GROUP SMART HEALTH – MICRO INSURANCE

PROSPECTUS

Introduction

Group Smart Health – Micro Insurance is a comprehensive group insurance policy which can be customised as per the requirements of the group. The policy consists of various sections which can be taken as per the group requirements.

Key Sections & Benefits

- Personal Accident Benefit
- Animal, Insect and Reptile Attack Benefit
- Specific Vector Borne Disease Benefit
- Specific Communicable Disease Benefit
- Hospital Daily Cash Benefit
- Critical Illness Benefit

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

The Benefits available under this Policy are described below. The customer may opt for any one or more of the Benefits under one or more Sections. Optional Benefits may be opted only if atleast one of the Basic Benefits have been opted. The Policy Schedule/ Certificate of Insurance will specify which of the following Benefits are applicable and in force for the Insured Person. Benefits will be payable subject to the terms, conditions and exclusions of this Policy and the respective Sections and subject to Sum Insured/ Sub-limits/ Deductible/ Franchise/ Co-payment, if any and applicability specified in respect of that Benefit in the Policy Schedule/ Certificate of Insurance.

SECTION A – PERSONAL ACCIDENT BENEFIT

I. BASIC BENEFITS

Benefit 1: Accidental Death Benefit

We will pay the Sum Insured as specified against this Benefit in Policy Schedule/ Certificate of Insurance, if the Insured Person dies solely and directly due to an Injury sustained in an Accident which occurs during the Period of Cover. 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.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 2: Permanent Total Disablement (PTD) Benefit

We will pay the Sum Insured as specified against this Benefit in Policy Schedule/ Certificate of Insurance, if the Insured Person suffers Permanent Total Disablement of the nature specified below, solely and directly due to an Accident which occurs during the Period of Cover. Provided that,

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- The Permanent Total Disablement occurs within 12 months from the date of that Accident.
- The 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.

Sr. No	Nature of the Permanent Total Disablement
1	Loss of use of both eyes; OR
2	Loss of use of / physical separation of two entire hands; OR
3	Loss of use of / physical separation of two entire feet; OR
4	Loss of use of / physical separation of two entire hands and two entire feet; OR
5	Loss of use of one eye AND Loss of use of / physical separation of one entire hand; OR
6	Loss of use of one eye AND Loss of use of / physical separation of one entire foot; OR
7	Loss of use of two hands; OR
8	Loss of use of two feet; OR
9	Loss of use of one hand and Loss of use of one foot; OR
10	Loss of use of one eye AND Loss of use of one hand; OR
11	Loss of use of one eye AND Loss of use of one foot;

We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit and under Benefit 2 under Section B in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 3: Permanent Partial Disablement (PPD) Benefit

We will pay the percentage of the Sum Insured as specified against this Benefit in Policy Schedule/ Certificate of Insurance, if the Insured Person suffers Permanent Partial Disablement of the nature specified below, solely and directly due to an Accident which occurs during the Period of Cover. Provided that,

- The Permanent Partial Disablement occurs within 12 months of the date of that Accident.

The maximum amount payable in respect of multiple nature of disablement (more than 100%) would be restricted to Sum Insured opted by the Insured for this Benefit as mentioned in the Policy Schedule/ Certificate of Insurance.

Sr. No.	Nature of the Permanent Partial Disablement	% of Sum Insured payable
1	**Loss of Use / Physical Separation -**	
	one entire hand	50
	One entire foot	50
	Loss of Use of one eye	50
	Loss of toes – all	20
	Great both phalanges	5
	Great – one phalanx	2
	Other than great if more than one toe lost each	1
2	Loss of Use of both ears	50

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3	Loss of Use of one ear	20
4	Loss of four fingers and thumb of one hand	40
5	Loss of four fingers	35
6	**Loss of thumb -**	
	Both phalanges	25
	One phalanx	10
7	**Loss of Index finger -**	
	Three phalanges	10
	Two phalanges	8
	One phalanx	4
8	**Loss of middle finger -**	
	Three phalanges	6
	Two phalanges	4
	One phalanx	2
9	**Loss of ring finger -**	
	Three phalanges	5
	Two phalanges	4
	One phalanx	2
10	**Loss of little finger -**	
	Three phalanges	4
	Two phalanges	3
	One phalanx	2
11	**Loss of metacarpus -**	
	First or second (additional)	3
	Third, fourth or fifth (additional)	2

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 4: Temporary Total Disablement (TTD) Benefit

If the Insured Person sustains an Injury in an Accident which occurs during the Period of Cover and which completely incapacitates the Insured Person from engaging in any employment or occupation of any description whatsoever which the Insured Person was capable of performing at the time of that Accident, We will pay the weekly benefit specified in the Policy Schedule/ Certificate of Insurance for each week or part thereof for which the Temporary Total Disablement continues. Provided that,

- We will not make payment for more than the number of weeks as specified in the Policy Schedule/ Certificate of Insurance.
- The Temporary Total Disablement is certified in writing by a Medical Practitioner to have commenced within 30 days from the date of that Accident.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 5: Common Carrier Accident Benefit (Accidental Death)

In case of the death of the Insured Person due to an Accident which occurs during the Period of Cover while travelling in a Common Carrier as specified in the Policy Schedule/ Certificate of Insurance, then we will pay the amount as specified against this Benefit in Policy Schedule/ Certificate of Insurance, provided that the Insured Person's death in accordance with Benefit 1 of Section A occurs within 12 months from the date of that Accident.

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This cover will be in addition to the Sum Insured mentioned for Section A (Benefit 1) Accidental Death Benefit.

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

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 6: Common Carrier Accident Benefit (PTD)

In case of the Permanent Total Disablement of the Insured Person due to an Accident which occurs during the Period of Cover while travelling in a Common Carrier as specified in the Policy Schedule/ Certificate of Insurance, then we will pay the amount as specified against this Benefit in Policy Schedule/ Certificate of Insurance, provided that the Insured Person's Permanent Total Disablement in accordance with Benefit 2 of Section A occurs within 12 months from the date of that Accident.

This cover will be in addition to the Sum Insured mentioned for Section A (Benefit 2) Permanent Total Disablement (PTD) Benefit.

We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 7: Accidental Hospitalisation (Inpatient)

If an Insured Person suffers an Injury due to an Accident during the Period of Cover that requires Inpatient Hospitalisation then, We shall reimburse the amount up to the limit specified against this benefit in the Policy Schedule/ Certificate of Insurance, towards the Medical Expenses incurred in respect of a medical treatment or Surgery for the Injury sustained, provided that:

- the Hospitalisation is for a minimum and continuous period of 24 hours
- the Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
- the Medical Expenses incurred are Reasonable and Customary Charges;

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.

Benefit 8: Burns Benefit

We will pay the amount specified in the table below to the Insured Person up to the limit specified in the Policy Schedule / Certificate of Insurance if an Insured Person sustains burns directly due to an Accident that occurs during the Period of Cover which results in conditions specified in the table below, provided that:

- The burns are not self-inflicted by the Insured Person in any way; and

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- A Medical Practitioner has confirmed the diagnosis of the burn and the percentage of the surface area of the burn to Us in writing.
- If the bodily injury results in more than one of the nature of burns specified below, We shall be liable to pay for only the highest benefit among all.

Maximum amount payable in respect of multiple nature of disablement (more than 100%) would be restricted to Sum Insured opted by the Insured for this Benefit as mentioned in the Policy Schedule / Certificate of Insurance.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Nature of Burns	**Percentage of Sum Insured payable**
1. Head	
a. Third degree burns of 8% or more of the total head surface area	100%
b. Second degree burns of 8% or more of the total head surface area	50%
c. Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
d. Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
e. Third degree burns of 2% or more, but less than 5% of the total head surface area	60%
f. Second degree burns of 2% or more, but less than 5% of the total head surface area	30%
2. Rest of the body	
a. Third degree burns of 20% or more of the total body surface area	100%
b. Second degree burns of 20% or more of the total body surface area	50%
c. Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
d. Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
e. Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
f. Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
g. Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
h. Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

Benefit 9: Broken Bones Benefit

We will pay the amount as per percentage mentioned below in table of the Sum Insured as specified in the Policy Schedule / Certificate of Insurance if an Insured Person sustains fracture directly due to an Accident that occurs during the Period of Cover and which results in conditions specified in the table below:

Sr. No.	**Particulars**	**Percentage of Sum Insured payable**
1	Fractures of the Skull:	

	a) Compound fracture with damage to the brain tissue	100%
	b) Compound fracture without damage to the brain tissue	75%
	c) All other fractures	50%
2	Fractures of hip or pelvis (excluding thigh or coccyx):	
	a) Multiple fractures (at least one compound & one complete)	100%
	b) All other compound fractures	50%
	c) Multiple fractures, at least one complete	30%
	d) All other fractures	20%
3	Fracture of thigh or heel:	
	a) Multiple fractures (at least one compound & one complete)	50%
	b) All other compound fractures	40%
	c) Multiple fractures, at least one complete	30%
	d) All other fractures	20%
4	Fracture of Lower Leg, Clavicle, Ankle, Elbow, Upper or Lower Arm (including wrist, but excluding Colles-type fracture):	
	a) Multiple fractures (at least one compound & one complete)	40%
	b) All other compound fractures	30%
	c) Multiple fractures, at least one complete	20%
	d) All other fractures	12%
5	Fractures of Lower Jaw:	
	a) Multiple fractures (at least one compound & one complete)	30%
	b) All other compound fractures	20%
	c) Multiple fractures, at least one complete	16%
	d) All other fractures	8%
6	Fractures of Shoulder Blade, Kneecap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes and heel):	
	a) All compound fractures	20%
	b) All other fractures	10%
7	Colles type fracture to the Lower Arm:	
	a) Compound	20%
	b) Other	10%
8	Fractures of Spinal Column (Vertebrae but excluding coccyx):	
	a) All compression fractures	50%
	b) All spinous, transverse process or pedicle fractures	30%
	c) All other vertebral fractures	20%
9	Fractures of Rib or Ribs, Cheekbone, Coccyx, Upper Jaw, Nose, Toe and toes, finger or fingers:	
	a) Multiple fractures (at least one compound & one complete)	16%
	b) All other compound fractures	12%
	c) Multiple fractures, at least one complete	8%
	d) All other fractures	4%

The Benefit specified above will be payable provided that:

- Any Fracture which results due to any Illness or disease (including malignancy) or due to osteoporosis shall not be payable under this benefit;
- If an Insured Person suffers a Fracture not specified in the table above but the Fracture is due to an Injury that is suffered during the Period of Cover solely and directly due to an Accident that occurs during the Period of Cover, then Our medical advisors will determine the amount payable, if any

Maximum amount payable in respect of multiple nature of fracture (more than 100%) would be restricted to Sum Insured opted by the Insured for this Benefit as mentioned in the Policy Schedule / Certificate of Insurance.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 10: Convalescence Benefit (due to Accident)

We will pay the Sum Insured specified in the Policy Schedule/Certificate of Insurance for this Benefit if the Insured Person is admitted in a Hospital due to an Accident during the Period of Cover for a minimum period as specified in the Policy Schedule/ Certificate of Insurance.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

II. OPTIONAL BENEFITS

Benefit 11: Carriage of Dead Body

If We have admitted a Claim for Accidental Death in accordance with Benefit 1/ Benefit 5 of Section A, We will pay the amount as specified in the Policy Schedule/ Certificate of Insurance for this cover for transporting the Insured Person's body from the place of death to the place of residence.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 12: Funeral Expenses

In case of the unfortunate death of the Insured Person due to an Accident in accordance with Benefit 1/ Benefit 5 of Section A, We will pay the amount as specified in the Policy Schedule/ Certificate of Insurance for the funeral expenses of the Insured Person.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 13: Accidental Medical Expenses Extension

If we have admitted a Claim for Accidental Death or Permanent Total Disablement or Permanent Partial Disablement or Temporary Total Disablement in accordance with Benefit 1, 2, 3, 4, 5, 6, 8 or 9 of Section A as opted, then We will in addition reimburse the Medical Expenses incurred by the Insured Person provided that such treatment is following the Accident.

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This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 14: Purchase of Blood

If we have admitted a Claim following an Injury the Insured Person suffers due to an Accident during the Period of Cover, We will in addition reimburse the actual expenses upto the limit specified in the Policy Schedule/ Certificate of Insurance incurred in purchasing blood through a Hospital or blood bank for the purpose of the Insured Person's medical or surgical treatment provided that such treatment is following the Accident.

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.

Benefit 15: Transportation of imported medicine

If we have admitted a Claim following an Injury the Insured Person suffers due to an Accident during the Period of Cover, We will in addition reimburse the actual expenses upto the limit specified in the Policy Schedule/ Certificate of Insurance incurred on freight charges for importing medicines to India, provided that:

- Such medicines, formulations or their alternatives are not available in India, and
- Such medicines are necessary for the medical or surgical treatment of the Insured Person in a Hospital following the Accident and is prescribed by the treating Medical Practitioner.
- Such medicines shall not include any drugs under clinical trial or medicines, formulations or molecules of unproven efficacy.

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.

Benefit 16: Modification of Residence / Vehicle

If We have admitted a Claim for Permanent Total Disablement or Permanent Partial Disablement in accordance with Benefit 2 or 3 or 6 of Section A, then We will reimburse the expenses incurred up to the limit specified against this cover in the Policy Schedule/ Certificate of Insurance to allow for improvements to be carried out in the Insured Person's residence and/ or vehicle which are certified in writing by a Medical Practitioner to be necessary and following the Accident.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 17: Cost of Support Items

If We have admitted a Claim for Permanent Total Disablement or Permanent Partial Disablement in accordance with Benefit 2 or Benefit 3 or Benefit 6 of Section A, then We will reimburse the amount up to the limit specified in the Policy Schedule / Certificate of Insurance towards:
Reasonable and Customary Charges for the purchase of support items such as artificial limbs, crutches, stretcher, tricycle, wheelchairs, intra-ocular lenses, spectacles or any other item which in the opinion of a Medical Practitioner is/ are necessary for the Insured Person or are necessitated by a Medical Practitioner following an Injury sustained in the Accident.

