiums were not paid and it is still active, you can apply to reinstate (restart) this policy within three years from the date your premiums were not paid.

If we approve your reinstatement application, this policy will no longer be reduced paid-up cover, and the original benefit amount will apply.

If this policy ended because premiums weren't paid

You can apply to reinstate (restart) this policy within three years of it ending, if it ended because the premiums were not paid. You cannot reinstate this policy if the surrender benefit has been paid.

If we approve your reinstatement application, the policy benefits will be effective from the date we reinstate this policy.

⚠ **This policy will restart from the date we reinstate it.**

What you need to do

To apply to reinstate this policy, you need to do the following:

- Send us a written request to reinstate this policy using our standard for and provide any other document and information we will ask to CustomerConnect.ph@fwd.com, or call our 24/7 Customer Connect Hotline at **+632 8888 8388.**
- Pay us all premiums due for this policy, including any interest, at an interest rate we set upon our confirmation.

What happens next

We will review your request, and if we are satisfied that you have met our requirements, we will reinstate this policy.

The main people under your policy

We refer to the policy owner, insured person, and beneficiaries throughout this policy document. This section explains who they are, what rights they have, and how they are treated under your policy.

Policy owner (you)

You (the policy owner) own this policy, and your details are shown in the policy data page or endorsement. Only you can make changes to, or enforce any rights under your policy subject to your irrevocable beneficiaries' permission.

You receive all of the benefits under this policy, except for the death benefit and funeral benefit which are paid to the beneficiaries.

Changing the policy owner

What you need to do

To change the policy owner, you need to tell us in writing and give us any other information we need.

What we will do

We will provide a letter documenting the change.

Using your policy as collateral

You can choose to assign the benefits under your policy to someone else (assignee) as collateral for a loan. We will only recognize a policy assignment if we have made a record of it, and issued you with a policy endorsement.

What you need to do

If you want to assign your policy interests, you need to send us a signed and notarized collateral assignment form and provide us with any additional information we need.

What we will do

We will make a record of your assignment, and provide you with acknowledgement in writing.

We are not responsible for the effect, sufficiency or validity of any assignment.

⚠ **If you owe us money under this policy, our rights will take priority over any other person or assignee.**

Insured person

This is the person you chose for us to protect under this policy. You can also be the insured person or you can choose someone else such as your spouse. The insured person cannot receive any benefit under this policy, and cannot make changes to your policy, unless you are also the insured person.

Beneficiaries

The beneficiaries are the people you chose to receive any amounts paid under this policy when the insured person dies. You can appoint one or more beneficiaries, and you may decide how much of the death benefit each beneficiary will receive.

Choosing your beneficiaries

The law sets certain requirements for who can be named as your beneficiary. If you are the policy owner and the insured person, you can choose any person as your beneficiary. If you are not the insured person, anyone you choose as beneficiary must have an 'insurable interest' in both you and the insured person when your policy starts.

⚠ **Any person generally has an insurable interest in another person if they gain a financial benefit or support from that person being alive and in good health.**

If it is found that a beneficiary did not have an insurable interest in both you and the insured person, they will be disqualified from being a beneficiary

⚠ **You can choose any legal entity (including a corporation, partnership, charity, or trust) to be a beneficiary.**

Rights

Beneficiaries receive the death benefit under your policy. Beneficiaries cannot receive any other benefit under your policy, and they cannot make changes to your policy.

Types of beneficiaries

When you choose your beneficiaries, you classify them as 'revocable' or 'irrevocable', and 'primary' or 'contingent'. These choices affect how easily you can change your policy, and who is first in line to receive the benefits.

Revocable or irrevocable

Your beneficiaries will be revocable or irrevocable.

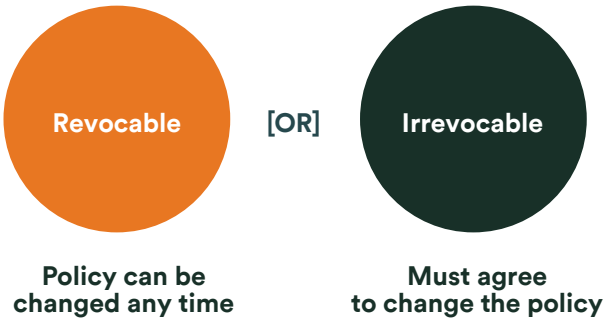
Revocable

If you make all of your beneficiaries revocable, you can make any change to your policy without the permission of your revocable beneficiaries.

Irrevocable

If you make any of your beneficiaries irrevocable, you need written permission from all of your irrevocable beneficiaries if you are making a change that will reduce any death benefit they can receive under this policy.

Beneficiaries are considered to be irrevocable if you made no changes to your beneficiaries while the insured person was alive.



