SANA

HEALTH INSURANCE POLICY

GasanMamo
INSURANCE
We're always there

Sana Health Insurance Policy

Contents

Health insurance isn't just about jumping queues and it certainly isn't just for the wealthy few. It's simply about feeling confident that you're in control

Introduction

This guide has been designed to explain the terms and conditions of your health insurance plan, including what is covered, what is not covered and how to make a claim.

If you have any questions about the contents of this guide or any other aspect of your policy, please contact GasanMamo Insurance Ltd. on 2134 5123 or sana@gasanmamo.com.

Our customer care team and claims department are always available to assist you with your health insurance needs.

Your peace of mind is as important to us as it is to you

The contract of insurance

All Sana products are underwritten by GasanMamo Insurance Limited, Company Registration Number C3143, who is authorised to carry on business of insurance regulated by the Malta Financial Services Authority.

This policy is a contract of indemnity between you, the policyholder, and us, GasanMamo Insurance Ltd.

The policy is formed by your application form and the following policy documents:
- this booklet
- the policy schedule
- any endorsements attached to the policy schedule
- the table of benefits of your chosen plan

Please check your policy schedule to ensure that the details we hold are correct.

Direct settlement of medical bills

Call GasanMamo before having any treatment

GasanMamo has arrangements with participating hospitals and clinics which offer excellent standards of medical care. Direct settlement of your medical bills is possible with these participating hospitals and clinics in the case of day-patient or in-patient treatment. This means, that if you require day-patient or in-patient treatment from one of these hospitals or clinics, GasanMamo will be able to settle your medical bills directly with the hospital or clinic on your behalf. Failure to allow us to manage direct settlement may expose you to additional costs.

Our arrangements with these hospitals and clinics may change from time to time, so it is important to call us before having any medical treatment. We will then be able to confirm your level of cover, whether your chosen hospital or clinic is a participating one and if the treatment you require is covered by your chosen plan.

If the treatment is given as part of an emergency then it may not be possible for you to call us beforehand. However, you should ask someone to call us as soon as possible in order to make sure that if and when you are admitted to hospital, they will have all the necessary details to contact us and arrange for a direct settlement.

This service is subject to the terms and conditions of your chosen plan and the treatment must be preauthorised by us.

The direct settlement facility is only made available with our full refund plans and it is not available for out-patient treatment, with the exception of a few diagnostic procedures such as MRI, CT and PET scans. Where direct settlement is not available, you are required to submit a completed claim form together with the original receipts of your treatment. More information on how to claim for out-patient treatment is outlined in the claims section of this booklet.

Definitions

Some words used in this booklet have special meanings which are explained below.

1. **Accident**
   A sudden and unexpected injury to the body caused by something external which is violent and visible.

2. **Acute medical condition**
   A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

3. **Alternative therapy**
   This refers to any diagnostic tests, treatment, therapy and products whose theoretical bases and techniques diverge from conventional medical methods.

4. **Area of cover**
   The area of cover refers to the geographical area within which you are eligible to receive treatment. This will depend on which plan you have chosen and will be listed in the table of benefits under your chosen plan.

5. **Beneficiary**
   The insured member/s and/or dependant/s as herein defined as the case may be.

6. **Cancer drugs**
   This refers to drugs to cure the acute phase of the cancer.

7. **Chronic medical condition**
   A disease, illness or injury which has at least one of the following characteristics:
   - It continues indefinitely and has no known cure.
   - It recurs or is likely to recur.
   - It is permanent.
   - You need to be rehabilitated or specially trained to cope with it.
   - It needs long-term monitoring, consultations, check ups, examinations or tests.
   - It leaves residual disability.
   - It causes an irreversible physical and/or mental change.

8. **Congenital condition**
   Any abnormality, deformity, disease, illness or injury which is present at birth whether diagnosed or not.

9. **Cosmetic and reconstructive treatment or surgery**
   Treatment or surgery which serves to modify or improve the appearance of a physical feature, defect or irregularity.

10. **Course of cancer treatment**
    A course of cancer treatment refers to a maximum of six cycles of chemotherapy or six weeks of radiotherapy for the acute phase of the cancer.

11. **Date of joining**
    The day on which you joined the policy which you are covered by.

12. **Day-patient treatment**
    Treatment which, for medical reasons, means you have to occupy a bed in a hospital or day-patient unit because you need a period of clinically-supervised recovery but do not have to stay overnight.

13. **Dependant/s**
    Any person insured under your policy, other than the policyholder.

14. Disfiguring accident

A sudden and unexpected injury to the body which causes deformity caused by something external which is violent and visible.

15. Drugs and dressings

Drugs or dressings prescribed by a medical practitioner and used for the treatment of an acute medical condition which is covered by your policy.

16. Emergency

A sudden and unexpected acute medical condition, which, without treatment within 48 hours of onset, could result in death or cause serious bodily impairment.

17. Emergency dental treatment

Emergency dental treatment that is necessary to repair or to replace damaged teeth following your involvement in an accident/fortuity.

18. Excess/Deductible

That portion of the claim paid by you before your policy benefits become payable.

19. Fair and reasonable fees

The charge usually made for a particular service by members of the medical profession of the same or similar standing within the same geographical area. A fair and reasonable fee will be calculated by taking into account the complexity of the treatment involved, the degree of professional skill and other relevant factors. A list with the most common procedures and out-patient services can be found on our website. The list may be updated from time to time at our discretion.

20. GasanMamo Insurance

Refers to GasanMamo Insurance Limited, Company Registration Number C3143, who is authorised to carry on business of insurance regulated by the Malta Financial Services Authority.

21. General practitioner

A registered medical practitioner in general practice and recognised by us.

22. Group

A group who have a shared agreement with us through their sponsor and whose administration is coordinated through a single appointed representative.

23. Home country

Home country refers to the country of your permanent residence or in which you last had a permanent residence before residing in Malta or to the country from where your passport was issued.

24. Hospital/clinic

A hospital/clinic can be either:

- A state national hospital/clinic or
- A private hospital/clinic.

25. In-patient treatment

Treatment which, for medical reasons, means that you have to occupy a hospital bed overnight or for longer.

26. Inception date

The date on which your insurance cover first starts.

27. Incident

An event that is distinctive and has happened unexpectedly and arising from an acute medical condition.

28. Insured

Any person insured under your policy and named on the policy schedule.

29. Medical practitioner

A person who has a degree in the practice of medicine, surgery or dentistry, having attended a medical school recognized by us. This person must be licensed to practice such medicine by the relevant licensing authority in the country were treatment is given.

