LiveWise

PROSPECTUS

KEY HIGHLIGHTS OF THE POLICY (COVERS)

Covers will be available to the Insured Person, only if that particular cover is specifically mentioned in the Policy Schedule and also as per the Optional Covers opted by the Insured Person.

In-patient Treatment	Day Care Treatment	Modern Treatments	Pre-Hospitalization Medical Expenses
Post-Hospitalization Medical Expenses	AYUSH Treatment	Domiciliary Hospitalisation	Organ Donor Cover
Road Ambulance Cover	Cumulative Bonus	Unlimited Restoration Benefit	Unlimited E-consultations
Health Services	Annual Health Check-up	Double Cover	Cumulative Bonus Booster
Consumables Cover	Value Added Services	Wellness Benefit	Air Ambulance Cover
Pre-existing disease Waiting Period Modification	Specified disease/ procedure Waiting Period Modification	Smart Select	Room Category Modification
Deductible	Voluntary Co-Payment		

1) SAILENT FEATURES OF THE POLICY

Eligibility	
Min Entry Age	91 Days for Child and 18 years for Adult
Maximum Entry Age	No limit
Maximum Entry age for children	25 years, after which the Child will be considered as an Adult
Exit Age/ Renewal	The Policy provides for life-long renewal
Sum Insured	5 lac/ 7.5 lac/ 10 lac/15 lac/ 25 lac / 50 lac/ 100 lac
Policy Period	1/2/3 years
Policy Type	Individual/ Family Floater
Relationship covered	
For Individual	In case of an Individual Policy, each Insured person under the policy will have a separate sum insured.

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.

	Individual Policy - Self, Spouse / Partner, Your natural or adopted dependent children, Your parents, Your parents-in-law, Your siblings, Brother in Law, Sister in Law, Grandparents, Grandchild(ren).
For Family Floater	In case of a Family Floater policy, one family will share a single Sum Insured. Family Floater policy - A family floater policy can cover a maximum of 2 adults and 3 dependent children under a single policy Relationships covered - Self, Spouse / Partner, Your natural or adopted dependent children
	Natural/ Appointed Guardian can also take insurance for minor under their guardianship.
Premium Rate	Premium rate is as per Annexure to prospectus
Instalment Facility	Quarterly, Monthly and Half-yearly
Initial waiting period	30 days (Not applicable for accident cases)
Waiting period for Pre-existing Diseases	36 months for all age groups
Specified disease/ procedure Waiting Period	24 months for all age groups

Discounts and Loadings under the Policy	• Discounts
	  • Tenure Discount –
	  o 2 year policy – 4%
	  o 3 year policy – 6%
	  • Family Discount (Not applicable for Floater Policies) –
	  o Upto 2 members - 5%
	  o More than 2 members - 10%
	  • Cross Sell Discount (Applicable if the policyholder has one live policy) – 5%
	  • Group Employee Discount (Discount to employees of Zurich and Kotak Group companies) – 5%
	  • Aggregator Discount – 5%
	  • Direct Website Discount – 5%
	  • Discount in Lieu of Commission – 15%
	• Loadings
	  • Instalment facility (Applicable for one year policies)–
	  o Monthly Premium - 4%
	  o Quarterly Premium – 3.5%
	  o Semi Annual Premium - 2%

Pre-Policy Medical check-up	<table><tr><td>Sum Insured</td><td>5 / 7.5 / 10 / 15 / 25 Lacs</td><td>50/ 100 Lacs</td></tr><tr><td>Age</td><td>56 Years & Above</td><td>All ages</td></tr></table> In addition to the above, based on the declarations made in the proposal form and the medical assessment done by the Underwriter, the customer may be requested to undergo medical tests. Medical tests will be facilitated by us and conducted at Our network of diagnostic centers. The validity of such tests will be up to 30 days. The details of the medical test and the centre at which such tests shall be conducted will be informed to you before the medical examination.
Underwriting Loading	Underwriting loading up to 200% based on criteria mentioned in underwriting manual.