Primary or contingent beneficiaries

Your beneficiaries will be primary or contingent. Primary beneficiaries are first in line to receive the death benefit. If there are no living primary beneficiaries, we will pay the death benefit to the contingent beneficiaries, if any.

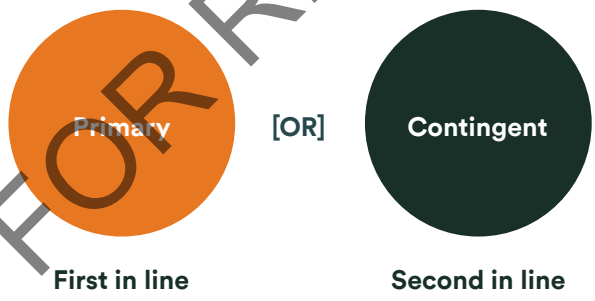
⚠ **Contingent beneficiaries are the back-ups for your primary beneficiaries. They only receive a benefit if there are no primary beneficiaries.**

Primary

We will pay the entire death benefit to the surviving primary beneficiaries in the shares you have chosen. If you have not chosen any shares, we will pay them in equal shares.

Contingent

If there are no living primary beneficiaries, we will pay the entire death benefit to the surviving contingent beneficiaries, if any, in the specific shares you have chosen. If you have not chosen any specific shares, we will pay them in equal shares.



Substitute beneficiaries when there are no primary or contingent beneficiaries

We think it's important to be ready for anything, so your policy has rules if there are no primary or contingent beneficiaries when the insured person dies. This may happen if the beneficiaries have been disqualified by law, or if they die before the insured person.

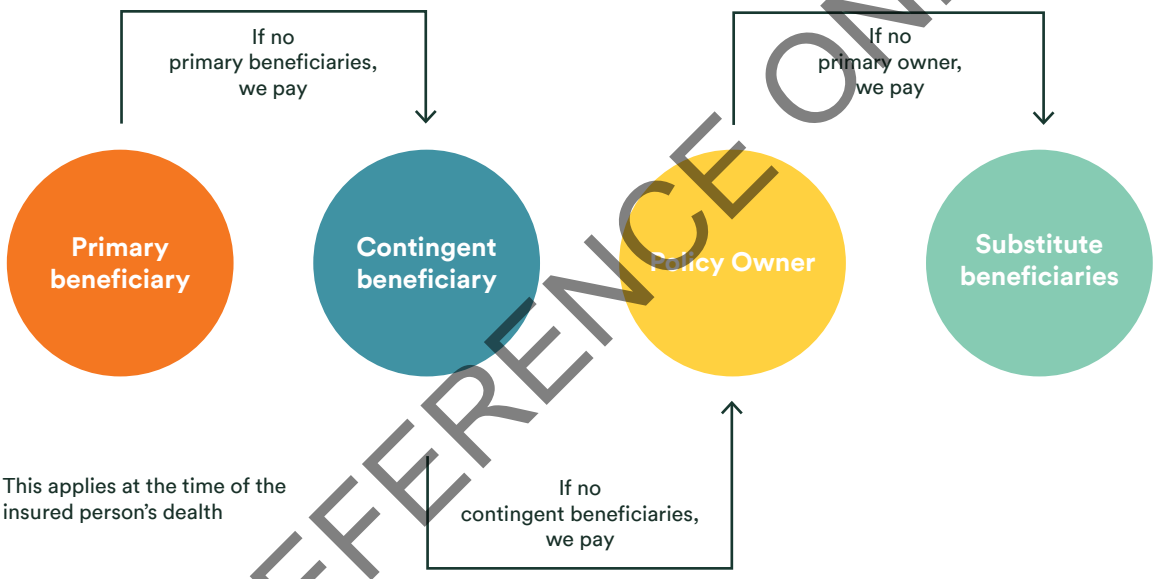
If there are no primary or contingent beneficiaries, we will pay you the basic death benefit, and any benefits paid under a supplementary rider in the event of death. Otherwise, we will pay those benefits in equal shares to whoever comes highest up on the list below.

The insured person's:

- legal spouse;
- legitimate children;
- illegitimate children;
- parents;
- brothers and sisters; or
- half-brothers and half-sisters.

If we cannot pay any of the people above, the death benefit will be paid to the insured person's estate.

Beneficiary payment order



Changing a beneficiary

You can change or add a beneficiary at any time before your policy ends.
If you have any irrevocable beneficiaries and you want to:

- reduce the death benefit share of the irrevocable beneficiaries; or
- remove any of the irrevocable beneficiaries;

you need to get the consent of the current irrevocable beneficiaries whose death benefit may be reduced, before we can make the change.

What you need to do

To change the beneficiary, you need to tell us in writing and give us any other information we need (including the consent of any of the irrevocable beneficiaries).

What we will do

We will provide a letter documenting the change.