30. Medically necessary

Treatment that in the opinion of:

1. either the insured's general practitioner or specialist and
2. us or a medical advisor acting on our behalf

is both appropriate and consistent for the medical condition diagnosed, which in accordance with medical practice, if not given, would have serious and adverse effects on the insured's health.

31. Medical underwriting

The process by which your application form is evaluated on the basis of your medical history and age in order to set the premium rate for the policy, to decide whether to offer coverage or not and whether to apply exclusions on the policy for medical conditions/symptoms/injuries that were existent prior to the inception of your policy whether medical advice has been sought or not.

32. Nurse

A qualified nurse whose name is currently on the relative professional nursing register of the country in which treatment is carried out.

33. Out-patient treatment

Treatment received in a hospital or pharmacy consulting room or an out-patient clinic where you do not go in for day-patient or in-patient treatment.

34. Pandemic

An epidemic (a sudden outbreak) that becomes very widespread and affects a whole region, a continent or the world.

35. Participating hospitals/clinics

A hospital/clinic which we recognize as one of our supporting hospitals/clinics at the time that treatment is to be received. The list of participating hospitals/clinics is subject to change from time to time.

36. Period of cover

The period set out on your policy schedule during which cover is in place and for which the premium has been paid.

37. Physiotherapist

A physiotherapy practitioner who is registered according to local requirements or who has a certificate of specialist accreditation that is recognized by us or approved by us for the medical treatment required.

38. Policy

The insurance contract between you and GasanMamo Insurance. The terms of this contract are subject to the following documents:

- the application form you filled in at inception
- your policy schedule
- any endorsements attached to the schedule
- the table of benefits of your chosen plan and
- the conditions laid out in this booklet.

39. Policy schedule

The certificate giving details of the policyholder, the dependants, the sponsor (if applicable) and any endorsements, exclusions and/or restrictions which may form part of the policy.

40. Policyholder
The first person named on the policy schedule who has entered into a contract of insurance with us.

41. Pre-existing medical condition
Any disease, illness or injury for which you have received medical advice or treatment or of which you have experienced symptoms prior to the inception date of your policy, whether medical attention has been sought or not.

42. Road ambulance
A road vehicle designed to be used as a road ambulance and operated by a registered ambulance service.

43. Sana Health Insurance
A brand of health insurance products owned and operated by GasanMamo Insurance Limited.

44. Schedule of surgical procedures
The current list of surgical procedures maintained by the company, the more common of which may be found on our website. The list of surgical procedures may be updated from time to time at our discretion.

45. Specialist /Consultant
A medical practitioner who:
- is registered in terms of local requirements and who is or has been a consultant in a national hospital and is currently practising in that appointment in the area of specialisation for which the beneficiary needs treatment; or
- has a certificate of specialist accreditation that is recognized by us; and
- is approved by us for the medical treatment required.

46. Sponsor
The company or individual with whom we have entered into an agreement to provide you with cover under a group health insurance policy.

47. Table of benefits
The table showing the various benefits and benefit limits and the total overall amount payable in each policy year under your chosen plan.

48. Therapists
These include physiotherapists, chiropractors, osteopaths, acupuncturists, homeopaths, podiatrists and other therapists who are registered with the Council for Professions Complementary to Medicine or as otherwise agreed by us.

49. Treatment
Any medically necessary surgical or medical procedure, consultation, test or investigation to diagnose, cure or actively and substantially relieve an acute medical condition. This must be carried out or controlled by a registered medical practitioner or any other therapist as may be agreed by us.

50. We/us/our/the company
This refers to GasanMamo Insurance Limited.

51. You/your
This refers to the policyholder and/or anyone else insured under the policy as shown on the policy schedule.

What is covered by your policy

Benefits will be paid in accordance with the table of benefits of your chosen plan.

Should you have any queries, we always recommend that you call us on 2134 5123 before receiving any treatment.

1. Accident and/or emergency treatment

We pay for accident and/or emergency treatment provided that:

- the accident or medical condition did not occur before the inception date of your policy;
- the accident or medical condition is not related to an exclusion on your policy, and;
- the treatment required is covered under your chosen plan.

2. Acute medical condition

We pay for treatment of an acute medical condition provided that this condition has not been specifically excluded from your policy and that it is not a pre-existing medical condition.

3. Alternative therapy

We pay for treatment given by chiropractors, osteopaths, acupuncturists, homeopaths, physiotherapists and podiatrists. We may also consider paying other forms of therapy at our sole discretion. However, all treatment received by such therapists must be referred by a general practitioner and/or specialist. Therapy provided by such practitioners will be limited to 10 sessions in a 24 month period from date of injury for each medical condition requiring treatment.

4. Area of cover

We pay for eligible treatment within the area of cover of your chosen plan.

5. Cancer treatment

We pay oncology related charges, including radiotherapy, chemotherapy, MRI, CT and PET scans, consultants' fees and drugs, for the acute phase of the cancer treatment when treatment is received in a participating hospital, whether as an out-patient, as a day-patient or as an in-patient. We shall continue to cover drugs that may be required to keep the cancer in remission or to prevent relapse and any follow up consultations and investigations directly relating to the cancer for up to five years from the date of diagnosis.

6. Emergency dental care

We pay for treatment to repair or to replace broken sound natural teeth immediately following involvement in an accident, injury or dental trauma. Benefit will be payable from the emergency dental care benefit including any diagnostic procedures such as radiology and CT scan which are medically necessary as part of the treatment for which you are covered for if this is part of your chosen plan and treatment must be completed within 1 month from date of injury. This benefit does not apply for the repair of dental implants, crowns or dentures.

7. General practitioner's fees

We pay for treatment received by a general practitioner provided that the treatment relates to an acute medical condition. We shall also cover minor procedures performed under local anaesthetic by a general practitioner. Such procedures will be covered under a separate benefit according to the limits of your chosen plan.

8. In-patient medical expenses

Hospital charges

- We pay for hospital charges in a participating hospital for day-patient and/or in-patient treatment, including nursing services and meals and beverages which are included in the hospital's package price.
- In-patient pathology, radiology, physiotherapy and other necessary and approved diagnostic tests.

- Theatre fees, eligible prostheses and appliances, drugs and dressings, intensive care.
- All charges must be fair and reasonable.
- All treatment which requires you to occupy a hospital bed must be medically necessary and referred by your consulting doctor.

Personal items such as telephone calls, television and/or internet connections and guest meals are not covered.

The above charges may be paid in full as long as they are fair and reasonable and your chosen plan covers you in full. Payment can be done directly with the hospital or clinic provided that a recognised specialist has overall control of your medical treatment and that the treatment is received in a participating hospital or clinic. Failure to allow us to manage direct settlement may expose you to additional costs.

