Health Maximiser

Dear Sir/ Madam,

We welcome you to the Zurich Kotak family. We are glad to inform you that your proposal has been accepted and Health Maximiser (UIN: ZUKHLIP25057V022425) ("Combi Product") has been issued to you. The Combi Product is jointly issued by Zurich Kotak General Insurance Company (India) Limited and Kotak Mahindra Life Insurance Company Limited ("KLI"); wherein Health Premier (UIN: ZUKHLIP25054V052425) is issued by Zurich Kotak General Insurance Company (India) Limited and Kotak Term Plan (UIN: 107N005V06) is issued by KLI.

The benefits under the two policies of this Combi Product are distinct as per the respective policies as offered by the respective insurers.

Free-look Period:

In case you are not agreeable to any of the provisions stated in the Combi Product, then you have the option of returning the Combi Product to us stating the reasons thereof within 30 days from the date of the receipt of the Combi Product. The cancellation request should be submitted to your nearest branch or sent directly to the Head Office of any of the Insurers. On receipt of your letter along with the original policy documents, we shall arrange to refund the premium paid by you after deducting expenses on medical examination and the stamp duty charges; and the proportionate risk premium for period on cover. A Combi Product once returned shall not be revived, reinstated or restored at any point of time and a new proposal will have to be made for the issue of a new Combi Product.

For the policy issued by Zurich Kotak General Insurance Company (India) Limited, the Free-look cancellation option is not available at the time of its renewal. You shall not be allowed to cancel the policies individually during the Free-look Period. An application for cancellation of either of the policies during the Free-look Period will cancel this Combi Product in its entirety.

Policy Documents:

Your two enclosed policy documents are important legal documents and should be kept in safe custody. A copy of the proposal form submitted by you is also enclosed for your information and record. The policy documents issued to you are subject to the tax laws prevailing in India and you are advised to consult your tax advisor for the tax benefits available under these policy documents.

Other Essential Aspects:

1. The liability to settle the claim as under the respective policies vests with respective insurers, i.e. for the benefits under life policy, it vests with KLI and for the benefits under health policy it vests with Zurich Kotak General Insurance Company (India) Limited. This shall be subject to the terms and conditions as mentioned under the respective policy documents.
2. The legal/ quasi legal disputes, if any, are dealt by the respective insurers for the respective policies issued.
3. Post the Free-look Period, you are eligible to continue with either of the policies of the Combi Product, discontinuing the other during the policy term. In such a scenario, you shall be covered under the individual policy of the respective insurer you have chosen to continue.
4. The health policy of Zurich Kotak General Insurance Company (India) Limited under this Combi Product is ordinarily renewable except on the grounds of fraud, moral hazard or misrepresentation or non-compliance of any of the provisions by you.
5. The premium payment options under the respective policy documents are provided in their respective policy schedules.
6. All Policy servicing requests pertaining to this Combi Product shall be received by either of the Insurers. However, all requests impacting the premium or policy terms and conditions as under the respective policy documents shall be serviced by the respective Insurers and the Insurer receiving such requests shall only facilitate it if such request is not pertaining to the policy document issued by it.
7. The Insurers may mutually decide to terminate the arrangement of Combi Product wholly or in part, only with cause and after making a joint application for receiving the requisite approval from IRDAI. The same shall be intimated to you ninety (90) days prior to the termination of the present arrangement. Upon such termination, you shall, at your sole discretion have the option of choosing to continue with either or both of your policies. However, your policies will continue until the expiry or termination of the individual policies in accordance with the terms and conditions of the respective policies.

Contact us:

The addresses for correspondence for each insurer are specified below. If you notice any discrepancy relating to the policies, please return the policy documents to any of the insurers immediately along with a letter stating the discrepancy. To enable us to serve you better, you are requested to quote your policy number and client ID number in all future correspondence.

We hope this Combi Product meets your expectations and this is the beginning of a long relationship with you. It will be our pleasure to serve you, protect you and be with you; assuring you of our best services at all times.

Best wishes,

Zurich Kotak General Insurance Company (India) Limited
CIN: U66000MH2014PLC260291. IRDAI Reg. No. 152. Registered & Corporate Office: 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India. Toll free: 1800 266 4545 I Email: care@zurichkotak.com I Website: www.zurichkotak.com

Kotak Mahindra Life Insurance Company Limited
CIN: U66030MH2000PLC128503, IRDAI Registration No. 107, Regd. Office: 8th Floor, Plot # C- 12, G- Block, BKC, Bandra (E), Mumbai- 400051. Website: https://www.kotaklife.com/ | kli.in/WECARE
WhatsApp: 9321003007 | Toll Free No.: 1800 209 8800.

Kotak Term Plan

A Non-Linked Non-Par Individual Pure Protection Life Insurance Plan

PART B

Definitions:

i. **Act:**
Means Insurance Act, 1938, as amended from time to time.

ii. **Age:**
Refers to the age of the Life Insured on the last birthday (as per English calendar).

iii. **Annualised Premium:**
Means the total of all Premiums payable by the Policyholder in one Policy year excluding the underwriting extra Premiums and loadings for modal Premium.
The Annualised Premium shall also exclude Goods and Services Tax and Cess and Rider Premium, if any.

iv. **Appointee:**
Means the person so named in the Schedule, who is appointed by the Policyholder to receive the payout of the applicable Benefit(s) of this Policy on behalf of the Nominee (in case the Nominee is a minor at the time of such payout).

v. **Assignee:**
Means the person to whom the Policy is assigned and the notice of which is endorsed on the Policy by the Insurer

vi. **Assignor:**
Means the person who assigns/ transfers the rights under the Policy to the Assignee.

vii. **Assignment:**
Means the process of transferring the rights and Benefits to an Assignee. Assignment should be in accordance with the provisions of Section 38 of Insurance Act, 1938 as amended from time to time.

viii. **Basic Sum Assured:**
Means the amount mentioned in the Schedule. This is the amount guaranteed on Death where all the due Premiums have been paid in full.

ix. **Benefit(s):**
Means the respective benefit(s) of this Policy as enumerated under Part C of this Policy Document which the Insurer shall provide to the Policyholder; subject to the terms and conditions set forth in this Policy.

x. **Board:**
Means the Board of Directors of the Company.

xi. **Claimant:**
Means, the Policyholder; or the Life Insured; or the Assignee; or the nominee; or the legal heir of the Policyholder or the nominee, as the case may be

xii. **Date of Commencement of Policy:**
Means the date mentioned in the Schedule as Date of Commencement of Policy.

xiii. **Date of Commencement of Risk:**
Means the date mentioned in the Schedule as Date of Commencement of Risk.

xiv. **Date of Issue:**
Means the date mentioned in the Schedule as Date of Issue.

xv. **Grace Period:**
Means the time granted by the Company i.e. 30 days from the due date for the payment of Premium for annual, half-yearly and quarterly mode and 15 days for monthly mode without levy of any interest or penalty during which time the Policy is considered to be in-force with the risk cover without any interruption as per the terms of the Policy.
Grace Period is not applicable for Single Premium payment option under this Policy.

xvi. **Lapse:**
Means cessation of the benefits under the Policy upon non-payment of the due Premiums within the Grace Period, as per the terms and conditions of this Policy Document.

xvii. **Life Insured:**
Means the person to whom the life cover has been provided under this Policy and whose name is mentioned in the Schedule respectively.

xviii. **Nomination:**
Means the process of nominating a person(s) in accordance with provisions of Section 39 of the Insurance Act, 1938 as amended from time to time.

xix. **Nominee:**
Means the person(s) nominated by the Policyholder under this Policy and who is (are) authorized to receive the death benefit claim payable under this Policy; if the conditions specified in this Policy are satisfied and subject to the provisions of Section 39 of the Insurance Act, 1938 as amended from time to time.

xx. **Policy:**
Means the contract of insurance entered into between the Policyholder and the Insurer as evidenced by Policy Document.

xxi. **Policyholder:**
Means the respective person whose name is mentioned in the Schedule.

xxii. **Policy Document:**
Means the present contract of insurance which has been issued on the basis of the proposal, other representations and documents submitted by the Policyholder and/or the Life Insured(s).

xxiii. **Policy Term:**
Means the period mentioned in the Schedule, it is the period during which the Life Insured is covered, subject to the Policy being in force at the time of the death of Life Insured.

xxiv. **Premium**
Means the Single Premium (for Single Premium payment option) or the total initial basic premium and subsequent premiums due and payable under the Policy. The premium shall be subject to taxes as may be applicable from time to time.

xxv. **Premium Payment Term**
This is the period during which the Policyholder shall pay the Premium to get the full benefits as mentioned in the Schedule of the Policy.

xxvi. **Revival:**
Means reinstatement of the lapsed Policy in accordance with the provisions of the Policy Document. Revival may be of the following two types and the same may be made before the date of maturity of the Policy but, within the timelines indicated below:

a. 'Minor Revival': means revival made within six months from the due date of the first unpaid Premium causing the Policy to Lapse; and
b. 'Major Revival': means revival made after six months but within five years from the due date of the first unpaid Premium causing the Policy to Lapse.

xxvii. **Surrender:**
Means the termination of the Policy by the Policyholder before the Date of Maturity, in accordance with the provisions of the Policy Document.

xxviii. **Surrender Value:**
Means an amount, if any, that becomes payable in case of surrender, in accordance with the terms and conditions of the policy.

xxix. **UIN:**
Means the unique identification number of this product that is allotted by IRDAI; and is mentioned in the Schedule.

xxx. Words importing the masculine gender shall include the feminine gender and vice versa.

xxxi. Words in the singular shall include the plural and vice versa.

PART C

1. **Benefits Payable**
The following benefits are payable provided all the due Premiums have been paid up to date.

A. **Basic Death Benefit:**
If all the due Premiums are paid up to date, the benefit available on the death of Life Insured shall be the Basic Sum Assured. This benefit is payable as a lump sum. Once this benefit is paid, the Policy terminates and no further benefits are payable.

B. **Maturity Benefit:**
No benefit shall become payable under the Policy upon survival of the Life Insured to the date of maturity specified in the Schedule of the Policy.

C. **Rider Benefits:**
These benefits are only payable subject to the terms and conditions of the respective rider terms and conditions, if the Policyholder had opted for riders.

i. Kotak Accidental Death Benefit Rider (UIN – 107B001V04)

ii. Kotak Permanent Disability Benefit Rider (UIN – 107B002V03)

iii. Kotak Critical Illness Plus Benefit Rider (UIN – 107B020V02)

2. **Premiums Payable**

The annual Premiums as aforesaid are payable in advance on the anniversary of the date of commencement of the Policy.

With the consent of the Company, the Premiums can be paid by half-yearly or quarterly instalments. Furthermore, if Policyholder desires to pay Premiums electronically, he/she can opt for the monthly Premium payment mode, with the consent of the Company.

A grace period of 30 days from the due date of Premium payment will be allowed in case of annual, half-yearly or quarterly Premium payment modes whilst, in case of monthly Premium payment mode a grace period of 15 days from the due date of Premium payment will be allowed.

Premiums may be revised by the Company to give effect to any changes in the prevailing tax laws or other legislation.

In the event of death of the Life Insured during the grace period and/or before the payment of the premium then due, and if the death claim is admitted, the Basic Sum Assured will be reduced by the due instalment Premium at the time of death.

For cases where the Premium is not paid annually in advance, whether the Policy is in grace period or not, if the full year's premium has not been paid in the year of death, the balance of that year's Premium shall be deducted from the Basic Sum Assured before it becomes payable.

The Company may by way of written intimation remind the Policyholder of the Premiums due and payable under this policy. However, whether or not such intimation is received by the Policyholder, it shall be the sole responsibility of the Policyholder, at all times, to discharge the Premium obligations as mentioned herein.

Likewise, it shall not be obligatory on the Company to issue any communication to a Policyholder conveying that his/her Premium paying instrument (including those for any other payments under the policy) has bounced and/or any standing instructions by the Policyholder to a bank has not been honoured, thereby resulting in non-payment/non-receipt of the Premium(s)/payments under the policy. As mentioned above it shall be the sole responsibility of the Policyholder, to ensure that the Premiums as mentioned herein (including for any other payments under the policy) are duly and properly discharged.

Mode of Premium payment: As mentioned in the Schedule under this Policy.

Goods and Services Tax and Cess at prevailing applicable rate will be collected together with the Premiums.

Special Conditions, if any: Refer the Schedule under this Policy.

PART D

1. **Lapse**

   In case the due Premiums are not paid within the Grace Period, the policy together with the rider benefits, if any, shall lapse from the due date of the first unpaid Premium.

   Fresh nomination, and assignment is not allowed during lapse period. The lapsed Policy can be revived as mentioned under the 'Revival' section in Part D of this Policy Document.

2. **Revival**

   The Policyholder can revive the lapsed policy with or without rider benefits added to the policy, by making an application within a period of five years from the due date of the first unpaid Premium and before the date of maturity of the policy.

   The policy may be revived on the following terms:

1.	within six months from the due date of the first unpaid Premium ("Minor Revival");	without evidence of good health;	on payment of a) Premiums in arrears, and; b) Interest at such rates as may be prescribed by the Company from time to time on Premiums in arrears (currently 9% per annum of outstanding premiums). Interest charge may be revised from time to time with prior approval from IRDAI
2.	after six months but within five years from the due date of the first unpaid Premium and before the date of maturity of the policy ("Major Revival");	on production of evidence of good health and good habits by the Policyholder/Life Insured /attending physician of the Life Insured, as the case may be to the satisfaction of the Company and also the evidence of there being no adverse change in the personal or family history or occupation of the Life Insured; In such cases, extra Premiums and any other documents may be required based on the Board Approved Underwriting Policy (BAUP);	on payment of a) Premiums in arrears, and; b) Interest at such rates as may be prescribed by the Company from time to time on Premiums in arrears. Interest charge of 9% is currently applicable, which may be revised from time to time with prior approval from IRDAI. Extra Premiums may be required based on the Board Approved Underwriting Policy (BAUP)

   The Company may, at its absolute discretion, accept or decline the request for revival (made by the Policyholder in writing) of a lapsed policy, or accept the request for revival on such terms and conditions as it deems fit. The revival of the policy will be effective after the Company's approval is communicated in writing to the Policyholder.