Premiums and Loans

You need to keep paying your premiums for this policy during the duration (number of years payable) shown in the policy data page.

We have the right to change the premium for this policy if approved by the Insurance Commission. If we do, we will notify you at least 45 days before your anniversary date.

When you need to pay your premiums

When you apply for this policy, you will be told how much you need to pay and when the premiums are due (the premium due dates).

The frequency of your premiums for this policy (for example every month, or once a year) will be shown in the policy data page.

What happens if you don't pay your premiums

31-day grace period to pay

We give you a 31-day grace period after the premium due date to pay the premium. This policy will continue if you pay the premium within the grace period.

Non-forfeiture options if you don't pay within the 31-day grace period

If we do not receive payment within the grace period, you can tell us to do one of the following non-forfeiture options.

- Continue this policy, but change it to reduced paid-up cover (see details below); or
- Continue this policy under an automatic premium loan arrangement (see details below); or
- Surrender (end) your policy, and receive the cash value.

If you have not told us your choice, we will use the reduced paid-up cover non-forfeiture option.

Reduced paid-up coverage

Under this option, we keep this policy active, but reduce the policy benefits. This means that the expiry date will remain the same, but the benefit amount will be lower.

We determine the new benefit amount based on the available cash value and the insured person's age at the date of the change.

While this policy is still active, you can apply to change this policy back from reduced paid-up cover within three years from the date you missed your premium. See page 13 Reinstating your policy for details.

Automatic premium loan

You can nominate for premiums due to be automatically borrowed from this policy's cash value. We will notify you in writing when we lend you the premium due. However, the amount lent will not exceed this policy's cash value less any indebtedness. When this option takes effect, this policy will continue to be active for a period proportionate to the amount borrowed after which time this policy will terminate with any remaining cash value of this policy being refunded to you.

Policy loan

You can apply to us for a policy loan, for any purpose including premium payments for your policy, if the following conditions apply:

- the cash value of your policy has a minimum value based on our current rules and procedures;
- the loan amount you applied for is lower than your cash value less any outstanding loans; and
- your policy has not been changed to reduced paid-up cover.

If we accept your application, you will owe us the amount loaned (the principal) as well as interest on that amount. We will advise you of the interest rate we will apply and we will apply interest on a daily basis from the date we provide the loan.

Repaying your policy loan

You can repay any part of the principal and interest owed at any time.

Policy ends if loan balance is greater than the cash value

Your policy will automatically terminate (end) when the outstanding loan balance is greater than the cash value of your policy.

What you need to do

To apply for a policy loan, you need to send us a completed policy loan request form and any other information we request.

If we accept your application, you need to repay the principal and interest.

What we will do

We will review your application, and if we approve, we will provide you with the loan amount and advise you of the interest rate.

Keeping it legal

Contract and governing law

This policy is a legal contract of insurance between you and us, and is governed by Philippine law. Under this policy, we agree to provide the policy benefits, and you agree to keep to the terms and conditions of your policy.

We rely on your information

We relied on the information you and the insured person gave us during the application process to provide you with this policy. It is important that you and the insured person had given us complete, correct, and true information, as this information helped us decide if you and the insured person were eligible for this policy, and what you needed to pay.

You must let us know immediately if the information you or the insured person gave us was not complete, correct, or true. If you don't let us know and don't provide complete, correct, or true information, your benefits under this policy will be affected and, in some cases, we may cancel this policy.

Incorrect age or gender

If we discover that we were given the incorrect age or gender for the insured person, we will adjust the benefit amount of this policy to reflect the correct age and gender.

If the insured person was not eligible for insurance coverage at their correct age or gender, we will treat this policy as having never existed, and we will refund all premiums you have paid for this policy less any outstanding loans.

Contestability

If we contest (dispute) a claim, we will review the claim and decide if we have any reason to treat this policy as having never existed. If we do, we will not pay any benefit, and we will refund all premiums you have paid less any outstanding loans (to you or to your beneficiaries).

Death

We can contest (dispute) the validity of any death benefit claim within two years from:

- the effective date or the date we last reinstated this policy (whichever is later); and
- the date of the increase in the benefit amount (for the increased amount)

if we discover that you or the insured person did not give us complete, correct, or true information when you applied for this policy.

We cannot contest (dispute) the validity of any death benefit claim after the two-year period, unless we are allowed by law or jurisprudence.

Major and Minor Critical Illness

We can contest (dispute) the validity of any major and minor critical illness benefits claim (including any increase) anytime, unless we are disallowed by law or jurisprudence.

Time limit on legal action

No one can take legal action in connection with your policy after five years from the time the reason for the legal action arose. Legal actions done on your policy can be made anywhere within the legal jurisdiction of the Philippines.

Payments under the policy

All amounts paid to us, or by us, in connection with your policy will be paid in the currency shown in the policy data page.