- Dependent Child under family floater policies after completion of 25 years shall be considered as adult for premium computation.
- 80 D benefit will not be available if any member other than self, spouse, dependent children, parents covered under Family Floater Policy
- In case of Individual Policy, if any member other than self, spouse, dependent children, parents are covered then 80D benefit will not be available to these members

TABLE OF BENEFITS

Base Covers	
In-patient Treatment	Upto Sum Insured
Day Care Treatment	All Day-care Surgeries & Procedures
Modern Treatments	Upto Sum Insured
Pre-Hospitalization Medical Expenses	60 days prior to hospitalization
Post-Hospitalization Medical Expenses	180 days after discharge
AYUSH Treatment	Upto Sum Insured
Domiciliary Hospitalisation	Upto Sum Insured
Organ Donor Cover	Upto Sum Insured
Road Ambulance Cover	Upto INR 20000 per year
Cumulative Bonus	50% increase in the Base Sum Insured for each renewal upto a maximum of 100%
Unlimited Restoration Benefit	Restoration up to the Base Sum Insured unlimited times in a Policy Year
Unlimited E-consultations	Available for Consultations with General Physicians

Health Services	Health Portal - Doctor on chat, Healthy tips reminder, etc. Discounts on services such as consultations, diagnostics, maternity etc at our network.
Optional Covers	
Annual Health Check-up	For each Insured Person for specified tests on cashless basis
Double Cover	100% of the Base Sum Insured as double cover
Cumulative Bonus Booster	100% increase in the Base Sum Insured for each claim free year upto a maximum of 5 times of the Base Sum Insured
Consumables Cover	Indemnity cover for Non-Medical items and consumables
Value Added Services	a. Dental Benefit b. OPD Benefit c. Maternity Benefit d. Get Fit Benefit
Wellness Benefit	a. Access to Digital Fitness Coaching b. Access to Artificial Intelligence Fitness Coaching c. Access to Nutritionist/Wellness Coach d. Renewal discount based on the step count
Air Ambulance Cover	Upto INR 5 Lacs per year
Pre-existing Diseases Waiting Period Modification	Option to reduce Pre-existing disease waiting period from 36 months to 24/12 Months
Specified disease/ procedure Waiting Period Modification	Option to reduce specified disease/ procedure waiting period of 24 months to 12 months
Smart Select	For listed Smart Select hospitals – Upto Sum Insured Other than listed Smart Select hospitals – Upto Sum Insured with additional co-payment of 20% in case of claim
Room Category Modification	Shared Room Cover Single Private Room Cover
Deductible	INR 25000/ INR 50000/ INR 100000/ INR 200000/ INR 500000/ INR 1000000
Voluntary Co-payment	10% / 15% / 20% / 25% / 30% / 35% / 40% / 45% / 50%

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

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

(a) availability of Total Sum Insured
(b) for any single Claim during a Policy Year, the maximum Claim amount payable shall be sum total of Base Sum Insured, Cumulative Bonus, Cumulative Bonus Booster (if applicable), Double Cover (if applicable)
(c) any sum insured or sub-limits specified in respect of that Cover for the Insured Person or sub-limits as specified in the Policy Schedule and
(d) the terms, conditions and exclusions of this Policy

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

2.A Base Covers

2.A.1. Hospitalization Expenses

If an Insured Person is diagnosed with an Illness or suffers an Injury and which requires the Insured Person to be admitted in a Hospital in India during the Policy Year and while the Policy is in force for:

2.A.1.1 In-patient Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalization provided that:

(a) The Hospitalisation is for a minimum and continuous period of 24 hours
(b) the Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
(c) the Medical Expenses incurred are Reasonable and Customary and may be for one or more of the following:
   i. Room Rent and other boarding charges;
   ii. ICU Charges;
   iii. Operation theatre expenses;
   iv. Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
   v. Qualified Nurses' charges;
   vi. Medicines, drugs and other allowable consumables prescribed by the treating Medical Practitioner;
   vii. Investigative tests or diagnostic procedures directly related to the Injury/Illness for which the Insured Person is Hospitalized
   viii. Anaesthesia, blood, oxygen and blood transfusion charges;
   ix. Surgical appliances and prosthetic devices recommended by the attending Medical Practitioner that are used intra operatively during a Surgical Procedure.
   x. Inpatient physiotherapy charges;

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

2.A.1.2 Day Care Treatment

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

(a) the Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;

(b) the Medical Expenses incurred are Reasonable and Customary;