If you are covered by a limited plan, in-patient treatment will have to be paid directly by you. We will then refund you what is fair and reasonable, up to the limits of your policy, as indicated on the table of benefits, provided that you submit a completed claim form together with the original receipts of the treatment.

If treatment is not available in a participating hospital or clinic but is available in another hospital or clinic, we will, at our reasonable discretion and after being requested to do so, nominate one or more hospitals and/or clinics for the purpose of the private treatment which is covered by your policy. The treatment must be preauthorised by us in writing.

Before being admitted into hospital, we require you to forward a medical report from the attending specialist informing us of:
- the diagnosis and prognosis, if possible;
- the date when you first noticed the symptoms of the condition you require treatment for;
- the treatment received before being admitted into hospital;
- the treatment you will be receiving to cure your acute medical condition.

9. In-patient specialists' fees, including surgeons' and anaesthetists' fees

We will pay specialists' fees, provided that these are considered to be fair and reasonable.

If you are covered by a full refund plan and should the specialist agree, we may pay him/her directly.

If you are insured under a limited plan, you will have to pay the specialist's fees and claim a refund from us. We shall pay up to the limits of the policy as indicated on the table of benefits, provided that a completed claim form is submitted together with the original receipts of the treatment.

10. Maternity cash benefit

The maternity cash benefit will only be payable if the birth takes place more than 12 months after the mother's date of joining and if the mother has since remained an insured person. A cash benefit will be payable in relation to a normal pregnancy which leads to a natural birth and must be claimed within 3 months of the child's birth, upon presentation of an original birth certificate and the ante-natal record card. Any out-patient payments which have been paid for any pregnancy complications will be deducted from this benefit. If payment for pregnancy complications equals or exceeds this benefit then this benefit will not be paid. The maternity cash benefit cannot be claimed in conjunction with any other benefit covered by your policy.

11. MRI, CT & PET scans

We pay for MRI, CT and PET scan charges at participating hospitals and as recommended by your attending specialist, provided that they are carried out to determine and/or assess an acute medical condition which is covered by your policy. This benefit does not include dental Scans.

A medical report from your specialist, indicating the acute medical condition, is to be forwarded to us before going for an MRI, CT or PET scan.

12. Nursing at home

To qualify for the nursing at home benefit, nursing must:

- be approved by us in writing before it takes place, after we have received a medical report from the attending specialist detailing the acute medical reason for its necessity;
- be related to, and immediately follow, a period of day-patient or in-patient treatment covered by the policy;
- be necessary (i.e. without which you would have to be hospitalized);
- be given by a qualified nurse under the direction and supervision of a specialist;
- is needed to provide medical care, not personal assistance, domestic or social reasons.

13. Organ transplants and donor organs

We pay for organ transplants where you are the recipient of the operation. We do not pay for the costs of acquiring donor organs even if these are necessary for an organ transplant for which you are covered under your policy. We do not pay for any treatment relating to organ transplants and/or the acquisition of donor organs if the recipient of the operation is not covered under your policy. We do not pay for any treatment in any way associated with organ transplants where you are the donor of the operation.

14. Out-patient drugs and dressings

We pay for out-patient drugs and dressings, for the acute phase of your treatment prescribed to you by your consulting doctor, up to the limits of your chosen plan. Drugs payable under this benefit are restricted to prescription-only drugs. Over-the-counter drugs are not covered by your policy. A copy of the prescription must be presented together with all original invoices/receipts and a completed claim form within 3 months from the date of treatment. Invoices/receipts must clearly delineate the relevant drugs and their costs.

15. Out-patient medical expenses

We pay for charges relating to specialist/consultant's fees, pathology, radiology and other approved diagnostic tests in accordance with the table of benefits of your chosen plan.

You are requested to forward all original invoices/receipts together with a completed claim form within 3 months from the date of treatment.

16. Out-patient surgical procedures

We pay for charges for surgical procedures performed by a specialist under local anaesthesia in a hospital or pharmacy consulting room or an out-patient clinic where you do not go in for day-patient or in-patient treatment.

17. Outside area of cover

We pay for emergency treatment which arises suddenly and of which you were not aware of prior to your departure to the USA & Canada up to the same level as what would have been payable had the same treatment been received privately in Malta (fair and reasonable charges apply) and up to a maximum of €50,000 per policy year. We will not pay for any costs arising from a medical condition if you travel against the advice of a qualified medical practitioner or would be travelling against the advice of a qualified practitioner had you obtained advice.

18. Prostheses and appliances

We pay for surgically implanted standard prosthetic devices and/or appliances for which you must be eligible, provided that these are medically necessary as part of the treatment which you require and which is covered by your policy and with prior authorisation from us. Other medical prostheses and devices which are not surgically implanted are not covered by your policy.

19. Psychiatric treatment

We pay for psychiatric treatment whether this is received as an out-patient as a day-patient or as an in-patient, provided that you have been insured for more than two continuous years before the first symptoms were noticed. We shall stop paying benefit as soon as it becomes apparent that a medical condition is chronic in nature. All psychiatric treatment must be preauthorised by us in writing and is limited to treatment received in Malta.

20. Road ambulance services

We shall pay for road ambulance services provided that such services:

- are related to treatment which is covered by your policy;
- are medically necessary (e.g. you are confined to a bed or injured).

Benefits for road ambulance services are as follows:

- From your home or place of employment to a participating hospital.
- From the location where you get injured or are taken ill to a participating hospital.
- Between hospitals.
- Between an air/sea port and a participating hospital.
- From hospital to your home.

If you are insured under an in-patient only plan the road ambulance charges will only be covered if you are kept in hospital either as day-patient or in-patient.

21. State hospital cash benefit

We pay a cash benefit for in-patient treatment received in a state hospital, where treatment was received free of charge, on presentation of an original discharge letter. This benefit is only applicable for treatment which would have been covered under the other sections of your policy and which is not related to an exclusion. This benefit does not apply to psychiatric treatment of any kind.

22. Worldwide Emergency Service - Intana Global

Intana Global is a worldwide, 24 hours a day emergency medical service, which is only available to persons insured under our international plans. Intana Global must be notified immediately of an illness or injury which requires you to go into hospital, while outside of Malta as an in-patient. If this is not possible because the condition is serious then contact must be made as soon as possible after you are hospitalised. Immediate contact should be made with Intana Global before arrangements are made for repatriation.

An experienced Assistance Coordinator will deal with your enquiry and will make sure that:

- hospitals are contacted if necessary;
- necessary medical fees are guaranteed;
- medical advisors are consulted;
- repatriation to Malta is arranged, by the most appropriate method, if this is considered to be medically necessary.