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.

Benefit 18: Children Education Grant

If We have admitted a Claim for Accidental Death or Permanent Total Disablement in accordance with Benefit 1, 2, 5 or 6 of Section A, then We will pay the amount as specified against this Benefit in Policy Schedule/ Certificate of Insurance, in respect of Insured Person's dependent child under the Age of 25 and unmarried as on the date of Accident towards the Dependent child's education, irrespective of whether the child (children) is an Insured Person under this Policy.
Provided that,

- The dependent child is pursuing an educational course as a full time student at an educational institution and not have any independent source of income.
- Irrespective of the number of Children, maximum amount payable is the Sum Insured as mentioned in the Policy Schedule / Certificate of Insurance.
- Any Claim towards this cover that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal guardian.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 19: Marriage expenses for Children

If We have admitted a Claim for Accidental Death or Permanent Total Disablement in accordance with Benefit 1, 2, 5 or 6 of Section A, then We will pay the amount as specified against this Benefit in Policy Schedule/ Certificate of Insurance, in respect of the Insured Person's Dependent child under the age of 25 and unmarried as on the date of Accident, irrespective of whether the Child is an Insured Person under this Policy.

- Irrespective of the number of Children, maximum amount payable is the Sum Insured as mentioned in the Policy Schedule/ Certificate of Insurance.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 20: Widowhood Cover

If an Insured Person's Spouse suffers an Accident during the Period of Cover and this is the sole and direct cause of the Spouse's death within 12 months from the date of that Accident, then We will pay the amount as specified in the Policy Schedule/ Certificate of Insurance.
Provided that, We will not make any payment for any Claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy:

- Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).
- Medical or surgical treatment except as necessary being solely and directly a result of an Accident.
- Actual or alleged dowry harassment.
- Actual or attempted self-immolation.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 21: Ambulance Charges (Accidental Hospitalisation)

If we have admitted a Claim under this Policy, then We will reimburse the Reasonable and Customary Charges incurred up to the limit specified in the Policy Schedule/ Certificate of Insurance for this Extension towards transportation of the Insured Person by a healthcare or Ambulance service provider to a Hospital for treatment of an Injury following an Accident.

Provided that:

- The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;
- 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.
- The limit under Ambulance cover is applicable for each claim admitted under the policy.

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.

Benefit 22: Accidental Pre & Post Hospitalization Expenses Benefit

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses following an Injury/ Accident that occurs during the Period of Cover provided that:

(a) We have admitted a Claim for Benefit 7: Accidental Hospitalisation (Inpatient) 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.

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.

Benefit 23: Domestic travel for medical treatment due to accident

If an Insured Person, suffering Injury due to an Accident during the Period of Cover, is travelling 50 kms or more from his/ her residential address to a nearby place as necessitated by treating Medical Practitioner for undergoing an Inpatient treatment which is not possible in the Insured person's current place of residence, then We will reimburse the amount up to the limit specified in the Policy Schedule/ Certificate of Insurance.
Provided that

- Transportation is under medical supervision in respect of the Insured Person and the Insured Person is medically cleared, by the treating Medical Practitioner, for travel, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.
- 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 adequate treatment facilities at the existing Hospital.

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.

Benefit 24: On Duty Cover

If we have admitted claim under this Section, then Benefits/ covers under this Section will be restricted to,

- Any event occurred in office or during official visit, training, seminars, conference etc and such Injuries should be arising out of and in the course of employment during the official working hours including travelling to and from office, training, seminars and conference, etc.
- Any event occurred in educational institutions, during attending class, in school/ college premises etc, and including travelling to and from and during field trips, school seminars, competitions, etc. conducted outside the school/ college premises.

Benefit 25: Legal Expenses

If an Insured Person gets into any legal litigations due to any involvement in an Accident, then we will reimburse the legal/court expenses borne by the Insured Person up to the limit specified in the Policy Schedule/ Certificate of Insurance.
This benefit will exclude:

- Any litigation invoked against the insured arising out of road traffic accident.
- Litigation against the Insured invoked for criminal intention.
- Any award against the Insured declared by a court of law.
- Any award/order against the Insured declared by Judicial or quasi-judicial authorities.

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.

Benefit 26: Dental Expenses due to Accident

If an Insured Person suffers Dental Injury or damage to his natural teeth and/or gums due to an Accident during the Period of Cover, then We will reimburse the amount up to the limit specified in the Policy Schedule/ Certificate of Insurance towards:

- the Medical Expenses incurred for Dental Treatment including any Emergency Care/ treatment by a Dentist

This benefit will exclude:

- Any instructions for plaque control, oral hygiene and diet
- Any treatment which is cosmetic in nature.

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.

This cover is applicable over and above the Benefit 7: Accidental Hospitalisation (Inpatient) if opted.

Benefit 27: Coma Benefit (due to Accident)

We will pay the Sum Insured as specified against this Benefit in the Policy Schedule/ Certificate of Insurance if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and as defined below:

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.

We will only accept one claim under this Benefit during the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This cover will be in addition to the Sum Insured mentioned for Section A (Benefit 2) Permanent Total Disablement and Section A (Benefit 6) Common Carrier Accident Benefit (PTD).

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 28: Child Care Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death, We will pay the Sum Insured as specified against this Benefit in Policy Schedule/ Certificate of Insurance in respect of the surviving Dependent Children of the Insured Person, irrespective of whether the child is an Insured Person under this Policy.

This Benefit shall be payable subject to the following:

- The Dependent Child's other parent also dies as a result of the same Accident or has pre-deceased the Insured Person.
- Our maximum, total and cumulative liability under this Benefit is the Sum Insured, irrespective of the number of surviving Dependent Children of the Insured Person.
- We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease.

For the purpose of this Benefit, Dependent Child means a child of the Insured Person who is less than Age 25 on the date of the Accident.

This cover will be in addition to the Sum Insured mentioned for the Section A (Benefit 1) Accidental Death Benefit or Section A (Benefit 5) Common Carrier Accident Benefit (Accidental Death).

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 29: Parental Care Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death or Permanent Total Disablement, We will pay the Sum Insured as specified against this Benefit in Policy Schedule/ Certificate of Insurance in respect of the surviving parents of the Insured Person, irrespective of whether the parent(s) is an Insured Person under this Policy.

This Benefit shall be payable subject to the following:

- Our maximum, total and cumulative liability under this Benefit is the Sum Insured, irrespective of whether one or both parents of the Insured Person are alive.
- We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This cover will be in addition to the Sum Insured mentioned for the Section A (1) Accidental death/ Section A (Benefit 2) Permanent Total Disablement/ Benefit 5 Common Carrier Accident Benefit (Accidental Death) / Benefit 6 Common Carrier Accident Benefit (PTD).

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 30: Counselling Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death or Permanent Total Disablement, We will reimburse the amount as specified against this Benefit in the Policy Schedule/ Certificate of Insurance in respect of the expenses incurred on professional counselling in respect of the Insured Person or the Nominee/legal heir (as the case may be) provided that We have admitted a claim under Benefit 1, Benefit 2, Benefit 5 or Benefit 6 of Section A.

We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 31: Repatriation in case of Permanent Total Disablement

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Permanent Total Disablement of the Insured Person, We will reimburse the Sum Insured as specified against this Benefit in Policy Schedule/ Certificate of Insurance in respect of transporting the Insured Person from the place of Accident or Hospitalization to the residence of the Insured Person.

This Benefit shall be payable subject to the following:

- We have admitted a claim under Benefit 2 or Benefit 6 of this Section in respect of that Insured Person.
- The Accident occurred in a location that is not the city/place of residence of the Insured Person.
- We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 32: Air Ambulance (Accident Related)

We will indemnify the amount up to the limit specified in the Policy Schedule/ Certificate of Insurance 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 Accident to the nearest hospital provided that:

(a) We have admitted a Claim under Section A
(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.

Benefit 33: Assault Cover

We will pay the Sum Insured as specified against this Benefit in the Policy Schedule/ Certificate of Insurance if the Insured Person suffers an Injury due to an Accident which is a violent crime or Assault that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized.

We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person.

For the purpose of this Benefit, **Assault** means any unlawful use of force inflicted by an individual(s) upon an Insured Person that is a criminal offence in the jurisdiction in which it occurs and which results in Injury to the Insured Person.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 34: Sports Activity Cover

We will pay the Sum Insured as specified against the respective Benefits opted for in the Policy Schedule/ Certificate of Insurance if an Insured Person suffers from an Accidental Injury sustained while engaged in a Professional Sport(s)/ Adventure Sports(s) carried out in accordance with the guidelines, codes of good practice and recommendations for safe practices as laid down by a governing body or authority.

If this Sports Activity Cover is in force in respect of the Insured Person, then General Exclusion 2.9 and Specific Exclusions applicable to Section A (vi) and (vii) will not be applicable for the purpose of this Policy in respect of that Insured Person.

SPECIAL CONDITIONS APPLICABLE FOR MULTIPLE CLAIMS

Claim amount payable under more than one of the below mentioned Benefits:

- Benefit 1 (Accidental Death Benefit), Benefit 2 (Permanent Total Disablement (PTD) Benefit & Benefit 3 (Permanent Partial Disablement (PPD) Benefit),
- Benefit 8 (Burns Benefit),
- Benefit 34 (Sports Activity Cover)

are subject to the following:

(i) No compensation would be payable under more than one Benefit pertaining to the same disablement.
(ii) In calculating the amount available to the Insured person under any of these covers/benefits, We shall deduct the amount previously paid/utilized for any of these covers/benefits from the Sum Insured of the cover/benefit under which the Claim has been lodged.
(iii) Maximum amount payable would be the Sum Insured of the respective cover/ benefit.

SPECIFIC EXCLUSIONS APPLICABLE TO SECTION A

We shall not be liable to make any payment for any claim under Section A of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

(i) Any Hospitalisation consequent to any condition arising from or traceable to any disease of the organs of generation, malignant disease of mammary gland, pregnancy, childbirth, abortion or miscarriage or any complications and/or sequels arising from the foregoing.
(ii) Disease, Injury, death or disablement directly or indirectly due to war, whether declared or not, or any warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other end's invasion, act of foreign enemy hostilities or civil commotion or rebellion, military, naval or air service or breach of law, hunting, steeple chasing, revolution, insurrection, mutiny, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.
[Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a Scheduled Airline or whether such an aircraft has a single engine or multiengine;]
(iii) Circumcision or strictures, vaccination, inoculation, sex change, beauty treatment of any description, intentional self-injury, dissipation, general debility, "run down" conditions and "general overhaul", intemperance, use of intoxicating drugs, liquors or any diseases, Injury, death or disablement directly or indirectly due to any one or more of them.
(iv) Any Injury present prior to the commencement of Period of Cover, whether or not if the same has been treated, or for which Medical Advice, diagnosis, care or treatment has been sought before the commencement of this Policy. Any Illness, complication or ailment arising out of or connected to such Injury.
(v) Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, disease, Illness, Hospitalisation of Insured Person

(a) from intentional self-injury, suicide or attempted suicide;
(b) whilst under the influence of intoxicating liquor or drugs;
(c) whilst engaging in aviation or ballooning, or whilst mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airlines in the world
(d) [Standard type of aircraft means any aircraft duly licensed to carry passengers (for hire or otherwise) by appropriate authority irrespective of whether such an aircraft is privately owned or chartered or operated by a Scheduled Airline or whether such an aircraft has a single engine or multiengine;]
(e) directly or indirectly caused by venereal disease except HIV/ AIDS ;
(f) arising or resulting from the Insured Person committing any breach of law.

(vi) Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), of Insured Person from participation in winter sports, skydiving/parachuting, hang gliding, bungee jumping, scuba diving, mountain climbing (where ropes or guides are customarily used), riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), participation in any Professional Sports, any bodily contact sport or any other hazardous or potentially dangerous sport for which the Insured Person is untrained, unless specifically covered under the Policy.

(vii) Payment of compensation in respect of Injury, disease, Illness, Hospitalisation of Insured Person from participation in winter sports, skydiving/parachuting, hang gliding, bungee jumping, scuba diving, mountain climbing (where ropes or guides are customarily used), riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), participation in any Professional Sports, any bodily contact sport or any other hazardous or potentially dangerous sport for which the Insured Person is untrained, unless specifically covered under the Policy.

(viii) Arising from ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, nuclear weapon materials or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission or nuclear fusion.

(ix) Death, disablement (whether of a permanent nature or of a temporary nature), Injury, disease, Illness, Hospitalisation of Insured Person resulting directly or indirectly arising out of, contributed to or caused by, or resulting from or in connection with any act of Nuclear, Chemical, Biological Terrorism (as defined below) regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

(a) For the purpose of this exclusion "Nuclear, Chemical, Biological Terrorism" shall mean the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.
(b) "Chemical" agent shall mean any compound, which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants, or material property.
(c) "Biological" agent shall mean any pathogenic (disease producing) micro-organism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) which cause Illness and/or death in humans, animals or plants.