We will only make payments in the Philippines.

Payments are not adjusted for inflation or deflation

Article 1250 of the Civil Code of the Philippines does not apply to any payments under your policy. Article 1250 says:

"In case an extraordinary inflation or deflation of the currency stipulated should supervene, the value of the currency at the time of establishment of the obligation shall be the basis of payment..."

⚠ **No adjustments are made if there is any extraordinary rise or fall in the value of the currency you chose for your policy.**

Medical definitions for major critical illness

A major critical illness means any of the conditions specified below. We can change these definitions from time to time to reflect changes in medical terminologies and practices subject to the approval of Insurance Commission. If we do change them, we will tell you in writing. All diagnosis must be confirmed by a medical practitioner defined in page 34 Important words and phrases.

Group 1: Cancers

1. Late-stage cancers	A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. The cancer must be confirmed by histological evidence of malignancy. The following are not classified as Late stage cancers but, instead, are classified as Early Stage Cancers under the '**Medical definitions for minor critical illness**' section: – Early bladder cancer: papillary carcinoma (Ta) of bladder – Early chronic lymphocytic leukemia: chronic lymphoctic leukemia (CLL) RAI Stage one or two – Early prostate cancer: prostate cancer histologically described using the TNM classification as T1a or T1b or prostate cancers described using another equivalent classification – Early thyroid cancer: thyroid cancer histologically described using the TNM Classification as T1N0M0 including papillary micro-carcinoma of thyroid where the tumor is less than one cm in diameter – Early invasive melanomas: invasive melanomas of less than 1.5 mm breslow thickness or less than clark level three – Carcinoma in situ: as defined in '**Medical definitions for minor critical illness**' section. Non-melanoma skin cancer and all carcinoma in-situ of skin or earlier stages do not meet the definition of Late Stage Cancers or Early Stage Cancers.

Group 2: Major organ failure

2. Aplastic anemia	Chronic persistent bone marrow failure which results in anemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following: – Blood product transfusion – Marrow stimulating agents – Immunosuppressive agents, or – Bone marrow transplantation.
3. Chronic liver disease	End-stage liver failure as evidenced by each of permanent jaundice, ascites and hepatic encephalopathy.

4. Chronic lung disease	End-stage lung disease, causing chronic respiratory failure, as evidenced by all of the following: – FEV1 test results consistently less than one litre – The requirement for permanent supplementary oxygen therapy for hypoxemia – Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2 < 55mmHg), and – Dyspnea at rest.
5. Chronic recurrent pancreatitis	The Chronic Relapsing Pancreatitis as a result of progressive severe destruction with all of the following characteristics: – Recurrent acute pancreatitis for a period of at least two years – Generalize calcium deposits in pancreas from imaging study, and – Chronic continuous pancreatic function impairment resulting in mal-absorption of intestine (high fat in stool) or diabetes.
6. Crohn's disease	A chronic, transmural inflammatory disorder of the bowel, as evidenced with continued inflammation in spite of optimal therapy, with all of the following having occurred: – Stricture formation causing intestinal obstruction requiring admission to hospital – Fistula formation between loops of bowel, and – At least one bowel segment resection The diagnosis must be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.
7. Fulminant viral hepatitis	A sub-massive to massive necrosis of the liver by the hepatitis virus, leading precipitously to liver failure. The diagnosis in respect of this illness must be evidenced by all of the following: – A rapidly decreasing liver size – Necrosis involving entire lobules, leaving only a collapsed reticular framework – Rapid deterioration of liver function tests – Deepening jaundice, and – Hepatic encephalopathy.
8. Loss of hearing (Deafness)	– The irreversible loss of hearing at least 80 decibels in all frequencies in both ears as a result of illness or accident. The inability to hear must be established for a continuous period of six months and must (at the end of that period) be deemed permanent on the basis of audiometric and sound-threshold test results.
9. Loss of sight (Blindness)	Total and irreversible loss of sight in both eyes as a result of illness or accident.
10. Major organ and bone marrow transplant	The actual undergoing (as a recipient) of a transplant, solely as a result of irreversible end-stage failure, of either: – One of the following human organs: (a) heart, (b) lung, (c) liver, (d) kidney or (e) pancreas, or – Human bone marrow replaced by hematopoietic stem cells only and which is preceded by total bone marrow ablation.

