GROUP MEDICAL SUBSCRIPTION CONTRACT

ISSUED BY

First Insurance Company

King Abdullah 2nd Street – P.O Box 189 Amman 11822 Jordan
Tel: 5777555 – fax: 5777550

This part concerns the **First Insurance Company** ONLY
The stamp duty was levied in accordance with the "Stamp Duties on Income" law no. 20 for year 2001"

Contract No.: ---------
Policyholder Name: ----------
Address: P.O.Box ---- - - Jordan Tel : ----------
Contract Effective Date: ----------
Contract Expiry Date : ----------

Clause (1)

A – Preamble

This policy constitutes an agreement between **First Insurance Company** hereinafter called "the Company", in its capacity as Manager of the TAKAFUL Insurance System applied in the Company and The Policyholder whose name is stated in the policy schedule and who requested to insure his interests against risks subject to the terms and conditions of this policy and had paid the premium agreed upon, or undertook to pay it upon request, and donated the whole or part of his premium to indemnify the losses sustained by any of other policyholders on the basis of mutual co-operation between them, as per the attached principles and conditions of Takaful.

The Company hereby agrees to compensate The Policyholder from the Takaful Fund for any loss of or damage to the Interest specified in the policy or in any of its endorsements. The compensation will not, under any circumstances, exceed the sum insured stated in the Schedule plus any expenses which may become due from The Policyholder subject to the policy conditions.

The Policyholder agrees also to authorize The Company to manage the insurance operations on the basis of Wakala pre known fees and to invest the premium as per Islamic Mudarabah.

For First Insurance Company **For - POLICY HOLDER**

PRINCIPLES AND CONDITIONS OF TAKAFUL

1. The principles and rules of the Islamic Shareeah regarding Takaful operations will be applied as per Shareeah Committee decisions.

2. The policyholder agrees to CO-Operate with the other policyholders 10 indemnify the losses sustained by anyone of them. The company indemnifies the policyholder from the Takaful monies (the premiums & their revenues) according to the policy Conditions.

3. The policyholder donates the whole or part of the premium he or she pays, to indemnify the losses which the others may suffer on a Co-operative & Takaful basis.

4. The company administers the Takaful operations to the best interest of the policyholders in Consideration of a known percentage of the premium income. This percentage should have been declared prior to the beginning of the calendar year.

5. The company invests the Takaful premiums 10 the best interest of the policy holders on an Islamic Mudarabah basis in consideration of a percentage of the investment returns. This percentage should be declared in the company's offices prior to the start of the calendar year.

6. The insurance premiums surplus (if any) at the end of each year should be returned to the policyholders after the technical and legal reserves has been deducted.

7. The policyholder in any insurance branch contributes in the claims paid 10 other policyholders in other branches.

8 The policyholders who tail to receive their share of the surplus within three years are considered donators of their share to protect the policyholder's interest.

Clause 2 - Definitions

Words, Terms, Expressions, and Abbreviations used in the context of this Insurance contract and all Additional Benefits, Tables and Application Forms should have the meanings set forth below:

2.1

Company: FIRST INSURANCE COMPANY that issued this contract hereinafter called the "Company".

2.2

Contract: the Medical Insurance Contract with all clauses, endorsements, declarations, list of benefits, and schedules whereby the Company guarantees cover of the benefits set forth in the Schedule of Benefits and its appendices (hereinafter called Contract Appendices) subject to terms, conditions, limitations, exclusions, proposal form, medical network providers and membership card provided herein all of which are part of this contract.

2.3

Policyholder: the natural person or entity that applied for this insurance in his/her own capacity as well as in the name and on behalf of his/her employees and their legal dependents whose applications has been formally accepted by the Company.

2.4

Insured: the employee and/or policyholder and /or legal dependent and/or beneficiary listed in the application of this insurance or included thereafter, and has been formally accepted by the Company provided not to exceed the age of 65, and whose name is shown in the List of Insured attached to this Contract or any subsequent endorsement and is considered as eligible according to terms and conditions of the Contract hereinafter called the Insured.