CLAIMS DOCUMENTS FOR SECTION A

a) Basic documents required for all Claims:

(i) Photo Identity Proof (Any one) - Voter ID, Passport, PAN Card, Driving License, Ration Card, Aadhar, or any other proof accepted by the KYC norms as approved by the Company and which is admissible in court of law
(ii) Duly completed and signed Claim form in original as prescribed by Us.
(iii) Copy of FIR (if done)/ Panchnama (if done) /Police Inquest Report (if done) duly attested by the concerned Police Station;
(iv) Copy of Medico Legal Certificate (if conducted) duly attested by the concerned Hospital;

b) In case of Accidental Death – Benefit 1

(i) Attested Copy of Death certificate issued by the office of Registrar of Birth & Deaths;
(ii) Death summary issued by a Hospital;
(iii) Attested Copy of Post Mortem Report (if conducted);
(iv) Copies of Medical records (if available), investigation reports (if available), if admitted to hospital
(v) Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to the satisfaction of the Company for the purpose of a valid discharge in case nomination is not filed by deceased.
(vi) Certificate, if applicable, from the Bank/Financial Institution stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.

c) Documents required in case of Permanent Total Disablement (Benefit 2) /Partial Disablement (Benefit 3)/ Temporary Total Disablement (Benefit 4)

(i) Original treating Medical Practitioner's certificate describing the disablement;
(ii) Original Discharge summary from the Hospital;
(iii) Photograph of the Insured Person reflecting the disablement;
(iv) Prescriptions and consultation papers of the treatment; Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board.
(v) Copies of Medical records (if available), investigation reports (if available), if admitted to hospital.
(vi) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable

d) Additional documents required in case of Temporary Total Disablement (Benefit 4)

(i) Leave/Absence Certificate from Employer (If Employed)
(ii) Medical Practitioner's certificate confirming the Injury and advising rest/ unfit to work for specified number of days
(iii) Fitness Certificate

Basic documents should be submitted as mentioned above along with documents list against each section of loss given below:

Personal Accident Benefit – Section A (Other Benefits)	
Benefit 5 - Common Carrier Accident Benefit (Accidental Death)	a. List of documents as enumerated under Accidental Death b. Proof of Travel (Ticket or boarding pass)
Benefit 6 - Common Carrier Accident Benefit (PTD)	a. List of documents as enumerated under PTD b. Proof of Travel (Ticket or boarding pass)
Benefit 7 - Accidental Hospitalisation (Inpatient)	a. Original copies of Hospitalization bills, Consultations, investigation reports & bills, prescriptions and invoices, Discharge card issued by hospital

Benefit 8 - Burns Benefit	a. Certificate from the treating doctor certifying the extent of burns injury, Copy of treatment papers
Benefit 9 - Broken Bones Benefit	a. X-Ray/ MRI/ CT-Scan/ Radiology Films/ Reports confirming the extent of fracture, Copy of treatment papers, Copy of discharge card (if admitted)
Benefit 10 - Convalescence Benefit (due to Accident)	a. Hospital discharge card/ summary
Benefit 11- Carriage of dead body	a. Documents as enumerated under Claim for Accidental Death Claim b. Receipts for proof of carriage of dead body/ repatriation of remains
Benefit 12 - Funeral Expenses	a. Documents as enumerated under Claim for Accidental Death Claim
Benefit 13 - Accidental Medical Expenses Extension	a. All Original invoices of medical expenses due to accident at the hospital
Benefit 14 - Purchase of Blood	a. Original invoice of expenses incurred towards blood purchase
Benefit 15 - Transportation of imported medicine	a. All Original invoices towards transportation of imported medicine supported by the prescription of medical practitioner b. Treating doctor's certificate specifying the need of such transported medicines
Benefit 16 - Modification of Residence / Vehicle	a. Original invoice of actual expenses incurred
Benefit 17 - Cost of Support Items	a. Prescriptions of treating Medical Specialist for support items b. Original invoice of actual expenses incurred
Benefit 18 - Children Education Benefit	a. Proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate or Adoption Papers (if adopted). b. Photo Identity Proof of Child c. Age proof of Child d. Certificate from Educational Institution describing course details
Benefit 19 - Marriage expenses for Children	a. Proof of relationship with the Insured and Photo Identity Proof of Child/ Age proof of the dependent child
Benefit 20 - Widowhood cover	a. Proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents/Birth Certificate or Adoption Papers (if adopted). b. Death certificate of the deceased c. Copy of treatment papers d. Medical documents / Post Mortem (if done) mentioning the cause of death e. If nominee is other than the legal wife, marriage certificate or any other valid document of the widow to support the relationship with the deceased.
Benefit 21 - Ambulance Charges (Accidental Hospitalisation)	a. Original Bill from a certified Ambulance Service Provider or Hospital b. Doctor's advice for Ambulance

Benefit 22 - Accidental Pre & Post Hospitalisation Expenses Benefit	a. Original copies of Consultations, bills & receipts towards medical expenses, investigation reports & bills, prescriptions and invoices
Benefit 23 - Domestic travel for medical treatment due to accident	a. Original invoice of the ticket expenses incurred b. Prescription from the medical practitioner stating the line of medical treatment and city where medical treatment needs to be sought and its unavailability in the current city of treatment
Benefit 24 - On Duty cover	a. Medical papers/employer certificate indicating the place of accident
Benefit 25 - Legal Expenses	a. Supporting expense bill & receipt incurred towards the legal expenses
Benefit 26 - Dental Expenses due to Accident	a. Original copies of medical bills, Consultations, investigation reports & bills, prescriptions and invoices
Benefit 27 - Coma Benefit (due to Accident)	a. Certificate from the treating doctor certifying the cause and severity of Coma b. Copy of all treatment papers along with medical investigation reports
Benefit 28 - Child Care Benefit	a. Documents as enumerated under Claim for Benefit 1 b. Death Certificate of the Insured and Insured's spouse c. Proof of relationship of children with insured such as passport/ Aadhaar with full DOB (election card / PAN card) d. Age proof of children such as passport,/Aadhaar card with full DOB (election card / PAN card)
Benefit 29 - Parental Care Benefit	a. Documents as enumerated under Claim for Benefit 1 or Benefit 2 (As per the nature of injury) b. Proof of relation such as passport, birth certificate school/college leaving certificate of insured
Benefit 30 - Counselling Benefit	a. Documents as enumerated under Claim for Benefit 1 or Benefit 2 (As per the nature of injury) b. Proof of counselling sessions along with certified councillors prescription or certificate
Benefit 31 - Repatriation in case of Permanent Total Disablement	a. All original bills associated with the repatriation expenses
Benefit 32 - Air Ambulance (Accident Related)	a. Original copies of Hospitalization bills, Consultations, investigation reports & bills, prescriptions and invoices, Discharge card issued by hospital
Benefit 33 - Assault Cover	a. Original copies of Hospitalization bills, Consultations, investigation reports & bills, prescriptions and invoices, Discharge card issued by hospital, FIR if filed
Benefit 34 - Sports Activity Cover	a. List of documents as enumerated under Accidental Death or Permanent Total Disablement b. proof of participation in sports activity such as tickets.

SECTION B – ANIMAL, INSECT AND REPTILE ATTACK BENEFIT

Benefit 1: Death due to Animal, Insect and Reptile Attack Benefit

We will pay the Sum Insured as specified against this Benefit in the Policy Schedule/ Certificate of Insurance if the Insured Person suffers an Injury due to an Accident caused by bite, attack and/or sting of an animal, reptile or insect through direct violent skin contact that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 90 days from the date of the Accident.

We will pay the Sum Insured if the Insured Person suffers an Injury due to an Accident caused by bite or attack of an animal through direct violent skin contact that occurs during the Period of Cover and that Injury results in the Insured Person contracting rabies which solely and directly results in the Insured Person's death within 90 days from the date of the Accident.

On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all cover under this Policy in respect of the Insured Person shall immediately and automatically cease.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 2: Permanent Total Disablement due to Animal, Insect and Reptile Attack Benefit

We will pay the Sum Insured as specified against this Benefit in the Policy Schedule/ Certificate of Insurance if the Insured Person suffers an Injury due to an Accident caused by bite, attack and/or sting of an animal, reptile or insect through direct violent skin contact that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's Permanent Total Disablement (as defined under Benefit 2 of Section A) within 90 days from the date of the Accident provided that:

(a) If the Insured Person suffers Injuries resulting in more than one Permanent Total Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.

(b) We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit and under Benefit 2 under Section A in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 3: Permanent Partial Disablement due to Animal, Insect and Reptile Attack Benefit

We will pay the Sum Insured as specified against this Benefit in the Policy Schedule/ Certificate of Insurance if the Insured Person suffers an Injury due to an Accident caused by bite, attack and/or sting of an animal, reptile or insect through direct violent skin contact that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's Permanent Partial Disablement (as defined under Benefit 3 of Section A) within 90 days from the date of the Accident provided that:

(a) If the Insured Person suffers Injuries resulting in more than one Permanent Total Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.

(b) We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit and under Benefit 3 under Section A in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other

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applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 4: Hospitalisation Expenses due to Animal, Insect and Reptile Attack Reimbursement Benefit

We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule/ Certificate of Insurance for the Medical Expenses incurred if the Insured Person suffers an Injury due to an Accident caused by bite, attack and/or sting of an animal, reptile or insect through direct skin contact that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's Hospitalization as an Inpatient within 7 days from the date of the Accident provided that:

(a) The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
(b) We will reimburse only those Medical Expenses that are Reasonable and Customary Charges.
(c) We shall not be liable to make any payment in respect of any non-payable items as specified in Annexure II
(d) If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We will pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.
(e) 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.

Benefit 5: Hospital Daily Cash Benefit for Animal, Insect and Reptile Attack

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care due to Animal, Insect and Reptile Attack during this Period of Cover.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

This Benefit will be applicable over and above the Daily Cash Benefits mentioned under Section E if opted.

Benefit 6: OPD Benefit for Animal, Insect and Reptile Attack

We will reimburse the reasonable and customary charges upto the limit as specified in the Policy Schedule/ Certificate of Insurance towards out-patient medical expenses incurred towards animal, insect and reptile attack in respect of Insured person:
(a) Diagnostic procedures like laboratory tests, MRI's, CAT Scan, Pathology tests
(b) Medical Practitioners consultations
(c) Pharmacy expenses
(d) Non-surgical and Minor surgical procedures and treatments like stitching, dressing under local anaesthesia, etc

(e) Others treatments like physiotherapy, acupuncture, chiropody, homeopathy, etc.

This Benefit will be applicable over and above the benefits opted under Section I OPD Benefit, if any.

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.

General Exclusion2.4, 2.20 and 2.38 of the Policy Wordings stands deleted to the extent of this Cover only.

Benefit 7: Convalescence Benefit for Animal, Insect and Reptile Attack

We will pay the Sum Insured specified in the Policy Schedule/Certificate of Insurance for this Benefit if the Insured Person is admitted in a Hospital due to bite, attack and/or sting of an animal, reptile or insect through direct skin contact that occurs during the Period of Cover for a minimum period as specified in the Policy Schedule/ Certificate of Insurance.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION B

We shall not be liable to make any payment for any claim under Section B of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

- Any Injury sustained while working professionally with any animals reptiles or insects.
- Arising from Dengue, Malaria, Filariasis, Kala azar, Chikungunya, Japanese encephalitis
- Any Illness of any kind caused or infected only by or transmitted only by or in any way attributed to virus, parasite, bacteria or any microorganism including where the virus, parasite, bacteria or any other microorganism is introduced and/ or caused by bites of insects, reptiles, animals and/or other vector.

CLAIMS DOCUMENTS FOR SECTION B

a) Basic documents required for all Claims:

(i) Photo Identity Proof (Any one) - Voter ID, Passport, PAN Card, Driving License, Ration Card, Aadhar, or any other proof accepted by the KYC norms as approved by the Company and which is admissible in court of law

(ii) Duly completed and signed Claim form in original as prescribed by Us.

(iii) Copy of FIR (if done)/ Panchnama (if done) /Police Inquest Report (if done) duly attested by the concerned Police Station;

(iv) Copy of Medico Legal Certificate (if conducted) duly attested by the concerned Hospital;

Animal, Insect and Reptile Attack Benefit– Section B	
Benefit 1 - Death due to Animal, Insect and Reptile Attack Benefit	List of documents as enumerated under Accidental Death (Benefit 1 - Section A)
Benefit 2 - Permanent Total Disablement due to Animal, Insect and Reptile Attack	List of documents as enumerated under PTD (Benefit 2 - Section A)

Benefit	
Benefit 3 - Permanent Partial Disablement due to Animal, Insect and Reptile Attack Benefit	List of documents as enumerated under PPD (Benefit 3 - Section A)
Benefit 4 - Hospitalisation Expenses due to Animal, Insect and Reptile Attack Reimbursement Benefit	Original copies of Hospitalization bills, Consultations, investigation reports & bills, prescriptions and invoices, Discharge card issued by hospital
Benefit 5 - Hospital Daily Cash Benefit for Animal, Insect and Reptile Attack	a. Discharge Summary of Hospital b. Original hospitalisation Bills & Investigation reports stating cause of Hospitalisation
Benefit 6 - OPD Benefit for Animal, Insect and Reptile Attack	Original copies of Consultations, Hospital bills, receipts, investigation reports & bills, prescriptions and invoices
Benefit 7 - Convalescence Benefit for Animal, Insect and Reptile Attack	a. Hospital discharge card/ summary

SECTION C – SPECIFIC VECTOR BORNE DISEASE BENEFIT

For the purpose of this cover, Specific Vector Borne Disease includes Dengue, Malaria, Filariasis, Kala azar, Chikungunya, Japanese encephalitis, Zika Virus

For the purpose of this Benefit, we shall not be liable to make any payment, if the Specific Vector Borne Disease is first diagnosed within a period of 30 days (or as mentioned on the Policy Schedule/ Certificate of Insurance) from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.

Benefit 1: Specific Vector Borne Disease related Fixed Benefit

We will pay the Sum Insured as specified against the Specific Vector Borne Disease in the Policy Schedule/ Certificate of Insurance if an Insured Person is diagnosed with the Specific Vector Borne Disease which is evidenced by laboratory diagnosis and prescribed tests and provided that:

(i) We shall not be liable to make any payment under this Benefit, if the Specific Vector Borne Disease is first diagnosed prior to the commencement of the Period of Cover
(ii) The first laboratory diagnosis of the Specific Vector Borne Disease is certified and attested by a registered pathologist

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater)

Benefit 2: Specific Vector Borne Disease related Hospitalisation Benefit

We will reimburse the amount up to the limit as specified against the Specific Vector Borne Disease in the Policy Schedule/ Certificate of Insurance if an Insured Person is diagnosed with the Specific Vector Borne Disease that solely and directly requires the Insured Person to be hospitalized as an Inpatient during the Period of Cover provided that:

(i) The Hospitalization is for Medically Necessary Treatment of the Specific Vector Borne Disease and is commenced and continued on the written advice of the treating Medical Practitioner.