By medically necessary, we mean that if an insured member is admitted to a hospital while outside of Malta and in the opinion of a doctor appointed by us, the medical facilities of the country s/he is in, are not suitable or adequate, s/he will be entitled to repatriation. This effectively means that the insured member will be entitled to be returned to Malta by a regular airline or by any other means of transport we consider appropriate. We will decide the means of transport and the date and time.

You will not be eligible to make use of this emergency service if:

- the medical condition you are suffering from is not covered by your policy;
- the medical condition you are suffering from does not necessitate immediate in-patient treatment or does not impede you from continuing to travel or to work;
- the medical condition you are suffering from results from your participation in abseiling, canoeing,

cliff diving, hang-gliding, hot-air ballooning, jet skiing, mountaineering, parachuting, quad biking, rock climbing, scuba diving, sky diving or any other activity that is deemed to be dangerous by us (if you are unsure about what may be considered to be a dangerous activity and/or your level of cover, please call us before participating in any such events);

- you need to be moved from a ship, oil-rig platform or any similar off-shore location;
- at the time the need for the service arises, you are insured or, if this insurance did not exist, you would be insured against these costs by an existing insurance policy or policies;
- we have not been informed about the accident or illness, for which you require the service, within 30 days of it happening;
- the accident or illness occurs while you are travelling to a country or area that the UK's Foreign and Commonwealth Office (FCO) lists as a place which, for any reason, it advises against.

We will not be liable for:

- any failure to provide the service or for any delays in providing it unless the failure or delay is caused by our negligence;
- failure or delay in providing the service if, by law, the service cannot be provided in the country in which it is needed;
- failure or delay caused by any reason beyond our control including but not limited to strikes, flight conditions and/or visa restrictions;
- your injury or death while you are being transported (this means from the moment that you are physically in contact with Intana Global to the point where you are relinquished into the care of an independent hospital or clinic).

The cost of the Intana Global emergency service is paid for by us. The operation and availability of the service is governed by the terms, conditions and exclusions in this policy booklet as well as any exclusions or restrictions appearing on your policy schedule. Any treatment you receive through Intana Global will be covered under the relevant benefits of your chosen plan and be subject to their respective limits.

UK tel: +44 (0) 20 7902 7405
UK fax: +44 (0) 20 7928 4748

email: ops@intana-global.com
website: www.intana-global.com

Please quote your policy number and state that you are insured by GasanMamo Insurance, Malta.

Optional Benefits

1. Preventive Treatment Package

- **Eye examination**
  We pay for 1 eye examination every 2 years carried out by an optometrist/ophthalmologist up to the limit specified in your chosen plan. We do not pay for any treatment you may need as a result of your check-up under this benefit.

- **Dental examination**
  We pay for annual dental check-ups carried out by a dental practitioner up to the limit specified in your chosen plan. We do not pay for any treatment you may need as a result of your check-up under this benefit.

- **Mammogram/Breast ultrasound**
  We pay for a mammogram/breast ultrasound for women over 45 years of age every 2 years up to the limit specified in your chosen plan. We do not pay for any treatment you may need as a result of your check-up under this benefit.

- **Prostate examination & PSA test**
  We pay for a prostate examination and PSA testing for men over 45 years of age every 2 years up to the limit specified in your chosen plan. We do not pay for any treatment you may need as a result of your check-up under this benefit.

- **Blood tests & blood pressure monitoring**
  We pay for blood pressure monitoring and the below routine blood tests every year for members over 40 years of age up to the limit specified in your chosen plan. We do not pay for any treatment you may need as a result of your check-up under this benefit.
  - Complete Blood Count
  - Liver Function Test
  - Lipid Profile
  - Fasting Blood Glucose

- **Gynaecological examination**
  We pay for an annual gynaecological check-up including a cervical smear test up to the limit specified in your chosen plan. We do not pay for any treatment you may need as a result of your check-up under this benefit.

- **Stress ECG**
  We pay for a stress ECG for members over 45 years of age every 2 years up to the limit specified in your chosen plan. We do not pay for any treatment you may need as a result of your check-up under this benefit.

Terms & conditions

- These benefits are only payable for charges you incur after 6 months of being a holder of the Preventive Treatment Package.
- Benefit will not be paid for medical conditions for which you are excluded for on your policy schedule.
- The Preventive Treatment Package can only be taken up when buying a GasanMamo medical policy or when renewing your GasanMamo medical policy.
- The Preventive Treatment Package must be taken up by all the members of your policy.
- The Preventive Treatment Package can only be taken up together with an in and out–patient plan.
- We have the right not to offer these benefits at renewal or to amend the premiums at renewal.

2a. Repatriation to your home country

We will pay for the reasonable costs of repatriation to your home country by a regular airline in economy class or by any other means of transport we consider appropriate. We will decide the means of transport as well as the date and time of transport. Any person accompanying the patient will be responsible for his/her own expenses.

Repatriation will be covered in the event that you suffer an acute medical condition which is covered by your policy, subject to the following:

- The acute medical condition has to be unexpected, life threatening and arising from a cause outside of your control.
- Repatriation must be considered medically necessary by us and/or by a medical expert appointed by us.
- The treatment you require does not relate to a pre-existing medical condition or any other medical condition which is excluded by your policy.
- Repatriation must follow your being hospitalised for an acute medical condition which is covered by your policy.
- Treatment for the acute medical condition from which you are suffering is unavailable in the country where the incident happened.
- The cost of repatriation will be covered up to a maximum limit of €30,000 per incident and will be limited to up to 1 incident per policy year. This limit forms part of the overall annual maximum limit of your chosen plan.
- The date of repatriation must fall within an insurance period for which you have repatriation cover.
- Cover for repatriation will not apply for any disease, illness or injury for which you have received medical advice or treatment or of which you have experienced symptoms prior to the inception date of your policy and/or when this inclusion was added to the policy, whether medical attention has been sought or not.

2b. Repatriation of mortal remains

In the event of your death we will pay for the reasonable costs up to a maximum limit of €30,000 for the repatriation of your mortal remains.

- We will pay for the transportation of your bodily remains to your home country. Transport from the airport in your home country is not included.
- We will pay for the casket used for the transportation of your bodily remains as long as it is certified for airline transport.
- We will pay for the reasonable costs of preparation of your mortal remains.
- We do not pay for the cost of cremation and other associated expenses.
- We do not pay for the transportation of anyone accompanying the body or ashes.
- We do not pay for the cost of urns, coffins, visitation, burial or funeral expenses.
- We will not be liable for loss, damage or any other impairment to your bodily remains incurred during the repatriation process.
- We will not be liable to pay for repatriation of your mortal remains if your death occurs after the policy expires.

