FWD insurance

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FWD The One

This is your contract for your insurance policy.

Read it to understand all the benefits as well as the important terms and conditions that apply to your insurance cover. Don't worry, we've made it as easy to read as possible.

If you need help, call our hotline: +632 8888 8388

Contents

About this policy

Thank you for choosing FWD. We're pleased to be protectingyou, 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 the 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 15 Important words and phrases. Please refer to this section when you need to.

Beneficiaries
Benefit amount
Claimant
Effective date
Endorsement
Expiry date
Insured person
Policy
Policy data page
Policy owner
Premium due date
We, us and our
You and your

What makes up this 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.
- Any supplementary benefit that you have chosen.
- The application form and any documents you provided with it.
- Any policy endorsement.
- The rewards terms and conditions.

Supplementary benefits can be added to your policy for added protection against serious events.

A policy endorsement is the document we provide to tellyou about any official change to this 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.

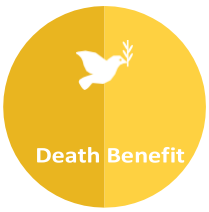
Antonio Manuel G. De Rosas
President and Chief Executive Officer

The One

This policy pays a lump sum if the insured person dies.

Your benefits at a glance

You can claim the following benefits while this policy is active.



Details on page 4

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

This is a simplified diagram. For more important details see page 4 What you are covered for.

Supplementary benefits

You can choose to add supplementary benefits to your policy for added protection. The details of any supplementary benefits you have will be shown on your policy data page, or in a policy endorsement (if you add the supplementary benefit after your policy started).

This is a protection product

This The One policy, and any supplementary benefits you may have added, is a protection product and does not contain any savings or investment components. This policy provides a death benefit.

What you are covered for

In this section, we explain what benefits you are covered for, and any conditions that apply to those benefits. Generalexclusions also apply – see page 6 What we do not cover.

You can claim the following benefits while this policy is active.

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

Making a claim

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 needed for the claim.

What you or the beneficiary needs to do

You or the beneficiary must make every effort to send your claim to us within 90 days of the insured person's death 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 Customer Connect Hotline on +632 8888 8388 and we'll help you with your claim.

Claims may be delayed or even declined if they are sent in after 90 days. Don't risk it!

What we will do

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

Taking unpaid premiums from benefit payments

If there are any unpaid premiums, we will deduct these amounts from the benefit payment when we pay it.

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 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, or last reinstatement date. In this case, we will return all premiums you have paid to the beneficiaries. We will pay the benefit if the insured person committed suicide while insane at any time.

When this policy starts and ends

When this 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 this policy contract

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.

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.

Canceling this policy

You can cancel this policy by sending us a written request within15 days after this policy has been electronically delivered to you.

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

This 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 cancel this policy;
- on the expiry date of this policy as shown in the policy data page;
- on the premium due date, if you have not paid your premium for thispolicy after the 31-day grace period.

The claimant can claim the benefit after this policy ends if the insured person's 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 CustomerConnect Hotline at +632 8888 8388. We are here for you 24/7.

Major changes to this policy such as "change in beneficiaries" will require you to submit the policy change form.

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

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 9 Types of beneficiaries to find out more about irrevocable beneficiaries.

This policy is not changed unless we give you a policy endorsement.

Reinstating this policy

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.

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 form 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, effective on the date we set.

The main people under this 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 this 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 this policy.

You receive all the benefits under this policy, except for the death benefit which is paid to the beneficiaries.

If you have any irrevocable beneficiaries or assignees, you will need their permission to make certain changes to this policy. See page 10 Types of beneficiaries for details.

Using this policy as collateral

You can choose to assign the benefits under this 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 to you with a policy endorsement.

What you need to do to assign your policy

You need to provide us a signed and notarized collateral assignment form along with any additional information we need. Call our 24/7 Customer Connect Hotline at +632 8888 8388 and they will guide you through the process.

What we will do

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

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

Insured person

This is the person you chose for us to protect under this policy. The policy insured can be the policy owner. We will pay the death benefit upon the death of this person.

Beneficiaries

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

Beneficiaries receive the death benefit under this policy. Beneficiaries cannot receive any other benefit under this policy, and they cannot make changes to this 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. You can choose any legal entity (including a corporation, partnership, charity, or trust) to be a beneficiary.

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.

Revocable — Policy can be changed any time

[OR]

Irrevocable — Must agree to change the policy

Primary or contingent

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 specific shares you have chosen. If you have not chosen any shares, we will pay them in specific 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.