Further,
(a) We will not cover any OPD Treatment under this Benefit.
(b) In case of Individual Policy, this payout will be available on individual basis and in case of Floater Policy the payout will be available on floater basis

2.A.1.3 Modern Treatments

We will indemnify the Medical Expenses incurred on the following advance technology methods (wherever medically indicated) either as In-patient or as part of Day Care Treatment in a Hospital during the Policy Period:
(i) Uterine Artery Embolization and HIFU (High intensity focused ultrasound)
(ii) Balloon Sinuplasty
(iii) Deep Brain stimulation
(iv) Oral chemotherapy
(v) Immunotherapy- Monoclonal Antibody to be given as injection
(vi) Intra vitreal injections
(vii) Robotic surgeries
(viii) Stereotactic radio surgeries
(ix) Bronchial Thermoplasty
(x) Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)
(xi) IONM - (Intra Operative Neuro Monitoring)
(xii) Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.

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

2.A.1.4 Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

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

Further,
(a) We will pay Pre-Hospitalisation Medical Expenses up to the 60 days preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment; provided that the Company shall not be liable to make payment for any Pre-hospitalization Medical Expenses that were not incurred during the Policy Year.

(b) We will pay Post-Hospitalisation Medical Expenses up to 180 days 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

2.A.1.5 AYUSH Treatment

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

(a) The AYUSH Treatment is administered by a Medical Practitioner who holds a valid practicing license in respect of such AYUSH Treatments;
(b) The Insured Person is admitted to AYUSH Hospital for In-patient treatment or Day Care treatment

Further,

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

3.4 Permanent Exclusion (27) shall not be applicable to the extent of AYUSH treatment.

2.A.1.6 Domiciliary Hospitalisation

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

(a) We will cover medical expenses of an Insured person for treatment of a disease, Illness or Injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable.
(b) The domiciliary hospitalisation is Medically Necessary and follows the written advice of a Medical Practitioner
(c) The Medical Expenses incurred are Reasonable and Customary Charges;
(d) The Insured Person's Domiciliary Hospitalisation extends for at least 3 consecutive days in which case We will pay Medical Expenses from the first day of Domiciliary Hospitalisation;
(e) If a claim is accepted under this Benefit, then We shall pay Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses under Section 2.A.1.4 for the same Illness/Injury.

Further,

(a) We shall not indemnify for any Medical Expenses incurred for the treatment of any of the following Illnesses/conditions under this Cover:
    i. Asthma;
    ii. Bronchitis;

iii. Chronic Nephritis and Chronic Nephritic Syndrome;
iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis;
v. Diabetes Mellitus and Insipidus;
vi. Epilepsy;
vii. Hypertension;
viii. Influenza, cough and cold;
ix. psychiatric or psychosomatic disorders;
x. Pyrexia of unknown origin for less than 10 days;
xi. Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
xii. Arthritis, Gout and Rheumatism.

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

2.A.1.7 Organ Donor Cover

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ during the Policy Period, provided that:

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

Further,

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

Room Rent Conditions applicable for 2.A.1. Hospitalization Expenses:

The eligible Room rent or Room category coverage under the Policy is "No limit" or as opted for and specified in the Policy Schedule, subject to maximum of Sum Insured opted. For ICU accommodation, we will cover up to Sum Insured opted or as specified in the Policy Schedule.

2.A.2 Road Ambulance Cover

We will indemnify the amount incurred up to the limit specified in the Policy Schedule for the reasonable expenses incurred by You on availing ambulance services offered by a healthcare or

Ambulance service provider for your necessary transportation to the Hospital for treatment of an Illness or Injury following an Emergency provided that:

(a) We have accepted a Claim under Hospitalization Expenses and the Ambulance service relates to the same illness / medical condition
(b) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;

Further,

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

2.A.3 Cumulative Bonus

We will increase Your Base Sum Insured by 50% subject to the maximum limit of 100% at the end of the Policy Year if the Policy is renewed with Us provided that:

(a) Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons who were Insured Persons in the immediately completed Policy Year;
(b) If the Base Sum Insured is increased at the time of Renewal, then the Cumulative Bonus will be calculated on the Base Sum Insured of the immediately completed Policy Year;
(c) If the Base Sum Insured is reduced at the time of Renewal, then the applicable Cumulative Bonus will be applicable on the renewed policy Base Sum Insured.
(d) Cumulative Bonus will be carried forward to the next Policy Year, provided the Insured Person renews the Policy before the expiry of the Grace Period.
(e) If the Policy Period is more than one year, then any Cumulative Bonus that has accrued for the Policy Year will be credited at the end of the Policy Year and shall be available for any claims made in the subsequent Policy Year.
(f) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a floater basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest among all the Insured Persons.
(g) If the Insured Persons in the expiring Policy are covered on a floater basis and such Insured Persons renew their expiring Policy with Us into two or more floater/individual policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Base Sum Insured of each Renewed Policy.
(h) The 'Unlimited Restoration Benefit' and Optional Benefit: 'Double Cover' amount shall not be considered while calculating 'Cumulative Bonus'.
(i) Accrued 'Cumulative Bonus' can be utilized for Base Covers - 'Hospitalization Expenses', ' Road Ambulance Cover' under the Policy.

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2.A.4 Unlimited Restoration Benefit

If a Claim is payable under the Policy, We will provide restoration up to the Base Sum Insured unlimited times in a Policy Year, only after the Base Sum Insured, the Cumulative Bonus (if any), Cumulative Bonus Booster (if any) and Double Cover (if any) have been completely exhausted in that Policy Year, provided that:

(a) A Claim will be admissible under the Unlimited Restoration Benefit only if the Claim is admissible under Cover 'Hospitalization Expenses'.
(b) The restored sum insured can be utilised in respect of any illness (related as well as different) and its complications except for claim under "Any one Illness" condition.
(c) All Insured Persons will be eligible to utilize the restored amount for any Illness or Injury pertaining to that Policy Year.
(d) Applicable Cumulative Bonus/ Cumulative Bonus Booster/ Double Cover (if opted for) shall not be considered while calculating Unlimited Restoration Benefit.
(e) No Cumulative Bonus/ Cumulative Bonus Booster (if opted for) will apply on the restored sum insured;
(f) The restored sum insured will apply to all Insured Persons on the same basis as the Base Sum Insured i.e. individual sum insured in case of Individual Policy and floater sum insured in case of Floater Policy;
(g) Any restored sum insured which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year;
(h) The Sum Insured available under this Benefit can only be utilized for Covers – 'Hospitalization Expenses' and 'Road Ambulance Cover'.

2.A.5 Unlimited E-consultations

We shall offer unlimited e consultations with qualified General Physicians at our network during the Policy Year through any digital mode of communication (Voice/Video Call /Chat /Email Chat/ etc.)

2.A.6 Health Services

The Benefits listed below shall be available to the Insured Persons.

Health Portal: The insured may access health related information and services such as Doctor on chat, Healthy tips reminder, Digital locker for medical records etc. as available on Company's website/ Mobile application.

Discount Connect: The Insured Person may access Special rates for OPD, Diagnostics, maternity, Pharmacy etc. through Network as available on the Company's website/ Mobile application.

2.B Optional Covers

2.B.1 Annual Health Check-up

On the Insured Person's request, We will arrange for the Insured Person's Annual health check-up at Our Network Provider on cashless basis for the specified tests listed below subject to:

- This Benefit shall be available only once during a Policy Year per Insured Person.
- This will be offered regardless of any claim admitted/ registered under the Policy.

Medical Tests applicable for Insured Persons who are of Age 18 years or above on the Policy Period Start Date

Sum Insured	List of Medical tests
<=10 lacs	Complete Blood Count (CBC), Urine Routine, ESR, ABO Group & Rh Type, Blood Sugar Fasting, Cholesterol, Cholesterol Direct LDL, Cholesterol-HDL, Triglycerides, Total Cholesterol/HDL Ratio, Creatinine, Blood Urea Nitrogen, Bun/ Creatinine Ratio, Uric Acid
> 10 lacs	Complete Blood Count (CBC), Urine Routine, ESR, ABO Group & Rh Type, Blood Sugar Fasting, Cholesterol, Cholesterol Direct LDL, Cholesterol-HDL, Triglycerides, Total Cholesterol/HDL Ratio, Creatinine, Blood Urea Nitrogen, Bun/ Creatinine Ratio, Uric Acid, Treadmill Test

Medical Tests applicable for Insured Persons who are of Age below 18 years on the Policy Period Start Date