2.5

Employee: employee shall be deemed to refer to a full time active employee of the Policyholder for remuneration and is registered in the Social Security.

2.6

Dependent: wife/wives or husband of the Insured under this Contract and his/her unmarried children under the age of 18 or under the age of 25 if still a full time university student. In the latter case, the premium applicable to the dependent shall be same as that applicable to the adult.

2.7

Plan: is the plan designated on issue of Contract or subsequent endorsements for each Insured and in the Application submitted to and accepted by the Company whether in respect of class or Insured status or premium rate and is hereinafter called the Plan.

2.8

Contract Effective Date: the first minute of the day, month, and year on which the Contract takes effect for the first time or each subsequent renewal.

2.9
Contract Expiration Date: the last minute of the day, month, and year on which the Contract expires.
2.10
Enrollment Date: the first minute of the day, month, and year when the Insured is enrolled after written acceptance of the Company of his/her application.
2.11
Termination Date: the last minute of the day, month, and year on which the Insured's coverage is terminated as a result of deletion upon request of the Policyholder, or his/her status as legal dependent no longer holds or upon cancellation of this Contract.
2.12
Renewal Date: the date that follows the Contract Expiration Date.
2.13
Cancellation Date: the last minute of the day, month, and year on which this Contract is canceled as a result of the Policyholder written notice and/or as a result of the none fulfillment of the Policyholder's obligations as set forth in this Contract.
2.14
Hospital: any medical facility, public or private, legally licensed under Jordan laws to provide medical treatment to sick and injured persons. The facility must consist of organized premises, possesses the technical equipment necessary for diagnosis and surgical operations and to provide health care service by a staff of at least one resident physician and qualified nurses.

The term Hospital excludes outpatient clinics, sanitariums, physiotherapy centers, health clubs, nursing homes, and similar institutions including centers for treatment of addiction and/or alcoholism.
2.15
Physician: any person (other than the Policyholder/Insured) licensed under Jordan laws and registered with the Jordan Physicians Syndicate to practice medicine and/or surgery.
2.16
Appointed Medical Network: a group of Physicians, Hospitals, Clinics, Medical Centers, Pharmacies, Radiology Centers, Laboratories, Physiotherapy Centers, Dental Centers, and Optical Centers forming a network through special official contractual arrangements with the Company to provide free access medical services to the Insured in accordance with the terms and coverage stipulated in this Contract .
2.17
Membership Card: a personalized card issued in the name of each Insured facilitating his/her access to the healthcare services covered under this Contract and provided by the Appointed Medical Network.

2.18
Eligible Expenses: the customary and reasonable legal medical expenses for health care services in the Hashemite Kingdom of Jordan incurred by the insured as a result of sickness and/or injury covered under this Contract sustained while this contract is in force and subject to prices agreed upon and limits set forth in the Schedule of Benefits.
2.19
Territory of Occurrence: the country where the Insured incurred medical expenses as a result of a health condition that required health services covered under this Contract.
2.20
Out patient Treatment Form: form issued by the Company provided to the Insured to be completed by the Network physician. Completion of this form is mandatory and is a prerequisite to any outpatient treatment at the Network.
Any form or part there from completed by a non-Network facility is not acceptable.
2.21
Agreed Rates: the official medical providers tariff in force (Jordan Physician Syndicate and the Ministry of Health) as well as Insurance Funds Association, Private Hospitals Association, and the agreements between the Company and Network providers in the Hashemite kingdom of Jordan.
2.22
Pre -Hospitalization Form: form that must be completed by the attending physician and submitted to the Company at least 24 hours prior to any hospital admission except for emergency cases. This procedure is mandatory and is a pre requisite to any hospitalization coverage. The Company's decision on the form is binding both on the Company and Insured.
2.23
Surgery: any medical manual or instrumental treatment of injuries or disorders of the body.
2.24
Day Case: hospitalization that includes surgery or other medical procedures for cases, not excluded under this Contract, that do not need an overnight confinement at hospital requiring at the same time medical attention and care in a Hospital.
2.25
Emergency Case: a health condition resulting from a sudden sickness or bodily injury, not excluded under this Contract, requiring immediate medical care or surgery and confinement to a hospital emergency room/facility. Emergency treatment in an emergency room is covered only if treatment cannot be performed in outpatient clinics and in cases where the patient cannot reach such outpatient clinics without jeopardizing his/her life.
2.26
Accident: a sudden violent accidental means causing a bodily injury to the Insured that needs treatment.