(ii) We shall not be liable to make any payment under this Benefit, if the Specific Vector Borne Disease is first diagnosed prior to the commencement of the Period of Cover.
(iii) We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
(iv) If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.
(v) 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.

Benefit 3: Hospital Daily Cash Benefit for Specific Vector Borne Disease

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care due to the Specific Vector Borne Disease as specified in the Policy Schedule/ Certificate of Insurance during this Period of Cover.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

This Benefit will be applicable over and above the Daily Cash Benefits mentioned under Section E if opted.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

Benefit 4: OPD Benefit for Specific Vector Borne Disease

We will reimburse the reasonable and customary charges upto the limit as specified in the Policy Schedule/ Certificate of Insurance towards out-patient medical expenses incurred towards the specific vector borne disease in respect of Insured person:
(a) Diagnostic procedures like laboratory tests, MRI's, CAT Scan, Pathology tests
(b) Medical Practitioners consultations
(c) Pharmacy expenses
(d) Non-surgical and Minor surgical procedures and treatments like stitching, dressing under local anaesthesia, etc
(e) Others treatments like physiotherapy, acupuncture, chiropody, homeopathy, etc.

This Benefit will be applicable over and above the benefits opted under Section I OPD Benefit, if any.

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.

General Exclusion2.4, 2.20 and 2.38 of the Policy Wordings stands deleted to the extent of this Cover only.

Benefit 5: Convalescence Benefit for Specific Vector Borne Disease

We will pay the Sum Insured specified in the Policy Schedule/Certificate of Insurance for this Benefit if the Insured Person is diagnosed and admitted in a Hospital due to the Specific Vector Borne Disease as specified

in the Policy Schedule/ Certificate of Insurance during this Period of Cover for a minimum period as specified in the Policy Schedule/ Certificate of Insurance.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

CLAIMS DOCUMENTS FOR SECTION C

a) Basic documents required for all Claims:
(i) Photo Identity Proof (Any one) - Voter ID, Passport, PAN Card, Driving License, Ration Card, Aadhar, or any other proof accepted by the KYC norms as approved by the Company and which is admissible in court of law
(ii) Duly completed and signed Claim form in original as prescribed by Us.

b) Documents required for Specific Vector Borne Disease related Hospitalisation Benefit
(i) Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis, wherever applicable
(ii) Out-patient consultation paper, wherever applicable
(iii)Indoor case papers of treating hospital, if available

c) Documents required for Hospital Daily Cash Benefit for Specific Vector Borne Disease
(i) Discharge Summary of Hospital
(ii) Original hospitalisation Bills & Investigation reports stating cause of Hospitalisation

d) Documents required for OPD Benefit for Specific Vector Borne Disease
(i) Original copies of Consultations, Hospital bills, receipts, investigation reports & bills, prescriptions and invoices

e) Documents required for Convalescence Benefit for Specific Vector Borne Disease
(i) Hospital discharge card/ summary

Specific Vector Borne Disease Benefit – Section C	
Dengue	Positive NS1 antigen test or Ig M- Elisa test
Malaria	Diagnosis must be confirmed positive/reactive by microscopy or malaria rapid diagnostic test (RDT) signed and attested by registered pathologist OR hospital discharge summary (duly filled and attested) confirming diagnosis as Malaria
Filariasis	Antigen detection in blood sample or IgG4 Antibody detection using routine assays
Kala azar	Direct Agglutination Test or Rapid dipstick test or ELISA for detecting IgG Anemia, Leucopenia, thrombocytopenia and Hypergammaglobulinemia
Chikungunya	Presence of IgM and IgG anti chikungunya antibodies.
Japanese encephalitis	Ig M antibody detection in serum or cerebrospinal fluid

Zika Virus	Rapid Zika Virus IgG/IgM/plaque-reduction neutralization testing (PRNT) performed by CDC

SECTION D – SPECIFIC COMMUNICABLE DISEASE BENEFIT

For the purpose of this cover, Specific Communicable Disease includes Typhoid/Entric Fever, Swine Flu, Hepatitis A, Tuberculosis, Pneumonia and Nipah Virus

For the purpose of this Benefit, we shall not be liable to make any payment, if the Specific Communicable Disease is first diagnosed within a period of 30 days (or as mentioned on the Policy Schedule/ Certificate of Insurance) from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.

Benefit 1: Specific Communicable Disease related Fixed Benefit

We will pay the Sum Insured as specified against the Specific Communicable Disease in the Policy Schedule/ Certificate of Insurance if an Insured Person is diagnosed with the Specific Communicable Disease which is evidenced by laboratory diagnosis and prescribed tests and provided that:

(i) We shall not be liable to make any payment under this Benefit, if the Specific Communicable Disease is first diagnosed prior to the commencement of the Period of Cover
(ii) The first laboratory diagnosis of the Specific Communicable Disease is certified and attested by a registered pathologist

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater)

Benefit 2: Specific Communicable Disease related Hospitalisation Benefit

We will reimburse the amount up to the limit specified against the Specific Communicable Disease in the Policy Schedule/ Certificate of Insurance if an Insured Person is diagnosed with the Specific Communicable Disease that solely and directly requires the Insured Person to be hospitalized as an Inpatient during the Period of Cover provided that:

(i) The Hospitalization is for Medically Necessary Treatment of the Specific Communicable Disease and is commenced and continued on the written advice of the treating Medical Practitioner.
(ii) We shall not be liable to make any payment under this Benefit, if the Specific Communicable Disease is first diagnosed prior to the commencement of the Period of Cover.
(iii) We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
(iv) If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.
(v) 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.

Benefit 3: Hospital Daily Cash Benefit for Specific Communicable Disease

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's

Hospitalisation for Inpatient Care due to the Specific Communicable Disease as specified in the Policy Schedule/ Certificate of Insurance during this Period of Cover.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

This Benefit will be applicable over and above the Daily Cash Benefits mentioned under Section E if opted.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

Benefit 4: OPD Benefit for Specific Communicable Disease

We will reimburse the reasonable and customary charges upto the limit as specified in the Policy Schedule/ Certificate of Insurance towards out-patient medical expenses incurred towards the specific communicable disease in respect of Insured person:

(a) Diagnostic procedures like laboratory tests, MRI's, CAT Scan, Pathology tests
(b) Medical Practitioners consultations
(c) Pharmacy expenses
(d) Non-surgical and Minor surgical procedures and treatments like stitching, dressing under local anaesthesia, etc
(e) Other treatments like physiotherapy, acupuncture, chiropody, homeopathy, etc.

This Benefit will be applicable over and above the benefits opted under Section I OPD Benefit, if any.

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.

General Exclusion2.4, 2.20 and 2.38 of the Policy Wordings stands deleted to the extent of this Cover only.

Benefit 5: Convalescence Benefit for Specific Communicable Disease

We will pay the Sum Insured specified in the Policy Schedule/Certificate of Insurance for this Benefit if the Insured Person is diagnosed and admitted in a Hospital due to the Specific Communicable Disease as specified in the Policy Schedule/ Certificate of Insurance during this Period of Cover for a minimum period as specified in the Policy Schedule/ Certificate of Insurance.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

CLAIMS DOCUMENTS FOR SECTION D

a) Basic documents required for all Claims:

(i) Photo Identity Proof (Any one) - Voter ID, Passport, PAN Card, Driving License, Ration Card, Aadhar, or any other proof accepted by the KYC norms as approved by the Company and which is admissible in court of law
(ii) Duly completed and signed Claim form in original as prescribed by Us.

b) Documents required for Specific Communicable Disease related Hospitalisation Benefit

(i) Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis, wherever applicable
(ii) Out-patient consultation paper, wherever applicable
(iii)Indoor case papers of treating hospital, if available

c) Documents required for Hospital Daily Cash Benefit for Specific Communicable Disease

(i) Discharge Summary of Hospital
(ii) Original hospitalisation Bills & Investigation reports stating cause of Hospitalisation

d) Documents required for OPD Benefit for Specific Communicable Disease

(i) Original copies of Consultations, Hospital bills, receipts, investigation reports & bills, prescriptions and invoices

e) Documents required for Convalescence Benefit for Specific Communicable Disease

(i) Hospital discharge card/ summary

Specific Communicable Disease Benefit – Section D	
Typhoid/Entric Fever	Widal Test
Swine Flu	Throat swab/Respiratory specimen fo Swine flu influenza A virus
Hepatitis A	1) Hepatitis A Virus(HAV) 2) Hepatomegaly in USG abdomen 3) Liver function test shows elevated SGOT/SGPT
Tuberculosis	1) Montoux tuberculin skin test (TST) 2) Sputum for Acid Fast Bacillus(AFB) 3) Chest X ray 4) Blood Test for M tuberculosis infection
Nipah Virus	1) Real time polymerase chain reaction(RT-PCR) & Antibody detection by ELISA
Pneumonia	1) Chest X-ray

SECTION E – HOSPITAL DAILY CASH BENEFIT

I. BASIC BENEFITS

Benefit 1: Hospital Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care including AYUSH Treatment during this Period of Cover.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

Benefit 2: Accident Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care including AYUSH Treatment during this Period of Cover provided that:

(a) The Hospitalisation is following an Injury due to an Accident during this Period of Cover

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

Benefit 3: ICU Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care including AYUSH Treatment in an ICU during this Period of Cover.

If only Base Cover 1.2 Accident Daily Cash Benefit is opted for along with this cover, payout under this benefit will be restricted to Hospitalisation in an ICU following an Injury due to an Accident.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

You can opt for any one of the Base Covers or a combination of 2 Base Covers or all 3 Base Covers.

II. OPTIONAL BENEFITS

Benefit 4: Companion Benefit

We will pay the Daily Cash Amount, specified in the Policy Schedule/ Certificate of Insurance under this Benefit towards expenses incurred on one accompanying person at the Hospital/Nursing Home for each and every completed day of the Insured Person's Hospitalisation during this Period of Cover provided that:

(a) We have admitted a Claim for the Basic Benefits under this Section in respect of the same Hospitalisation;
(b) In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

Companion will include “Your spouse, children, siblings and parent(s)”

Benefit 5: Joint Hospitalisation

We will pay the Sum Insured specified in the Policy Schedule/ Certificate of Insurance under this Benefit if two or more Insured Persons (Insured Person and his Family members) under the same Policy are jointly hospitalized as an inpatient during the Period of Cover provided that:

(a) We have admitted a Claim for the Basic Benefits under this Section in respect of the same Hospitalisation for any one Insured Person;
(b) This benefit is payable on lump sum basis irrespective of number of insured persons jointly hospitalized under this Policy (individual/floater)

We shall be liable to make payment under this cover only once during the Policy Year.

Benefit 6: Parent Accommodation

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

(a) We have admitted a Claim for the Basic Benefits under this Section in respect of the same Hospitalisation;
(b) The Insured Person hospitalized is a Child aged 12 years or below
(c) In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

Benefit 7: Maternity Benefit

We will pay the Daily Cash Amount, specified in the Policy Schedule/ Certificate of Insurance under the Maternity Benefit for the delivery of the Insured Person's child (including cesarean section) or for the Medically necessary and lawful termination of pregnancy for each and every completed day of the Insured Person's Hospitalisation during this Period of Cover subject to the following:

(a) The treatment is taken as an In-patient in a Hospital
(b) Maternity Benefit Waiting Period as mentioned in the Policy Schedule/ Certificate of Insurance shall apply
(c) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

General Exclusion 2.18 of the Policy Wordings stands deleted to the extent of this Benefit only.

Condition for Claims:

In case the Insured Person opts for Maternity Benefit, the Daily Cash Amount applicable against this cover will be paid in respect of each and every completed day for Maternity related Hospitalisation. There will be no additional payout under the Basic Benefits - Hospital Daily Cash Benefit, ICU Daily Cash Benefit and Accident Daily Cash Benefit.

Benefit 8: New Born Baby Benefit

We will pay the Daily Cash Amount, specified in the Policy Schedule/ Certificate of Insurance under the New Born Baby Benefit for each and every completed day of the Hospitalisation of the Insured Person's New Born Baby during this Period of Cover subject to the following:

(a) The treatment is taken as an In-patient in a Hospital
(b) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

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.

Benefit 9: Worldwide Cover

If we have admitted a claim under this Section, then Benefits / covers opted under this Section will be available on a worldwide basis.

Permanent Exclusion 2.40 of the Policy Wordings stands deleted to the extent of this Benefit only.

SPECIAL CONDITIONS APPLICABLE FOR CLAIMS

Deductible/ Franchise

In case the Policy covers Hospital Daily Cash Benefit, ICU Daily Cash Benefit and Accident Daily Cash Benefit, the Deductible/ Franchise will be applied only once on the entire duration of the stay in the hospital for each and every claim separately.

Illustration:

Scenario 1:
Maximum number of days: 30. The Insured Person stays in the Hospital for 10 days and Policy Deductible is 3 days. Out of the 10 days, first 4 days is Normal Room and remaining 6 days is ICU.

The Deductible will be applied for the first 3 days. The Insured will get the Hospital Daily Cash Benefit for the 4th day and for the remaining 6 days, he will get the ICU Daily Cash Benefit.

Scenario 2:
Maximum number of days: 30. The Insured Person stays in the Hospital for 10 days and Policy Deductible is 3 days. Out of the 10 days, first 4 days is ICU and remaining 6 days is Normal Room.