11. Medullary cystic disease	A progressive hereditary disease of the kidneys characterized by the presence of cysts in the medulla in both kidneys, tubular atrophy and interstitial fibrosis with the clinical manifestations of anemia, polyuria and renal loss of sodium. The condition must present as the chronic irreversible failure of both kidneys to function, requiring regular renal dialysis. Diagnosis must be supported by renal biopsy.
12. Progressive Scleroderma	A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. An unequivocal diagnosis of this disease must be supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys such that two of the following criteria are met: – Pulmonary involvement showing carbon monoxide diffusing capacity (DLCO) < 70% of the predicted value, or forced expiratory volume in 1 sec (FEV1), forced vital capacity (FVC) or total lung capacity (TLC) < 75% of the predicted value – Renal involvement showing glomerular filtration rate (GFR) < 60 ml/min – Cardiac involvement showing evidence of either congestive – heart failure, cardiac arrhythmia requiring medication, or pericarditis with moderate to large pericardial effusion.
13. Renal failure	Chronic irreversible failure of both kidneys, requiring either permanent renal dialysis or kidney transplantation.
14. Terminal illness	Means the conclusive diagnosis by a medical practitioner that the insured person is suffering an illness that is expected to result to his/her death within 12 months. The insured person must no longer be receiving active treatment other than that for pain relief.
15. Ulcerative colitis	Acute fulminant ulcerative colitis with life threatening electrolyte disturbances meeting the following criteria: – the entire colon is affected with severe bloody diarrhea, and – the necessary treatment is total colectomy as – diagnosed based on histopathological features.

Group 3: Heart and blood vessel related

16. Cardiomyopathy	An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class III or Class IV, or its equivalent, for at least six months based on the following classification criteria: – Class III - Marked functional limitation. Affected patients are comfortable at rest but performing activities involving less than ordinary exertion will lead to symptoms of congestive cardiac failure. – Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced. The diagnosis of Cardiomyopathy must be supported by echographic findings of compromised ventricular performance.

17. Coronary artery disease	Severe coronary artery disease in which at least three major coronary arteries are individually occluded by a minimum of 60%or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded). For purposes of this definition, “major coronary artery” means any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).
18. Heart attack (Myocardial infarction)	Death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. This diagnosis must be supported by three or more of the following four criteria which are consistent with a new heart attack: – New electrocardiogram (ECG) changes proving infarction – History of typical chest pain for which the insured person is admitted to hospital – Left ventricular ejection fraction less than 50% measured 3 months or more after the event – Diagnostic elevation of cardiac enzyme CK-MB or diagnostic elevation of Troponin T > 1 mcg/L (1 ng/ml) or AccuTnI > 0.5ng/ ml or equivalent threshold with other Troponin I methods. All other acute coronary syndromes, including, but not limited to, unstable angina, micro infarction and minimal myocardial damage do not meet the definition of ‘Heart Attack (Myocardial Infarction)’.
19. Heart valve surgery	The actual undergoing of open-heart surgery to replace or repair heart valve abnormalities. The diagnosis of heart valve abnormality must be supported by cardiac catheterization or echocardiogram and the procedure must be considered medically necessary. Repair via intra-vascular procedure, key-hole surgery or similar techniques do not meet the definition of ‘Heart Valve Surgery’.
20. Primary pulmonary arterial hypertension	Primary pulmonary hypertension with substantial right ventricular enlargement, established by investigations including cardiac catheterization and resulting in permanent physical impairment to the degree of at least Class IV of the New York Heart Association classification of cardiac impairment. Class IV is defined as the inability to carry out any activity without discomfort. Symptoms of Congestive Cardiac Failure are present even at rest. With any increase in physical activity, discomfort will be experienced.
21. Surgery to aorta	The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The procedure must be considered medically necessary by a cardiologist. Surgery performed using only minimally invasive or intra-arterial techniques do not meet the definition of ‘Surgery to Aorta’.

Group 4: Neuro-muscular related

22. Alzheimer's disease	Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease or irreversible organic disorders, resulting in there being at least three of the activities of daily living. The diagnosis must be clinically confirmed by medical practitioner who specializes in Alzheimer's disease.
23. Apallic syndrome	Universal necrosis of the brain cortex with the brainstem intact. The definite diagnosis must be evidenced by specific findings in neuro-radiological tests and medically documented for at least one month.
24. Benign brain tumor	A benign tumor in the brain as evidenced by all of the following: – the tumor is life threatening – it has caused damage to the brain, and – it has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit. The presence of the underlying tumor must be supported by findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. Cysts, granulomas, vascular malformation, hematomas and tumors of the pituitary gland or spine do not meet the definition of 'Benign Brain Tumor'.
25. Cerebral aneurysm requiring surgery	Actual undergoing of brain surgery with craniotomy to correct an abnormal dilation of cerebral arteries, involving all three layers of the walls of the cerebral arteries. The aneurism must be at least 10 millimeter in size or increasing by at least 0.95 millimeter per year and the need for surgery must be confirmed by a neuro- surgeon as evidenced by the results of cerebral angiography. Infection aneurysms, mycotic aneurysms, limited craniotomy and burr-hole procedures do not meet the definition of 'Cerebral Aneurysm Requiring Surgery.'
26. Coma	A coma that persists for a continuous period of at least 96 hours and evidenced by all of the following: – There is no response to external stimuli for at least ninety-six 96 hours – Life support measures are necessary to sustain life, and – There is brain damage that results in a permanent neurological deficit. The permanence of the neurological deficit must be assessed by a neurologist at least 30 days after the onset of the coma.
27. Loss of independent existence	Inability to perform without the continuous assistance of another person at least three of the activities of daily living for a continuous period of at least six months and leading to a permanent inability to perform the same. The benefit for Loss of Independent Existence will automatically cease after the insured person attains age 65.