2.27
Hospitalization: confinement to a Hospital for at least 24 hours due to a health condition, not excluded under this Contract, that cannot be treated in outpatient clinics.
2.28
Maternity: Hospitalization for normal vaginal or Caesarean delivery or legal abortion and any complications arising there from, prenatal, and post natal care within the limits stated in the policy Schedule. All such expenses are covered once only in a policy year.
2.29
Hospitalization Class: the Room and Board class specified in the Policy Schedule that the policyholder has selected to be applied for the Insured's hospitalization.
2.30
Chronic Disease: a disease requiring a lifetime continuous treatment.. All chronic medications are prescribed on a special form.
2.31
Outpatient Services: all services identified in the Contract that do not require In-Hospital treatment such as doctor visit and /or prescribed medication and/or laboratory tests and/or radiology and/or physiotherapy…etc
2.32
Deductibles and Co-Insurance: the amount or percentage of the health care cost that should be borne by the Insured as stipulated in the Schedule of Benefits.
2.33
Pre-existing Condition: any disease, impairment, disability, or health condition that exited before enrollment date for which the Insured has obtained medical advice, or treatment or any medical services (including, but not limited to medication) or there were symptoms that necessitated the Insured to obtain medical advice, or diagnosis or medical care or treatment. .
2.34
None- Network: medical facilities that do not come under definition 2.17 above. Should the Insured require the services of such facilities, he/she shall pay directly and submit the invoices to the Company within two weeks from the date he/she obtained the services after which the Company shall not be liable. The Company shall reimburse the Insured in accordance with the terms of this Contract and the limits stipulated therein.
2.35
Waiting Period: a period of time from enrollment date of the Insured that must expire before cover of certain medical conditions specified in the Contract shall take effect.
2.36
Individual Contract: contract where the Policyholder is a natural person responsible for premium payment and any other obligation under the Contract on his/her behalf and on behalf of any dependents insured under the Contract.

2.37
Group Contract: contract where the Policyholder is a company or a commission, or a governmental body or an establishment legally registered ... etc. that shall be responsible for premium payment and other obligations under the Contract on behalf of all insured and their dependents under the Contract.
2.38
Reasonable and Customary Medical Expenses: the medical expenses covered under this Contract that are reimbursed to the Policyholder or the Network and that are within the limits specified in this Contract and the level of charges agreed upon with the Network and the official and legal charges recognized in the locality.
2.39
Schedule of Benefits: the schedule where all benefits, limits, services and coverage under this Contract are specified.
2.40
Health Condition: all cases and/or causes and/or services and/or treatments and/or diseases, not excluded under this Contract, that fall under the limit specified in the Schedule of Benefits for a specific diagnosed case.
2.41
Additional Benefits: all benefits included in the Schedule of Benefits that are not considered as basic benefits and these are:
2.41.1 Maternity Benefits
2.41.2 Physiotherapy Benefits
2.41.3 Optical Benefits
2.41.4 Dental Benefits
2.41.6 Chronic Diseases Benefits
2.41.7 Pre-existing Conditions Benefits.