The Deductible will be applied for the first 3 days. The Insured will get the ICU Daily Cash Benefit for the 4th day and for the remaining 6 days, he will get the Hospital Daily Cash Benefit.

Scenario 3:
Maximum number of days: 30. The Insured Person stays in the Hospital for 10 days and Policy Franchise is 3 days. Out of the 10 days, first 4 days is ICU and remaining 6 days is Normal Room.

As the Franchise limit of first 3 days is crossed, the Insured will get the ICU Daily Cash Benefit for 4 days and for the remaining 6 days, he will get the Hospital Daily Cash Benefit.

Maximum Payout

In case the Insured Person's Hospitalisation covers Hospital Daily Cash Benefit or ICU Daily Cash Benefit or Accident Daily Cash Benefit or combination of these, the highest of the Daily Cash Amount applicable will be paid in respect of each and every completed day depending on the type of Hospitalisation (Illness/ ICU/ Accident). There will be no cumulative payout under these 3 Benefits and only the highest of the payout applicable will be paid.

Illustration:

Scenario 1:
Maximum number of days: 30
Hospital Daily Cash Benefit – Rs. 1000 per day
ICU Daily Cash Benefit – Rs. 2000 per day
Policy Deductible – 1 day

The Insured Person gets hospitalised and stays in the Hospital for 10 days. Out of the 10 days, first 4 days is Normal Room and remaining 6 days is ICU.

In this case, the payout will be as follows:

	Total number of days	Total Payout
Hospital Daily Cash Benefit (after one day Deductible)	3 days	3 * 1000 per day = Rs. 3000
ICU Daily Cash Benefit (*)	6 days	6 * 2000 per day = Rs. 12000

Payable amount – Rs. 15000/-

(*) The Insured is eligible for the higher payout of ICU Benefit in this scenario.

Scenario 2:
Maximum number of days: 30
Hospital Daily Cash Benefit – Rs. 1000 per day
Accident Daily Cash Benefit – Rs. 2000 per day
Policy Deductible – 1 day

The Insured Person gets hospitalised due to Accident and stays in the Hospital in a Normal Room for 10 days.

In this case, the payout will be as follows:

	Total number of days	Total Payout
Accident Daily Cash Benefit (after one day Deductible)	9 days	9 * 2000 per day = Rs. 18000

Payable amount – Rs. 18000/-

As the Accident Daily Cash Payout is higher, only the higher payout is made in the above scenario.

Scenario 3:

Maximum number of days: 30
Hospital Daily Cash Benefit – Rs. 1000 per day
Accident Daily Cash Benefit – Rs. 2000 per day
ICU Daily Cash Benefit – Rs. 3000 per day
Policy Deductible – 1 day

The Insured Person gets hospitalised due to Accident and stays in the Hospital in a Normal Room for first 4 days and ICU for next 6 days.

In this case, the payout will be as follows:

	Total number of days	Total Payout
Accident Daily Cash Benefit (after one day Deductible)	3 days	3 * 2000 per day = Rs. 6000
ICU Daily Cash Benefit	6 days	6* 3000 per day = Rs. 18000

Payable amount – Rs. 24000/-

As the Accident Daily Cash Payout is higher, only the higher payout is made in the above scenario for first 4 days. ICU Daily Cash Benefit is also provided for the remaining 6 days

Maximum Coverage Limit

- The maximum number of days coverage will be as mentioned in the Policy Schedule/ Certificate of Insurance per Insured Person/ per family. If all claims in a Policy Year do not meet the Maximum Coverage Limit, then it is agreed and understood that there will be no carry-over of days to the subsequent Policy Year or any future renewals of the Policy.

- In case the Policy covers Hospital Daily Cash Benefit or ICU Daily Cash Benefit or Accident Daily Cash Benefit or combination of these, the maximum number of days under each Benefit will be considered individually as mentioned in the Policy Schedule/ Certificate of Insurance.

Illustration:

Maximum number of days for Hospital Daily Cash: 30 days
Maximum number of days for ICU Daily Cash: 15 days
Hospital Daily Cash Benefit – Rs. 1000 per day
ICU Daily Cash Benefit – Rs. 2000 per day
Policy Deductible – 1 day

The Insured Person gets hospitalised and stays in the Hospital for 50 days. Out of the 50 days, first 20 days is in ICU and remaining 30 days is Normal Room.

In this case, the payout will be as follows:

	Total number of days	Total Payout

ICU Daily Cash Benefit (after one day Deductible)	15 days	15 * 2000 per day = Rs. 30000
Hospital Daily Cash Benefit (*)	29 days	29 * 1000 per day = Rs. 29000

Payable amount – Rs. 59000/-

(*) The Insured is eligible for the Hospital Daily Cash payout in this scenario from the 16th day although the Insured is in ICU as the 15 days of ICU Benefit have been utilised. From the 16th day, Insured will get a Hospital Daily Cash Benefit upto the maximum number of days opted.

CLAIMS DOCUMENTS FOR SECTION E

Sr. No.	Name of the Cover	Documents
1.	Hospital Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
2.	Accident Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
3.	ICU Daily Cash Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
4.	Companion Benefit	Hospital discharge card/ summary and document to confirm relationship with the Patient
5.	Joint Hospitalisation	Hospital discharge card/ summary of each Insured Person hospitalised
6.	Parent Accommodation	Copy of discharge card and document to confirm relationship with the Patient

SECTION F –CRITICAL ILLNESS BENEFIT

For the purpose of this Benefit, the list of Critical Illness includes

- 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 (Idiopathic) Pulmonary Hypertension
    7. End Stage Liver Failure
    8. Cardiomyopathy
    9. Alzheimer's Disease
    10. Parkinson's Disease
    11. End stage Lung Failure
    12. Apallic Syndrome
    13. Medullary Cystic Disease
    14. Systemic lupus erythematosus with Renal Involvement
    15. Aplastic Anaemia
    16. Bacterial meningitis

17. Multiple system atrophy
18. Progressive scleroderma
19. Specific Cancer Benefit (Cervix/ Breast/ Mouth/ Throat)

- Undergoing for the first time of the following surgical procedures, more specifically described below:
    20. Major Organ / Bone Marrow Transplant;
    21. Open heart replacement or repair of heart valves
    22. Open chest CABG
    23. Aorta Graft Surgery
    24. Pulmonary artery graft surgery
    25. Brain surgery
    26. Pneumonectomy

- Occurrence for the first time of the following medical events more specifically described below:
    27. Coma of Specified Severity
    28. Stroke resulting in permanent symptoms;
    29. Permanent Paralysis of Limbs;
    30. Myocardial Infarction (First Heart Attack- of specified severity)
    31. Third Degree Burns
    32. Deafness
    33. Loss of Speech
    34. Blindness
    35. Major Head Trauma

The Critical Illnesses and the conditions applicable to the same are more particularly described under Annexure III.

For the purpose of this Benefit, we shall not be liable to make any payment, if the signs and symptoms of the Critical Illness first commenced atleast 90 days (or as mentioned on the Policy Schedule/ Certificate of Insurance) after the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.

Benefit 1: Specific Critical Illness Benefit

We will pay the Sum Insured as specified in the Policy Schedule/ Certificate of Insurance to the Insured Person on the first diagnosis of any of the Specific Critical Illness as mentioned in the Policy Schedule/ Certificate of Insurance during the Period of Cover, provided that the signs or symptoms of the Critical Illness first commenced after the applicable waiting period and subsequent to completion of the Survival period as mentioned in the Policy Schedule/ Certificate of Insurance.

We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 2: Critical Illness Daily Cash Benefit

We will pay the Daily Cash Amount, subject to Deductible/ Franchise, as specified in the Policy Schedule/ Certificate of Insurance under this Benefit for each and every completed day of the Insured Person's Hospitalisation for Inpatient Care during this Period of Cover solely and directly due to the Critical Illnesses listed in the Policy Schedule/ Certificate of Insurance , provided that the signs or symptoms of the Critical Illness first commenced after the applicable waiting period as mentioned in the Policy Schedule/ Certificate of Insurance.

We shall be liable to make payment only for the maximum number of days per policy year per Insured Person/ per family as specified in the Policy Schedule/Certificate of Insurance for this Cover.

This Benefit will be over and above the Daily Cash Benefits mentioned under Section E if opted.

In case of Individual Policy, the maximum number of days will be on individual basis and in case of Floater Policy the maximum number of days will be on floater basis.

Benefit 3: CI Related Hospitalisation Benefit

We will reimburse the amount up to the limit specified against the Specific Critical Illness as mentioned in the Policy Schedule/ Certificate of Insurance if an Insured Person is diagnosed with the Specific Critical Illness that solely and directly requires the Insured Person to be hospitalized as an Inpatient during the Period of Cover provided that:

The signs or symptoms of the Critical Illness first commenced after the applicable waiting period as mentioned in the Policy Schedule/ Certificate of Insurance.

(i) The Hospitalization is for Medically Necessary Treatment of the Specific Critical Illness and is commenced and continued on the written advice of the treating Medical Practitioner.
(ii) The Insured Person's stay in the Hospital should continue for a minimum period of 24 successive hours.
(iii) We shall not be liable to make any payment under this Benefit, if the Specific Critical Illness is first diagnosed prior to the commencement of the Period of Cover.
(iv) We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
(v) If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

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.

Benefit 4: Critical Illness OPD Benefit

We will reimburse the reasonable and customary charges upto the limit as specified in the Policy Schedule/ Certificate of Insurance towards out-patient medical expenses incurred towards the specific critical illness after the applicable waiting period as mentioned in the Policy Schedule/ Certificate of Insurance in respect of Insured person:

(a) Diagnostic procedures like laboratory tests, MRI's, CAT Scan, Pathology tests
(b) Medical Practitioners consultations
(c) Pharmacy expenses

(d) Non-surgical and Minor surgical procedures and treatments like stitching, dressing under local anaesthesia, etc
(e) Others treatments like physiotherapy, acupuncture, chiropody, homeopathy, etc.

This Benefit will be applicable over and above the benefits opted under Section I OPD Benefit, if any.

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

General Exclusion2.4, 2.20 and 2.38 of the Policy Wordings stands deleted to the extent of this Cover only.

CLAIMS DOCUMENTS FOR SECTION F

a) Documents required in case of Critical Illness Claims

(i) Duly completed claim form;
(ii) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
(iii) Name of the Insured Person;
(iv) Name, date of occurrence and medical details confirming the event giving rise to the Claim.
(v) 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.
(vi) Original Policy document;
(vii) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;
(viii) Original investigation test reports, indoor case papers, if available;
(ix) 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.
(x) Any other documents as may be required by Us.

b) **Documents required for CI Related Hospitalisation Benefit**
(i) Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis, wherever applicable
(ii) Out-patient consultation paper, wherever applicable
(iii) Indoor case papers of treating hospital, if available

c) **Documents required for Critical Illness Daily Cash Benefit**
(i) Discharge Summary of Hospital
(ii) Original hospitalisation Bills & Investigation reports stating cause of Hospitalisation

d) **Documents required for Critical Illness OPD Benefit**
(i) Original copies of Consultations, Hospital bills, receipts, investigation reports & bills, prescriptions and invoices

e) Additional 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.

1) CANCER OF SPECIFIED SEVERITY
   i. Details of the treatment received by the Insured Person from the inception of the ailment.
   ii. Letter from treating consultant stating presenting complaints with duration and the past medical history.
   iii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
   iv. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
   v. Blood Tests.
   vi. Any other specific investigation done to support the diagnosis like the Pap smear/ Mammography, etc.
   vii. Any other documents as may be required by Us.

2) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS
   i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   ii. 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)
   iii. Dialysis Papers/Receipts done in recent past.
   iv. Renal scan
   v. Letter from the nephrologists stating the diagnosis of End Stage Kidney Failure.
   vi. Any other documents as may be required by Us.

3) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS
   i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
   ii. MRI / CT Scan Report.
   iii. Electro-myogram report
   iv. Biopsy / Cytology Report
   v. Specific Blood Tests: Creatinine Phosphokinase /Anti Nuclear Antibodies, C - reactive protein /Autoimmune work up
   vi. Any other relevant Blood investigations.
   vii. Confirmation from the Central/State Government Hospital about diagnosis of Multiple Sclerosis and the duration of the same.
   viii. Any other documents as may be required by Us.

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

5) BENIGN BRAIN TUMOR
   i. Details of the treatment received by the Insured Person from the inception of the ailment.
   ii. Letter from treating consultant stating presenting complaints with duration and the past medical history.

iii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
iv. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
v. Blood Tests.
vi. Neurological examination report by Neurologist
vii. Any other documents as may be required by Us.

6) PRIMARY PULMONARY HYPERTENSION

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. MRI / CT Scan Report.
iii. Echocardiography report
iv. Computed tomography (CT), magnetic resonance imaging (MRI), and lung scanning
v. Pulmonary angiography
vi. Any other documents as may be required by Us.

7) END STAGE LIVER DISEASE / FAILURE

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

8) MAJOR ORGAN /BONE MARROW TRANSPLANT

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. 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)
iii. Letter from a specialist Doctor confirming the need of transplantation (Organs Specified are: Heart, lung, Liver, pancreas, kidney, bone marrow)
iv. Any other documents as may be required by Us.

9) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

10) OPEN CHEST CABG

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
iii. Stress test/ Tread Mill Test
iv. Letter from treating consultant suggesting Coronary Angiography and CABG

v. Coronary Angiography report / CT Angiography Report
vi. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT,
vii. LDH / Electrolytes
viii. X-ray / 2D-Echocardiography Report
ix. Thallium Scan Report
x. Any other documents as may be required by Us.