List of Medical tests
Physical Examination (Height, Weight and Body Mass Index (BMI)), Eye Examination, Dental Examination and Scoring, Growth Charting, Doctor Consultation, Urine Examination (Routine and Microscopic)

2.B.2 Double Cover

In case this Cover is opted for, We will provide an additional 100% of Base Sum Insured as Double Cover, which can be utilized for claims incurred under the Policy, for the particular Policy Year, provided that:

i. The benefit shall be available only if the Company has accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy
ii. The benefit shall be available only after full exhaustion of Base Sum Insured under the Policy.
iii. The Company's overall liability for all claims, in aggregate, within a Policy Year under this benefit shall be limited to 100% of the Base Sum Insured
iv. While calculating Cumulative Bonus, Double Cover shall not be considered.
v. Any unutilized Double Cover Sum Insured, in whole or in part shall not be carried forward to subsequent Policy Years.

vi. The Double Cover will be available on individual basis for individual policies and on floater basis for floater policies.

2.B.3 Cumulative Bonus Booster

You can opt for the Cumulative Bonus Booster as an extension to Cumulative Bonus benefit and all provisions stated under the Cumulative Bonus benefit will be applicable to Cumulative Bonus Booster in addition to the below mentioned terms and conditions:

a) If no claim has been made in the expiring Policy Year and the Policy is renewed with the Company without any break, the Insured Person would receive a flat 100% increase in the Sum Insured on a cumulative basis as Cumulative Bonus Booster for each completed and continuous Policy Year.
b) Cumulative Bonus Booster will be over and above the Base Sum Insured and Cumulative Bonus accrued under the Policy.
c) In any Policy Year, the accrued Cumulative Bonus Booster shall not exceed 500% of the Base Sum Insured available in the expiring policy or renewed Policy, wherever the sum insured is lower.
d) In the event of a claim there is no impact on the accrual of Cumulative Bonus Booster
e) The restoration amount and Double Cover will not be considered while calculating Cumulative Bonus Booster.
f) In case no claim is made in the particular Policy Year, Cumulative Bonus Booster would be credited automatically to the subsequent Policy year, even in case of multi-year Policies.
g) At the time of Policy renewal if the Policyholder chooses not to renew this Optional Benefit, then the Cumulative Bonus Booster under the expiring Policy shall be forfeited.

2.B.4 Consumables Cover

In case this Cover is opted for, We will cover the cost of Non-Medical items, listed under Annexure II List 1 of the Policy, incurred towards Medically Necessary Hospitalization of the Insured Person, arising out of Disease/ Illness or Injury.

The cover is available subject to the claim being admissible under Part II 2.A.1.1 In-patient Treatment and/ or Benefit 2.A.1.2 Day Care Treatment cover under this Policy and the expenses on Non-medical items are related to the same Illness/ Injury.

3.4 Permanent Exclusion (16) shall not be applicable for this benefit.

2.B.5 Value Added Services

The Benefits listed below shall be available to the Insured Persons as per the Pack opted and specified in the Policy Schedule.

The Benefits available can be availed via mobile application/ health portal. All services shall be provided through our service provider's network subject to availability at the time of appointment.

The notifications related to the Insured Person's appointments as per the benefit opted, will be communicated via SMS, email and the program specific mobile application/portal. The mobile app must be downloaded within 30 days of the policy start date to avail this benefit.

30 days waiting period will be applicable to avail the benefit under this cover.

2.B.5.1 Dental Benefit

The Benefits shall be available to the Insured Persons as per the Pack opted and specified in the Policy Schedule, The Insured Person shall have access to the below mentioned Benefits through our Service Provider's Network as specified on the Health portal/ App.

Benefits
Unlimited Tele consultations with Dentists
Unlimited Physical OPD Consultations - Within Network as defined by Service Provider
Discount on dental treatments/procedures

Any unutilized services cannot be carried forward to the next Policy Year.

3.4 Permanent Exclusion (19) shall not be applicable for this Benefit.

2.B.5.2 OPD Benefit

The Benefits listed below shall be available to the Insured Persons as per the Pack opted and specified in the Policy Schedule. The Benefits available can be availed only on cashless basis upto the limits specified below via Health portal/ App. All services shall be provided through our Service Provider's Network subject to availability at the time of appointment.