We will not be liable for:

- any failure to provide the service or for any delays in providing it unless the failure or delay is caused by our negligence;
- failure or delay in providing the service if, by law, the service cannot be provided in the country in

which it is needed;
- failure or delay caused by any reason beyond our control including but not limited to strikes, flight conditions, government officials, weather and other acts of God and/or visa restrictions;
- your injury or death while you are being transported;
- any expenses you incur for services not arranged or preauthorised by us;
- repatriation should you have been living outside of Malta for more than 120 days of the policy year when the incident occurs while covered on the International Plan.

You will not be eligible for repatriation cover if:

- the medical condition you are suffering from does not necessitate immediate in-patient treatment or does not impede you from continuing to travel or to work;
- the medical condition you are suffering from results from your participation in abseiling, canoeing, cliff diving, hang-gliding, hot-air ballooning, jet skiing, mountaineering, parachuting, quad biking, rock climbing, scuba diving, sky diving or any other activity that is deemed to be dangerous by us (if you are unsure about what may be considered to be a dangerous activity and/or your level of cover, please call us before participating in any such events);
- you need to be moved from a ship, oil-rig platform or any similar off-shore location;
- at the time the need for the service arises, you are insured or, if this insurance did not exist, you would be insured against these costs by an existing insurance policy or policies;
- we have not been informed about the accident or illness, for which you require the service, within 30 days of it happening;
- the accident or illness occurs while you are travelling to a country or area that the UK's Foreign and Commonwealth Office (FCO) lists as a place which, for any reason, it advises against.

Cover variations

- If you are insured under any of the Vital Plans or the Key Plans, repatriation cover shall mean transport from Malta to your home country. You will be covered up to specific limits as indicated on your chosen plan for any medical expenses incurred once you land in your home country excluding USA & Canada subject that all premiums due have been paid.

- If you are insured under the International Plan, repatriation cover shall mean transport from any country excluding USA & Canada to your home country. You will be eligible to claim for medical expenses in your home country subject that all premiums due have been paid.

What is not covered by your policy

Should you have any queries, we always recommend that you call us on 21 345 123 before receiving any treatment.

1. Addictive disorders /Substance abuse

We do not pay for treatment directly or indirectly related to or associated with alcohol abuse, drug abuse, solvent abuse, eating disorders or any other addictive condition of any kind.

2. AIDS/HIV and sexually transmitted infections

We do not pay for costs relating to sexually transmitted infections. This includes Acquired Immunodeficiency Syndrome (AIDS), AIDS-related Complex (ARC) and all illness caused by and/or related to the Human Immunodeficiency Virus (HIV).

3. Allergy disorders

We do not pay for investigations/treatment relating to allergies.

4. Appliances and medical aids

We do not pay for medical aids and appliances including spectacles, splints, contact lenses, hearing aids, wheelchairs, stair lifts and the like.

5. Behavioural disorders

We do not pay for conditions such as conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, attachment disorder, adjustments disorders, as well as all treatments that encourage positive social-emotional relationships, such as communication therapies, floor time and family therapy.

6. Body modifications

We do not pay for treatment for any illness, diseases or injuries arising from the deliberate altering of the human anatomy or physical appearance.

7. Chronic medical condition

We do not pay for the treatment of a non-acute, chronic condition (including a mental condition or injury). A chronic condition is a disease, illness or injury which has at least one of the following characteristics:

- It continues indefinitely and has no known cure.
- It recurs or is likely to recur.
- It is permanent.
- You need to be rehabilitated or specially trained to cope with it.
- It needs long-term monitoring, consultations, check ups, examinations or tests.
- It leaves residual disability.
- It causes an irreversible physical and/or mental change.

8. Complications from excluded conditions/treatment

We do not pay for the costs of treatment relating to complications directly or indirectly caused by a disease, illness or injury for which cover has been specifically excluded under your policy.

9. Congenital conditions

We do not pay for treatment of congenital abnormalities and birth defects and any direct or indirect complications or related treatment whether it was diagnosed or not at birth.

10. Contraception, infertility, assisted reproduction, and sterilization

We do not pay for treatment and investigations directly or indirectly related to or associated with contraception, infertility, assisted reproduction, sterilization (or its reversal) or any consequence of any of them.

11. Cosmetic/reconstructive surgery or treatment

We do not pay for cosmetic/reconstructive surgery or treatment or for their direct complications, whether or not for psychological reasons. We shall pay for a surgical operation to restore your appearance after a disfiguring

accident for which you must be covered under your policy or as a direct result of surgery for cancer, provided that you have been continuously insured with us since before the accident occurred or the cancer developed and with prior approval by us. We will not cover for treatment involving the removal of healthy tissue (i.e. tissue which is not diseased), or the removal of surplus or fat tissue, whether or not it is needed for medical or psychological reasons. Treatment is to be received within 12 months from the date of accident or surgery.

12. Dental or orthodontic treatment

We do not pay for orthodontics, periodontics, endodontics, preventive dentistry, general dental care and oral surgical procedures except for the surgical removal of buried or impacted wisdom teeth, surgical removal of complicated buried roots and enucleation of cyst of jaw.

13. Developmental/speech/motor skills disorders

We do not pay for treatment related to developmental delay whether physical or psychological. We do not pay for speech disorders, motor skills disorders and learning difficulties even if these are not related to developmental delay.

14. Experimental treatment

We do not pay for treatment which, in our opinion, is considered experimental or has not been proved to be medically effective through scientific research and accepted as good practice by a competent authority.

15. Eyesight

We do not pay for any investigations or treatment relating to the correction of eyesight, including the cost of spectacles, contact lenses, laser treatment or any other method of treatment unless such treatment is required due to an injury or as a result of an acute medical condition.

16. Fees for medical reports/completing claim forms

We do not pay for fees charged by a medical practitioner for providing medical reports or completing claim forms or for the issue of medical certificates.

17. Fees incurred due to social and domestic reasons

We do not pay for fees charged for accommodation and ancillary items, home nursing and rehabilitation, if such costs are incurred for social and domestic reasons.

18. Food intolerance

We do not pay for food intolerance/allergy investigations.

19. Foot care

We do not cover treatment relating to bunions, calluses, clavus, corns, hyperkeratosis and keratotic lesions, keratoderma, nails (except surgery for ingrown nails), plantar keratosis, tyloma or tylomata, tylosis, the reduction of nails, including the trimming of nails. We also do not cover any treatment and investigations relating to the evaluation of the foot, biomechanics and recommendation of footwear. The costs of insoles and corrective footwear are not covered.