   In the event, the Lapsed Policy is not revived within five years of due date of the first unpaid Premium and before the date of maturity of the Policy, the Policy shall stand terminated and the benefits payable under the Policy shall cease.

   All benefits under the policy will be reinstated on the revival of the policy.

   Rider cannot be revived independently and can only be revived along with the revival of the base plan.

3. **Surrender**

   No surrender value will be applicable for Regular Premium payment option.

   Single Premium paying option, will acquire Surrender Value on payment of single Premium.

   The Company will pay a Surrender Value for the single premium payment option, calculated as follows:

   - 75% x Single Premium Paid x (1- 1/ Policy term) x Outstanding Policy Term/ Policy Term

   Surrender Value is applicable only for the base plan subject to above.

Once the Surrender Value is paid, the policy shall stand terminated and no further benefits are provided.

4. **Loans**

Loans under this policy are not allowed.

5. **Conversion Option**

The Policyholder has the option to cancel this policy and take out a new policy. The Policyholder would get an underwriting credit for the sum assured on the policy subject to the following:

- This Plan is in full force at the time this option is exercised
- The conversion option is exercised more than five years before the date of maturity of this policy
- No health loadings (extra Premium) or other restrictions have been placed on this policy
- The product choice (excluding Term Cover products) available at the time this option is exercised
- The Premium rates and sum assured limits applicable at the time this option is exercised
- The age and term limits applicable at the time this option is exercised

6. **Free Look Provision**

The Policyholder is offered a 30 days' free look period to review the terms and conditions of the Policy (except for policies having a policy term of less than a year) beginning from the date of receiving the Policy Document in electronic form. In case the Policyholder is not agreeable to any terms and conditions of the Policy or otherwise; then subject to no claims having been made hereunder, the Policyholder may choose to return the Policy to the Insurer for cancellation, stating the reasons thereof within the aforesaid free look period.

Should the Policyholder choose to return the Policy, the Policyholder shall be entitled to a refund of the Premium paid after deducting the proportionate risk Premium for the period of cover, stamp duty charges and expenses of medical examination (if any). A Policy once returned shall not be revived, reinstated or restored at any point of time and a new proposal will have to be made for a new Policy. Where Rider(s) are available under the base Policy and so opted by the Policyholder, the same would also stand cancelled when the free look provision of the base Policy is exercised.

PART E

Not applicable

PART F

1. **Suicide Exclusion**

   i. In case of Life Insured's death due to suicide within 12 months from the Date of Commencement of Risk, of the Policy or from date of Revival of the Policy, as applicable; the nominee or Claimant of the Policyholder shall be entitled to; 80% of the total premiums paid (including extra premium, if any) provided the Policy is in force.

   ii. In case of Life Insured's death due to suicide after 12 months from Date of Commencement of Risk, of the Policy, following will be applicable:

   - Within one year of the date of Revival of the Policy when the revival is done within 6 months from the date of first unpaid Premium, Suicide Exclusion shall not be applicable and the Basic Death Benefit under the product shall be payable.
   - Within one year of the date of Revival, when the revival is done after 6 months from the date of first unpaid Premium, the nominee or Claimant of the Policyholder shall be entitled to the higher of; 80% of total premiums paid (including extra premium, if any) or Surrender value (if any) at the time of death, provided the Policy is in force.

2. **Forfeiture of Policy:**

   The Policy will be forfeited if,
   - any Premium is not duly paid and the policy has not acquired any surrender value as stated above, and/or
   - the policy has not been revived as provided under Clause on Revival of Lapsed Policy hereof,
   - any condition herein contained or endorsed hereon is contravened.

3. **Fraud/ Misstatement**

   The provisions of Section 45 of the Insurance Act 1938, as amended from time-to-time, will be applicable to this contract. [A Leaflet containing the simplified version of the provisions of Section 45 is enclosed in Annexure – 3 for reference]

4. **Nomination and Assignment**

   i. Assignment is allowed as per Section 38 of the Act, as amended from time-to-time. [A Leaflet containing the simplified version of the provisions of Section 38 is enclosed in Annexure – 1 for reference.

   ii. Nomination is allowed as per Section 39 of the Act, as amended from time-to-time. [A Leaflet containing the simplified version of the provisions of Section 39 is enclosed in Annexure – 2 for reference].

   iii. In case of lapsation of the Policy, fresh Nomination and Assignment will not be allowed.

   iv. The provisions of nomination shall not apply to any policy of the life insurance to which Section 6 of the Married Women's Property (MWP) Act, 1874, applies or has at any time applied. Assignment will not be permitted when the Policy is issued under the MWP Act.

   v. By registering the nomination or change in nomination, the Company does not express any opinion upon the validity nor accepts any responsibility on the nomination.

5. **Issuance of Duplicate Policy Document**

   The Policyholder may request for issuance of duplicate Policy Document by making a request to the Company in writing or in the prescribed form as the case may be. Issuance of duplicate Policy Document shall be made subject to the following conditions:

   i. The Policyholder pays the applicable fee as per the prevailing policy servicing manual of the Company.
   ii. The Policyholder submits an affidavit cum indemnity in the format prescribed by the Company

   Free Look clause shall not be applicable with respect to such duplicate Policy Document

6. **Policy Alteration**

   Alterations, if any, within the contract such as increase/ reduction in Sum Assured/ premium, replacement of Policy Document etc. as defined in the Policy will be charged separately.

   - Major alterations such as change in Policy Term, Premium Payment Term etc. are not allowed. Increase in Sum Assured is not allowed however; decrease in Sum Assured shall be allowed subject to the minimum Sum Assured allowed under the plan.
   - For minor alterations such as change in name/ address/ phone no. etc. shall be allowed. The Policyholder is requested to refer the policy servicing manual of the Company for the list of changes allowed.
   - The charges for Policy alterations including issue of duplicate policy document shall be as per the prevailing policy servicing manual of the Company.

7. Claims

In the unfortunate event of death of the Life Insured, the benefit will be paid to the Beneficiary or to such person(s) as directed by a court of competent jurisdiction in India.

All claims payable will be subject to production of proof of the claim event satisfactory to the Company, such other requirements as stipulated by the Company and the legal title of the claimant, satisfactory to the Company.

The Company reserves its rights to condone the delay on merits for delayed claims, where the delay is genuine and proved to the reasons beyond the control of the Life Insured/claimant

The Primary documents normally required for processing a claim are:

i.
- A statement that the claim event (i.e. death) has occurred along with the Death Certificate.
- Details of the policy under which the insured is covered
- Date of the claim event
  - Place of occurrence of claim event (i.e. residence/hospital etc.), the address of such place,
  - Bank Account Details

ii. Cause of claim event with supporting documents.

iii. Proof of claim event with supporting documents (e.g. copy of death certificate in the case of a death claim/hospital reports in the case of a critical illness claim etc.)

iv. Original policy document.

v. Proof of age of the insured, if this has not been previously admitted by the Company (e.g. birth certificate, school leaving certificate etc.).

vi. Recent photograph of the beneficiary, as mentioned above.

vii. Current residential and permanent address proof and identity proof of beneficiary, as mentioned above.

viii. Photocopy of Bank Pass Book/Bank Statement of beneficiary, as mentioned above showing name of Bank, location of Bank Branch, Name of Account Holder and Account No.

ix. Documents relied on for taking the said Policy.

The Company reserves the right to call for any additional information and documents required to satisfy itself as to the validity of a claim. The amount due under this policy is payable at the office of the Company situated at Mumbai, but the Company may fix an alternative place of payment for the claim at any time before or after the policy has become a claim.

The claimant shall submit the claim intimation form along with the necessary documents at any of the Insurer's branches or send the documents directly to the Insurer's head office at the below mentioned address:

Claims Department,
Kotak Mahindra Life Insurance Company Limited,

9th floor, Intellion Square (Bldg No. 4), Infinity IT Park, Gen. AK Vaidya Marg, Malad (E), Mumbai-400 097.

The claim can also be intimated to the Insurer online from the Insurer's website; and the Claimant can also write to the Insurer's claims department at kli.claimsmitra@kotak.com.

8. Notice

Any notice, information or instruction to the Company must be in writing and delivered to the address intimated by the Company to the Policyholder which is currently:

Customer Care,

Kotak Mahindra Life Insurance Company Ltd, Kotak Towers, 7th Floor, Zone IV, Building No. 21, Infinity Park, Off Western Express Highway, Goregaon Mulund Link Road, Malad (East), Mumbai 400097 Toll Free: 1800 209 8800 kli.in/WECARE

The Company may change the address stated above and intimate the Policyholder of such change by suitable means.

The Policyholder is also advised to promptly notify the Company of any change in his/her address and/or that of his/her nominee to ensure timely and effective communication of policy related information to the Policyholder.

Any notice, information or instruction from the Company to the Policyholder shall be mailed to the address specified in the proposal form or to the changed address as intimated to the Company in writing.

9. Electronic Transactions

The Policyholder will adhere to and comply with all such terms and conditions as prescribed by the Insurer from time to time, and all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or any combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by the Insurer or on behalf of the Insurer, for and in respect of this Policy, or in relation to any of the Insurer's products and services, shall constitute legally binding and valid transactions when executed in adherence to and in compliance with the terms and conditions for such facilities, as may be prescribed by the Insurer from time to time.

Similarly, the electronic communication received from the Policyholder/Life Insured/Legal Heir/Nominee (including their digital signature/online consent) with respect to the Policy shall be legally binding, if the same is made in accordance with the terms and conditions of this Policy and other terms and conditions of the Insurer from time to time with respect to individual transactions.

10. **Jurisdiction:**
Without prejudice to the generality of the aforesaid provisions, this Policy shall be governed by the laws of India.

PART G

Grievance Redressal System

1. For resolution of grievances:
In case the Policyholder/ complainant has any complaint(s) or grievance(s) against the Insurer, he/ she may approach the Insurer using any of the following modes for resolution:
   - visit any of the Insurer's nearest branches;
   - write to the Insurer's customer service department at - Customer Care, Kotak Mahindra Life Insurance Company Limited, 9th floor, Intellion Square (Bldg No. 4), Infinity IT Park, Gen. AK Vaidya Marg, Malad (E), Mumbai-400 097;
   - call the Insurer's toll free number at 1800 209 8800;
   - write to the Insurer at https://kli.in/WECARE

   Escalation mechanism of the Insurer:
   In case the Policyholder/ complainant is not satisfied with the decision provided by the above office(s) or has not received any response within 14 days, he/ she may contact the Grievance Redressal Officer of the Insurer using any of the following modes for resolution:
   - write to the Insurer's Grievance Redressal Officer at - The Grievance Redressal Officer, Kotak Mahindra Life Insurance Company Limited, 9th floor, Intellion Square (Bldg No. 4), Infinity IT Park, Gen. AK Vaidya Marg, Malad (E), Mumbai-400 097;
   - call the Grievance Redressal Officer at 1800 209 8800;
   - write an email to the Grievance Redressal Officer at kli.grievance@kotak.com

2. If the Policyholder/ complainant is not satisfied with the above response or does not receive a response from the Insurer within 14 days, he/ she may approach the grievance cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:
   Bima Bharosa Shikayat Nivaran Kendra
   TOLL FREE NO: 155255 or 1800 4254 732
   Website: https://bimabharosa.irdai.gov.in/

   Address for communication for complaints:
   Policyholder's Protection & Grievance Redressal Department,
   Insurance Regulatory and Development Authority of India,
   Sy.No.115/1, Financial District, Nanakramguda,
   Gachibowli, Hyderabad - 500032.

3. In case the Policyholder/ complainant is not satisfied with the decision/ resolution of the Insurer, he/ she may approach the respective insurance ombudsman at the address given below in accordance with the Insurance Ombudsman Rules, 2017 as amended, if the grievance pertains to:
   (a) delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
   (b) any partial or total repudiation of claims by the Insurer;
   (c) disputes over premium paid or payable in terms of the insurance Policy;
   (d) misrepresentation of Policy terms and conditions at any time in the Policy Document or policy contract;
   (e) legal construction of insurance policies in so far as the dispute relates to claim;
   (f) policy servicing related grievances against the Insurer and their agents and intermediaries;
   (g) issuance of life insurance Policy, including health insurance policy which is not in conformity with the Proposal Form submitted by the proposer;

(h) non-issuance of insurance Policy after receipt of premium in life insurance including health insurance; and

(i) any other matter resulting from the violation of provisions of the Insurance Act, 1938 as amended from time to time or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the Policy contract, in so far as they relate to issues mentioned at clauses (a) to (f).

Details of insurance ombudsman:

Ahmedabad:

Office of the Insurance Ombudsman,
Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001.
Tel.: 079 - 25501201/02/05/06
Email: bimalokpal.ahmedabad@cioins.co.in
Jurisdiction: Gujarat, Dadra & Nagar Haveli, Daman and Diu.

Bengaluru:

Office of the Insurance Ombudsman,
Jeeva1n Soudha Building,PID No. 57-27-N-19
Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078.
Tel.: 080 - 26652048 / 26652049
Email: bimalokpal.bengaluru@cioins.co.in
Jurisdiction: Karnataka.

Bhopal:

Office of the Insurance Ombudsman,
Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market,
Bhopal – 462 003.
Tel.: 0755 - 2769201 / 2769202
Email: bimalokpal.bhopal@cioins.co.in
Jurisdiction: Madhya Pradesh, Chhattisgarh.

Bhubaneswar:

Office of the Insurance Ombudsman,
62, Forest park, Bhubaneswar – 751 009.
Tel.: 0674 - 2596461 /2596455
Email: bimalokpal.bhubaneswar@cioins.co.in
Jurisdiction: Odisha.

Chandigarh:

Office of the Insurance Ombudsman,
S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017.
Tel.: 0172 - 2706196 / 2706468
Email: bimalokpal.chandigarh@cioins.co.in
Jurisdiction: Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.

Chennai:

Office of the Insurance Ombudsman,
Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018.
Tel.: 044 - 24333668 / 24335284
Email: bimalokpal.chennai@cioins.co.in
Jurisdiction: Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).

Delhi:

Office of the Insurance Ombudsman,
2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002.
Tel.: 011 - 23232481/23213504
Email: bimalokpal.delhi@cioins.co.in
Jurisdiction: Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

Guwahati:
Office of the Insurance Ombudsman,
Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road,
Guwahati – 781001(ASSAM).
Tel.: 0361 - 2632204 / 2602205
Email: bimalokpal.guwahati@cioins.co.in
Jurisdiction: Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

Hyderabad:
Office of the Insurance Ombudsman,
6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004.
Tel.: 040 - 23312122
Email: bimalokpal.hyderabad@cioins.co.in
Jurisdiction: Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.