Primary — First in line

[OR]

Contingent — Second in line

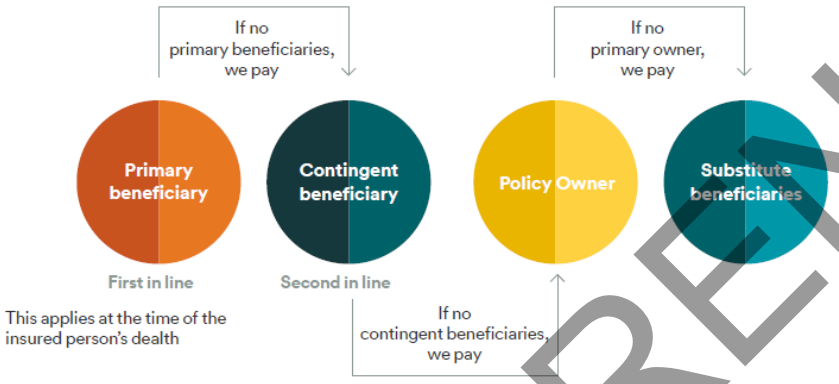
Substitute beneficiaries

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.

Should this happen, we will pay the policy owner the death benefit in the event of death. Otherwise, we will pay the death benefit to any of the surviving relations of 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, we will pay the death benefit 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

You may renew your coverage until age 99 by paying your premiums regularly.

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 renewal date.

When you need to pay your premiums

When you apply for this policy, you will be told how much you need to payand when the premiums are due (the premium due dates). You need to keep paying your premiums until the date shown on the policy data page.

The frequency of your premiums for this policy (for example every quarter, semi-annual, or once a year) will be shown on the policy data page.

When you renew your policy, the amount you need to pay may change depending on your age.

You will enjoy No Premium Increase after every 5 years if you continually renew your plan on time. This applies to both this base plan's premium and any supplementary rider which you may have.

What happens when you do not pay your premiums

31-day grace period

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. If we do not receive the premium within the grace period, your policy will end.

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 sex

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

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

Contestability

We can contest (dispute) the validity of any claim within two years from the effective date or the date we last reinstated this policy (whichever is later) 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 claim after the two-year period unless we are allowed by law or jurisprudence.

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 (to you or to your beneficiaries).

Time limit on legal action

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

Payments under your policy

All amounts paid to us, or by us, in connection with your policy willbe 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 an extraordinary rise or fallin the value of the currency you chose for your policy.

Important words and phrases

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

Beneficiaries	The person or people you chose to receive the death benefit under this policy if the insured person dies.
Benefit amount	Refers to the benefit amount or sum assured of thispolicy as stated in the policy data page.
Claimant	The beneficiaries if the claim is a death benefit.
Effective date	The day this policy and insurance coverage start.
Endorsement	The document we provide to record any official change to this policy when we issue it or throughout the life of the policy. An endorsement can only be issued by an authorized FWD employee.
Expiry date	The date shown on the policy data page, when this policy and insurance coverage ends.
Insured person	The person insured under this policy and shown under 'insured' on the policy data page.
Policy	All of the documents listed below. – 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.
Policy data page	The document that shows: – your name and details; – the effective date and expiry date of this policy; – the benefit amount; – the premium you have paid; and – the policy premium due dates.
Policy owner	You, the person who owns this policy. Your details are shown under 'owner' on the policy data page. We also use the term 'you', or 'your' in this policy document.
Premium due date	The date your premium is due to be paid, shown on your policy data page.
We, us, and our	FWD Life Insurance Corporation, the issuer of your policy.
You, and your	You, the person who owns this policy. Your details are shown under 'owner' on the policy data page.

Important notice: 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 8523 8461 to 70 or email publicassistance@insurance.gov.ph. The official website of the Insurance Commission is www.insurance.gov.ph