20. Health hydros, spas and nature cure clinics

We do not pay for treatment received in health hydros, spas, and nature cure clinics or in any similar establishments even if they are registered as a hospital/clinic and/or you have been referred by your consulting doctor.

21. Hotel accommodation and travel costs

We do not pay for hotel accommodation and/or travel costs even if they are related to the treatment of an acute medical condition.

22. Hormone Replacement Therapy (HRT)

We do not pay for Hormone Replacement Therapy (HRT) except when it is medically necessary following surgery which is covered by your policy. The cost of such treatment will only be paid up to 6 months from the date of the surgery and up to the limits of your chosen plan.

23. Incurable medical condition

We do not pay for palliative treatment given for an incurable medical condition.

24. Life support machines

We do not pay for the use of life support machines or similar devices beyond the first 14 days of use.

25. Organ transplants and donor organs

We do not pay for the costs of acquiring donor organs even if these are necessary for an organ transplant for which you are covered under your policy. We do not pay for any treatment relating to organ transplants and/or the acquisition of donor organs if the recipient of the operation is not covered under your policy. We do not pay for any treatment in any way associated with organ transplants where you are the donor of the operation.

26. Outpatient clinic/hospital fee

We do not pay for any clinic/hospital fees which may be charged in addition to the cost of outpatient treatment and/or services.

27. Pandemics

We do not pay for the treatment of illnesses arising from a pandemic.

28. Participating hospitals/clinics

We do not pay for treatment received at a hospital/clinic that is not a participating hospital/clinic unless it is preauthorised by us in writing.

29. Pre-existing medical conditions

We do not pay for treatment/investigations for any disease, illness or injury for which you have received medical advice or treatment or of which you have experienced symptoms prior to the inception date of your policy, whether medical attention has been sought or not.

30. Pregnancy and childbirth complications

We do not pay for pregnancy and childbirth complications; except for the following conditions if the mother has been insured for a continuous period of 12 months

- miscarriage or when the foetus has died and remains with the placenta in the womb;
- still birth;
- abnormal cell growth in the womb (hydatidiform mole);
- foetus growing outside the womb (ectopic pregnancy);
- heavy bleeding in the hours and days immediately after childbirth (post-partum haemorrhage);
- afterbirth left in the womb after delivery of the baby (retained placental membrane);
- caesarean delivery if this is medically necessary due to a condition for which you are covered for under your chosen plan. Elective caesareans are not covered by your policy;
- abortion if this is required due to an immediate threat to the life of the mother;
- complications from any of the above.

31. Prescribed out-patient drugs and dressings

We do not pay for prescribed out-patient drugs and dressings except as specified in your chosen plan.

32. Puberty, menopause and ageing

We do not pay for treatment to relieve symptoms that are associated with the bodily changes arising from or related to puberty, menopause and/or ageing.

33. Refusing medical advice

We do not pay for treatment required as a result of failure to seek or follow medical advice.

34. Rehabilitation and convalescence

We do not pay for hospital accommodation for rehabilitation or convalescence, even if following an acute medical condition.

35 . Renal dialysis

We do not pay for renal dialysis except for short-term renal dialysis for up to 6 weeks immediately prior

and/or after you undergo a kidney transplant if this is considered to be medically necessary.

36. Routine and preventive medical treatment and investigations

We do not pay for routine or preventive medical examinations, investigations or tests including but not limited to breast and prostate screening, eyesight tests, hearing tests, smear tests and bone densitometry tests.

37. Sex reassignment

We do not pay for treatment arising from or related to sex or gender reassignment or to a sex change and any direct or indirect consequence of it.

38. Sexual impotence and sexual problems

We do not pay for treatment of impotence or for any direct or indirect consequence of it.

39. Self-inflicted injury or suicide

We do not pay for treatment arising directly or indirectly from a deliberate self-inflicted injury or for attempted suicide.

40. Skin disorders

We do not pay for treatment relating to warts and skin tags.

41. Sleep disorders

We do not pay for treatment relating to insomnia, sleep apnoea, snoring or any other sleep related breathing problems.

42. Sports activities

We do not pay for injuries:

- arising during the performance of and training for a sports activity for which you receive payment or sponsorship;
- arising during the performance of and training for sporting activities within the framework of organised competitions and races;
- arising during the performance of and training for extreme, dangerous or adrenaline sports or directly related thereto such as but not limited to: abseiling, canoeing, cliff diving, hang-gliding, hot-air ballooning, jet skiing, mountaineering, parachuting, quad biking, rock climbing, scuba diving, sky diving or any other activity that is deemed to be dangerous by us (if you are unsure about what may be considered to be a dangerous activity and/or your level of cover, please call us before participating in any such events);
- arising from the same sport.

43. Unrecognised providers and specialists

We do not pay for treatment and/or diagnostic procedures carried out by providers and/or medical practitioners who are not recognised or licensed by the competent authorities in the country where they practise or who have been temporarily or permanently removed from the Medical Council's Registry or who have been notified by us in writing that we do not recognise them as such.

44. Vaccinations

We do not pay for the cost of any vaccinations unless they are given to you to treat an acute medical condition which is covered by your policy. The cost of such treatment will only be paid up to the limits of your chosen plan.

45. Wars, contamination and riots

We do not pay for treatment arising from nuclear or chemical contamination, war, terrorism, invasion, act of a foreign enemy, hostilities (whether war is declared or not), civil war, riot, civil disturbance, criminal activity, rebellion, revolution, military force or coup.

46. Weight and eating disorders

We do not pay for treatment directly or indirectly relating to weight and/or eating disorders including but not limited to: anorexia, bulimia, binge eating disorder, avoidant/restrictive food intake disorder and obesity.

General conditions

This section explains the general conditions of your policy.

1. Addition of new born children

If a child is born to an insured mother/father who has been insured for the whole 12 months prior to the child's birth, you must notify us in writing and submit an original birth certificate within 3 months of his/her birth. We will then cover the new born child under your policy with effect from his/her date of birth and immediately cover him/her for conditions which may arise after his/her birth except if such conditions are connected to a congenital abnormality. If a child is born with a congenital abnormality an application form will have to be completed, giving us details of his/her medical history. No premium will be charged for the child until the next renewal date from the child's date of birth. We do not allow this concession if the child was born due to any method of assisted conception or if s/he has been adopted.

2. Arbitration

All differences arising out of this policy shall be referred to the decision of an arbitrator appointed under the provisions of the arbitration act within one month after a written request by you or us. An award must be made by the arbitrator before any court proceedings can be started against us. If we refuse liability for a claim and this claim is not referred to arbitration within one year from the date of such refusal, the claim shall be deemed to have been withdrawn and cannot subsequently be revived.