Jaipur:
Office of the Insurance Ombudsman,
Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.
Tel.: 0141 - 2740363
Email: bimalokpal.jaipur@cioins.co.in
Jurisdiction: Rajasthan

Ernakulam:
Office of the Insurance Ombudsman,
2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.
Tel.: 0484 - 2358759 / 2359338
Email: bimalokpal.ernakulam@cioins.co.in
Jurisdiction: Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

Kolkata:
Office of the Insurance Ombudsman,
Hindustan Bldg. Annexe, 4th Floor,
4, C.R. Avenue, KOLKATA - 700 072.
Tel.: 033 - 22124339 / 22124340
Email: bimalokpal.kolkata@cioins.co.in
Jurisdiction: West Bengal, Sikkim, Andaman & Nicobar Islands.

Lucknow:
Office of the Insurance Ombudsman,
6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001.
Tel.: 0522 - 2231330 / 2231331
Email: bimalokpal.lucknow@cioins.co.in
Jurisdiction: Districts of Uttar Pradesh- Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.

Mumbai:
Office of the Insurance Ombudsman,
3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.
Tel.: 69038821/23/24/25/26/27/28/28/29/30/31
Email: bimalokpal.mumbai@cioins.co.in
Jurisdiction: Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).

Noida:
Office of the Insurance Ombudsman,
Bhagwan Sahai Palace, 4th Floor, Main Road,
Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301.
Tel.: 0120-2514252 / 2514253
Email: bimalokpal.noida@cioins.co.in
Jurisdiction: State of Uttarakhand and the following Districts of Uttar Pradesh- Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun,

Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

Patna:
Office of the Insurance Ombudsman,
2nd Floor, Lalit Bhawan, Bailey Road,
Patna 800 001.
Tel.: 0612-2547068
Email: bimalokpal.patna@cioins.co.in
Jurisdiction: Bihar, Jharkhand.

Pune:
Office of the Insurance Ombudsman,
Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth,
Pune – 411 030.

Tel.: 020-41312555
Email: bimalokpal.pune@cioins.co.in
Jurisdiction: Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Annexure 1

Section 38 - Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

01. This policy may be transferred/assigned, wholly or in part, with or without consideration.
02. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.
03. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
04. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
05. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.
06. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
07. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
08. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced.
09. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
    a. not bonafide or
    b. not in the interest of the policyholder or
    c. not in public interest or
    d. is for the purpose of trading of the insurance policy.
10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.
11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.
12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.
13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
    a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR
    b. where the transfer or assignment is made upon condition that
        i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
        ii. the insured surviving the term of the policy

    Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.
14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
    a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
    b. may institute any proceedings in relation to the policy
    c. obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings
15. Any rights and remedies of an assignee or transferee of a life insurance policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by this section.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policy Holders are advised to refer to official Gazette Notification for complete and accurate details.]

Annexure 2

Section 39 - Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

01. The policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.
02. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.
03. Nomination can be made at any time before the maturity of the policy.
04. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.
05. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.
06. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.
07. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
08. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a nomination or cancellation or change thereof.
09. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.
10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the nomination.
11. In case of nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.
12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).
13. Where the policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or
    d. spouse and children
    e. or any of them
    the nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.
14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act, 2015.
16. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.
17. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act, 2015, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policy Holders are advised to refer to official Gazette Notification for complete and accurate details.]

Annexure 3

Section 45 - Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended by Insurance Laws (Amendment) Act, 2015 are as follows:

01. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 yrs from
    a. the date of issuance of policy or
    b. the date of commencement of risk or
    c. the date of revival of policy or
    d. the date of rider to the policy

    whichever is later.
02. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
    a. the date of issuance of policy or
    b. the date of commencement of risk or
    c. the date of revival of policy or
    d. the date of rider to the policy

    whichever is later.

    For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.
03. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
    a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
    b. The active concealment of a fact by the insured having knowledge or belief of the fact;
    c. Any other act fitted to deceive; and
    d. Any such act or omission as the law specifically declares to be fraudulent.
04. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
05. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the mis-statement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.
06. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.
07. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.
08. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.
09. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policy Holders are advised to refer to official Gazette Notification for complete and accurate details.]

HEALTH PREMIER

POLICY WORDING

Preamble

This is a contract of insurance between You and Us which is subject to the receipt of the premium in full and the terms, conditions and exclusions of the Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form. Please inform Us immediately of any change in the address, state of health or any other changes affecting You or any Insured Person.

PART I

1. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Endorsements:

Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

Accident	means sudden, unforeseen and involuntary event caused by external, visible and violent means
Admission	means the Insured Person's admission to a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness
Alternative Treatment (AYUSH)	refers to the medical and/ or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems
Ambulance	means a road vehicle operated by a healthcare/ ambulance service provider and equipped for the transport and paramedical treatment of the person requiring medical attention
Any one Illness	means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken
Associated Medical Expenses	means Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioners (including surgeons, anesthetists and specialists)

AYUSH Hospital	is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following: a. Central or State Government AYUSH Hospital or b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion: i. Having at least 5 in-patient beds; ii. Having qualified AYUSH Medical Practitioner in charge round the clock; iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out; iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
AYUSH Day Care	means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion: i. Having qualified registered AYUSH Medical Practitioner(s) in charge; ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out; iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
Base Sum Insured	a. For Individual sum insured basis (Individual Policy), the amount specified in the Policy Schedule against an Insured Person which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of that Insured Person.

	b. For Family Floater sum insured basis (Floater Policy), the amount specified in the Policy Schedule which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of any one and/or all Insured Persons. If the Policy Period is more than one year, then the Base Sum Insured will apply afresh to each Policy Year in the Policy Period, but any portion of the Base Sum Insured which remains un-utilised in any Policy Year shall not be carried forward to any subsequent Policy Year in the Policy Period.
Break in policy	means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
Cashless Facility	means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved
Claim	means a demand made by You for payment of any benefit under the Policy in respect of an Insured Person
Condition Precedent	means a policy term or condition upon which the Insurer's liability under the policy is conditional upon
Congenital Anomaly	means a condition which is present since birth, and which is abnormal with reference to form, structure or position **a) Internal Congenital Anomaly** Congenital anomaly which is not in the visible and accessible parts of the body. **b) External Congenital Anomaly** Congenital anomaly which is in the visible and accessible parts of the body.
Co-Payment	means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
Cumulative Bonus	means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium
Day care centre	means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under – i. has qualified nursing staff under its employment;

	ii. has qualified medical practitioner/s in charge; iii. has fully equipped operation theatre of its own where surgical procedures are carried out; iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel
Day Care Treatment	means medical treatment, and/or surgical procedure which is: i. undertaken under General or Local Anaesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and ii. which would have otherwise required hospitalization of more than 24 hours Treatment normally taken on an out-patient basis is not included in the scope of this definition
Deductible	means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
Dental treatment	means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery
Disclosure to information norm	The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
Domiciliary Hospitalisation	means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances: i. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or ii. The patient takes treatment at home on account of non-availability of room in a hospital.
Emergency	means a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.
Emergency Care	means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner* to prevent death or serious long term impairment of the insured person's health

Family Floater	means a Policy described as such in the Policy Schedule where You and Your family members as mentioned in Eligibility (Part III) and named in the Schedule are insured under this Policy as at the Policy Period Start Date. The Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your family members mentioned in the Policy Schedule during each Policy Period.
Grace Period	means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing diseases. Coverage is not available for the period for which no premium is received.
Hospital	means any institution established for *in-patient care* and *day care treatment* of illness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act Or complies with all minimum criteria as under: i. has qualified nursing staff under its employment round the clock; ii. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places; iii. has qualified medical practitioner (s) in charge round the clock; iv. has a fully equipped operation theatre of its own where surgical procedures are carried out v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel
Hospitalisation	means admission in a Hospital for a minimum period of 24 consecutive *'In-patient Care'* hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours
Illness	means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment (a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery. (b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

	1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests 2. it needs ongoing or long-term control or relief of symptoms 3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it 4. it continues indefinitely 5. it recurs or is likely to recur
Injury	means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner
Inpatient care	means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event
Instalment Premium	Shall mean the defined proportion of the applicable annual premium with respect to the Insured Person(s) payable at regular frequency as defined in the Policy Schedule.
Insured Person(s)	means the persons named in the Policy Schedule, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium received
Intensive Care Unit	means an identified section, ward or wing of a *hospital* which is under the constant supervision of a dedicated *medical practitioner*(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
ICU Charges	ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
Maternity expenses	Maternity expenses means; a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization); b) expenses towards lawful medical termination of pregnancy during the policy period
Medical Advice	means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription
Medical Expenses	means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not

	been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
Medically Necessary Treatment	means any treatment, tests, medication, or stay in hospital or part of a stay in *hospital* which i. is required for the medical management of the illness or injury suffered by the insured; ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity; iii. must have been prescribed by a *Medical Practitioner*; iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India
Medical Practitioner	means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude You and Your Immediate Family. "Immediate Family would comprise of Your spouse, children, brother(s), sister(s) and parent(s).
Migration	means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credit gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer
Network Provider	means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility
New Born Baby	New born baby means baby born during the Policy Period and is aged upto 90 days.
Non-Network Provider	means any Hospital, day care centre or other provider that is not part of the network
Notification of Claim	means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication
OPD treatment	means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
Plan	means the Plan stated in the Policy Schedule which is applicable to all Insured Persons and specifies the amounts of benefits available
Policy	means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The

	Policy contains details of the extent of cover available to You, what is excluded from the cover and the terms & conditions on which the Policy is issued to You.
Policy Period	means the period commencing from Policy Start Date and time as specified in Policy Schedule and terminating at midnight on the Policy End Date as specified in Policy Schedule
Policy Schedule	means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
Policy Year	means a period of twelve months beginning from the Policy Period Start Date and ending on the last day of such twelve-month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.
Portability	means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer
Pre-existing Disease	means any condition, ailment, injury or disease: a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer or b) for which medical advice or treatment was recommended by, or received from, a physician not more than 36 months prior to the date of commencement of the policy.
Pre-Hospitalisation Medical Expenses	means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that: i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
Post Hospitalisation Medical Expenses	means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that: i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and ii. The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.
Qualified Nurse	means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India

Reasonable& Customary Charges	means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
Renewal	means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods
Room Rent	means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses
Surgery or Surgical Procedure	means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a *Medical Practitioner*
Third Party Administrator (TPA)	means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
Unproven/ Experimental Treatment	means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven
You/Your/Policyholder	means the policyholder/Insured Person named in the Policy Schedule
We/ Our/Us	means Zurich Kotak General Insurance Company (India) Limited

PART II

2. WHAT WE WILL PAY (COVERS AVAILABLE UNDER THE POLICY)

The Covers available under this Policy are described below. Covers will be available to the Insured Person, only if that particular cover is specifically mentioned in the Policy Schedule as per the Plan opted by You, subject to

(a) availability of Base Sum Insured and Cumulative Bonus(if any)
(b) the terms, conditions and exclusions of this Policy and
(c) any sum insured or sub-limits specified in respect of that Cover and any limits applicable under the Plan in force for the Insured Person as specified in the Policy Schedule

2.1 In-patient Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization that occurs during the Policy Period following an Illness or Injury provided that:

(a) The Hospitalisation is for a minimum and continuous period of 24 hours
(b) the Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(c) the Medical Expenses incurred are Reasonable and Customary and may be for one or more of the following:
   i. Room Rent and other boarding charges;
   ii. ICU Charges;
   iii. Operation theatre expenses;
   iv. Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
   v. Qualified Nurses' charges;
   vi. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
   vii. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized
   viii. Anaesthesia, blood, oxygen and blood transfusion charges;
   ix. Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
   x. Inpatient physiotherapy charges;

2.2 Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:
(a) the Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(b) the Medical Expenses incurred are Reasonable and Customary ;

Further,
(a) We will only cover the Medical Expenses for those Day Care Treatments which are listed in Annexure II of this Policy. The complete list of Day Care Treatments covered is also available on Our website [www.zurichkotak.com];
(b) We will not cover any OPD Treatment under this Benefit.

2.3 Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses following an Illness or Injury that occurs during the Policy Period provided that:
(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy and the Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses relate to the same Illness/medical condition;

Further,
(a) We will pay Pre-Hospitalisation Medical Expenses up to the number of days as mentioned in the Policy Schedule preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;

(b) We will pay Post-Hospitalisation Medical Expenses up to the number of days as mentioned in the Policy Schedule immediately following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment.

2.4 Ambulance Cover

We will indemnify the amount incurred up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You on availing ambulance services offered by a healthcare or Ambulance service provider for your necessary transportation to the Hospital for treatment of an Illness or Injury following an Emergency provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the Ambulance service relates to the same illness / medical condition
(b) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;

Further,

(a) We will also provide cover under this benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.
(b) In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.5 Organ Donor Cover

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the Base Sum Insured (subject to availability), provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the Insured Person;
(b) The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules;
(c) The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advise;

Further,

(a) In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(b) We will not cover expenses towards the donor in respect of:
    (i) Any Pre-Hospitalization Medical Expenses or Post-Hospitalization Medical Expenses;
    (ii) Costs directly or indirectly associated to the acquisition of the organ;
    (iii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

2.6 Alternative Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Alternative Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period up to the limits of the Base Sum Insured (subject to availability), provided that:

(a) The Alternative Treatment is administered by a Medical Practitioner who holds a valid practicing license in respect of such AYUSH Treatments;
(b) The Insured Person is admitted to AYUSH Hospital as an Inpatient or for Day Care treatment as specified under 2.1 (In-Patient Treatment) and 2.2 (Day Care Treatment) respectively. .