Service Type	Pack 1	Pack 2	Pack 3	Pack 4	Pack 5	Pack 6	Pack 7
Cover Limit	**INR 10,000**	**INR 10,000**	**INR 20,000**	**INR 20,000**	**INR 50,000**	**INR 50,000**	**INR 50,000**
Teleconsultations with GPs	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Teleconsultations with Specialists	Yes	Yes	Yes	Yes	Yes	Yes	Yes
In-Clinic consultations with GPs	Unlimited usage with a capping of Rs.600 per consultation	Unlimited usage with a capping of Rs.600 per consultation	Capped at 80% of Sum Insured	Capped at 80% of Sum Insured	Capped at 80% of Sum Insured	Capped at 80% of Sum Insured	Capped at 80% of Sum Insured

In-Clinic consultations with Specialists	No	No					
Prescribed Diagnostics within the Service Provider Network on cashless basis for the above mentioned Teleconsultations and In-Clinic consultations	Unlimited usage upto Rs 600 per prescription	Unlimited usage upto Rs 600 per prescription	Capped at 20% of Sum Insured	Capped at 20% of Sum Insured	Capped at 20% of Sum Insured	Capped at 20% of Sum Insured	Capped at 20% of Sum Insured
Discounted Pharmacy	Yes	Yes	Yes	Yes	Yes	Yes	Yes

3.4 Permanent Exclusion (19) shall not be applicable for this Benefit.

Any unutilized services cannot be carried forward to the next Policy Year.

2.B.5.3 Maternity Benefit

The Benefits shall be available to the Insured Persons as per the Plan opted and specified in the Policy Schedule, The Insured Person shall have access to the Benefits given below through our Service Provider's Network as specified on the Health portal/ App.

The Benefits available can be availed only on cashless basis upto the limits specified below via Health portal/ App. All services shall be provided through our Service Provider's Network subject to availability at the time of appointment.

Benefits	
Maternity Benefit#	Upto Rs. 25,000/- discount within Network as defined by Service Provider
Discount on Gynaecologist Consultation, Diagnostics, Vaccination, Pharmacy	Up to 20% discount within Network as defined by Service Provider
* For detailed list of Network as defined by Service Provider, kindly refer to Mobile App/ Health Portal	

#This benefit will not be applicable for termination of pregnancy / complications traceable to pregnancy.

3.4 Permanent Exclusion 15(i) shall not be applicable for this Benefit.

2.B.5.4 Get Fit Benefit

The Benefits listed below shall be available to the Insured Persons who are above 12 years of age as per the Pack opted as specified in the Policy Schedule and can be availed only on cashless basis upto the limits specified below via Health portal/ App. All services shall be provided through our Service Provider's Network subject to availability at the time of appointment.

Service Type	Pack 1	Pack 2	Pack 3	Pack 4	Pack 5	Pack 6	Pack 7
Pre-recorded Fitness & Yoga Sessions (300+)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Guided Meditations and Mental Health Podcasts (150+)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8 Gym Sessions per month (6 Month Plan)	No	Yes	No	No	No	No	No
12 Gym Sessions per month (6 Month Plan)	No	No	No	Yes	No	Yes	No
Unlimited Sessions (6 Month Plan)	No	No	No	No	No	No	Yes

Note - # Number of sessions will be as per the Pack opted and mentioned in the Policy Schedule.

Terms and Conditions for Value Added Services:

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

- 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 notifications related to the Insured Person's OPD appointments/ consultations or medications will be communicated via SMS, email and the program specific mobile application/portal. The mobile app must be downloaded within 30 days of the policy risk start date to avail this benefit.

2.B.6 Wellness Benefit

The Benefits listed below shall be available to the Insured Persons covered as Adult aged 18 years and above in the Policy via mobile application/ health portal:

1) Discount on renewal premium under our Wellness Benefit wherein You need to complete number of steps per day as per the table given below, that will help You in improving Your well-being.