11) AORTA GRAFT SURGERY

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

12) COMA OF SPECIFIED SEVERITY

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

13) STROKE RESULTING IN PERMANENT SYMPTOMS

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

14) PERMANENT PARALYSIS OF LIMBS

i. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
ii. Electro-myogram Report
iii. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
iv. 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.

v. Any other document as may be required by the company

15) FIRST HEART ATTACK - OF SPECIFIED SEVERITY

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

16) THIRD DEGREE (OR MAJOR) BURNS

i. Certificate from the treating specialist Doctor indicating the classification / degree of burns
ii. Following medico-legal documents if Done
(i) FIR
(ii) Panchanama
(iii)Inquest Panchanama
(iv)Police Final Report/Charge Sheet (Based on FIR)
iii. Any other documents as may be required by Us.

17) DEAFNESS OR LOSS OF HEARING

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Pure tone testing report
iii. Audiometry report
iv. Confirmation of Diagnosis by ENT specialist along with duration
v. All treatment papers and medical investigation test reports
vi. Any other documents as may be required by Us.

18) LOSS OF SPEECH

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Confirmation of Diagnosis by ENT specialist along with cause and duration
iii. All treatment papers and medical investigation test reports
iv. Any other documents as may be required by Us.

19) SPECIFIC CANCER BENEFIT (CERVIX/ BREAST/ MOUTH/ THROAT)

i. Details of the treatment received by the Insured Person from the inception of the ailment.
ii. Letter from treating consultant stating presenting complaints with duration and the past medical history.
iii. Histopathology / Cytology / FNAC / Biopsy / Immuno-histochemistry reports.
iv. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
v. Blood Tests.
vi. Any other specific investigation done to support the diagnosis like the Pap smear/ Mammography, etc.

vii. Any other documents as may be required by Us.

20) CARDIOMYOPATHY

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical reports: X-ray echo, cardiac catheterization, myocardial biopsy, stress test, ECG, CAG, blood test wherever applicable
iii. Clinical examination by doctor which suggest cardiomyopathy.
iv. Treating doctor must specify the exact diagnosis as Cardiomyopathy along with its exact cause.
v. Any other documents as may be required by us.

21) ALZHEIMER'S DISEASE

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised
ii. Clinical examination finding of inability to perform normal daily.
iii. Medical reports: CT SCAN, PET scan brain, MRI.
iv. Neurologist prescription certifying the disease.
v. Any other documents as may be required by us

22) PARKINSON'S DISEASE

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Neurologist prescription certifying the disease
iii. Medical Report: PET, SPECT SCAN
iv. Any other documents as may be required by us.

23) END STAGE LUNG FAILURE

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical reports: Forced expiratory volume (FEV1 test), Arterial Blood gas analysis, x-ray, blood test wherever applicable.
iii. Chest physician's prescription certifying the disease.
iv. Any other documents as may be required by us.

24) APALLIC SYNDROME

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical reports: MRI, CT scan, PET scan, blood gas analysis, thyroid, CBC, Liver function test(LFT)
iii. Neurologist prescription certifying the disease.
iv. Any other documents as may be required by Us.

25) MEDULLARY CYSTIC DISEASE

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical reports: Creatinine, uric acid, renal biopsy, USG Kidney
iii. Urologist prescription certifying the diagnosis as Medullary Cystic disease.
iv. Any other documents as may be required by us.

26) SYSTEMIC LUPUS ERYTHEMATOSUS

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical reports: Anti-nuclear antibody test(ANA),anti-extractable nuclear antigen(anti-ENA),immunofluorescence(IF),Antiphospholipid antibody, CBC, Liver function test(LFT),Kidney function test(KFT),Glomerular function test(GFR)
iii. Rheumatologist prescription certifying the disease.
iv. Any other documents as may be required by Us.

27) APLASTIC ANEMIA

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical reports: CBC, Renal Function Test, Electrolytes, LFT, Thyroid test, it B12, Folic acid, Bone marrow biopsy.
iii. Hematologist's prescription stating the diagnosis of Aplastic Anemia.
iv. Any other documents as may be required by Us.

28) BACTERIAL MENINGITIS

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical reports: CBC, C-Reactive Protein, electrolytes, Blood culture, Cerebrospinal fluid culture, CT scan, MRI Brain,
iii. Clinical examination finding of inability to perform normal daily activity.
iv. Neurologist prescription certifying the disease.
v. Any other documents as may be required by Us.

29) MULTIPLE SYSTEM ATROPHY

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Clinical findings suggestive of multiple system atrophy.
iii. Medical reports: MRI, CT scan, blood test and test confirming the diagnosis.
iv. Consulting physician's prescription stating the disease.
v. Any other documents as may be required by Us.

30) PROGRESSIVE SCLERODERMA

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Blood Test: CBC, Liver Function Test, Kidney Function Test, Anti-Nuclear Antibody,Anti-Sci-70(anti-topoisomerase),Anti U3,Anti –RNA polymerase wherever applicable.
iii. Consulting physician's prescription stating the disease.
iv. Any other documents as may be required by us.

31) PULMONARY ARTERY GRAFT SURGERY

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical report: CT scan, perfusion scan, Echo, Right heart catheterization, pulmonary angiogram.
iii. Consulting physician's prescription stating the disease.
iv. Any other documents as may be required by us.

32) BRAIN SURGERY

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical reports: CT scan and MRI Brain, Cerebrospinal fluid examination, Electroencephalogram(EEG),CT Angiogram, MRA(Magnetic resonance angiogram),cerebral angiogram to confirm the exact diagnosis.
iii. Neurologist prescription certifying the disease.
iv. Any other documents as may be required by Us.

33) PNEUMONECTOMY

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical report: X-ray, CT scan chest, Bronchoscopy for lung tumor.
iii. Letter from the chest physician stating the exact cause of lung disease leading to Pneumonectomy.
iv. Any other documents as may be required by Us.

34) BLINDNESS

i. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
ii. Medical Report: Visual acuity test, field of vision test
iii. Ophthalmologist prescription certifying the diagnosis with exact cause.
iv. Any other documents as may be required by Us.

35) MAJOR HEAD TRAUMA

i. Letter from treating doctor stating the exact cause of injury leading to head injury, presenting complaints of the patient with the duration, impact of injury on patients normal daily life.
ii. Medical report: MRI,CT brain
iii. Any other documents as may be required by Us.

SECTION G – LOSS OF JOB BENEFIT

Benefit 1: Loss of Job Benefit due to Accident

If the Insured Person is terminated or temporarily suspended from employment by his/her employer due to an injury sustained during an Accident during the Period of Cover in accordance with the employer's rules/regulations or in accordance with applicable Indian law or the directives of any Public Authority, We will pay the Insured Person in a manner as specified in the Policy Schedule/ Certificate of Insurance subject to a maximum of specified Sum Insured provided that:

- The period of termination or temporary suspension from employment by the Insured Person's employer during the Period of Cover is not less than 30 consecutive days.
- The Insured Person is a salaried employee of the employer at the stage of termination or temporary suspension.
- Loss Of Job occurs within a period of 3 months (or as mentioned in the Policy Schedule/ Certificate of Insurance) from the date of Accident

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 2: Loss of Job Benefit due to Critical Illness

If the Insured Person is terminated or temporarily suspended from employment by his/her employer on the

first diagnosis of any of the Critical Illness as specified under Section F or as mentioned in the Policy Schedule/ Certificate of Insurance during the Period of Cover, in accordance with the employer's rules/regulations or in accordance with applicable Indian law or the directives of any Public Authority provided that the signs or symptoms of the Critical Illness first commenced after the applicable waiting period as mentioned in the Policy Schedule/ Certificate and after the commencement of the first Policy Period of this Policy with Us, We will pay the Insured Person in a manner as specified in the Policy Schedule/ Certificate of Insurance subject to a maximum of specified Sum Insured provided that:

- The period of termination or temporary suspension from employment by the Insured Person's employer during the Period of Cover is not less than 30 consecutive days.
- The Insured Person is a salaried employee of the employer at the stage of termination or temporary suspension.
- Loss Of Job occurs within a period of 3 months (or as mentioned in the Policy Schedule/ Certificate of Insurance) from the date of diagnosis of Critical Illness

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 3: Loss of Job Benefit due to Illness/ Injury

If the Insured Person is terminated or temporarily suspended from employment by his/her employer due to an illness or injury sustained during an Accident during the Period of Cover in accordance with the employer's rules/regulations or in accordance with applicable Indian law or the directives of any Public Authority, We will pay the Insured Person in a manner as specified in the Policy Schedule/ Certificate of Insurance subject to a maximum of specified Sum Insured provided that:

- The period of termination or temporary suspension from employment by the Insured Person's employer during the Period of Cover is not less than 30 consecutive days.
- The Insured Person is a salaried employee of the employer at the stage of termination or temporary suspension.
- Loss Of Job occurs within a period of 3 months (or as mentioned in the Policy Schedule/ Certificate of Insurance) from the date Illness/ Injury

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

In case the Insured Person has opted for all the above 3 Benefits under Loss of Job, the highest of the Benefit Amount applicable will be paid. There will be no cumulative payout under these 3 Benefits and only the highest of the payout applicable will be paid.

SPECIFIC EXCLUSIONS APPLICABLE TO SECTION G

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 following:

a) The Insured Person's termination or temporary suspension from employment is due to any dishonesty or fraud or poor performance on the part of the Insured Person or his wilful violation of any rules of the employer or laws for the time being in force or any disciplinary action against the Insured Person by the employer.
   - The Insured Person being self-employed;
   - Any Claim relating to unemployment from a job which is casual, temporary, seasonal or contractual in nature or any Claim relating to an employee not on the direct rolls of the employer;
   - Unemployment at the time of inception of the Policy Period or arising within first 30 days of inception of the Policy Period.

b) Any unemployment from a job under which no salary or any remuneration is provided to the Insured Person.
c) Any suspension from employment on account of any pending enquiry being conducted by the employer/ Public Authority.
d) Any unemployment due to resignation, retirement.
e) Any unemployment due to non-confirmation of employment after or during such period under which the Insured Person was under probation.

CLAIMS DOCUMENTS FOR SECTION G

a) Policy Number
b) Name of the Policyholder
c) Name of the Insured Person in whose relation the Claim is being lodged
d) Cause of loss of job
e) Any other information, documentation as requested by Us
f) Duly completed claim form.
g) Original Policy document.
h) Certificate from the employer of the Insured Person confirming the termination or temporary suspension from employment furnishing the date of termination or temporary suspension from employment with the reasons for the same. In case of temporary suspension the period of suspension and the reasons for the same should also be mentioned in such certificate.
i) Appointment letter.
j) Last 3 Months Salary Slip.
k) Form 16 for the last year.
l) Contact details of employer-phone no. mobile no., email ID, contact person in HR/Admin/Personnel dept.
m) VISA proof and Passport copy in case of Insured Person is not resident in India.
n) Age proof of Insured Person: Election ID Card / PAN Card/ School Leaving
o) Certificate / Copy of passport.
p) Any other document as required by Us to investigate the Claim or Our obligation to make payment for it.

For Claims related to Injury/ Accident

(i) Name, date of occurrence and accident details confirming the event giving rise to the Claim.
(ii) Copy of FIR (if done)/ Panchnama (if done) /Police Inquest Report (if done) duly attested by the concerned Police Station;
(iii) Copy of Medico Legal Certificate (if conducted) duly attested by the concerned Hospital;
(iv) Copies of Medical records (if available), investigation reports (if available), if admitted to hospital.
(v) Prescriptions and consultation papers of the treatment
(vi) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable
(vii) Any other documents as may be required by Us.

For Claims related to Illness/ Critical Illness

(i) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
(ii) Name, date of occurrence and medical details confirming the event giving rise to the Claim.
(iii) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;
(iv) Original investigation test reports, indoor case papers, if available;
(v) 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.

(vi) Additional Documentation Required for each of the Critical Illnesses as listed in Section F

(vii) Any other documents as may be required by Us.

SECTION H –RECURRING PAYOUT BENEFIT

Benefit 1: Recurring Payout Benefit due to Accident

If an Insured Person is admitted in a Hospital for a minimum period as specified in the Policy Schedule/ Certificate of Insurance for an Injury due to an Accident that occurs during the Period of Cover, then We will pay the EMI Amount upto the number of EMI(s) specified in the Policy Schedule/ Certificate of Insurance, from the first EMI Amount falling due after the admission in a Hospital in accordance with the loan re-payment schedule issued by the financier on disbursement of the Loan (account number as stated in the Policy Schedule/ Certificate of Insurance).

For non-loan/ non-EMI related payouts, if an Insured Person is admitted in a Hospital for a minimum period as specified in the Policy Schedule/ Certificate of Insurance for an Injury due to an Accident that occurs during the Period of Cover, then We will pay the fixed amount upto the number of times as specified in the Policy Schedule/ Certificate of Insurance.

Benefit 2: Recurring Payout Benefit due to Critical Illness

If an Insured Person is diagnosed with any of the Critical Illnesses as specified under Section F or as mentioned in the Policy Schedule/ Certificate of Insurance during the Period of Cover, then We will pay the EMI Amount upto the number of EMI(s) specified in the Policy Schedule/ Certificate of Insurance, from the first EMI Amount falling due after the onset of the event in accordance with the loan re-payment schedule issued by the financier on disbursement of the Loan (account number as stated in the Policy Schedule/ Certificate of Insurance).

For non-loan / non-EMI related payouts, if an Insured Person is diagnosed with any of the Critical Illnesses as specified under Section F or as mentioned in the Policy Schedule/ Certificate of Insurance during the Period of Cover, then We will pay the fixed amount upto the number of times as specified in the Policy Schedule/ Certificate of Insurance.

Benefit 3: Recurring Payout Benefit due to Illness/ Injury

If the Insured Person is admitted in a Hospital due to an Illness/ Injury for a minimum period as specified in the Policy Schedule/ Certificate of Insurance during the Period of Cover, then We will pay the EMI Amount upto the number of EMI(s) specified in the Policy Schedule/ Certificate of Insurance, from the first EMI Amount falling due after the admission in a Hospital in accordance with the loan re-payment schedule issued by the financier on disbursement of the Loan (Policy Schedule/ Certificate of Insurance).