Further,

(a) In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.7 Domiciliary Hospitalisation

We will indemnify the Medical Expenses incurred on the Insured Person's Domiciliary Hospitalization during the Policy Period following an Illness or Injury that occurs during the Policy Period up to the limits of the Base Sum Insured (subject to availability), provided that:

(a) We will cover medical expenses of an Insured person for treatment of a disease, Illness or Injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable.
(b) The domiciliary hospitalisation is Medically Necessary and follows the written advice of a Medical Practitioner
(c) The Medical Expenses incurred are Reasonable and Customary Charges;
(d) The Insured Person's Domiciliary Hospitalisation extends for at least 3 consecutive days in which case We will pay Medical Expenses from the first day of Domiciliary Hospitalisation;

Further,

(a) We shall not indemnify for any Medical Expenses incurred for the treatment of any of the following Illnesses/conditions under this Cover:
    i. Asthma;
    ii. Bronchitis;
    iii. Chronic Nephritis and Chronic Nephritic Syndrome;
    iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
    v. Diabetes Mellitus and Insipidus;
    vi. Epilepsy;
    vii. Hypertension;
    viii. Influenza, cough and cold;
    ix. psychiatric or psychosomatic disorders as mentioned below;
        a. 2021 ICD-10-CM Diagnosis Code F32: Major depressive disorder, single episode
        b. 2021 ICD-10-CM Diagnosis Code F41: Other anxiety disorders
        c. ICD-10-CM Diagnosis Code F34: Persistent mood [affective] disorders
        d. ICD-10-CM Diagnosis Code F31: Bipolar disorder
        e. ICD-10-CM Diagnosis Code F20: Schizophrenia

f. ICD-10-CM Diagnosis Code F50 :Eating disorders
g. ICD-10-CM Diagnosis Code F84 :Autistic disorder
h. ICD-10-CM Diagnosis Code F79 :Unspecified intellectual disabilities
i. ICD-10-CM Diagnosis Code F90 : Attention-deficit hyperactivity disorders
j. ICD-10-CM Diagnosis Code F42 : Obsessive-compulsive disorder

x. Pyrexia of unknown origin for less than 10 days;
xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
xii. Arthritis, Gout and Rheumatism.

(b) In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.

2.8 Annual Health Check-up

We will arrange for one free health check-up at Our Network Provider for each Insured Person that is above 18 years of Age, for each Policy Year for the specified tests. This will be offered regardless of any claim admitted/ registered under the Policy.

The health check-up will consist of the following tests for all eligible Insured Persons, however, these tests are subject to revision at Our discretion and will be communicated to Insured Person(s).

(a) CBC;
(b) MER;
(c) Serum Cholesterol;
(d) Serum Creatinine;
(e) SGPT /SGOT
(f) ECG;
(g) Random Blood Sugar.

2.9 Restoration Benefit

We will provide a 100% restoration of the Base Sum Insured amount once in a Policy Year if the Base Sum Insured and the Cumulative Bonus (if any) is insufficient as a result of previous Claims in that Policy Year, provided that:

(a) The restored sum insured will not be available in respect of any Illness (including its complications) for which a Claim has already been accepted / paid in that Policy Year for the same Insured Person.
(b) The restoration of sum insured shall not apply to the first claim in that Policy Year unless related to an Injury due to Accident where the claim amount exceeds the Base Sum Insured.

Further,

(a) No Cumulative Bonus will apply on the restored sum insured;
(b) The restored sum insured will apply to all Insured Persons on the same basis as the Base Sum Insured i.e. individual sum insured in case of Individual Policy and floater sum insured in case of Floater Policy;

(c) Any restored sum insured which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year;
(d) Restoration of sum insured will be in addition to the Base Sum Insured.

2.10 Cumulative Bonus

We will increase Your Base Sum Insured by 10% subject to the maximum limit specified in the Policy Schedule at the end of the Policy Year if the Policy is renewed with Us provided that:
(a) Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons who were Insured Persons in the immediately completed Policy Year;
(b) If the Base Sum Insured is increased at the time of Renewal, then the Cumulative Bonus will be calculated on the Base Sum Insured of the immediately completed Policy Year;
(c) If the Base Sum Insured is reduced at the time of Renewal, then the applicable Cumulative Bonus will be applicable on the renewed policy Base Sum Insured.
(d) Cumulative Bonus will be carried forward to the next Policy Year, provided the Insured Person renews the Policy before the expiry of the Grace Period.
(e) If the Policy Period is more than one year, then any Cumulative Bonus that has accrued for the Policy Year will be credited at the end of the Policy Year and shall be available for any claims made in the subsequent Policy Year.
(f) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.
(g) If the Insured Persons in the expiring Policy are covered on a floater basis and such Insured Persons renew their expiring Policy with Us into two or more floater/individual policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Base Sum Insured of each Renewed Policy.
(h) Any earned Cumulative Bonus shall not be available for claims under Maternity Benefit, New Born Baby Cover, Vaccination Expenses, Critical Illness Cover and Personal Accident Cover.

2.11 Second E-Opinion Cover

We will facilitate the Insured person for availing a Second E-Opinion on his / her medical condition occurring during the Policy Period, provided that:
(a) We shall only provide access to an E-opinion and this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner;

Further,
(a) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.
(b) The Insured person is free to choose whether or not to obtain the expert opinion and if obtained whether or not to act on it

2.12 Health and Rewards

We will provide incentives to reward the Insured Person(s) for taking care of his her health/fitness through regular preventative and wellness habits. You can earn reward points for the activities mentioned below. The activities may attract additional charges (decided at Our discretion) to be directly payable by You. The activities undertaken by You will be rewarded by Us in the form of reward points as per the terms and conditions mentioned below. You can redeem these reward points in accordance with the redemption terms and conditions.

- **List of Wellness Activities:**

(a) Health Risk Assessment (HRA)
Health Risk Assessment questionnaire is used as a tool for evaluation of health and quality of life. It helps you to understand your lifestyle and its impact on your health status. The HRA will be an online assessment provided by Us through vendor tie-ups. This can be undertaken only once per Insured Person in a Policy Year.

You can earn 250 reward points on completion of HRA per Insured Person, in case of Individual Policy and maximum up to 500 reward points per family in case of Floater Policy in a Policy Year.

Insured Person(s) only above 18 years of Age will be eligible to undergo HRA.

However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.

We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made thereby.

(b) Health Check-Up
The Company provides for health check-up as per Benefit 2.8 Annual Health Check-Up. You will be provided reward points for undergoing the Health Check-Up. We will facilitate in booking the appointment and arrange for the check-up through any of our Network Providers.
You can earn 500 reward points for undergoing Health Check-Up per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy in a Policy Year. If the result of all the medical test parameters are within normal limit/ range, additional 500 reward points per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy will be awarded in a Policy Year.
However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the test and if done whether or not to act on it.

We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(c) Preventive Check-Up

You can also earn reward points by undergoing certain other diagnostic and preventive health check-up at any diagnostic centre at Your own expenses. You shall have to submit medical reports of these tests to Us.

List of the Tests eligible under this are mentioned below:

Name of the Test	Applicability
Heart related screening tests (2D echo/ TMT/ ECG)	Individual above the age of 45 years
HbA1c / Complete lipid profile	Any age
PAP Smear/ Mammogram/ CA-125	Females above the age of 40 years
Prostate Specific Antigen (PSA)	Males above the age of 45 years
Vitamin Profile test (D3, B12 and TSH)	Any age
USG whole abdomen	Any age
Kidney Function test	Any age
Renal function test	Any age
Cardiac biomarker test	Any age
Body Fat Analysis	Any age

You can earn 250 reward points for undergoing preventive check-up per test per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy in a Policy Year. If the result of the medical test parameters mentioned above are within normal limits/ range, additional 250 reward points per test per Insured Person in case of Individual Policy and a maximum of 1,500 reward points per family in case of Floater Policy will be awarded in a Policy Year. One test will be considered only once for reward points during a Policy Year.

However, this shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the test and if done whether or not to act on it.
We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

(d) Fitness Initiatives

We will reward You for the following fitness & health related activities as given below which are undertaken after Policy Start Date.

Fitness Activities	Reward Points
Participation in Professional sporting events like Marathon/ Swimathon/Triathlon, etc.	500 points per event and 1000 points per Policy Year
Gym/ Yoga membership for 1 year	1000 per Policy Year
Sports Activity membership (Swimming/ Tennis/ Badminton/ for 1 year	1000 per Policy Year
Share your Fitness story	250 per Policy Year
Winning Health Quiz/ Contests organized by Us	250 per event and 500 points per Policy Year

- **Terms for Reward Point Accumulation under Health and Rewards:**

  You can earn maximum 5,000 reward points per Insured Person in case of Individual Policy and a maximum of 10,000 reward points per family in case of Floater Policy in a Policy Year. You should notify and submit relevant documents, bills etc. for various wellness activities within sixty (60) days of undertaking such activity.

- **Redemption of Reward Points:**

  Each Reward Point will be equivalent to 0.25 Rupees.

  You can redeem these Reward points (after conversion to the equivalent rupee amount) against any of the following options:

  (a) i) Outpatient medical expenses like consultation charges, medicine & drugs, dental expenses, wellness & preventive care and other miscellaneous charges
  ii) Diagnostic expenses and health check-ups through our Network providers.
  (b) In-patient Treatment and Day Care Treatment claims, provided that the Base Sum Insured, Cumulative Bonus and Restoration Sum Insured (if applicable) are exhausted during the Policy Year.
  (c) Payment of Co-payment, if applicable
  (d) Non-medical expenses listed under Annexure III

- **Terms for Redemption:**

  (a) Reward points not redeemed in the given Policy Year can be carried forward for a maximum up to 1 year from the date of expiry of the Policy Year in which they are earned.
  (b) Reward Points shall automatically lapse upon cancellation of the Policy. However, any unclaimed and accrued Points (from Previous Policy Year/ month) shall be available for redemption up to 1 year from the date of cancellation of the Policy unless the policy has been cancelled by Us on grounds of misrepresentation, fraud, nondisclosure or non-cooperation of the Insured.
  (c) Reward Points cannot be redeemed for the same activity against which the Reward points were earned at first. For e.g. If reward points are earned for undergoing "Preventive Check-Up –

HbA1c/ Lipid Profile" then the same points cannot be used for claiming under the diagnostic expenses for undergoing the said test.

(d) Redemption of the rewards points can be done twice during a Policy Year.

(e) Redemption of rewards points does not entail any cash benefit to be provided to You.

2.13 Value Added Benefits

The Benefits listed below are Value Added Benefits and shall be available to the Insured Persons specified in the Policy Schedule. Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. The activities may attract additional charges (decided at Our discretion) to be payable by You directly to the vendor.

VA 1	VA2	VA3
Online customer profile	Online customer profile	Online customer profile
Doctor directory	Doctor directory	Doctor directory
Doctor appointment	Doctor appointment	Doctor appointment
Online Pharmacy/ Online Diagnostics tests booking	Online Pharmacy/ Online Diagnostics tests booking	Online Pharmacy/ Online Diagnostics tests booking
Health tips/ articles	Health tips/ articles	Health tips/ articles
Home Health	Home Health	Home Health
	E-consultation	E-consultation
		Dietician/ Nutritionist opinion

(a) Online customer profile
Based on the HRA taken and health check-ups, if any, undertaken by the Insured Person, We will maintain an online customer profile through our vendor tie-up which can be accessed by the Insured Person to review his Health status.

(b) Doctor directory
We will provide with or arrange for an online platform through our vendor tie-up for providing access to information on general physicians, specialists and super specialists.

(c) Doctor appointment
We will provide with or arrange for an online platform through vendor tie-ups for fixing up doctor appointments for the Insured Person(s).

(d) Online Pharmacy, Diagnostic tests and other Health/ Wellness Offering
We will facilitate the Insured Person for various offerings on health and wellness services like Diagnostic Centers, Pharmacy, Gymnasiums, Yoga, etc. through the Network Providers/ vendor tie-ups.

(e) Health tips/ articles

We will provide You information on various health related applications, wellness training, maintaining fitness and good health, information on various diseases, dietary plans, etc. through periodic communications and through online platform.

(f) Home Health
We will provide through vendor tie-ups, Home Health services like physiotherapy, nursing care, trained attendants and medical equipments, for the Insured Person.

(g) E-consultations
We will provide with or arrange for an online platform through vendor tie-ups for providing with E-consultations to the Insured Person.

(h) Dietician & Nutritionist opinion
We will arrange for dieticians/ nutritionists through our vendor tie-ups to provide for counselling to the Insured Person.

Terms and Conditions for 2.12 Health and Rewards and 2.13 Value Added Benefits

- Any information provided by You shall be kept confidential
- For services which are provided through empanelled medical experts/ centres/ service providers, We are only acting as a facilitator, hence We would not be liable for any incremental cost of the services.
- All medical services are being provided by empanelled medical experts/ centres/ service providers who are empanelled after full due diligence. Nonetheless, Insured Person may consult their personal doctor before availing the medical services. The decisions to utilise the services will solely be at the Insured Person's discretion.
- We/Company/Us or its group entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges and expenses which an Insured Person/ You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
- This shall not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner. The Insured person is free to choose whether or not to undergo the same and if done whether or not to act on it.
- We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

2.14 Hospital Daily Cash

We will pay the daily cash amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during the Policy Period provided that:
(a) We have accepted a Claim for In-patient Treatment under the Policy;

(b) The Insured Person's Hospitalization extends for at least 3 consecutive days, in which case We will make payment under this Benefit from the first day of Hospitalization;
(c) We shall not be liable to make payment for more than the maximum number of days per Policy Year specified in the Policy Schedule for this Benefit.

Further,
(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(b) The payment under this benefit is over and above the Base Sum Insured.

2.15 Convalescence Benefit

We will pay the amount specified in the Policy Schedule for this Benefit if the Insured Person is admitted in Hospital for a minimum period of 10 consecutive days provided that:
(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalization;
Further,
(a) We shall not be liable to make payment under this Benefit in respect of an Insured Person more than once during the Policy Year.
(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(c) The payment under this benefit is over and above the Base Sum Insured.

2.16 Home Nursing Benefit

We will indemnify the amount specified in the Policy Schedule for this Benefit incurred for medical care services of a qualified nurse at the residence of the Insured Person following discharge from hospital after treatment for Illness/ Injury provided that:
(a) We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
(b) Such medical care services are confirmed as being necessary by the attending Medical Practitioner and the same relate directly to Illness/ Injury for which the Insured Person has undertaken treatment during the hospitalisation

Further,
(a) The cover is applicable for a maximum of 15 days during the Policy Year and after the completion of the number of days mentioned in the Post-Hospitalization Medical Expenses cover (2.3).
(b) In case of Individual policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(c) The payment under this benefit is within the Base Sum Insured.