Number of Healthy Days (10,000 Steps and above per day)	**Discount on Renewal Premium**
270 days and above	30%
240 – 269 days	20%
180 –239 days	15%
120 – 179 days	10%
< 120 days	Nil

Conditions applicable to this benefit:

a) The number of days specified in the table above should fall within Policy Year. The activities undertaken towards this benefit during the last 2 (two) months of the Policy tenure shall not be considered for reward calculation. The same shall carry forward and will be considered in next Policy Period.
b) This wellness benefit is available only for the adult members with age 18 years and above. However, in a Floater policy, this program shall be available only to the independent adult members and shall not be available to dependent children.
c) The above benefit will be applicable on Individual basis. In case of floater, average of number of Healthy days earned by all Insured Members shall be considered for calculating renewal discount. For example,' A' has attained 260 Healthy days and ' B' has attained 230 Healthy days, average of the Healthy days is 245 and accordingly the discount calculated is 20%. In case of multi tenure, average of number of Healthy days earned over the policy tenure shall be considered for discount.
d) Redemption against renewal premium will be available only at the time such renewal is due. Any earned rewards will lapse at the end of the grace period if the policy is not renewed with us.
e) In case of instalment premium mode is opted, then discount shall be considered only post payment of first 6 months of premium.

f) Vouchers of value equivalent to renewal discount amount can also be provided to Insured in case he/she does not wish for discount on renewal premium.

2) Access to Digital Fitness Coaching
3) Access to Artificial Intelligence Fitness Coaching
4) Access to Nutritionist/Wellness Coach

The above services (2, 3, 4) shall be available at Company's Network and available to Insured Members aged above 12 years subject to the following conditions:

i. The services will be provided through an empanelled Provider only. Choice of the Insured Person in utilizing the services of Provider will be entirely his/ her own and Company will have no liability towards the quality of services provided by the Provider
ii. The company shall not be responsible for any disputes arising between the Insured Person and the empanelled Provider
iii. The network under this benefit, does not constitute medical advice of any kind and it is not intended to be, and should not be, used to diagnose or identify treatment for a medical or mental health condition

The notifications related to Wellness Program will be communicated via SMS, email and the program specific mobile application. Details about reward points will be available on the program app or would be shared through SMS and/or Renewal Notice which would be sent to customers. The mobile app must be downloaded within 30 days of the policy risk start date to avail this benefit. The average step count completed by an Insured member would be tracked on our mobile application/ portal. We reserve the right to remove or reduce any count of steps if found to be achieved in unfair manner by manipulation.

2.B.7 Air Ambulance Cover

We will indemnify the Insured Person up to the amount as specified in Policy Schedule, for the Reasonable and Customary Charges necessarily incurred on availing Air Ambulance services, in India, offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation, provided that:

i. The treating Medical Practitioner certifies in writing that the severity or the nature of the Insured Person's Illness or Injury warrants the Insured Person's requirement for Air Ambulance;
ii. The transportation expenses under this Optional Benefit include transportation from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or transportation from one Hospital to another Hospital for the purpose of providing advanced/ better equipped medical support/aid to the Insured Person, following an Emergency;
iii. This benefit will be extended only through Cashless Facility, if the costs are certified and authorized by Us in advance. In case the Insured Person has a Life Threatening Medical Condition and the Insured Person (or his representatives) arranges for the emergency Air Ambulance at their own expense, then the Company will reimburse such costs incurred in accordance with the terms of this Optional Benefit

iv. Payment under this Optional Benefit is subject to a Claim for the same Illness or Injury being admitted by Us under 2.A.1. Hospitalization Expenses
v. Additional Documents to be submitted for any Claim under this Benefit:

a. It is a condition precedent to Our liability under this Optional Benefit that the following information and documentation shall be submitted to Us immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:
b. Medical reports and transportation details issued by the air ambulance service provider, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirm the necessity of air ambulance services
c. Documentary proof for expenses incurred towards availing Air Ambulance services.

2.B.8 Pre-existing Diseases Waiting Period Modification

In case this Cover is opted for, the applicable Pre-existing Diseases waiting period of 36 months shall be modified to specific time period as mentioned in the Policy Schedule.

This option is available only at the time of first purchase (at the inception) of Policy.

Cover once opted cannot be withdrawn from the Policy.

2.B.9 Specified disease/ procedure Waiting Period Modification

In case this Cover is opted for, the applicable Specified disease/ procedure waiting period of 24 months shall be modified to 12 months.

This option is available only at the time of first purchase (at the inception) of Policy

Cover once opted cannot be withdrawn from the Policy.