28. Motor neurone disease	Motor neurone disease of unknown etiology, as characterized by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones. These include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis. The condition must result in the insured person being unable to perform without the continuous assistance of another person at least three of the activities of daily living for a continuous period of at least three months and must (at the end of that period) be confirmed by a neurologist as progressive and resulting in permanent disability and neurological deficit.
29. Multiple sclerosis	The definite occurrence of multiple sclerosis, as evidenced by all of the following: – Investigations unequivocally confirm the diagnosis to be multiple sclerosis – Multiple neurological deficits have occurred over a continuous period of at least six months, solely and directly due to the diagnosis of multiple sclerosis, and – There is a well-documented history of exacerbations and remissions of said symptoms or neurological deficits.
30. Muscular dystrophy	A group of hereditary degenerative diseases of muscle, characterized by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal. The condition must result in the insured person being unable to perform without the continuous assistance of another person at least three of the activities of daily living for a continuous period of at least six months and must (at the end of that period) be deemed permanent by a consultant physician.
31. Paralysis	Total and irreversible loss of use of at least two entire limbs due to injury or disease. This condition must have persisted for a continuous period of at least six months and must (at the end of that period) be deemed permanent by a consultant neurologist.
32. Parkinson's disease	The unequivocal diagnosis of idiopathic Parkinson's Disease by a consultant neurologist, as evidenced by all of the following: – Cannot be controlled with medication – Shows signs of progressive impairment, and – Results in the insured person being unable to perform without the continuous assistance of another person at least three of the activities of daily living. The disability must have persisted for a continuous period of at least six months and at the end of that period must be deemed permanent by a consultant neurologist.

33. Stroke	A cerebro-vascular incident including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis, as evidenced by all of the following: – There is evidence of permanent neurological damage confirmed by a neurologist at least six weeks after the event, and – There are findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke. The following do not meet the definition of 'Stroke': – Transient ischemic attacks – Brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease – Vascular disease affecting the eye or optic nerve, and – Ischemic disorders of the vestibular system.

Group 5: Neuro-muscular related

34. Bacterial meningitis	Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit confirmed by a consultant neurologist. Confirmation of bacterial infection in cerebrospinal fluid by lumbar puncture is required and the neurological deficit must persist continuously for at least six weeks.
35. Encephalitis	Severe inflammation of brain substance, resulting in permanent neurological deficit which is documented for a minimum of 30 days
36. HIV/AIDS due to blood transfusion	Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, as evidenced by all of the following: – The infection was due to a blood transfusion that was medically necessary or given as part of a medical treatment – The blood transfusion was received in Philippines after the effective date or date of Reinstatement of this policy (whichever is later) – The source of the infection is established to be from the institution that provided the transfusion and the institution is able to trace the origin of the HIV tainted blood, and – The insured person does not suffer from thalassemia major or hemophilia. No payment will be made under this condition where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.
37. Loss of limbs	Severance of two limbs at or above wrist or ankle as a result of illness or injury.
38. Loss of speech	Total and irrecoverable loss of the ability to speak solely to the insured person's vocal cords being permanently damaged from an injury or disease. The inability to speak must be established for a continuous period of twelve months and must (at the end of that period) be deemed permanent on the basis of medical evidence furnished by an Ear, Nose and Throat Specialist.
39. Major burns	Third degree (full thickness of the skin) burns covering at least 20% of the surface of the insured person's body. Diagnosis must be evidenced by specific results using the Lund Browder Chart or equivalent burn area calculators.

40. Major head trauma with severe

Accidental head injury resulting in the insured person being unable to perform without the continuous assistance of another person at least three of the activities of daily living.

The neurological deficit must have persisted continuously for at least six weeks and must (at the end of that period) be deemed permanent by a consultant neurologist, as supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques.

For the avoidance of doubt, head injuries due to any other cause and spinal cord injuries do not meet the above description.

41. Occupationally acquired HIV/AIDS

Infection with the Human Immunodeficiency Virus (HIV) which resulted from an Accident occurring after the Effective Date or date of Reinstatement of this policy (whichever is later) and while the insured person was carrying out the normal professional duties of his/her occupation in Philippines. All of the following proofs must be submitted to Our satisfaction:

- The Accident giving rise to the infection must be reported to Us within 30 days of the Accident taking place;
- The Accident involved a definite source of the HIV infected fluids; and
- The sero-conversion from HIV negative to HIV positive occurring during the 180 days following the documented accident. This proof must include a negative HIV antibody test conducted within five days of the accident.