2.17 Daily Cash for Accompanying an Insured Child

We will pay the Daily Cash Amount specified in the Policy Schedule for this Benefit for each and every completed day of the Insured Person's Hospitalization during the Policy Period provided that:

(a) We have accepted a Claim for In-patient Treatment under the Policy;
(b) The Insured Person hospitalized is a Child aged 12 years or below
(c) We shall not be liable to make payment for more than the maximum number of days per Policy Year specified in the Policy Schedule for this Benefit.

Further,

(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(b) The payment under this benefit is over and above the Base Sum Insured.

2.18 Compassionate Visit

We will indemnify the costs of a return journey undertaken by air/ rail/ road (to and fro) up to the limit specified in the Policy Schedule under this Benefit for one of the Insured Person's Immediate Relative to travel from the place of the Immediate Relative's residence to the Hospital where the Insured Person is hospitalized, in case Hospitalization of the Insured Person extends beyond 5 consecutive days provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy

Further,

(a) In case of Individual policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(b) The payment under this benefit is over and above the Base Sum Insured.
(c) For the purpose of this Benefit, the term "Immediate Relative" would mean the Insured Person's spouse, children or parents.

2.19 Maternity Benefit

We will indemnify the Medical Expenses incurred up to the Maternity Benefit Sum Insured specified in the Policy Schedule for the delivery of the Insured Person's child (including cesarean section) or the Medically Necessary and lawful medical termination of pregnancy during the Policy Period provided that:

(a) The treatment is taken as an In-patient in a Hospital;
(b) The cover shall be available to the Insured Person who has been continuously covered for at least 36 months under this Benefit subject to the Portability & Continuity Benefits as applicable.

Further,

(a) We shall not be liable to pay for more than 2 events of deliveries across all Policy Periods with Us;

(b) We will cover pre-natal and post-natal expenses up to the amount specified in the Policy Schedule for this Benefit provided that We have accepted a Claim for delivery/termination under this Benefit;
(c) Ectopic pregnancy shall not be covered under this Benefit , but any Claims will be considered under In-patient Treatment;
(d) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(e) The payment under this benefit is over and above the Base Sum Insured.

Permanent Exclusion 3.5(15) of the Policy Wordings stands deleted to the extent of this Benefit only.

2.20 New Born Baby Cover

We will indemnify the Medical Expenses incurred on the Hospitalization of the Insured Person's New Born Baby during the Policy Period within the limits of the Maternity Sum Insured subject to the following:
(a) We have accepted a Claim for Maternity Benefit under the Policy.

Further,
(a) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).
(b) Any pre and post hospitalization expenses for the new born shall not be covered under this benefit.

You can cover the New Born Baby beyond 90 days on payment of requisite premium for the New Born Baby by way of an endorsement or at the next Renewal, whichever is earlier.

2.21 Vaccination Expenses

We will cover the Vaccination Expenses incurred on the Insured Person's Baby during the Policy Period up to the limit specified in the Policy Schedule subject to the following:
(a) We have accepted a Claim for Maternity Benefit under the Policy.
(b) The Insured Person whose maternity claim has been accepted by Us continues to renew the Policy with Us subsequently.

Further,
(a) The expenses will be covered from the birth till the Baby completes two years.
(b) Reimbursement claims for vaccination expenses can be submitted once during a Policy Year.
(c) The payment under this benefit is over and above the Base Sum Insured.

Permanent Exclusion 3.5 (22) of the Policy Wordings stands deleted to the extent of this Benefit only.

The Covers under Benefits 2.19, 2.20 and 2.21 are not available on a standalone basis and need to be availed in conjunction only.

2.22 Air Ambulance Cover

We will indemnify the amount up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You for ambulance transportation in an airplane or helicopter for emergency life threatening health conditions which require immediate and rapid ambulance transportation from the site of first occurrence of the Illness /Accident to the nearest hospital provided that:

(a) We have accepted a Claim for In-patient Treatment or Day Care Treatment under the Policy and the air ambulance service relates to the same Illness / medical condition
(b) The necessity of the use of the Air Ambulance is certified by the treating Medical Practitioner;

Further,
(a) We will also provide cover under this Benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.
(b) Return transportation to Your home by air ambulance is excluded
(c) In case of Individual policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis.
(d) The payment under this benefit is within the Base Sum Insured.

2.23 Critical Illness Cover

If the Insured Person is first diagnosed to be suffering from any of the following Critical Illnesses during the Policy Period, We will pay sum insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) On payment of additional premium, cover would be provided to each individual for the Policy Period.
(b) We shall not be liable to accept any Claim under this Cover if it pertains to any Critical Illness diagnosed within 90 days of the commencement of the first Policy Period of this Cover with Us;
(c) We shall not be liable in case any of the Critical Illnesses is a consequence of or arises out of any Pre-Existing Condition(s)/Disease.
(d) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,
(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater) and available for Insured Persons aged 18 years or above.
(b) The payment under this benefit is over and above the Base Sum Insured and will not impact the Base Sum Insured or the Cumulative Bonus (if any).

(c) Once a Claim has been accepted and paid for any of the listed Critical Illness, this benefit shall cease in respect of that Insured Person, but shall continue to be in force for other Insured Persons.

(d) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;

(e) In the event of a Claim arising under this Cover, We shall be given written notice of the Claim within 30 days from the date of the first diagnosis of the Critical Illness and We shall be provided the following information and documentation:

(i) The Claim documents stated in the Policy, provided that We will accept duly certified copies of the listed documents if the originals are required to be submitted to any other insurance company;

(ii) Written confirmation of the diagnosis of the Critical Illness from the treating Medical Practitioner;

"Critical Illness" for the purpose of this Cover is as mentioned below:

- First diagnosis of the below-mentioned Illnesses more specifically described below
  1. Cancer of specified severity
  2. Kidney failure requiring regular dialysis;
  3. Multiple Sclerosis with persisting symptoms;
  4. Motor Neurone Disease with Permanent Symptoms
  5. Benign Brain Tumor
  6. Primary Pulmonary Hypertension
  7. End Stage Liver Failure
- Undergoing for the first time of the following surgical procedures, more specifically described below:
  8. Major Organ / Bone Marrow Transplant;
  9. Open heart replacement or repair of heart valves
  10. Open chest CABG
  11. Aorta Graft Surgery
- Occurrence for the first time of the following medical events more specifically described below:
  12. Coma of Specified Severity
  13. Stroke resulting in permanent symptoms;
  14. Permanent Paralysis of Limbs;
  15. First Heart Attack of specified severity.
  16. Third Degree (or Major) Burns
  17. Deafness
  18. Loss of Speech

The Critical Illnesses and the conditions applicable to the same are more particularly described in Annexure IV.

2.24 Personal Accident Cover

We will pay Sum Insured upto the limit specified in the Policy Schedule for this Cover, subject to the following:

(a) On payment of additional premium, cover would be provided to each individual for the Policy Period.
(b) We shall not be liable to make payment under this Cover for more than once in respect of any Insured Person across all Policy Periods;

Further,
(a) This cover is applicable on an individual basis irrespective of type of policy (Individual/ Floater)
(b) The payment under this benefit is over and above the Base Sum Insured and will not impact the Base Sum Insured or the Cumulative Bonus (if any).
(c) Notwithstanding any provision to the contrary in the Policy, this Cover will be applicable on a worldwide basis;

- **Accidental Death**

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person dies solely and directly due to an Injury sustained in an Accident which occurs during the Policy Period, provided that the Insured Person's death occurs within 12 months from the date of that Accident.

Once a Claim has been accepted and paid under this Benefit then this Policy will automatically terminate in respect of that Insured Person only.

- **Permanent Total Disablement (PTD)**

We will pay the Sum Insured upto the limit specified in the Policy Schedule if the Insured Person suffers Permanent Total Disablement of the nature specified below solely and directly due to an Accident which occurs during the Policy Period provided that the Permanent Total Disablement occurs within 12 months from the date of that Accident:
(i) Loss of Use of both eyes, or Physical Separation/ Loss of Use of two entire hands or two entire feet, or one entire hand and one entire foot, or of such Loss of Use of one eye and such Physical Separation/ Loss of Use of one entire hand or one entire foot.
(ii) Physical Separation/ Loss of Use of two hands or two feet, or of one hand and one foot, or of Loss of Use of one eye and Loss of Use of one hand or one foot.
(iii) If such Injury shall as a direct consequence thereof, permanently, and totally, disable the Insured Person from engaging in any employment or occupation of any description whatsoever.

Once a Claim has been accepted and paid under this Benefit then the Personal Accident Cover will automatically terminate in respect of that Insured Person only.

2.25 Cap on Room Rent

If We have accepted a Claim for In-patient Hospitalization under the Policy and if the Insured Person incurs Room Rent that is higher than the eligible Room Rent as specified in the Policy Schedule then We will be liable to pay only a rateable proportion of the Associated Medical Expenses incurred in the proportion of the difference between the eligible Room Rent and the Room Rent actually incurred, provided that Reasonable and Customary costs incurred on medicines/pharmacy, medical consumables, medical implants and diagnostic costs will be reimbursed based on the actual amounts incurred.

Proportionate deductions will not be applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category. Further, proportionate deductions will not be applied in respect of ICU Charges.

In case this Cover is not opted for, Insured will get the eligible Room Rent and Associated Medical Expenses subject to Base Sum Insured including Cumulative Bonus and Restoration Benefit, if applicable.

Under this Cover, the Insured is entitled for a discount in the premium on opting for Cap on Room Rent.

3. WHAT WE WILL NOT PAY (EXCLUSIONS APPLICABLE UNDER THE POLICY)

We shall not be liable to make any payment under this Policy directly or indirectly for/ caused by/ based upon/ arising out of or howsoever attributable to any of the exclusions listed below. All waiting periods will apply individually to each Insured Person:

3.1 Pre-Existing Diseases (Code – Excl01)

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36/ 24 months (as mentioned in the Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36/ 24 months (as mentioned in the Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3.2 30 Day Waiting Period (Code – Excl03)

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3.3 Specified disease/ procedure waiting period (Code – Excl02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures

(a) Cataract*;
(b) Benign Prostatic Hypertrophy;
(c) Myomectomy, Hysterectomy unless because of malignancy;
(d) All types of Hernia, Hydrocele;
(e) Fissures and/or Fistula in anus, haemorrhoids/piles;
(f) Arthritis, gout, rheumatism and spinal disorders;
(g) Joint replacements unless due to Accident;
(h) Sinusitis and related disorders;
(i) Stones in the urinary and biliary systems;
(j) Dilatation and curettage, Endometriosis;
(k) All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
(l) Dialysis required for chronic renal failure;
(m) Tonsillitis, adenoids and sinuses;
(n) Gastric and duodenal erosions and ulcers;
(o) Deviated nasal septum;
(p) Varicose Veins/ Varicose Ulcers.

*Our maximum liability for any Claim for an Insured Person's cataract treatment shall be 10% of the Base Sum Insured up to a maximum of INR 100,000 per eye for each Policy Year of the Policy Period.

3.4 Maternity Benefit Waiting Period

Any treatment arising from or traceable to pregnancy, childbirth including caesarean section will not be covered until 36 months of continuous coverage has elapsed for that particular Insured Person since the inception of the Maternity Expenses Benefit under the Policy for that Insured Person.

This waiting period will be reduced by number of continuous preceding years of Maternity coverage of the Insured Person under previous health insurance policy by Us or any other health insurance plan with an Indian non-life insurer/ health insurer as per guidelines on portability issued by the insurance regulator.

3.5 Permanent Exclusions

We will not be liable under any circumstances, for any Claim in connection with or with regard to any of the following permanent exclusions as specified below:

1. Investigation & Evaluation(Code- Excl04)

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded

2. Rest Cure, rehabilitation and respite care (Code – Excl05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. Obesity/ Weight Control (Code – Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

4. Change-of- Gender treatments (Code – Excl07)

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

5. Cosmetic or plastic Surgery (Code – Excl08)

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

6. Hazardous or Adventure sports: (Code- Excl09)

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

7. Breach of law (Code – Excl10)

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. Excluded Providers: (Code- Excl11)

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

9. Code- Excl12

Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof

10. Code- Excl13

Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.

11. Code- Excl14

Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.

12. Refractive Error (Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

13. Unproven Treatments (Code – Excl16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

14. Sterility and Infertility (Code- Excl17)

Expenses related to sterility and infertility. This includes:

i. Any type of contraception, sterilization
ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
iii. Gestational Surrogacy
iv. Reversal of sterilization

15. **Maternity (Code- Excl18)**

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy
ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

16. Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;

17. Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;

18. Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services, medical supplies including elastic stockings, diabetic test strips, and similar products.

19. Expenses incurred on all dental treatment unless necessitated due to an Accident and treatment is taken in in-patient department of hospital or day care centre;

20. Acupressure, acupuncture, magnetic and such other therapies;

21. Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;

22. Vaccination or inoculation of any kind, unless it is post animal bite and there is hospitalisation as an in-patient;

23. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)

24. Treatment relating to Congenital external Anomalies;

25. Any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition;

26. Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;

27. Any treatment taken outside India;

28. Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;

29. Any consequential or indirect loss arising out of or related to Hospitalization;

30. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority;

31. Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;

32. All non-medical expenses listed in Annexure III (List I) of the Policy.

33. Any OPD treatment will not be covered

34. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.

35. Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), and Hyperbaric Oxygen Therapy will not be covered unless it forms a part of In-Patient Treatment in case of hospitalisation or part of discharge advice upto the Post hospitalisation period as specified in the Policy Schedule.

36. Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

4. CLAIM ADMINISTRATION

The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be Condition Precedent to admission of Our liability under this Policy:

(a) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;

(b) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person;

(c) We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such Claim;

(d) If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

5. CLAIMS PROCEDURE

On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to Our liability under the Policy the following procedure shall be complied with:

5.1 For Cashless Facility

Cashless Facility will be available at a Network Provider of the Company. The complete list of Providers is available on Our website (The list is updated as and when there is any change in the Network Provider) or can be obtained from Our call centre. In order to avail of Cashless Facility, the following procedure shall be followed:

(a) Pre-authorization for Planned Hospitalization:

At least 48 hours prior to a planned Hospitalization, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that planned Hospitalisation. Each such request must be accompanied by all the following details:

(i) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor
(ii) Copy of the Health Card We have issued to the Insured Person;
(iii) Proposed date of Admission.
(iv) Medical papers viz. All prescriptions, medical investigation reports etc.
(v) Photo ID
(vi) Address proof, and photo to comply with KYC norms

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection.