For non-loan/ non-EMI related payouts, if an Insured Person is admitted in a Hospital due to an Illness/ Injury for a minimum period as specified in the Policy Schedule/ Certificate of Insurance during the Period of Cover, then We will pay the fixed amount upto the number of times as specified in the Policy Schedule/ Certificate of Insurance.

Conditions Applicable to Section H - Benefits 1, 2, 3:

This Benefit shall be payable subject to the following:

- We shall not be liable to make any payment under this Benefit after the maximum number of EMI Amounts/ Fixed Amounts specified in the Policy Schedule/ Certificate of Insurance being paid or the Insured Person being discharged from the Hospital whichever is earlier.
- Any payments that are overdue and unpaid by the Insured Person prior to the occurrence of the Accident will not be considered for the purpose of this Benefit and shall be deemed as paid by the Insured Person.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

In case the Insured Person has opted for all the above 3 Benefits under Recurring Payout Benefit, the highest of the Benefit Amount applicable will be paid. There will be no cumulative payout under these 3 Benefits and only the highest of the payout applicable will be paid.

CLAIMS DOCUMENTS FOR SECTION H

a) Policy Number
b) Name of the Policyholder
c) Name of the Insured Person in whose relation the Claim is being lodged
d) Duly completed claim form.
e) Original Policy document.
f) Certificate, if applicable, from the Bank/Financial Institution stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.
g) Age proof of Insured Person: Election ID Card / PAN Card/ School Leaving
h) Any other document as required by Us to investigate the Claim or Our obligation to make payment for it.

For Claims related to Injury/ Accident

(i) Name, date of occurrence and accident details confirming the event giving rise to the Claim.
(ii) Copy of FIR (if done)/ Panchnama (if done) /Police Inquest Report (if done) duly attested by the concerned Police Station;
(iii) Copy of Medico Legal Certificate (if conducted) duly attested by the concerned Hospital;
(iv) Copies of Medical records (if available), investigation reports (if available), if admitted to hospital.
(v) Prescriptions and consultation papers of the treatment
(vi) Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable
(vii) Any other documents as may be required by Us.

For Claims related to Illness/ Critical Illness

(i) Certificate from the attending Medical Practitioner of the Insured Person confirming, inter alia,
(ii) Name, date of occurrence and medical details confirming the event giving rise to the Claim.
(iii) Original Discharge Certificate/Death Summary/Card from the hospital/ Medical Practitioner;
(iv) Original investigation test reports, indoor case papers, if available;
(v) 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.
(vi) Additional Documentation Required for each of the Critical Illnesses as listed in Section F
(vii) Any other documents as may be required by Us.

SECTION I – OPD BENEFIT

For the purpose of this Cover,
Outpatient **means** an Insured person who is not hospitalized but who visits a hospital, clinic or associated facility for diagnosis or treatment.

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.

Benefit 1: OPD Expenses

We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule/ Certificate of Insurance towards out-patient medical expenses in respect of Insured person:
(a) Diagnostic procedures like laboratory tests, MRI's, CAT Scan, Pathology tests
(b) Medical Practitioners consultations including Dental, Vision and ENT treatment
(c) Pharmacy expenses
(d) Non-surgical and Minor surgical procedures and treatments like stitching, dressing under local anaesthesia, etc.
(e) Others treatments like physiotherapy, acupuncture, chiropody, homeopathy, etc.
(f) Administration of Lucentis Injection

Provided that:

- The Medical Expenses incurred are Reasonable and Customary Charges
- Deductible/ Co-payment, as mentioned in the Policy Schedule/ Certificate of Insurance is applicable in respect of this benefit.

If You have opted for the Benefit 2, 3, and 5 under Section I separately, then the claim under the said covers will not be payable under the Benefit 1 - OPD Expenses.

General Exclusion2.4, 2.20 and 2.38 of the Policy Wordings stands deleted to the extent of this Cover only.

Benefit 2: OPD Dental Treatment

We will reimburse amount up to the limit specified against this benefit in the Policy Schedule/ Certificate of Insurance towards medical expenses incurred towards dental treatment including any Emergency treatment by a Dentist following an accident where the Insured Person suffers injuries or damage to his natural teeth and/or gums provided that:

- The Medical Expenses incurred are Reasonable and Customary Charges
- Deductible/ Co-payment, as mentioned in the Policy Schedule/ Certificate of Insurance is applicable in respect of this benefit.

This benefit also provides cover for:
(a) The fees for a dental practitioner and associated costs for carrying out routine dental procedures like clinical oral examinations, tooth scaling, normal fillings, minor procedures and non-surgical extractions
(b) Root canal treatment and surgical extraction of tooth

This Benefit will exclude

i. Any instructions for plaque control, oral hygiene and diet
ii. Any treatment which is cosmetic in nature.

General Exclusion2.4, and 2.38 of the Policy Wordings stands deleted to the extent of this Cover only.

Benefit 3: OPD Vision Treatment

We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule/ Certificate of Insurance towards the following Medical expenses incurred in respect of the Insured person related to Vision tests/ consultations/ treatments/ prescriptions including but not limited to:
(a) One eye examination by an optometrist or ophthalmologist per Policy year
(b) The provision of lenses/ eyeglass to correct vision
(c) Medical treatment of the eye
(d) Administration of lucentis injection

Provided that:

- The Medical Expenses incurred are Reasonable and Customary Charges
- Deductible/ Co-payment, as mentioned in the Policy Schedule/ Certificate of Insurance is applicable in respect of this benefit.

The Benefit will exclude:
i. Sunglasses/ lenses which are not prescribed by an optometrist or ophthalmologist
ii. Any treatment which is cosmetic in nature.

General Exclusion2.4, 2.20 and 2.38 of the Policy Wordings stands deleted to the extent of this Cover only.

Benefit 4: OPD AYUSH Treatment Expenses

We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule/ Certificate of Insurance towards out-patient medical expenses in respect of Insured person towards AYUSH treatment provided that:

- The Medical Expenses incurred are Reasonable and Customary Charges
- Deductible/ Co-payment, as mentioned in the Policy Schedule/ Certificate of Insurance is applicable in respect of this benefit.

The Benefit will exclude:
i. Any treatment which is cosmetic in nature.
ii. Any other non- allopathic treatment other than mentioned above

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

General Exclusion2.4, 2.20, 2.38 and 2.39 of the Policy Wordings stands deleted to the extent of this Cover only.

Benefit 5: OPD Accident Treatment Expenses

We shall reimburse the amount up to the limit specified against this benefit in the Policy Schedule/ Certificate of Insurance, towards the out-patient Medical Expenses incurred in respect of a medical treatment or Surgery for the Injury sustained by an Insured Person due to an Accident during the Period of Cover that requires out-patient Treatment provided that:

- The Medical Expenses incurred are Reasonable and Customary Charges
- Deductible/ Co-payment, as mentioned in the Policy Schedule / Certificate of Insurance is applicable in respect of this benefit.
- The treatment is not cosmetic in nature.

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.

General Exclusion2.4, 2.20 and 2.39 of the Policy Wordings stands deleted to the extent of this Cover only.

CLAIMS DOCUMENTS FOR SECTION I

a) Policy Number
b) Name of the Policyholder
c) Name of the Insured Person in whose relation the Claim is being lodged
d) Duly completed claim form.
e) Original copies of Consultations, bills, receipts, investigation reports & bills, prescriptions and invoices
f) Any other document as required by Us to investigate the Claim or Our obligation to make payment for it.

SECTION J – SURGERY BENEFIT

Benefit 1: Day Care Procedure Benefit

We will pay the Sum Insured as specified in the Policy Schedule/ Certificate Insurance for this Benefit if an Insured Person undergoes a Day Care Procedure as an inpatient for less than 24 hours in a Hospital or Day Care Centre during the Policy Period.

We shall be liable to make payment under this cover in respect of an Insured Person during the Policy Year as per the number to times/ claims mentioned in the Policy Schedule/ Certificate Insurance.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 2: Surgery Benefit

We will pay the Sum Insured/ number of EMIs in the manner as specified in the Policy Schedule/ Certificate of Insurance, for this Benefit as per the Category of the Surgery in the event of Insured Person's Hospitalisation for Inpatient Care during the Policy Period if an Insured Person undergoes a Surgery/ Surgical Procedure as listed and subject to the waiting period as mentioned in the Policy Schedule/ Certificate of Insurance.

For the purpose of this Benefit, the list of the Surgeries and the Category are more particularly described under Annexure IV.

For the purpose of this Benefit, We are not liable for any claim arising due to any surgery undertaken within

90 days (or as mentioned In the Policy Schedule/ Certificate of Insurance) from policy commencement date except those incurred as a result of Accident/Injury.
In case of renewals, this waiting period shall not be applicable to the extent of sum insured under the previous year's policy in force.

CLAIMS DOCUMENTS FOR SECTION J

Day Care Procedure Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill
Surgery Benefit	Hospital discharge card/ summary, copy of treatment papers, medical investigation reports and copy of hospital bill

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

SECTION K – MATERNITY COMPLICATION BENEFIT

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Schedule/ Certificate of Insurance) which is specified in the table below if an Insured Person suffers one or more of the medical complications (of the nature listed below) during maternity during the Period of Cover:

Sr No.	Maternity Complication	% of Sum Insured payable
1	Eclampsia	100%
2	Abruptio Placenta	100%
3	Placenta Increta	100%
4	Placenta Percreta	100%
5	Amniotic Fluid Embolism	100%
7	Disseminated Intravascular Coagulation	100%
8	Still Birth	50%
9	Pre-Eclampsia	25%
10	Hyperemesis Gravidarum requiring stay in Hospital as an in-patient for at least 48 successive hours	5%
11	Ectopic Pregnancy	25%
12	Any other maternal complication subject to applicable exclusions specified under this section requiring stay in Hospital as an in-patient for at least 48 successive hours	25%

For the purpose of this Policy the maternal complications listed above shall have the following meanings:

1. **Eclampsia** means a life threatening pregnancy complication that causes a pregnant woman, usually previously diagnosed with preeclampsia (high blood pressure and protein in the urine), to develop

seizures or coma.

2. **Abruptio Placenta** means premature separation of the placenta from the wall of the uterus
3. **Placenta Increta** means a condition in which part or all of the placenta remains firmly attached and invades the muscles of the uterus
4. **Placenta Percreta** means a condition in which part or all of the placenta remains firmly attached and grow through the uterine wall
5. **Amniotic Fluid Embolism** means an obstetric complication in which amniotic fluid, enters the blood stream of the mother to trigger a cardio respiratory arrest and/or massive bleeding
6. **Acute Fatty Liver of Pregnancy** means potentially fatal complication of the liver that occurs in the third trimester or early postpartum period caused by a disordered metabolism of fatty acids by mitochondria in the mother
7. **Disseminated Intravascular Coagulation** means the pathological process characterized by the widespread activation of the clotting cascade that results in the formation of blood clots in the small blood vessels throughout the body.
8. **Still Birth** means baby born with no signs of life at or after 28 weeks' gestation
9. **Pre-Eclampsia** means a pregnancy complication characterized by high blood pressure and signs of damage to another organ system, most often the liver and kidneys associated with proteinuria and which usually begins after 20 weeks of pregnancy in women whose blood pressure had been normal prior to the initiation of the pregnancy
10. **Hyperemesis gravidarum** is a pregnancy complication that is characterized by severe nausea, vomiting, weight loss, and possibly dehydration.
11. **Ectopic Pregnancy** means a condition where a fertilized egg implants itself outside of the uterus

This Benefit shall be payable subject to the following:

i. If the Insured Person dies undiagnosed before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but We may consider a claim under any other applicable Benefits under the Policy.
ii. We shall not be liable to make any payment under this Benefit, if the maternal complication occurs or is first diagnosed prior to the commencement of the Period of Cover or within a period of 30 days from the commencement of the Period of Cover or after the completion of 30 days following the delivery. This exclusion of first 30 days from the period of commencement of cover shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.
iii. If the Insured Person suffers for more than one of the maternal complications specified above, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.
iv. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

SPECIFIC EXCLUSIONS AND LIMITATIONSAPPLICABLE TOSECTIONK:

We shall not be liable to make any payment for any claim under Section D of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

(a) Any pregnancy arising out of In Vitro Fertilization, surrogacy or any other type of assisted reproduction.
(b) Medical Termination of Pregnancy

(c) Self-medication or any treatment that is not scientifically recognized or which is taken not in accordance with or against the advice of a Medical Practitioner.
(d) Any maternal complication arising on account of or in connection with any Pre-existing Disease
(e) Any claim arising on account of or in connection with any Neonatal Illness/condition
(f) Any complication that has occurred prior to the commencement of Period of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought.

CLAIMS DOCUMENTS FORSECTIONK:

On the occurrence of an Insured Event which may give rise to a claim under Section K of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 days of the occurrence of the Insured Event:
(a) Duly filled claim form
(b) All medical and diagnostic reports including first USG report indicating the date of conception Certificate from attending obstetrician clearly indicating the final diagnosis
(c) Indoor case papers of treating Hospital, if available
(d) Hospital Discharge summary duly signed and attested by treating Medical Practitioner confirming the diagnosis Cause of death certificate filled and duly attested by Hospital
(e) Any other document required by Us to assess the claim

SECTION L – HEALTH AND WELLLNESS BENEFIT

Wellness Program

By way of this Benefit the insured can avail any or all of the below mentioned services upto the limits/ frequency specified in the Policy Schedule/ Certificate of Insurance through the Network Provider or Vendor tie-up:

i. 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 to the Insured Person.

ii. Health Check-up
We will arrange for diagnostic/ preventative Health Check-Up at Our Network Provider based on the list of tests mentioned in the Policy Schedule/ Certificate of Insurance and as per the terms and conditions mentioned in the Policy Schedule/ Certificate of Insurance

iii. Report evaluation
We will provide report evaluation/ counselling for the test reports as per the tests conducted under (b) Health Check-up

iv. Online customer profile
Based on the HRA taken and the other Check-ups, if any, undertaken by the Insured Person, We will maintain an online customer profile through Vendor tie-ups which can be accessed by the customer to review his Health status.