This benefit is only payable when the occupation of the insured person is a medical practitioner, medical student, state registered nurse, medical laboratory technician, dentist (surgeon or nurse) or paramedical worker, registered with the appropriate body and working in a licensed medical center or clinic (in the Philippines).

No payment will be made under this condition where a cure has become available prior to the infection. “Cure” means any treatment that renders the HIV inactive or non-infectious.

42. Severe rheumatoid arthritis

Severe rheumatoid arthritis, with the diagnosis confirmed by a consultant rheumatologist and as evidenced by all of the following:

- X-ray reveals typical rheumatoid change
- The joint deformity change persists continuously for at least six months, and
- At least three of the following groups of joints are involved and deformed: (a) finger joints, (b) wrist joints, (c) elbow joints, (d) knee joints, (e) hip joints, (f) ankle joints or (g) spine.

The condition must result in the insured person being unable to perform without the continuous assistance of another person at least three of the activities of daily living for a continuous period of at least six months and must (at the end of that period) be deemed permanent by a consultant physician.

Medical definitions for minor critical illness

A minor critical illness means any of the conditions specified below. We can change these definitions from time to time to reflect changes in medical terminologies and practices subject to the approval of Insurance Commission. If we do change them, we will tell you in writing.

1. Accidental fracture of spinal column	A new spinal fracture caused by an accident, and requiring hospitalization for open surgical repair, resulting in a permanent neurological deficit in motor function or bladder function. The spinal column is defined as one bone as a whole, and the diagnosis of the fracture of the spinal column must be based on an examination of an X-ray or any other similar imaging technology by a specialist orthopaedic surgeon or a radiologist.
2. Angioplasty and other invasive treatments for coronary artery disease	Angioplasty and Other Surgeries for Coronary Artery means either of the following procedures: – Angioplasty and/or stenting, being the actual undergoing of balloon angioplasty and/or stenting to correct narrowing or blockage of one or more coronary arteries; or – The actual undergoing of atherectomy, laser relief, transmyocardial laser revascularisation, or other intra-arterial techniques to correct narrowing or blockage of one or more coronary arteries. Angiographic evidence must be provided that at least one coronary artery has stenosis of 50% or higher and the procedure must be certified as medically necessary and performed by a cardiologist.
3. Diabetic retinopathy	Diabetic Retinopathy means advanced changes to the retinal blood vessels as a consequence of diabetes mellitus. All of the following criteria must be met: – Presence of diabetes mellitus at the time of diagnosis of diabetic Retinopathy; – Visual acuity of both eyes is 6/18 or worse using Snellen eye chart; and – Actual undergoing of treatment such as laser treatment to alleviate the visual impairment.

4. Early stage cancer	Early Stage Cancer is any of the below conditions. – Early Bladder Cancer: Papillary carcinoma (Ta) of Bladder – Early Chronic Lymphocytic Leukemia: Chronic Lymphocytic Leukemia (CLL) RAI Stage one or two – Early Prostate Cancer: Prostate Cancer histologically described using the TNM Classification as T1a or T1b or Prostate cancers described using another equivalent classification – Early Thyroid Cancer: Thyroid Cancer histologically described using the TNM Classification as T1N0M0 Papillary microcarcinoma of thyroid where the tumor is less than one centimeter in diameter – Early Invasive Melanomas: Invasive melanomas of less than 1.5 mm Breslow thickness, or less than Clark Level 3. Nonmelanoma skin cancer and all carcinoma in-situ of skin or earlier stages do not meet the definition of Early Stage Cancer, or – Carcinoma in situ: as defined below. Carcinoma in situ (CIS) means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The CIS diagnosis must be supported by both a histopathological report and microscopic examination of the fixed tissue and supported by a biopsy result. In the case of the cervix uteri, pap smear results must be accompanied with cone biopsy or colposcopy with the cervical biopsy report clearly indicating presence of CIS. Clinical diagnosis alone does not meet this definition of CIS. Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, CIN II and CIN III (where there is severe dysplasia without CIS) does not meet the definition of CIS.
5. Loss of one limb	Total and irreversible loss of use of one entire limb (above elbow or above knee) due to illness or accident.
6. Loss of one lung	The complete surgical removal of a lung as a result of an illness of the insured person.
7. Removal of one kidney	The complete surgical removal of one kidney necessitated by any disease or accident of the insured person. The need for the surgical removal of the kidney must be certified to be medically-necessary by a nephrologist and/or surgeon. Kidney donation does not meet the definition of 'Removal of One Kidney.'
8. Severe osteoporosis	The occurrence of osteoporosis with fractures where the following conditions are met: – A fracture of the neck of femur or two vertebral body fractures, due to or in the presence of osteoporosis; – Bone mineral density measured in at least two sites by dualenergy x-ray densitometry (DEXA) or quantitative CT scanning is consistent with severe osteoporosis (T-score of less than -2.5); and – The insured person undergoes internal fixation or replacement of the fractured bone.