Turn Around Time (TAT) for issue of Pre-Authorization within 1 hours from receipt of complete documents for initial and within 3 hours from receipt of complete documents for final approval at the time of discharge.

In Case of Claim Contact Us at:
24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@zurichkotak.com

In the event of claims, please send the relevant documents to:
Family Health Plan (TPA) Ltd,
Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad, 500 034.

(b) Pre-authorization for Emergency Care:

If the Insured Person has been admitted into Hospital for Emergency Care, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that Emergency Care within 24 hours of commencement of Hospitalisation. Each such request must be accompanied by all the following details:

(i) Pre-authorization form available at the hospital helpdesk to be duly filled in and signed by Insured and treating doctor

(ii) Copy of the Health Card We have issued to the Insured Person;
(iii) Medical papers viz. All prescriptions, medical investigation reports etc.
(iv) Photo ID
(v) Address proof, and photo to comply with KYC norms

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/ Our TPA will request additional information or documentation in respect of that request with the provider.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorisation specifying reasons for the rejection. In circumstances where We/Our TPA refuse the request for pre-authorisation as there is insufficient Base Sum Insured or there is insufficient information to determine the admissibility of the request for pre-authorisation, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities in Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers on Our website or by calling Our call centre.

5.2 For Reimbursement Claims

We shall be given written notice of the Claim for reimbursement along with the following details at least within 30 days of the Insured Person's discharge from Hospital:

(i) The Policy Number;
(ii) Name of the Policyholder;
(iii) Name and address of the Insured Person in respect of whom the request is being made;
(iv) Nature of Illness or Injury and the treatment/surgery taken;
(v) Name and address of the attending Medical Practitioner;
(vi) Hospital where treatment/surgery was taken;
(vii) Date of Admission and date of discharge;
(viii) Approximate claim amount (if available)
(ix) Any other information that may be relevant to the Illness/ Injury/ Hospitalization.

If the Claim is not notified to Us within 30 days of the Insured Person's discharge from Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

Turn Around Time (TAT) for settlement of Reimbursement is within 15 days from the date of receipt of claim along with claim form (and necessary documents).

6. CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which the use of Cashless Facility has been approved, We will be provided with these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

(a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);
(b) Hospital discharge summary;
(c) First consultation and follow up treatment papers;
(d) Original bills and receipts from the Hospital/Medical Practitioner;
(e) Original bills from chemists supported by proper prescription;
(f) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
(g) Indoor case papers, if available;
(h) Implant Invoice/ Sticker, if available;
(i) Ambulance Invoice, if applicable;
(j) FIR (if done) or MLC (if conducted) for Accident cases ;
(k) Post mortem report (if conducted);
(l) KYC documents viz. Photo ID and address proof along with duly completed form.
(m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

For claims under which cashless facility has been approved, following documents will be provided by the Network hospital along with the above:

(n) Original Pre – authorization request
(o) Copy of Pre – authorization approval letter
(p) Copy of the photo identity document of the Insured Person;
(q) KYC documents obtained at the time of cashless facility.

- **Additional Documents for Personal Accident Cover:**

Accidental Death

(a) Original Death certificate issued by the office of Registrar of Birth & Deaths;
(b) Death summary issued by a Hospital, if applicable;

Permanent Total Disablement (PTD) resulting from Accident

(a) Original treating Medical Practitioner's certificate describing the disablement;
(b) Photograph of the Insured Person reflecting the disablement;
(c) Prescriptions and consultation papers of the treatment;

(d) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

- **Critical Illness Claim Documents**

a. Common list of documents for all Critical Illness:

1) Duly completed claim form;
2) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
   - **i.** Name of the Insured Person;
   - **ii.** Name, date of occurrence and medical details confirming the event giving rise to the Claim.
   - **iii.** Written confirmation from the treating Medical Practitioner that the event giving rise to the Claim does not relate to any Pre-Existing Disease or any Illness or Injury which was diagnosed within the first 90 days of commencement of first Policy Period with Us.
3) Original Policy document;
4) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;
5) Original investigation test reports, indoor case papers;
6) In the cases where Critical Illness arises due to an Accident, FIR copy or medico legal certificate (if done/conducted) will also be required wherever conducted. We may call for any additional necessary documents/information as required based on the circumstances of the claim.
7) Any other documents as may be required by Us.

If the Claim is not notified to Us within the time period specified above, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

b. Specific Documentation Required for each of the Critical Illnesses
Please note that the following are illustrative lists and we may seek additional documentation based on the facts and circumstances of the Claim and if done/conducted/available

1) CANCER OF SPECIFIED SEVERITY

i. Hospital Discharge Card photocopy
ii. Hospital Bills photocopy
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Details of the treatment received by the Insured Person from the inception of the ailment.
vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.
vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
ix. Blood Tests.
x. Any other specific investigation done to support the diagnosis like the PAP Smear/ Mammography, etc.
xi. Any other documents as may be required by Us.

2) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Blood Tests- Renal Function Tests specifically: Serum Creatinine, Blood Urea Nitrogen, Serum Electrolytes done in the recent past (Not more than Two Week period from the date of intimation of Loss)
vii. Dialysis Papers/Receipts done in recent past.
viii. Renal scan
ix. Letter from the nephrologists stating the diagnosis of End Stage Kidney Failure.
x. Any other documents as may be required by Us.

3) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. MRI / CT Scan Report.
vii. Electro-myogram report
viii. Biopsy / Cytology Report
ix. Specific Blood Tests: Creatinine Phosphokinase /Anti-nuclear antibodies, C- reactive protein /autoimmune work up
x. Any other relevant Blood investigations.

xi. Confirmation from the Central/State Government Hospital about diagnosis of Multiple Sclerosis and the duration of the same.
xii. Any other documents as may be required by Us.

4) MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

i. Hospital Discharge Card photocopy (in case of Hospitalization)
ii. Investigations Reports like Blood tests, EEG, Nerve Conduction test, etc
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment
iv. Electro-myogram Report
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status
vii. Any other document as may be required by the company

5) BENIGN BRAIN TUMOR

i. Hospital Discharge Card photocopy
ii. Hospital Bills photocopy
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Details of the treatment received by the Insured Person from the inception of the ailment.
vi. Letter from treating consultant stating presenting complaints with duration and the past medical history.
vii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
viii. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
ix. Blood Tests.
x. Neurological examination report by Neurologist
xi. Any other documents as may be required by Us.

6) PRIMARY PULMONARY HYPERTENSION

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. MRI / CT Scan Report.
vii. Echocardiography report
viii. Computed tomography (CT), magnetic resonance imaging (MRI), and lung scanning
ix. Pulmonary angiography
x. Any other documents as may be required by Us.

7) END STAGE LIVER DISEASE / FAILURE

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Ultrasound scan of liver
vii. CT and/or MRI scan of the liver
viii. X-ray and Liver function test
ix. Biopsy / FNAC (where applicable)
x. Any other documents as may be required by Us.

8) MAJOR ORGAN /BONE MARROW TRANSPLANT

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Scan / Histopathology / Cytology / FNAC / Biopsy report suggesting irreversible & non-compensatory changes of the particular organ. 8 Bone Marrow Biopsy Reports (Specifically In Case of Bone Marrow Transplant)
vii. Letter from a specialist Doctor confirming the need of transplantation (Organs Specified are: Heart, lung, Liver, pancreas, kidney, bone marrow)
viii. Any other documents as may be required by Us.

9) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. X-ray and 2D-Echocardiography Report.
vii. Letter from the Cardiologist / Cardiothoracic Surgeon suggesting valve replacement with the type of valve to be used.
viii. Any other documents as may be required by Us.

10) OPEN CHEST CABG

i. Photocopy Hospital Discharge Card
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports

v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
vii. Stress test/ Tread Mill Test
viii. Letter from treating consultant suggesting Coronary Angiography and CABG
ix. Coronary Angiography report / CT Angiography Report
x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
xi. LDH / Electrolytes
xii. X-ray / 2D-Echocardiography Report
xiii. Thallium Scan Report
xiv. Any other documents as may be required by Us.

11) AORTA GRAFT SURGERY

i. Photocopy Hospital Discharge Card
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
vii. Stress test/ Tread Mill Test
viii. Letter from treating consultant suggesting Coronary Angiography and CABG
ix. Coronary Angiography report / CT Scan
x. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
xi. LDH / Electrolytes
xii. X-ray / 2D-Echocardiography Report
xiii. Thallium Scan Report
xiv. Bio-markers for Aortic dissection
xv. Any other documents as may be required by Us.

12) COMA OF SPECIFIED SEVERITY

i. Hospital Discharge Card photocopy
ii. Investigations Reports like Blood tests, EEG, etc
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment
iv. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Glasgow coma scale grading.
v. Indoor case papers and / or ICU case papers indicating the history, signs, symptoms, line of treatment and daily charts like TPR, etc
vi. FIR / MLC / Panch nama for accident induced coma
vii. Any other document as may be required by the company

13) STROKE RESULTING IN PERMANENT SYMPTOMS

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit.
vii. MRI / CT scan/ 2D Echocardiography Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
viii. Blood tests (Lipid profile/Random Blood Sugar / Prothrombin Time/APTT/ Bleeding Time/ Clotting Time/Homocystiene levels)
ix. Any other documents as may be required by Us.

14) PERMANENT PARALYSIS OF LIMBS

i. Hospital Discharge Card photocopy
ii. Investigations Reports
iii. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
iv. Electro-myogram Report
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit and the degree/current status and duration of the Paralysis.
vii. Any other document as may be required by the company

15) FIRST HEART ATTACK - OF SPECIFIED SEVERITY

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Casualty Medical Officers/Emergency room papers with all details of Presenting Complaints and the Medical Examination by the attending physician.
vi. Subsequent Consultation Papers with the treating Medical Practitioner and the treatment received
vii. ECG on admission and subsequent ECG's
viii. Stress test/ Tread Mill Test
ix. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT, LDH / Electrolytes
x. X-ray / 2D-Echocardiography Report
xi. Thallium Scan Report
xii. Any other documents as may be required by Us.

16) THIRD DEGREE (OR MAJOR) BURNS

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports, treatment papers
v. Certificate from the treating specialist Doctor indicating the classification / degree of burns
vi. Following medico-legal documents if applicable
(i) FIR
(ii) Panchanama
(iii)Inquest Panchanama
(iv)Police Final Report/Charge Sheet (Based on FIR)
vii. Any other documents as may be required by Us.

17) DEAFNESS OR LOSS OF HEARING

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Pure tone testing report
vii. Audiometry report
viii. Confirmation of Diagnosis by ENT specialist along with duration
ix. All treatment papers and medical investigation test reports
x. Any other documents as may be required by Us.

18) LOSS OF SPEECH

i. Hospital Discharge Card photocopy
ii. Photocopy Hospital Bills.
iii. Pharmacy/Investigations Bills
iv. Investigations Reports
v. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
vi. Confirmation of Diagnosis by ENT specialist along with cause and duration
vii. All treatment papers and medical investigation test reports

Any other documents as may be required by Us.

- **Claims For Pre-Hospitalisation Medical Expenses And Post-Hospitalisation Medical Expenses**

(a) All Claims for Pre-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the Insured Person's discharge from Hospital along with the following information and documentation:

(i) Duly Completed Claim Form
(ii) Investigation Payment Receipt
(iii) Original Investigation Report
(iv) Original Pharmacy Bills
(v) Original Pharmacy Prescription
(vi) Copy of Discharge Summary

(b) All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need to send Medical Expenses being incurred along with the following information and documentation:
(i) Duly Completed Claim Form
(ii) Original bills and receipts from the Hospital/Medical Practitioner;

(iii) Investigation Payment Receipt
(iv) Original Investigation Report
(v) Original Pharmacy Bills
(vi) Original Pharmacy Prescription
(vii) Copy of Discharge Summary

PART III

General Terms and Clauses

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

3. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

5. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

6. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of thirty days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

7. Cancellation

i. The Policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall -

- For 1 year Policy-
  Refund proportionate premium for unexpired policy period subject to no claim(s) were made during the policy period.

- For Multi Year Policy -
  - For any policy year where the risk date has not yet started, the premium will be refunded without any deduction.
  - For any policy year where the risk has started, the premium will be refunded on a pro-rata basis for that policy year, provided no claim has been made during the policy year and in full for future policy years.

Additional Deductions - Notwithstanding the above, if (i) the risk under the Policy has already commenced, or (ii) only a part of the insurance coverage has commenced, and the option of Policy cancellation is exercised by the Policyholder, then expenses incurred by the Company on medical examination of the Policyholder will also be deducted before refunding of premium.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

9. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy

renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of atleast 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

11. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

12. Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 15 days (where premium is paid on monthly instalments) and 30 days (where premium paid in quarterly / half yearly/ annual instalments) would be given to pay the instalment premium due for the policy.

ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

13. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

14. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

15. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

16. Redressal of Grievance

In case of any grievance the insured person may contact the company through
Website: www.zurichkotak.com

Toll free: 18002664545
E-mail: care@zurichkotak.com

Courier:
Zurich Kotak General Insurance Company (India) Limited, 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievanceofficer@zurichkotak.com
For updated details of grievance officer, kindly refer the link:
https://www.zurichkotak.com/customer-support/grievance-redressal-process
For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@zurichkotak.com

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The details of the Insurance Ombudsman is available at:
https://www.zurichkotak.com/customer-support/grievance-redressal-process
The updated details of Insurance Ombudsman offices are also available on the website of Council for Insurance Ombudsmen: www.cioins.co.in/ombudsman
The details of the Insurance Ombudsman is available at Annexure I

Grievance may also be lodged through the Bima Bharosa Portal – https://bimabharosa.irdai.gov.in

17. Claim Settlement (Provision for Penal Interest)

i. . The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of claim along with claim form (and necessary documents).

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

18. Eligibility

Self, Your legally married spouse, Your natural or adopted dependent children, Your parents, Your parents-in-law and Your siblings

Natural/ Appointed Guardian can also take insurance for minor under their guardianship.