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v. Medical Centre Management
We will provide with or arrange for the maintenance of a Medical room equipped with a doctor at the designated work site chosen by You through the Network Provider.

vi. Diet & Nutrition Plans
We will arrange for dieticians/ nutritionist through our Vendor tie-ups to provide for counselling to the Insured Person

vii. Online Doctor Chat/ E-consultations
We will provide with or arrange for an online platform through our Network Provider for providing with Doctor Chat and e-consultations to the Insured Person

viii. Doctor Directory
We will provide with or arrange for an online platform to the Insured Person through our Vendor tie-ups for providing access to Doctor Directory containing information on General Practitioners, specialists and super specialists

ix. Doctor Appointment
We will provide with or arrange for an online platform to the Insured Person through Vendor tie-ups for fixing up Doctor Appointments for the Insured Persons

x. Health Camps - on campus
We will arrange for Health Camps for fitness assessments and overall health profiling at the designated work sites chosen by You through our Network Providers/ Vendor tie-ups

xi. Expert Sessions - on campus
We will arrange for Expert Chat sessions/ workshops with doctors, dieticians, nutritionists, psychologists at the designated work sites chosen by You to the Insured Person through Network Providers/ Vendor tie-ups

xii. Second E-Opinions:
We will provide second opinion in the electronic form to the Insured Person through our Vendor tie-up

xiii. Discounted offerings - on health and wellness services

We will facilitate the Insured Person for various offerings on health and wellness services like Diagnostic Centres, Pharmacy, Consultations, Gymnasiums, Yoga, etc.) through the Network Providers/ Vendor tie-ups

xiv. Disease Management Programs: Eg. Diabetes, Healthy Heart, Stress Management etc.
We will help the Insured Person track his health through our Vendor tie-ups who will guide in maintaining/ improving your health condition.

xv. Lifestyle/Wellness Management Programs: Eg Maternity, Quit Smoking
We will help the Insured person track his overall lifestyle and fitness well -being through our Vendor tie-ups who will provide guidance in undergoing there programmes

xvi. Personalized Health Records
We will provide with or arrange for an online platform to the Insured Person through our Vendor tie-ups

for maintaining the Health records for the Insured Persons

xvii. Health & Wellness Reminder Services

We will provide with or arrange for an online platform/ mobile application to the Insured Person for providing Health and Wellness Reminders like Vaccination alerts, Pill reminders, etc.

xviii. Health Concierge Desk/ Health Assistance Services (Opinions - Doctor on call/home, Ambulance services, Health tools)

You can contact Us to avail the following services:
1. Emergency assistance information such as nearest ambulance, blood bank, hospital, etc.
2. Referral for medical service provider, home nursing, etc.

xix. Home Health

We will provide with or arrange through Vendor tie-ups, Home Health services like physiotherapy, nursing care, trained attendants, medical equipment, etc. for the Insured Person

xx. Emergency Medical Evacuation/ Air Ambulance services

We will arrange through an Assistance provider for transportation of the Insured person beyond 150 kms from the place of residence/ injury/ accident or emergency situation

Terms and Conditions for Wellness Program:

- 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 be solely be at the Insured Person's discretion.
- 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.
- 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
- 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 Wellness services utilised.

SECTION M – OTHER BENEFITS

Benefit 1: Compassionate Visit Benefit

We will reimburse the costs of expenses incurred on tickets on a Common Carrier up to the limit specified in the Policy Schedule/ Certificate of Insurance for one of the Insured Person's Immediate Relatives to travel to the place of death or Hospitalization of the Insured Person provided that as a Condition Precedent We are given a detailed account of the expenses incurred along with the supporting bills and documents, substantiating such expenses.

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.

For the purpose of this cover, the term "Immediate Relative" would mean the Insured Person's spouse, children, siblings, parents or parents-in-law

Benefit 2: Repatriation of Mortal Remains

We will reimburse the costs incurred up to the limit specified in the Policy Schedule/ Certificate of Insurance for expenses incurred for transportation of the mortal remains (including ash) of the Insured Person from Hospital/ place of death to his/her current place of residence in case of the unfortunate death of the Insured Person due to a disease/ illness/ injury/ accident during the Period of Cover provided that as a Condition

Precedent, We are given a detailed account of the expenses incurred along with the supporting bills and documents, substantiating such expenses.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

Benefit 3: Convalescence Benefit

We will pay the Sum Insured specified in the Policy Schedule/Certificate of Insurance for this Benefit if the Insured Person is admitted in a Hospital for In-patient Treatment during the Period of Cover for a minimum period as specified in the Policy Schedule/ Certificate of Insurance.

We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year.

This benefit is applicable on an individual basis irrespective of type of policy (Individual/ Floater).

2. WHAT WE WILL NOT PAY (GENERAL 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:

2.1 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 months (or as mentioned in the Policy Schedule/ Certificate of Insurance) 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.

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d) Coverage under the policy after the expiry of 36 months (or as mentioned in the Policy Schedule/ Certificate of Insurance) for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2.2 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 (or as mentioned in the Policy Schedule/ Certificate of Insurance) 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
   i) Cataract;
   ii) Benign Prostatic Hypertrophy;
   iii) Myomectomy, Hysterectomy unless because of malignancy;
   iv) All types of Hernia, Hydrocele;
   v) Fissures and/or Fistula in anus, haemorrhoids/piles;
   vi) Arthritis, gout, rheumatism and spinal disorders;
   vii) Joint replacements unless due to Accident;
   viii) Sinusitis and related disorders;
   ix) Stones in the urinary and biliary systems;
   x) Dilatation and curettage, Endometriosis;
   xi) All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
   xii) Dialysis required for chronic renal failure;
   xiii) Tonsillitis, adenoids and sinuses;
   xiv) Gastric and duodenal erosions and ulcers;
   xv) Deviated nasal septum;
   xvi) Varicose Veins/ Varicose Ulcers.

2.3 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.

2.4 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.

2.5 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.

2.6 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

2.7 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.

2.8 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.

2.9 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.

2.10 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.

2.11 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.

2.12 Code- Excl12

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

2.13 Code- Excl13

Treatments received in heath 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.

2.14 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.

2.15 Refractive Error (Code – Excl15)

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

2.16 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.

2.17 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

2.18 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.

2.19 Maternity Benefit Waiting Period

(a) Expenses related to the treatment arising from or traceable to pregnancy, childbirth including caesarean section shall be excluded until the expiry of 36 months (or as mentioned in the Policy Schedule/ Certificate of Insurance) 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.

The above Waiting Period is applicable only if SECTION E – HOSPITAL DAILY CASH BENEFIT – Benefit 7 – Maternity Benefit is opted for.

2.20 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;

2.21 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 and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;

2.22 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.

2.23 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;

2.24 Acupressure, acupuncture, magnetic and such other therapies;

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

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

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

2.28 Treatment relating to Congenital external Anomalies;

2.29 Any treatment related to sleep disorder or sleep apnoea syndrome

2.30 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

2.31 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;

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

2.33 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;

2.34 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;

2.35 Non-medical expenses as listed in Annexure II (List I) of the Policy.

2.36 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.

2.37 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.

2.38 Any OPD treatment will not be covered.

2.39 Non-allopathic treatment other than AYUSH treament

2.40 Any hospitalisation treatment taken outside India

2.41 Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule/ Certificate of Insurance under Important Conditions

3. CLAIMS PROCESS

3.1 Claim Administration

The fulfilment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule/ Certificate of Insurance) 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, We may conduct Medical examination by any Medical Practitioner for this purpose when and so often as We may reasonably require. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person and We/Our representatives must be permitted to inspect the medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim;
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.

3.2 Claims Intimation

In the event of a Hospitalization claim under the Policy, We/ TPA must be notified either at call centre or in writing within 48 hours of the Hospitalization but not later than discharge from the Hospital. In case of an Accidental Death or Permanent Total Disablement/ Critical Illness claim under the Policy, We/ TPA must be notified either at call centre or in writing within 10 days from the date of occurrence of the Accident.

We/ TPA shall be provided the following necessary information and documentation in respect of the Claims is within 30 days of the Insured Person's occurred Injury/ Hospitalisation:

(a) Policy Number
(b) Name of the Policyholder
(c) Name of the Insured Person in whose relation the Claim is being lodged
(d) Nature of Accident (if Accident Case)
(e) Name and address of the attending Medical Practitioner and Hospital (if Admission has taken place)
(f) Date of Admission if applicable
(g) Any other information, documentation as requested 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.

3.3 Claims Documents

a) Basic documents required for all Claims:

i) Applicable KYC documents along with latest photographs, Valid Photo ID, address proof, etc.
ii) Duly completed and signed Claim form in original as prescribed by Us.

b) Benefit-wise Additional Documents:

Benefit-wise Additional Documents are enlisted in the respective Benefit Sections.

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. Cancellation

a. 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/ Upto 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.

b. 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.

7. 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.

8. 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;

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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

16. 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 last necessary document.

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)

Specific Terms and Clauses

1. Eligibility

Minimum Entry Age	1 day
Maximum Entry Age	No Limit

Insured Person will include Self (Group member) and the following relationships of the Group member: Lawfully wedded spouse (more than one wife)/ Partner (including same sex partners) and Live-in Partner, children (biological/ adopted/others), parents (biological/ foster), siblings (biological/ step), mother in-law, father in-law, son in-law, daughter in-law, brother in-law, sister in-law.
For the purpose of this Policy, Partner shall be taken as declared at the time of Start of the Policy Period and no change in the same would be accepted during a Policy Period. However, an Insured Person may request for change at the time of Renewal of the cover.

2. Material Change

Material information to be disclosed to Us includes every matter that You are aware of 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.

3. 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.

4. Terms and condition of the Policy

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

5. Cause of Action/ Currency for payments

Claims under this Policy shall be payable if the cause of action arises anywhere in the world except for the hospitalisation claims payable under Benefit Nos 7, 13, 21, 22 (Section A), Benefit 4, 5 (Section B), Benefit 2, 3 (Section C), Benefit 2, 3 (Section D), Benefit 2, 3 (Section F) as mentioned above wherein the cause of action shall be restricted strictly to the geographical boundaries of India \unless otherwise specifically provided in the Policy.

In case of Section E – Hospital Daily Cash Benefit, the covers will be applicable on Worldwide basis, provided Benefit10 – Worldwide Cover under this Section is opted for.

All Claims shall be payable in India and shall be paid in Indian Rupees only.

6. 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.

7. Role of Group Administrator/ Policyholder

(a) The Policy holder should provide the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.
(b) In case of employer-employee policies, the employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.
(c) In case of such policies, claims of the individual employees may be processed through the employer
(d) In case of non-employer-employee policies, We shall generally issue the Certificate of Insurance. However, We may provide the facility to the Group Administrator to issue the Certificate of Insurance to the members.
(e) In case of such policies, the Group Administrator may facilitate the claims process for the members however the payment will be made only to the beneficiary which is the Insured Person

8. Renewal of Policy

Renewal notice for policies issued on Auto Renewal Basis:

- The Insurance Company shall automatically renew the Policy annually for the period it has been issued for. However on expiry of the Policy after completing its entire auto renewal period the Insurance Company shall not deduct any renewal premium nor give notice that such renewal premium is due.
- Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the Insured Person that may result to enhance the risk of the Insurance Company under the guarantee hereby given.
- No renewal receipt shall be valid unless it is on the printed form of the Insurance Company and signed by an authorised official of the Insurance Company. Any change in the risk will be intimated to the Insurance Company by the Insured Person. Nothing herein or otherwise shall affect the Company's right to impose any additional terms and conditions on renewal or restrict any renewal terms as to premium or otherwise.
- The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to the Insurance Company on or before the date of expiry of the Policy and in no case later than Grace Period of at least 30 days or as informed by Insurer from time to time.

Zurich Kotak General Insurance Company (India) Limited (Formerly known as Kotak Mahindra General Insurance Company 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.

9. Auto Debit / ECS (Electronic Clearing System) Payment Facility:

You may opt for the Auto Debit/ECS payment facility for your premium payments under this Policy subject to such facility being specifically availed by the Master Policyholder for all its group members/beneficiaries under the Policy. This facility can be opted by you for automatic premium payment under this Policy by submitting a duly signed Auto Debit/ECS mandate form in physical or electronic form. It may be noted that:

a. The premium amount under the Policy may 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 Auto Debit/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 Auto Debit/ECS mandate by giving Us at least 15 days' notice before the due date of next premium due under the Policy

The Auto Debit/ECS payment facility shall be governed by the guidelines issued by the Reserve Bank of India (and as may be amended from time to time)

10. 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.

11. 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/ Certificate of Insurance.
No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

12. 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/ Certificate of Insurance, during normal business hours or contact Our call centre.

13. 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,

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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.

14. Assignment Clause

An assignment of this policy of insurance, wholly or in part, whether with or without consideration, may be made only by an endorsement upon the policy itself or by a separate instrument, signed in either case by the assignor and attested by at least one witness, specifically setting forth the fact of transfer or assignment and the reasons thereof, the antecedents of the assignee and the terms on which the assignment is made. Such assignment shall be operative as against the Company effective from the date the Company receives a written notice of the assignment/request and endorses the same on the Policy.

The Company may, accept the assignment, or decline to act upon any endorsement, where it has sufficient reason to believe that such transfer or assignment is not bona fide or is not in the interest of the policyholder or in public interest or is for the purpose of trading of insurance policy. However, by recording the assignment the Company does not express any opinion upon the validity nor accepts any responsibility on the assignment.

15. 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.

16. 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.

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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.
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	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	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	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.
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	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	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	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).