Clause 3 – Insured

The person or his/her dependents the Company has agreed to cover under this Contract upon application of the Policyholder and whose name appears in the list of insured attached to this Contract or any subsequent endorsement in consideration of premium payment. The Policyholder agrees that no application for addition of Insured during Contract duration is acceptable except for the following:

1- New born after a waiting period of 14 days provided born in good health, with no congenital defect or disease, and without impairment due to delivery and subject to Company's acceptance within 30 days of birth, unless otherwise stated in the Schedule of Benefits.
2- A newly acquired spouse.
3- A newly hired full time employee and his/her dependents.

Clause 4 - Insurance Application Form

The initial application and subsequent applications by persons proposed for insurance shall be made on the Application Form provided by the Company duly signed by the applicant and Policyholder agreeing to all Exclusions and Contract Limits.
Any deposit or payment on account made before the acceptance of the application does not constitute consent to the submitted application.
The Company reserves the right to reject the application and refund the advanced amount.

Clause 5 - Scope of Coverage

The scope of coverage for any Insured is the set of benefits along with their limitations, extensions, and exclusions (that is the PLAN selected by the Policyholder and accepted by the Company) and subject to the general terms, conditions and exclusions of this Contract.
The Policyholder, Insured and Dependents agree that the Company shall not be liable for any expenses that are payable or covered by another party.
The expenses reimbursed under this Contract are those incurred while this contract is valid. In case of treatment requiring uninterrupted hospital confinement that starts during the validity of this Contract, then expenses incurred after expiry of Contract is covered only subject to clause 18 of this Contract.
The applicable scope of coverage per Insured is as set forth in the Schedule of Benefits that specifies the basis of indemnity, class, limits, deductible and/or coinsurance, and any special terms applicable to each level of service depending on nature of services, provider and territory of occurrence.

Clause 6 – Premiums

The policyholder undertakes to pay the first periodical premium immediately on issue of Contract and the subsequent due premiums as stipulated in the Contract at the company's main office or branches unless the Company specifies a different place through a letter or endorsement, otherwise this Contract shall not be valid.
The Policyholder agrees that in case of nonpayment of premiums at the due date, the Company has the right to cancel the Contract within one week from the due date without giving notice. The Policyholder shall not revoke the cancellation and shall relief the Company from any responsibility upon such action.
In case of Group Contract, the Company reserves the right to revise the Premium rate if there shall be a change in the number of participants (excluding the dependents) of more than 25%.
Cover under this Contract shall not take effect until the first periodical premium is duly paid in addition to issuance fees and stamps fees.

Clause 7 – Additions and Deletions

If Dependents are included in this Contract, then all eligible Dependents of the Insured should be included at inception and no one shall be excluded.
The Policyholder may request the addition of newly acquired Dependents and newly hired Employees while this Contract is in force by written notice to the Company.
The Company reserves the right to decline the addition, accept it at standard conditions and rates, or accept it at special conditions stating the reason for the decision. Addition shall not be effective unless written acceptance in a form of an endorsement, duly signed and stamped, is issued by the Company.
The premium for such an addition shall be calculated prorata from date of addition to the Contract Expiration Date.
The policyholder may require the termination of cover of an Insured in case of his/her death, or on becoming entitled for Medical insurance cover under another program, or termination of his/her services at the Policyholder. A Dependent's membership shall automatically terminate upon death of the Insured, termination of the Insured's membership, or if the Dependent ceases to be eligible as a Dependent.
Written request should be given to the Company and the termination shall be effective after official acceptance of the Company .

The refund premium for such a termination shall be calculated prorata from date of cancellation to the Contract Expiration Date. However, if there shall be any settled claims for the particular member, then the Company shall not refund any part of the annual premium.
Amount of three JOD will be collected for issuing new I.D card instead of lost one, and in case of deletion or any other amendments and/ or corrections.