In case of multiple Insured Person(s) covered under a Policy, the covers mentioned in Part II are applicable to all the Insured Person(s) in accordance with the premium paid and Plan opted unless specifically excluded as per the terms and conditions of the respective Cover.

19. Material Change

Material information to be disclosed to Us includes every matter that You are aware of or could reasonably be expected to know that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

20. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

21. Terms and condition of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

22. Zone Classification

Zone I: Mumbai (including Thane and Navi Mumbai) and Delhi (including NCR areas)
Zone II: Kolkata, Hyderabad, Chennai, Pune, Bangalore and Gujarat
Zone III: Rest of India excluding the locations mentioned under Zone I & Zone II

- Identification of Zone will be based on the city of the Proposer.
- A single Zone shall be applicable to all members covered under the Policy.

- You also have an option of selecting another Zone from the applicable Zones of any of the Insured Person(s) in the Policy.
- Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal.
- Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.

Co-payment

- Persons paying Zone I premium can avail treatment all over India without any Co-payment.
- Persons paying Zone II premium can avail treatment in Zone II and Zone III without any co-payment
- Persons paying Zone III premium can avail treatment in Zone III only without any co-payment

Co-payment for treatment in a Higher Zone

In case of treatment taken in a city, in a Zone higher than the eligible Zone for the Insured Person, the Co-payment percentages as below shall apply:

Applicable Zone	Treatment Taken at	Co-payment applicable
Zone II	**Zone I**	**10%**
Zone III	**Zone I**	**20%**
Zone III	**Zone II**	**10%**

23. Underwriting and Loadings

We may apply a risk loading up to a maximum of 200 % per Insured Person on the premium payable (excluding statutory levies & taxes) based on the declarations made in the proposal form and the health status of the persons proposed for insurance.

Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 200% of Premium excluding applicable Taxes.

We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent on the applicable additional premium.

In case policies are accepted with loadings, waiting period for Pre-Existing Disease Waiting Period (Section 3.1) as well as 2 Year Waiting Period (Section 3.3) shall continue to be applicable.

24. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

25. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both You and Us to be adjudicated or interpreted in accordance with Indian law and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

26. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of policy.

27. Communications & Notices

Any communication, notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address per Our records in respect of this Policy.

In Our case, at Our address specified in the Policy Schedule.

No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

28. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified in the Policy Schedule, during normal business hours or contact Our call centre.

29. ECS/ Auto Debit Payment Facility:

You are eligible for availing the ECS / Auto Debit payment facility for your premium payments under this Policy. This facility can be opted for automatic premium payment under this Policy for such premium paying term as availed by you under this Policy by submitting a duly signed ECS / Auto Debit mandate form. You may opt for any premium payment term as per your convenience but in accordance with the Policy terms and conditions. Please note that this facility may not be

available for all the Banks at present however and you are requested to kindly visit website: www.zurichkotak.com to check the updated list of all partner banks facilitating the ECS /Auto Debit facility from time to time. Additionally, the following conditions shall apply in case of ECS / Auto Debit facility opted by you –

a. The premium payment under the Policy shall be subject to change on renewal which would be in accordance with the terms and conditions of the Policy
b. The Policy shall get cancelled in the event of failure of ECS transaction towards payment of premium under the Policy and/or non-receipt of premium within the Grace Period under the Policy
c. The renewal premium amount under the Policy shall be communicated to you in advance i.e. minimum 45 days before the renewal date
d. You have the right to withdraw the ECS /Auto Debit mandate by giving Us at least 15 days' notice before the due date of next premium due under the Policy

The term ECS / Auto Debit herein shall be governed by the Electronic Clearing Service (Debit) Procedural Guidelines issued by the Reserve Bank of India (as may be amended from time to time) and shall mean an electronic facility for effecting periodic insurance premium payment transactions in an automated manner.

30. Electronic Transactions

You agree to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/confirmed by the Insured.

31. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate in the case of any Insured Person's demise during the policy period/year:
Termination of cover takes place on account of death of the insured person and pro-rata refund of premium of deceased insured person is processed for the unexpired policy period, provided no

claim has been made. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

32. Sanction Exclusion Clause

Notwithstanding any other terms under this agreement, no insurer shall be deemed to provide coverage or will make any payments or provide any service or benefit to any insured or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

Annexure I
Details of Insurance Ombudsman

Office Details	Jurisdiction of Office Union Territory, District
Ahmedabad: Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Bengaluru: Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 **Email: bimalokpal.bengaluru@cioins.co.in**	Karnataka.
Bhopal: Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 **Email: bimalokpal.bhopal@cioins.co.in**	Madhya Pradesh and Chattisgarh.
Bhubneshwar: Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 **Email: bimalokpal.bhubaneswar@cioins.co.in**	Orissa.
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Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet,	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).

CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 **Email: bimalokpal.chennai@cioins.co.in**	
Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 **Email: bimalokpal.delhi@cioins.co.in**	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
Guwahati: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
Jaipur: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan**.**
Ernakulam: Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015.Tel.: 0484 - 2358759 / 2359338 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
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Lucknow:	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot,

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Mumbai: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Patna: Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar and Jharkhand.
Pune: Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

Annexure II
List of Day Care Surgeries

Sr No	ENT		
1	Stapedotomy	23	Tympanoplasty (Type II)
2	Myringoplasty(Type I Tympanoplasty)	24	Reduction of fracture of Nasal Bone
3	Revision stapedectomy	25	Excision and destruction of lingual tonsils
4	Labyrinthectomy for severe Vertigo	26	Conchoplasty
5	Stapedectomy under GA	27	Thyroplasty Type II
6	Ossiculoplasty	28	Tracheostomy
7	Myringotomy with Grommet Insertion	29	Excision of Angioma Septum
8	Tympanoplasty (Type III)	30	Turbinoplasty
9	Stapedectomy under LA	31	Incision & Drainage of Retro Pharyngeal Abscess
10	Revision of the fenestration of the inner ear	32	Uvulo Palato Pharyngo Plasty
11	Tympanoplasty (Type IV)	33	Palatoplasty
12	Endolymphatic Sac Surgery for Meniere's Disease	34	Tonsillectomy without adenoidectomy
13	Turbinectomy	35	Adenoidectomy with Grommet insertion
14	Removal of Tympanic Drain under LA	36	Adenoidectomy without Grommet insertion
15	Endoscopic Stapedectomy	37	Vocal Cord lateralisation Procedure
16	Fenestration of the inner ear	38	Incision & Drainage of Para Pharyngeal Abscess
17	Incision and drainage of perichondritis	39	Transoral incision and drainage of a pharyngeal abscess
18	Septoplasty	40	Tonsillectomy with adenoidectomy
19	Vestibular Nerve section	41	Tracheoplasty
20	Thyroplasty Type I	42	Excision of Ranula under GA
21	Pseudocyst of the Pinna - Excision	43	Meatoplasty
22	Incision and drainage - Haematoma Auricle		
	Ophthalmology		
44	Incision of tear glands	54	Removal of Foreign body from cornea
45	Other operation on the tear ducts	55	Incision of the cornea
46	Incision of diseased eyelids	56	Other operations on the cornea

47	Excision and destruction of the diseased tissue of the eyelid	57	Operation on the canthus and epicanthus
48	Removal of foreign body from the lens of the eye	58	Removal of foreign body from the orbit and the eye ball
49	Corrective surgery of the entropion and ectropion	59	Surgery for cataract
50	Operations for pterygium	60	Treatment of retinal lesion
51	Corrective surgery of blepharoptosis	61	Removal of foreign body from the posterior chamber of the eye
52	Removal of foreign body from conjunctiva	62	glaucoma surg
53	Biopsy of tear gland		
	Oncology		
63	IV Push Chemotherapy	91	Telecobalt Therapy
64	HBI-Hemibody Radiotherapy	92	Telecesium Therapy
65	Infusional Targeted therapy	93	External mould Brachytherapy
66	SRT-Stereotactic Arc Therapy	94	Interstitial Brachytherapy
67	SC administration of Growth Factors	95	Intracavity Brachytherapy
68	Continuous Infusional Chemotherapy	96	3D Brachytherapy
69	Infusional Chemotherapy	97	Implant Brachytherapy
70	CCRT-Concurrent Chemo + RT	98	Intravesical Brachytherapy
71	2D Radiotherapy	99	Adjuvant Radiotherapy
72	3D Conformal Radiotherapy	100	Afterloading Catheter Brachytherapy
73	IGRT- Image Guided Radiotherapy	101	Conditioning Radiothearpy for BMT
74	IMRT- Step & Shoot	102	Extracorporeal Irradiation to the Homologous Bone grafts
75	Infusional Bisphosphonates	103	Radical chemotherapy
76	IMRT- DMLC	104	Neoadjuvant radiotherapy
77	Rotational Arc Therapy	105	LDR Brachytherapy
78	Tele gamma therapy	106	Palliative Radiotherapy
79	FSRT-Fractionated SRT	107	Radical Radiotherapy
80	VMAT-Volumetric Modulated Arc Therapy	108	Palliative chemotherapy
81	SBRT-Stereotactic Body Radiotherapy	109	Template Brachytherapy
82	Helical Tomotherapy	110	Neoadjuvant chemotherapy
83	SRS-Stereotactic Radiosurgery	111	Adjuvant chemotherapy
84	X-Knife SRS	112	Induction chemotherapy
85	Gammaknife SRS	113	Consolidation chemotherapy
86	TBI- Total Body Radiotherapy	114	Maintenance chemotherapy

87	intraluminal Brachytherapy	115	HDR Brachytherapy
88	Electron Therapy	116	Mediastinal lymph node biopsy
89	TSET-Total Electron Skin Therapy	117	High Orchidectomy for testis tumours
90	Extracorporeal Irradiation of Blood Products		
	Plastic Surgery		
118	Construction skin pedicle flap	125	Fibro myocutaneous flap
119	Gluteal pressure ulcer-Excision	126	Breast reconstruction surgery after mastectomy
120	Muscle-skin graft, leg	127	Sling operation for facial palsy
121	Removal of bone for graft	128	Split Skin Grafting under RA
122	Muscle-skin graft duct fistula	129	Wolfe skin graft
123	Removal cartilage graft	130	Plastic surgery to the floor of the mouth under GA
124	Myocutaneous flap		
	Urology		
131	AV fistula - wrist	149	Ureter endoscopy and treatment
132	URSL with stenting	150	Vesico ureteric reflux correction
133	URSL with lithotripsy	151	Surgery for pelvi ureteric junction obstruction
134	Cystoscopic Litholapaxy	152	Anderson hynes operation
135	ESWL	153	Kidney endoscopy and biopsy
136	Haemodialysis	154	Paraphimosis surgery
137	Bladder Neck Incision	155	injury prepuce- circumcision
138	Cystoscopy & Biopsy	156	Frenular tear repair
139	Cystoscopy and removal of polyp	157	Meatotomy for meatal stenosis
140	Suprapubic cystostomy	158	surgery for fournier's gangrene scrotum
141	percutaneous nephrostomy	159	surgery filarial scrotum
142	Cystoscopy and "SLING" procedure	160	surgery for watering can perineum
143	TUNA- prostate	161	Repair of penile torsion
144	Excision of urethral diverticulum	162	Drainage of prostate abscess
145	Removal of urethral Stone	163	Orchiectomy
146	Excision of urethral prolapse	164	Cystoscopy and removal of FB
147	Mega-ureter reconstruction	165	Surgery for SUI
148	Kidney renoscopy and biopsy	166	URS + LL
	Neurology		
167	Facial nerve physiotherapy	174	Stereotactic Radiosurgery
168	Nerve biopsy	175	Percutaneous Cordotomy

169	Muscle biopsy	176	Intrathecal Baclofen therapy
170	Epidural steroid injection	177	Entrapment neuropathy Release
171	Glycerol rhizotomy	178	Diagnostic cerebral angiography
172	Spinal cord stimulation	179	VP shunt
173	Motor cortex stimulation	180	Ventriculoatrial shunt
	Thoracic surgery		
181	Thoracoscopy and Lung Biopsy	185	Thoracoscopy and pleural biopsy
182	Excision of cervical sympathetic Chain Thoracoscopic	186	EBUS + Biopsy
183	Laser Ablation of Barrett's oesophagus	187	Thoracoscopy ligation thoracic duct
184	Pleurodesis	188	Thoracoscopy assisted empyaema drainage
	Gastroenterology		
189	Pancreatic pseudocyst EUS & drainage	199	Colonscopy stenting of stricture
190	RF ablation for barrett's Oesophagus	200	Percutaneous Endoscopic Gastrostomy
191	ERCP and papillotomy	201	EUS and pancreatic pseudo cyst drainage
192	Esophagoscope and sclerosant injection	202	ERCP and choledochoscopy
193	EUS + submucosal resection	203	Proctosigmoidoscopy volvulus detorsion
194	Construction of gastrostomy tube	204	ERCP and sphincterotomy
195	EUS + aspiration pancreatic cyst	205	Esophageal stent placement
196	Small bowel endoscopy (therapeutic)	206	ERCP + placement of biliary stents
197	Colonoscopy ,lesion removal	207	Sigmoidoscopy w / stent
198	ERCP	208	EUS + coeliac node biopsy
	General Surgery		
209	infected keloid excision	251	Pancreatic Pseudocysts Endoscopic Drainage
210	Incision of a pilonidal sinus / abscess	252	ZADEK's Nail bed excision
211	Axillary lymphadenectomy	253	Subcutaneous mastectomy
212	Wound debridement and Cover	254	Rigid Oesophagoscopy for dilation of benign Strictures
213	Abscess-Decompression	255	Eversion of Sac a) Unilateral b)Bilateral
214	Cervical lymphadenectomy	256	Lord's plication
215	infected sebaceous cyst	257	Jaboulay's Procedure
216	Inguinal lymphadenectomy	258	Scrotoplasty
217	Incision and drainage of Abscess	259	Surgical treatment of varicocele
218	Suturing of lacerations	260	Epididymectomy
219	Scalp Suturing	261	Circumcision for Trauma