9. Surgical removal of pituitary tumor

The actual undergoing of surgical excision of pituitary tumor necessitated as a result of symptoms associated with increased intracranial pressure caused by the tumor, endocrinological disorder with pituitary origin or neurological deficit due to oppression of pituitary tumor onto normal brain tissue. The presence of the underlying tumor must be confirmed by imaging studies such as computed tomography scan or magnetic resonance imaging. The surgery must be certified to be medically necessary by a medical practitioner who specializes in this field.

Surgical excision of pituitary microadenoma (tumor of 8mm in size or below in diameter) does not meet the definition of 'Surgical Removal of Pituitary Tumor'.

The following Minor Critical Illnesses also apply while the insured person is aged 17 years or younger.

Important words and phrases

The list below explains the meanings of certain words and phrases used in this document.

90-day no-claim period	The 90-day no claim period means the 90 days after the latest of: – the start of coverage; – the last reinstatement date; or – the date of increase of the benefit amount (for the added benefit amount)
Accident	An accident is the abrupt, unexpected, and unwanted contact between the insured person and an external object or substance. The accident must be the sole and direct cause of the condition.
Activities of daily living	The activities of daily living refers to the following activities: – Washing : the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. – Dressing : the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances. – Transferring : the ability to move from a bed to an upright chair or wheelchair and vice versa. – Continence: the ability to control bowel and bladder function so as to maintain a satisfactory level of personal hygiene. – Feeding: the ability to feed oneself once food has been prepared and made available.
Benefit amount	Refers to the benefit amount or sum assured of this policy as stated in the policy data page.
Cancer-free for five years	Cancer-free for five years means that the insured person has been cancer-free continuously in the last five years as confirmed by the insured person's medical practitioner and supported by clinical, radiological, histological and laboratory evidence. The cancer-free period shall start on the date of completion of treatment of cancer, which shall include any surgery, chemotherapy, radiation therapy, immunotherapy, monoclonal antibody therapy or other conventional cancer treatments that have been used as prescribed by the insured person's medical practitioner.
Cash value	The amount shown in the table below that is used to determine: – the surrender benefit; and – the amount used to calculate your cover if this policy is changed to the reduced paid-up status because the premiums aren't paid.
Major critical illness	Major critical illness is any of the conditions listed and defined in page 22 Medical definitions for major critical illness. The insured person must be certified by a medical practitioner as suffering any of these covered conditions.

Minor critical illness	Minor critical illness is any of the conditions listed and defined in page 30 Medical definitions for minor critical illness. The insured person must be certified by a medical practitioner as suffering any of these covered conditions.
Medical practitioner	A medical practitioner is a person who is licensed and registered in the Philippines to practice medicine. Unless we agree in writing, a medical practitioner cannot be any of the following people: – you or the insured person; – your insurance agent, family member, business partner, employer, or employee; or – the insured person's insurance agent, family member, business partner, employer, or employee.
Pre-existing condition	Pre-existing condition means either: – latest of the effective date, the date of the last reinstatement, or the date of increase of benefit amount (for the added benefit amount) of this policy. The insured person may or may not know the presence of such condition. – A condition whose treatment, medication, advice, or diagnosis has been sought or received by the insured person before the latest of the effective date, the date of the last reinstatement, or the date of increase of benefit amount (for the added benefit amount) of this policy.

The Insurance Commission, with offices in Manila, Cebu and Davao, is the government office in charge of enforcing all laws related to insurance and supervising insurance companies and intermediaries. They help the general public in matters relating to insurance. For any questions or complaints, please contact the Public Assistance and Mediation Division (PAMD) of the Insurance Commission at 1071 United Nations Avenue, Manila. Phone **+632-85238461 to 70** or email **publicassistance@insurance.gov.ph**. The official website of the Insurance Commission is **www.insurance.gov.ph**

Table of non-forfeiture values

Policy Year	Age	With Major Critical Illness Claim		Without Major Critical Illness Claim	
		Guaranteed Cash Values	Reduced Paid-up Insurance	Guaranteed Cash Values	Reduced Paid-up Insurance
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

*Policy is paid-up since Waiver of Premium is applied upon claim of major critical illness

The values shown in this table of non-forfeiture values are for every PHP 1000.00 of benefit amount. These are guaranteed for the number of years indicated, as long as premiums are paid in full and where no indebtedness is assumed. You may request for the values applicable to the durations not shown in this table.