Clause 8 – Cancellation and Termination of Insurance

The Company and the Policyholder agree that this Contract shall be cancelled without giving reason in the following cases:
1-Upon official written 30 days notice from either party sent by registered mail or delivered by hand and duly signed for receipt. If the Policyholder initiated the cancellation, he/she shall waive his/her right to any refund premium if there shall be any reimbursed claims under the Contract.
2-The Company reserves the right to cancel the Contract without notice if the Policyholder is in breach of Contract such as misrepresentation, and/or non-disclosure and/or fraudulent abuse. The Company shall inform the Policyholder of the cancellation and its effective date by an official letter stating the reasons. The Company shall bear no liability consequential upon such cancellation and shall cease cover of any case after that date. In case of cancellation under this item , all premiums shall be forfeited .
3- The Company and/or Policyholder may cancel the participation of any Insured and/or Dependent subject to item 1 of this clause.
4-Membership of any Insured and his/her Dependents shall automatically cease upon reaching age 65 and/or upon death or if the Dependent ceases to be eligible as Dependent or if the Insured is no longer employed by the Policyholder.
The Policyholder agrees that the Company shall not bear any liability as a consequence of cancellation under this item.

Clause 9– Policyholder Declarations

The Policyholder agrees that the declarations in the application form and any subsequent forms or documents presented to the Company shall be the basis of this Contract and any endorsements thereof. Misrepresentation or non-disclosure on the part of the Policyholder/Insured shall entitle the Company to cancel this Contract or terminate the participation of a member without premium refund.
The Policyholder shall immediately inform the Company during the Contract duration or its renewal of any change in the Insured's occupation, activities, and residence and the

Company reserves the right to revise the terms, conditions , premium rate and eligibility for insurance under the Contract.

Clause 10- Claims and Non Network Claim's Notification

10.1- It is hereby understood and agreed that all claims under this Contract are solely made by the Policyholder; no participant shall have the right to claim directly from the Company.
Any claim, legal or else, shall not be effective unless made through the Policyholder whether during Contract period or after expiry.

10.2-In case of None Network admission to hospital, the Policyholder should notify the Company within 48 hours after admission unless the delay in notification is for a valid reason. Claims should be submitted on the forms specified by the Company together with original reports, invoices, and receipts. Copies thereof are not acceptable.
The Company may deduct any due unpaid installments of the annual premium from any claims due to the Policyholder.

Clause 11- Medical Malpractice

It is understood and agreed that the Company shall not hold any liability caused by medical malpractice on the part of the Network or None Network medical facilities, without prejudice to the Insured's right to claim directly from these facilities under the legal system.

Clause 12 – Subrogation

The Policyholder/Insured or any member agree that if the Company covers under this Contract any health condition caused by a third party , they shall subrogate their rights to the Company to pursue the responsible third party and shall provide and sign any documents that are necessary for the purpose of enforcing the Company's rights. Failing to do so, they shall be liable for any losses the Company might sustain as a result.

Clause 13- Geographical Scope:

This Contract covers participants within the borders of the Hashemite Kingdom of Jordan.

Clause 14- Currency:

Any payments under this Contract are made in Jordan Dinar.

Clause 15- Taxes and Duties :

The Policyholder undertakes to pay any taxes and duties due under prevailing laws and regulations.

Clause 16- Second Medical Opinion :

The Company reserves the right to ask for a second medical opinion when it deems necessary and bear any expenses incurred. The Company may refer the case to one of its medical consultants.

Clause 17- Change of Law :

Both parties agree that this Contract shall cover their contractual relation. Should any future changes in laws have effect on the Contract's applications, the Company may amend the terms and conditions with effect from the date of such changes.
This Insurance Contract is subject to the laws and regulations of the Hashemite Kingdom of Jordan.

Clause 18- Inpatient Treatment Post Date of Expiry :

An inpatient treatment that needs uninterrupted hospital confinement that takes place while this Contract is valid, shall be continued even if the Contract expires or is not renewed until the Insured is discharged or after seven days from admission to hospital whichever comes first. Hospitalization expenses covered shall be subject to terms and exclusions of this Contract.