220	infected lipoma excision	262	Intersphincteric abscess incision and drainage
221	Maximal anal dilatation	263	Psoas Abscess Incision and Drainage
222	Piles A) Injection Sclerotherapy B) Piles banding	264	Thyroid abscess Incision and Drainage
223	liver Abscess- catheter drainage	265	TIPS procedure for portal hypertension
224	Fissure in Ano- fissurectomy	266	Esophageal Growth stent
225	Fibroadenoma breast excision	267	PAIR Procedure of Hydatid Cyst liver
226	Oesophageal varices Sclerotherapy	268	Tru cut liver biopsy
227	ERCP - pancreatic duct stone removal	269	Photodynamic therapy or esophageal tumour and Lung tumour
228	Perianal abscess I&D	270	Excision of Cervical RIB
229	Perianal hematoma Evacuation	271	laparoscopic reduction of intussusception
230	Fissure in ano sphincterotomy	272	Microdochectomy breast
231	UGI scopy and Polypectomy oesophagus	273	Surgery for fracture Penis
232	Breast abscess I& D	274	Sentinel node biopsy
233	Feeding Gastrostomy	275	Parastomal hernia
234	Oesophagoscopy and biopsy of growth oesophagus	276	Revision colostomy
235	UGI scopy and injection of adrenaline, sclerosants - bleeding ulcers	277	Prolapsed colostomy- Correction
236	ERCP - Bile duct stone removal	278	Testicular biopsy
237	Ileostomy closure	279	laparoscopic cardiomyotomy(Hellers)
238	Colonoscopy	280	Sentinel node biopsy malignant melanoma
239	Polypectomy colon	281	laparoscopic pyloromyotomy(Ramstedt)
240	Splenic abscesses Laparoscopic Drainage	282	Keratosis removal under GA
241	UGI SCOPY and Polypectomy stomach	283	Excision Sigmoid Polyp
242	Rigid Oesophagoscopy for FB removal	284	Rectal-Myomectomy
243	Feeding Jejunostomy	285	Rectal prolapse (Delorme's procedure)
244	Colostomy	286	Orchidopexy for undescended testis
245	Ileostomy	287	Detorsion of torsion Testis
246	colostomy closure	288	lap.Abdominal exploration in cryptorchidism
247	Submandibular salivary duct stone removal	289	EUA + biopsy multiple fistula in ano
248	Pneumatic reduction of intussusception	290	Excision of fistula-in-ano
249	Varicose veins legs - Injection sclerotherapy	291	TURBT

250	Rigid Oesophagoscopy for Plummer vinson syndrome		
	Orthopedics		
292	Arthroscopic Repair of ACL tear knee	323	Partial removal of metatarsal
293	Closed reduction of minor Fractures	324	Partial removal of metatarsal
294	Arthroscopic repair of PCL tear knee	325	Revision/Removal of Knee cap
295	Tendon shortening	326	Amputation follow-up surgery
296	Arthroscopic Meniscectomy - Knee	327	Exploration of ankle joint
297	Treatment of clavicle dislocation	328	Remove/graft leg bone lesion
298	Arthroscopic meniscus repair	329	Repair/graft achilles tendon
299	Haemarthrosis knee- lavage	330	Remove of tissue expander
300	Abscess knee joint drainage	331	Biopsy elbow joint lining
301	Carpal tunnel release	332	Removal of wrist prosthesis
302	Closed reduction of minor dislocation	333	Biopsy finger joint lining
303	Repair of knee cap tendon	334	Tendon lengthening
304	ORIF with K wire fixation- small bones	335	Treatment of shoulder dislocation
305	Release of midfoot joint	336	Lengthening of hand tendon
306	ORIF with plating- Small long bones	337	Removal of elbow bursa
307	Implant removal minor	338	Fixation of knee joint
308	K wire removal	339	Treatment of foot dislocation
309	POP application	340	Surgery of bunion
310	Closed reduction and external fixation	341	intra articular steroid injection
311	Arthrotomy Hip joint	342	Tendon transfer procedure
312	Syme's amputation	343	Removal of knee cap bursa
313	Arthroplasty	344	Treatment of fracture of ulna
314	Partial removal of rib	345	Treatment of scapula fracture
315	Treatment of sesamoid bone fracture	346	Removal of tumor of arm/ elbow under RA/GA
316	Shoulder arthroscopy / surgery	347	Repair of ruptured tendon
317	Elbow arthroscopy	348	Decompress forearm space
318	Amputation of metacarpal bone	349	Revision of neck muscle (Torticollis release)
319	Release of thumb contracture	350	Lengthening of thigh tendons
320	Incision of foot fascia	351	Treatment fracture of radius & ulna
321	calcaneum spur hydrocort injection	352	Repair of knee joint
322	Ganglion wrist hyalase injection		
	Paediatric surgery		
353	Excision Juvenile polyps rectum	358	Sternomastoid Tenotomy

354	Vaginoplasty	359	Infantile Hypertrophic Pyloric Stenosis pyloromyotomy
355	Dilatation of accidental caustic stricture oesophagea	360	Excision of soft tissue rhabdomyosarcoma
356	Presacral Teratomas Excision	361	Excision of cervical teratoma
357	Removal of vesical stone	362	Cystic hygroma - Injection treatment
	Gynaecology		
363	Hysteroscopic removal of myoma	379	uterine artery embolization
364	D&C	380	Bartholin Cyst excision
365	Hysteroscopic resection of septum	381	Laparoscopic cystectomy
366	thermal Cauterisation of Cervix	382	Hymenectomy(imperforate Hymen)
367	MIRENA insertion	383	Endometrial ablation
368	Hysteroscopic adhesiolysis	384	vaginal wall cyst excision
369	LEEP	385	Vulval cyst Excision
370	Cryocauterisation of Cervix	386	Laparoscopic paratubal cyst excision
371	Polypectomy Endometrium	387	Repair of vagina (vaginal atresia)
372	Hysteroscopic resection of fibroid	388	Hysteroscopy, removal of myoma
373	LLETZ	389	Ureterocoele repair - congenital internal
374	Conization	390	Vaginal mesh For POP
375	polypectomy cervix	391	Laparoscopic Myomectomy
376	Hysteroscopic resection of endometrial polyp	392	Repair recto- vagina fistula
377	Vulval wart excision	393	Pelvic floor repair(excluding Fistula repair)
378	Laparoscopic paraovarian cyst excision	394	Laparoscopic oophorectomy
	Critical care		
395	Insert non- tunnel CV cath	398	Insertion catheter, intra anterior
396	Insert PICC cath (peripherally inserted central catheter)	399	Insertion of Portacath
397	Replace PICC cath (peripherally inserted central catheter		
	Dental		
400	Splinting of avulsed teeth	403	Oral biopsy in case of abnormal tissue presentation
401	Suturing lacerated lip	404	FNAC
402	Suturing oral mucosa	405	Smear from oral cavity

Annexure III

List I - List of non-medical expenses

Sr. No.	Items	Remarks
1	Baby Food	Not Payable
2	Baby Utilities Charges	Not Payable
3	Beauty Services	Not Payable
4	Belts/ Braces	Payable for cases who have undergone surgery of Thoracic or Lumbar Spine.
5	Buds	Not Payable
6	Cold Pack/Hot Pack	Not Payable
7	Carry Bags	Not Payable
8	Email / Internet Charges	Not Payable
9	Food Charges (other than Patient's Diet Provided by Hospital)	Not Payable
10	Leggings	Payable in case of Bariatric and Varicose Vein Surgery
11	Laundry Charges	Not Payable
12	Mineral Water	Not Payable
13	Sanitary Pad	Not Payable
14	Telephone Charges	Not Payable
15	Guest Services	Not Payable
16	Crepe Bandage	Not Payable
17	Diaper Of Any Type	Not Payable
18	Eyelet Collar	Not Payable
19	Slings	Not Payable
20	Blood Grouping and Cross Matching of Donors Samples	Not Payable
21	Service Charges Where Nursing Charge Also Charged	Post Hospitalization Nursing Charges Not Payable
22	Television Charges	Not Payable
23	Surcharges	Not Payable
24	Attendant Charges	Not Payable
25	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)	Not Payable
26	Birth Certificate	Not Payable
27	Certificate Charges	Not Payable
28	Courier Charges	Not Payable

29	Conveyance Charges	Not Payable
30	Medical Certificate	Not Payable
31	Medical Records	Not Payable
32	Photocopies Charges	Not Payable
33	Mortuary Charges	Payable Up to 24 Hrs, Shifting Charges Not Payable
34	Walking Aids Charges	Not Payable
35	Oxygen Cylinder (For Usage Outside The Hospital)	Not Payable
36	Spacer	Not Payable
37	Spirometre	Not Payable
38	Nebulizer Kit	Not Payable
39	Steam Inhaler	Not Payable
40	Armsling	Not Payable
41	Thermometer	Not Payable
42	Cervical Collar	Not Payable
43	Splint	Not Payable
44	Diabetic Foot Wear	Not Payable
45	Knee Braces (Long/ Short/ Hinged)	Not Payable
46	Knee Immobilizer/Shoulder Immobilizer	Not Payable
47	Lumbo Sacral Belt	Payable for cases who have undergone Surgery of Lumbar Spine
48	Nimbus Bed Or Water Or Air Bed Charges	Not Payable
49	Ambulance Collar	Not Payable
50	Ambulance Equipment	Not Payable
51	Abdominal Binder	Payable in case of post-surgery patients of Major Abdominal Surgery Including TAH, LSCS, Incisional Hernia Repair, Exploratory Laparotomy for Intestinal Obstruction, Liver Transplant Etc
52	Private Nurses Charges-Special Nursing Charges	Not Payable
53	Sugar Free Tablets	Not Payable
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)	Not Payable
55	ECG Electrodes	Not Payable
56	Gloves	Sterilized Gloves Payable / Unsterilized Gloves not payable
57	Nebulisation Kit	Not Payable

58	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]	Not Payable
59	Kidney Tray	Not Payable
60	Mask	Not Payable
61	Ounce Glass	Not Payable
62	Oxygen Mask	Not Payable
63	Pelvic Traction Belt	Payable in case of PIVD requiring traction
64	Pan Can	Not Payable
65	Trolly Cover	Not Payable
66	Urometer, Urine Jug	Not Payable
67	Ambulance	Payable - Ambulance from home to Hospital or inter-hospital shifts is Payable/ RTA - As Specific Requirement for critical injury is Payable
68	Vasofix Safety	Not Payable

List II – Items that are to be subsumed into Room Charges

Sr No	Item
1	Baby Charges (Unless Specified/Indicated)
2	Hand Wash
3	Shoe Cover
4	Caps
5	Cradle Charges
6	Comb
7	Eau-De-Cologne / Room Freshners
8	Foot Cover
9	Gown
10	Slippers
11	Tissue Paper
12	Tooth Paste
13	Tooth Brush
14	Bed Pan
15	Face Mask
16	Flexi Mask
17	Hand Holder
18	Sputum Cup
19	Disinfectant Lotions
20	Luxury Tax
21	Hvac
22	House Keeping Charges

23	Air Conditioner Charges
24	Im Iv Injection Charges
25	Clean Sheet
26	Blanket/Warmer Blanket
27	Admission Kit
28	Diabetic Chart Charges
29	Documentation Charges / Administrative Expenses
30	Discharge Procedure Charges
31	Daily Chart Charges
32	Entrance Pass / Visitors Pass Charges
33	Expenses Related To Prescription On Discharge
34	File Opening Charges
35	Incidental Expenses / Misc. Charges (Not Explained)
36	Patient Identification Band / Name Tag
37	Pulseoxymeter Charges

List III – Items that are to be subsumed into Procedure Charges

Sr No.	Item
1	Hair Removal Cream
2	Disposables Razors Charges (For Site Preparations)
3	Eye Pad
4	Eye Sheild
5	Camera Cover
6	Dvd, Cd Charges
7	Gause Soft
8	Gauze
9	Ward And Theatre Booking Charges
10	Arthroscopy And Endoscopy Instruments
11	Microscope Cover
12	Surgical Blades, Harmonicscalpel,Shaver
13	Surgical Drill
14	Eye Kit
15	Eye Drape
16	X-Ray Film
17	Boyles Apparatus Charges
18	Cotton
19	Cotton Bandage
20	Surgical Tape
21	Apron
22	Torniquet

23	Orthobundle, Gynaec Bundle

List IV – Items that are to be subsumed into costs of treatment

Sr No.	Item
1	Admission/Registration Charges
2	Hospitalisation For Evaluation/ Diagnostic Purpose
3	Urine Container
4	Blood Reservation Charges And Ante Natal Booking Charges
5	Bipap Machine
6	Cpap/ Capd Equipments
7	Infusion Pump– Cost
8	Hydrogen Peroxide\Spirit\ Disinfectants Etc
9	Nutrition Planning Charges - Dietician Charges- Diet Charges
10	Hiv Kit
11	Antiseptic Mouthwash
12	Lozenges
13	Mouth Paint
14	Vaccination Charges
15	Alcohol Swabes
16	Scrub Solution/ Sterillium
17	Glucometer& Strips
18	Urine Bag

Annexure IV

List of Critical Illness

1) Cancer Of Specified Severity

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

2) Kidney Failure Requiring Regular Dialysis

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

3) Multiple Sclerosis With Persisting Symptoms

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Neurological damage due to SLE is excluded.

4) Motor Neurone Disease With Permanent Symptoms

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

5) Benign Brain Tumor

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are **excluded**:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

6) Primary (Idiopathic) Pulmonary Hypertension

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort.
Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

7) End Stage Liver Failure

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
- i. Permanent jaundice; and
- ii. Ascites; and
- iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

8) Major Organ /Bone Marrow Transplant

I. The actual undergoing of a transplant of:
- i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:
- i. Other stem-cell transplants
- ii. Where only islets of langerhans are transplanted

9) Open Heart Replacement Or Repair Of Heart Valves

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

10) Open Chest CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:
- i. Angioplasty and/or any other intra-arterial procedures

11) Coma Of Specified Severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

12) Stroke Resulting In Permanent Symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

13) Permanent Paralysis Of Limbs

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

14) Myocardial Infarction (First Heart Attack Of Specified Severity)

I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure

15) Third Degree Burns

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

16) Deafness

I. Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

17) Loss Of Speech

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

18) Aorta Graft Surgery

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

(i) The following conditions are excluded:
a. Surgery performed using only minimally invasive or intra-arterial techniques.
b. Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

(ii) The diagnosis to be evidenced by any two of the following:
a. Computerized tomography (CT) scan
b. Magnetic Resonance Imaging (MRI) scan
c. Echocardigraphy (an ultrasound of the heart)
d. Angiography (Injecting X ray dye)
e. Abdominal ultrasound

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