3. Change of risk

If there are any changes relating to you or your dependants which may affect the information given to us upon application and/or at renewal, then you must inform us as soon as possible. You are also to inform us of any changes even if renewal terms have been offered and premium has been paid. In light of such changes we reserve the right to alter the premium and the policy terms or to cancel your cover or that of your dependant/s if the risk is deemed to be unacceptable by us.

4. Changes to your cover

You may make changes to your level of cover but these changes may only be done at renewal. If you want to increase your level of cover, you will have to complete an application form giving details of your medical history. Depending on your medical history declaration, you may have to agree to certain exclusions or restrictions to your cover before we accept your application. If you want to lower your level of cover, you may do so by sending written instructions to us. In this case, an application form is not required.

5. Compliance with policy terms

Our liability under this policy will be affected if you or any one or more of your dependants insured under this policy do not comply with the terms and conditions.

6. Contribution

If at any time of any claim arising under this policy there is any other insurance policy covering the same liability, you must disclose this information to us and we shall not be liable to pay or contribute more than the rateable proportion of the costs incurred.

7. Cover

The insurance policy is only effective after your application has been accepted by us and after you have agreed in writing to the proposed terms and conditions and the premium has been received by us.

8. Date of treatment

You are only eligible to receive benefits for treatment received and for drugs purchased within the period of cover. This means that any expenses you incur for treatment which you receive and/or for drugs which you purchase outside of the period of cover, will not be covered by your policy, even if the condition in question was diagnosed within an insured period and/or the treatment is a continuation of treatment which was covered by your policy.

9. Dependants

You may include persons other than yourself under your policy but these persons must elect the same plan that you are currently insured under and an additional premium must be paid for each of them. All persons to be added must complete an application form and be medically underwritten before joining your policy.

10. Eligibility

The maximum age at entry for new applicants is not to exceed 60 years. We may at our discretion accept

new applicants over the age of 60 years upon receiving a completed application form. The premium, terms and conditions of the policy will be decided by us.

11. General practitioner's referral

All specialist consultations must be referred by a general practitioner except for the following:

- Consultations with ophthalmologists
- Consultations with gynaecologists (only applicable for women)
- Consultations with paediatricians (only applicable for children under the age of 13 years)

12. Group cover

The terms and conditions of your health insurance policy are governed by an agreement between your sponsor and GasanMamo. There is no legal contract between you and GasanMamo covering your membership to the group's health insurance policy. To be covered under the group health insurance policy you must be confirmed by your sponsor. Your sponsor is responsible for letting you know of any variations to the terms and conditions of your policy. If you are unsure about your level of cover, please contact your group secretary. No changes to the group policy or people covered by it can be made unless specifically agreed on, in writing, by your sponsor and us. A group has to retain a minimum of 50% of its original members throughout the year. Should the group decrease below the required percentage a cancellation refund would not apply.

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13. Jurisdiction

Without prejudice to any arbitration proceedings in Malta under the current statutory provisions, this policy shall be subject to the exclusive jurisdiction of the Maltese Courts. We will pay only in respect of judgements, orders or awards that are delivered by or obtained from a court within Malta, or in arbitration in Malta under current statutory provisions. We will not pay in respect of any judgement, order or award obtained in Malta for the enforcement of a judgement or arbitration award obtained elsewhere or to costs and expenses of litigation recovered by any claimant from you or any other persons entitled to indemnity under this policy which costs and expenses of litigation are not incurred in Malta.

14. Law applicable to contract

The law of Malta will apply to this contract unless you and us agree otherwise.

15. Policy duration

The policy shall be for a period of one year (12 calendar months) commencing on the day indicated on the policy schedule and is subject to the terms in force at the time of each renewal. We reserve the right to refuse to renew your policy or to amend terms, conditions and/or premiums at renewal.

16. Premiums

Premiums may change from time to time but this policy will not be subject to any alteration in premium rates until the next renewal date. If you move age band the premium will then increase at the next renewal date. All premiums are payable in advance.

17. Residency clause

A member of the policy cannot be living or travelling outside of Malta for more than 120 days in any one insurance period unless authorised by us in writing. If you exceed 120 days of being away from Malta any claims that you submit may be delayed, compromised and/or even rejected.

18. Subrogation

We may take over and conduct in your name, or the name of the person claiming under your policy, the defence or settlement of any claim, or take proceedings for our own behalf but in your name, or in the name of anyone else insured by your policy, to recover any payment we have made under your policy. We shall have full discretion in the conduct of any proceedings or the settlement of any claim. The person who is seeking payment under this policy shall give us all the information we require and all the assistance necessary for us to achieve a settlement.

19. Transfer of cover

If you are transferring your policy from another insurer you will be requested to submit a copy of your latest policy schedule as any exclusions shown on the schedule will automatically be carried forward to your GasanMamo policy and will not be removed unless there is written communication between us and you specifically stating that we have agreed not to carry forward the said exclusions. You will still be required to complete an application form and be medically underwritten. Any new exclusions will be added to those already imposed by the previous insurer.

Payment of premium & cancellation of policy

1. You are responsible for paying the entire premium, including all relevant taxes and levies, for each person insured under your policy.

2. The premium must be paid by the date when it becomes due. If the premium is not paid by such a date, the policy shall be cancelled automatically, although we may, at our discretion, reinstate your cover if the premium is paid within 30 days of its due date and a medical declaration form is completed. If any premium or part thereof is due from the policyholder, then we may, in addition, defer payment of all claims lodged under the policy until such outstanding premiums have been paid in full.

3. If you are insured under a group health insurance policy and your sponsor does not pay the premiums and all relevant taxes and levies when due, your health insurance policy will not be valid. The renewal of your group health insurance policy is subject to your sponsor renewing the agreement with us. If your group policy ends you may apply for an individual policy, in which case, underwriting measures may apply.

4. The policy shall be for a period of one year, commencing on the day indicated on the policy schedule and is subject to the terms in force at the time of inception or renewal. We do not allow cancellation of the policy for any reason.

5. We may also cancel your policy at any time if you have misled us due to misrepresentation or non-disclosure or if you have knowingly claimed benefits for any purposes other than the ones provided under this policy. Failure to act in utmost good faith may also result in the cancellation of your policy. If we cancel your policy due to any of these reasons you will be notified by us in writing. In such cases we will not refund the premium which has been paid and we reserve the right to proceed judicially in accordance with the law. Similarly, we may cancel a group health insurance policy if there is reasonable evidence that the sponsor has misled us by giving false information or withholding necessary information from us.