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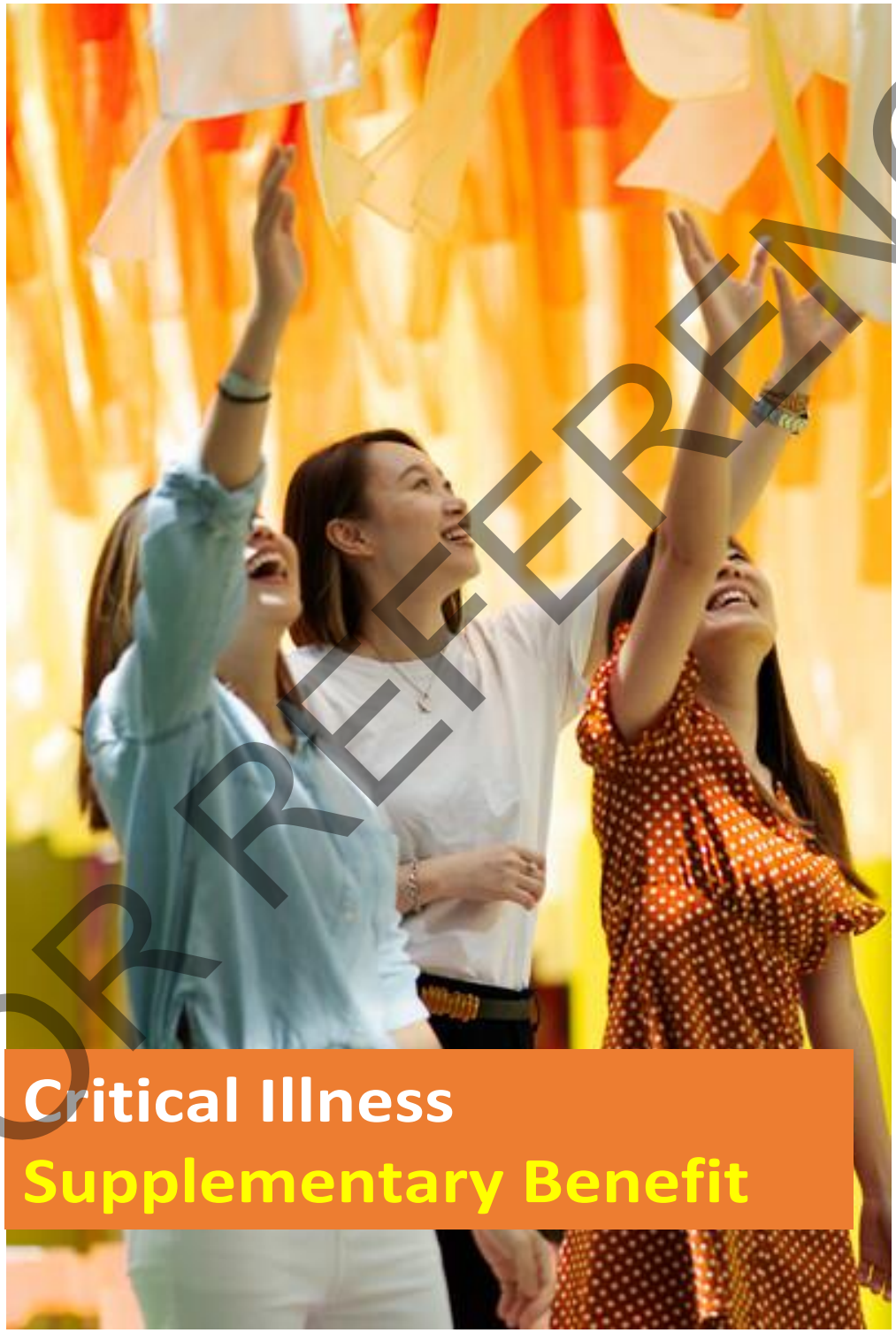

Critical Illness Supplementary Benefit

Contents

Critical Illness

This supplementary benefit pays extra lump sum if the insured person suffers major critical illness.

Part of this policy

This supplementary benefit is part of this policy as reflected in the policy data page.

All of the other terms of the base policy will also apply to this supplementary benefit. If there is a conflict between the base policy and this supplementary benefit, the terms and provisions of this supplementary benefit will apply.

The premiums of this supplementary benefit will not be included to the healthy life benefit of the base policy, if applicable.

Words with special meaning

Some words in this supplementary benefit have special meaning. We show those meanings on page 22 (What we mean by certain words). Please refer to this section when you need to.

90-day no-claim period
Accident
Activities of daily living
Base policy
Benefit amount
Major critical illness
Medical practitioner
Pre-existing condition

Your benefits at a glance

You can claim the following benefits while this supplementary benefit is active.

Details on page 3

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

This is a simplified diagram. For more important details, see page 3 (What you are covered for).

What you are covered for

You can claim the following benefits while this supplementary benefit is active

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 no-claim period; and
- the insured person survives at least 14 days after the diagnosis of the 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 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: Cancer	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. Primary pulmonary 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 neuron disease 29. Multiple sclerosis 30. Muscular dystrophy 31. Paralysis 32. Parkinson's disease 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 damage 41. Occupationally-acquired HIV/AIDS 42. Severe rheumatoid arthritis

Claiming this supplementary benefit

To claim for this supplementary 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 filling any forms or getting any documents or reports needed for the claim.

What you need to do

You must make every effort to send your claim to us within 90 days of the insured person's 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 at +632 8888 8388 and we'll help you with your claim.