Clause 19- Duality of Reimbursement:

If the Insured is entitled to reimbursement under any other Medical Schemes or from any other party, the Company shall be liable only for the difference between such reimbursement and that the insured is entitled to under this Contract. How ever, work related accidents and all cases resulting from nature of work are not covered under this policy.

Clause 20- Claim Settlement:

Payment of any sum or claim or medical expenses consequential to sickness or injury covered under this Contract shall relief the Company from its liability. The Policyholder waives his/her right to reclaim for same sickness or injury after receiving the reimbursement.
The limit specified in the Schedule of Benefits represents the sum of invoices submitted by the medical providers prior to claim settlement.

Clause 21- Legal and Legislative Jurisdiction:

This Contract is subject to the laws of the Hashemite Kingdom of Jordan.
Both parties agree that any disputes that may arise under, or out of this Contract shall be submitted to the Courts of Amman.
The parties may agree to submit disputes to arbitration under endorsement number (1) to be attached to this Contract.

Clause 22:

The Policyholder, Insured, and any participant to this Contract agree that the Company's account entries and documents are final and irrevocable. The Policyholder may dispute any account entries and/or account statements issued by the Company within seven days from receiving same, otherwise he/she admits that they are final and waives his/her right to revoke them at any governmental and/or semi governmental and/or legal body.

Clause 23:

General Exclusions:
It is understood and agreed upon that all the following cases, reasons, medical services, injuries, diseases, illnesses, and disabilities are excluded under this insurance policy

1. Suicide attempts, voluntary self-injury.
2. Committing or attempts to commit an illegal action. All medico legal cases.
3. All cases resulting from war, invasion, hostilities, or war-like operations, civil war, rebellion, mutiny, revolution, martial law and terrorist acts. naval, military or air force services or operations.
4. All cases related to hazardous activities such as: motor racing, mountaineering, motorcycling, parachute jumping, professional diving activities and professional sport teams.
5. All cases resulting from alcoholism, drug abuse and addiction, or hallucinatory substances.
6. Earthquakes, flood, volcano eruption, landslides and other natural hazards.
7. Pre-existing conditions which are known and not declared.
8. Cancer(test and treatment), Bulimia, Anorexia nervosa, Dialysis, AIDS, venereal diseases, all senility related cases, Alzheimer, and mental and psychiatric disorders , enuresis , sleeping disorder , developmental disorder.
9. Elective Non accident related plastic surgery, cosmetic related medicine, buco-maxiillo facial surgeries and related investigations and treatment.
10. Acne folliculitis, vitiligo, Hair loss, boldness, psoriasis, multiple sclerosis gamma knife, impetigo, sun burn, Isolations, vaccinations, circumcision.
11. Contraceptives medicines and methods, infertility and sterility treatments and tests, telemedicine. Hormones and vitamins (treatment and test). Screening test (torch).
12. All cases directed to hospital by a non-physician unless it is an emergency case. Acupuncture treatment and all cases under special exclusion.

13. Elective non-accident related surgery for the correction of refraction errors and acuteness of the sense of hearing and all auditory and vision accessories squint, keratoconus and corneal implantation and lenses.
14. All cases resulting from nuclear contamination, i.e. any exposure to ionizing radiation, radioactive contamination, nuclear processes, military material or nuclear waste of any kind and/or polluting hazardous or poisoning chemicals.
15. Elective non-accident Dental and Gum surgery (Excluding Bridges), epilepsy, congenital and hereditary diseases.
16. Artificial limbs, transplantation service expenses of donor and acquisition of organ in organ transplant and accessories such as: prostheses, wheel chair, orthopedic equipment, bandages …etc.
17. Epidemic and pandemic diseases and transmittable diseases (such as but not limited meningitis, measles, rubella, chicken pox, mumps ...etc) renal failure osteoporosis hepatitis S.A.R.S gastric banding and work related accidents and workmen's compensation.
18. Any In-patient treatment, tests, and other procedures that can be done on outpatient basis without jeopardizing the insured's health.
19. Unless mentioned in table of benefits (Physiotherapy, Maternity, Dental, Optical).
20. Medical malpractice insurance, any experimental medical treatment, general health examination and regular check up.
21. All substances, which are not considered as medicine. More than one unit of medicine except antibiotic, ant parasites, anti-fungal.
22. Expenses incurred for treatment or care at long term care facilities, old age home, health care and diet resorts, institutions for mental disabled, lunatic asylums.
23. Air and sea travel except as a passenger. Acupuncture treatment, Road traffic accidents, general allergic test genetic and autoimmune disease (test and treatment).
24. New born baby, 14 days after delivery neonatal I.C.U.