6. We reserve the right to refuse to renew your policy and/or amend terms, conditions and premiums or to cancel your policy if you or any of your dependants are living or travelling outside of Malta for more than 120 days in one insurance year.

7. We will not be liable to pay any claims you submit after your policy has been cancelled if a pro-rata refund has been issued for the unused period of insurance. This clause applies regardless of whether the date of the treatment you claim for lies within the insured period.

How to claim

Should you have any queries, we always recommend that you call us on 2134 5123 before receiving any treatment.

1. Before having any treatment we strongly recommend that you call us to confirm your level of cover and whether the treatment you require will be covered under your policy. Whenever possible, claims should be authorised in advance and you should call us even if referred to a specialist by a general practitioner. In order to confirm your cover before having treatment, we must receive all the necessary medical reports and other documentation if possible at least 5 working days prior to treatment. This is especially important if you require day-patient or in-patient treatment or if you require one or more diagnostic tests. Failure to allow us to manage direct settlement may expose you to additional costs.

2. Costs claimed for treatment you receive must be fair and reasonable and be necessarily incurred. The treatment must be wholly and exclusively for the treatment of an acute condition on a short term basis. The benefits of the policy are only payable in respect of treatment of a disease, illness or injury which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury or which leads to your full recovery.

3. Treatment of an acute condition cannot be for longer than 180 days in any policy year however, since we pay only for treatment of acute conditions that respond quickly to treatment we shall stop paying benefits as soon as it becomes apparent that a medical condition has become chronic.

4. The completed claim form which must be filled in separately for each patient and for each medical condition must be returned to us together with the original invoices/receipts, within three months of the date of treatment. We reserve the right to reject any claim which is not submitted within this period.

5. Copies and photocopies of any invoices/receipts will not be accepted. Alterations on original receipts and/or claim forms will also not be accepted unless endorsed and dated by the consulting doctor.

6. If we feel that we need further information to assess your claim, we may ask you to provide us with medical reports and/or other clinical information about the treatment and/or investigations. Any expenses related to acquiring these reports are to be paid by you.

7. We may appoint and cover the cost of an independent medical practitioner to advise us on the medical issues related to the claim. If required, the independent medical practitioner may also medically examine the insured and provide us with a report. If you do not allow the independent practitioner to examine you, we reserve the right not to pay the claim.

8. If at any time of any claim arising under this policy there is any other insurance policy covering the same liability, you must disclose this information to us and we shall not be liable to pay or contribute more than the rateable proportion of the costs incurred.

9. In the case of any claim, we will pay for your treatment or that of your dependants in accordance with the terms and conditions set out in this booklet and in accordance with your table of benefits.

10. We will only pay for medical expenses you incur and which are covered under your policy provided that all premiums due to us have been settled as agreed to at inception or renewal.

11. If any claim paid under this policy is in any respect fraudulent, the benefit paid and/or which is to be paid shall be forfeited and/or recoverable from the policyholder or insured person. Moreover we reserve the right to proceed judicially in such cases.

12. All claims are only made eligible for benefits under this policy if the treatment undertaken is:

- received by a general practitioner or by a specialist or other therapist, as may be agreed by us, who you have been referred to by a general practitioner;
- medically necessary, and is carried out solely to diagnose, treat and/or cure an acute medical condition as defined in this booklet.

Claim forms with backdated general practitioner referrals will not be accepted.

13. Payments of all claims will be made to the policyholder unless you instruct us in writing to do otherwise.

14. Charges incurred in a currency other than the euro which are eligible for benefit under your policy will be converted by us and paid in euro. Provided that you can submit reasonable proof, the rate of exchange applicable will be the one applied when:

- you exchanged cash at a foreign exchange bureau or;
- your account was debited or;
- you made a payment by credit card.

In the absence of such proof, the currency will be converted using the exchange rate of the euro published by one of the local commercial banks at the time that the payment is made by us. In the absence of the publication of a foreign currency's exchange rate by the local commercial banks, we will use the exchange rate published by a trusted internet-based foreign exchange service provider of our choice.

If GasanMamo agrees to pay a claim in a foreign currency other than the euro, the currency will be converted using the exchange rate of the euro published by one of the local commercial banks at the time that the payment is made by us. In the absence of the publication of a foreign currency's exchange rate by the local commercial banks, we will use the exchange rate published by a trusted internet-based foreign exchange service provider of our choice. Payments will be subject to any exchange control regulations which are in force at the time.

15. The company reserves the right to amend the procedure of how to make a claim. However, in the case of any changes to this procedure, you will be notified immediately or upon renewal as the case may be.

16. Ex-gratia payments may be made at our sole discretion. If we pay a claim that you are not entitled to receive benefits for under your policy, the payment will still be deducted from your policy's benefit limits and we will not be liable to pay related claims in the future.

17. Before any payments are made by us in respect of settling a claim, any excess which may be applicable under your policy, will be deducted from the amount which you are entitled to receive according to your chosen plan. After the excess is deducted, the remaining balance will be paid to you and/or the hospital/ clinic in which you sought treatment. The excess or deductible is applied once per medical condition, per insured person, per 6 month period from the date of first treatment, if treatment continues from one period of cover to another, the excess will therefore apply again.

Complaints procedure

As a valued customer you are right to expect fairness and a swift and courteous service at all times.

We recognise that you may sometimes be dissatisfied with our service. To help us improve, we would appreciate your honesty in telling us about your experience of our service. Your feedback will make all the difference.

What you should do if you have a complaint

Step 1 - Please speak to your usual insurance advisor or your GasanMamo Insurance contact.

Step 2 - If you remain dissatisfied or you feel your complaint remains unsolved, please write to the Managing Director, GasanMamo Insurance Ltd, Msida Road, Gzira, GZR 1405, making reference to your policy or claim number in any correspondence.

Step 3 - If, after making a complaint to us, you are still unhappy and feel the matter has not been resolved to your satisfaction you have the right to refer the matter to the Office of the Arbiter for Financial Services, First Floor, St Calcedonius Square, Floriana FRN 5130 or email on complaint.info@financialarbiter.org.mt.

Following these procedures will not affect your right to take legal action.

Telephone Monitoring

For our joint protection, telephone calls may be recorded and/or monitored.

Protection and Compensation Fund

The aim of the Protection and Compensation Fund is two-fold: (i) to pay for any claims against an insurer which have remained unpaid because the insurer became insolvent. These claims must be in respect of protected risks situated in Malta or protected commitments where Malta is the country of commitment, and (ii) to compensate victims of road traffic accidents in certain specified circumstances.

GasanMamo
INSURANCE
We're always there

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