What we pay

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

What we do not cover

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

Exclusions that apply to major critical illness benefits

90-day no-claim period	We will not pay any major 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 increased amount).
Drugs or alcohol	We will not pay any major 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 increased amount).
HIV	We will not pay any major critical illness benefit if the claim arises from diagnosis of cancer or encephalitis in the presence of human immunodeficiency virus (HIV) infection.
Psychiatric-related causes	We will not pay any major 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 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 it in this supplementary benefit.
Suicide or self-inflicted act	We will not pay any major 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 supplementary benefit's effective date, last reinstatement date, or date of any increase in the benefit amount (for the increased amount).
Unlawful acts	We will not pay any major critical illness benefit if the claim arises from you or the insured person committing any illegal or unlawful act (including terrorist act); or failure to act.
War	We will not pay any major critical illness benefit if the claim arises from war or any act of war (whether declared or not), or any civil or military uprising.

When this supplementary benefit starts and ends

When this supplementary benefit starts

This supplementary benefit starts on the effective date shown on the policy data page, unless we tell you that it will start on a different date. This supplementary benefit cannot start before the base policy. You can only claim for this supplementary benefit after it has started.

We will provide you this supplementary benefit 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.

When this supplementary benefit ends

This supplementary benefit ends on the earliest of the following dates:

- on the date of the insured person's death;
- on the date of diagnosis of a covered critical illness
- on the date we approve your request to surrender or cancel this supplementary benefit;
- on the expiry date of this supplementary benefit as shown on the policy data page;
- on the premium due date, if you have not paid your premium for this supplementary benefit after the 31-day grace period; or
- on the date the base policy ends. This includes the policy's cancellation, termination, and expiration.

You can claim a benefit after this supplementary benefit ends if the major critical illness happened before this supplementary benefit ended.

Reinstating this supplementary benefit

You can apply to reinstate this supplementary benefit within three years of it ending, if it ended because of non-payment of the premium.

This supplementary benefit can only be reinstated if the base policy is active (or is also reinstated).

This supplementary benefit will restart from the date we reinstate it.

What you need to do

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

- Send us a written request to reinstate this supplementary benefit using our standard form and provide any other document and information we will ask to CustomerConnect.ph@fwd.com, or call our 24/7 Customer Connect Hotline at +632 888 8388.
- Pay us all premiums due for this supplementary benefit, 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 supplementary benefit.

Premiums

You need to keep paying your premiums for this supplementary benefit during the duration (years payable) shown on the policy data page.

When you need to pay your premiums

When you apply for this supplementary benefit, 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 supplementary benefit (for example: every month, or once a year) will follow the frequency payment of the base policy.

You will enjoy No Premium Increase after every 5 years if you continually renew your plan on time. This applies to both this base plan's premium and this supplementary rider's premium.

What happens when you do not pay your premiums

31-day grace period

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

If you do not pay the premium due within the grace period, this supplementary benefit ends:

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 supplementary benefit. It is important that you and the insured person gave us complete, correct and true information, as this information helped us to decide if you and the insured person were eligible for this supplementary benefit, and what you need 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 this is not the case, your benefits under this supplementary benefit will be affected, and in some cases, we may cancel this supplementary benefit.

Incorrect age or sex

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

If the insured person was not eligible for insurance coverage at their correct age or sex, we will treat this supplementary benefit as having never existed, and we will refund all premiums you have paid for this supplementary benefit.

Contestability

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

Major Critical Illness

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

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 on page 22 (What we mean by certain words).

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:

- 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 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: 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.

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 liter – 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	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 three 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, keyhole 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 neuroradiological 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 neurosurgeon 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 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 neuron disease	Motor neuron disease of unknown etiology, as characterized by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. These include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis, and primary lateral sclerosis. 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 cerebrovascular 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 supplementary benefit (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 12 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 brain damage	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 supplementary benefit (whichever is later) and while the insured person was carrying out the normal professional duties of his/her occupation in Philippines. 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.

What we mean by certain words

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

90-day no-claim period	90-day no-claim 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 increased 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; – Mobility: the ability to move indoors from room to room on level surfaces; – 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
Base policy	Base policy refers to the policy document or policy contract where this supplementary benefit is attached.
Benefit amount	Refers to the benefit amount or sum assured of this supplementary benefit as stated on the policy data page.
Major critical illness	Major critical illness is any of the conditions listed and defined on page 11 (Medical definitions for major 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: – A condition which presented signs or symptoms that started before the latest of the effective date, the date of the last reinstatement, or the date of increase of benefit amount (for the increased amount) of this supplementary benefit. 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 increased amount) of this supplementary benefit.