Clause 24:

Specified Waiting Periods:

Waiting Periods

WAITING PERIODS (THE FOLLOWING BENEFITS ARE EXCLUDED DURING WAITING PERIOD SHOWN AGAINST THEM)	
CASE	**WAITING PERIOD**
HERNIA	6 MONTHS
HEMORRHOIDS, FISTULA, ANAL FISSURES	6 MONTHS
TONSILS, ADENOIDS, DEVIATED SEPTUM, SINUSITIS	6 MONTHS
KIDNEY AND URINARY TRACT STONES OPERATIONS , LITHOTRIPSY AND CYTOSCOPY	6 MONTHS
DISEASES AND OPERATIONS OF THE DIGESTIVE SYSTEM , ULCER AND ENDOSCOPY	6 MONTHS
MATERNITY AND DELIVERY	280 DAYS
UTERINE FIBROIDS, HYSTERECTOMY, ENDOMETRIOSIS	12 MONTHS
VARICOCELES, HYDROCELE, VARICOSE VEIN	12 MONTHS
CATARACT AND GLAUCOMA	12 MONTHS
ELECTIVE NON-ACCIDENT RELATED BACK PAIN OR SURGERY	12 MONTHS
Knee Surgery and Arthroscopy	12 MONTHS
Cardiovascular diseases and hypertension	12 MONTHS
Diabetes Mellitus and its complications	12 MONTHS

Clause 25:

Out of hospital benefit exclusions:

1- **All tests and treatments not required on the treatment form by the treating physician.**
2- **All tests not related to specific symptoms and/or disease.**
3- **All cosmetic products.**
4- **All contraceptive related medicines.**
5- **All substances which are not considered as medicines and not registered by ministry of health.**
6- **Fertility and sterility related tests and treatments**

Clause 26: special exclusions and conditions:

The special exclusions and conditions on the level of insured member or applied for certain service or benefit, and mentioned clearly in the contract and its appendices.

ARBITRATION

If any difference arises as to the amount to be paid under this Policy , such difference shall be referred to the decision of an arbitrator to be appointed in writing by the parties in difference or if they cannot agree upon a single arbitrator , to the decision of two arbitrators, one to be appointed in writing by each of the parties, within two calendar months after having been required in writing to do so by the other party, and if a party failed or refrained from doing so within two months after having received notice in writing from the other party, this party will have the liberty of appointing a sole arbitrator. In case of dispute between the arbitrators, an Umpire is to be appointed in writing by them before the commencement of resolving the dispute. The Umpire shall sit with the arbitrators and preside at their meetings. The death of any of the parties in difference shall not cancel or affect the other Arbitrators or the Umpire.

In case of death or resignation of the Arbitrator or the Umpire, the party who appointed him has the right of re-appointing a substitution.

Arbitration costs and Arbitrators or Umpire fees will be decided by the person who issues the Arbitration decision.

But in all cases, disputes including Arbitration Awards shall be resolved in accordance with the provisions of the valid Jordanian arbitration law.

The Insurer Signature
(First Insurance Co.)

The Policy Holder Signature
(----------)