2.B.10 Smart Select

In case, this Cover is opted, the policyholder is entitled for a discount subject to following conditions.

(a) If the Insured Person takes the Medical Treatment in hospitals other than those listed in Annexure III to the Policy wordings (please refer to website – www.zurichkotak.com for the updated list of Hospitals), then the Policyholder/Insured Person shall bear a co-payment of 20% on each and every Claim arising in such regard which will be in addition to any other co-payment (if any) applicable in the policy.
(b) However, no such additional co-payment shall be applicable if treatment is availed in the hospitals listed in Annexure III to the policy terms and conditions.

2.B.11 Room Category Modification

Notwithstanding anything to the contrary in the Policy, if this Optional Benefit is opted, the Company agrees to modify the Room Rent / Room Category to Single Private AC room / Shared room as specified in Policy schedule.

If the Insured Person is admitted in a Hospital room where the Room Category opted or Room Rent incurred is higher than the eligible Room Category/ Room Rent as specified in the Policy Schedule, then We will be liable to pay only a ratable proportion of the Associated Medical Expenses (including applicable surcharge and taxes thereon) in the proportion of the difference between the Room Rent actually incurred and the Room Rent specified in the Policy Schedule or the Room Rent of the entitled Room Category to the Room Rent actually incurred.

2.B.11.1 Shared Room Cover

In case, this Cover is opted, We will restrict the Room category coverage up to 'Shared Room' subject to maximum of Total Sum Insured under the Policy.

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

The "Room Rent Conditions" as mentioned under 2.A.1. Hospitalization Expenses will be applicable to this cover.

2.B.11.2 Single Private Room Cover

In case, this Cover is opted, We will restrict the Room category coverage up to 'Single Private AC Room' subject to maximum of Total Sum Insured under the Policy.

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

The "Room Rent Conditions" as mentioned under 2.A.1. Hospitalization Expenses will be applicable to this cover.

Note:

- The nomenclature of Room categories may vary from one hospital to the other. Hence, the final consideration will be as per the definition of the Rooms mentioned in the Policy.
- Further, proportionate deductions will not be applied in respect of ICU Charges.

2.B.12 Deductible

You can opt for a Deductible in the Policy which will be specified in the Policy Schedule. Wherever a Deductible is selected such amount will be applied for each Policy Year on the aggregate of all Claims in that Policy Year.

Deductible is applicable on the Benefits namely Hospitalization Expenses, Road Ambulance Cover, Consumables Cover, Double Cover and Air Ambulance Cover.

For the purpose of calculating the deductible and assessment of admissibility all claims must be submitted in accordance with Section 5 Claims Procedure.

All other terms, conditions, waiting periods and exclusions shall apply.

Deductible once opted can be Changed / withdrawn only at renewal subject to Underwriting.

Illustration for applicability of Deductible in the same Policy Year:

Sr No	Sum Insured	Deductible Opted	Claim Amount	Deductible Exhaustion	Balance Deductible	Claim Payable
At Inception	1000000	200000	0	0	0	0
Claim 1	1000000		150000	150000	50000	0
Claim 2	1000000		200000	150000+ 50000	0	150000
Claim 3	1000000		500000	200000	0	500000

2.B.13 Voluntary Co-Payment

If this Optional Benefit is opted, then the Insured Person will have an option to bear a Co-payment, as specified in the Policy Schedule, and the Company's liability shall be restricted to the balance amount payable.

The Co-payment proportion (If opted) shall be borne by the Insured Person on each Claim which will be applicable on the Benefits namely Hospitalization Expenses, Road Ambulance Cover, Consumables Cover, Double Cover and Air Ambulance Cover.

The Co-payment shall be applicable to each and every claim for each Insured member as defined in the Policy

Co-pay once opted can be Changed / withdrawn only at renewal subject to Underwriting

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

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

3.1 Pre-Existing Diseases (Code – Excl01)

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

3.2 30 Day Waiting Period (Code – Excl03)

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months (or period as mentioned in the Policy Schedule) 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
    1) Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders, Joint Replacement Surgery, Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
    2) Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal
    3) Septum Deviation, Sinusitis and related disorders

4) Benign Prostatic Hypertrophy
5) Cataract
6) Dilatation and Curettage
7) Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
8) Surgery of Genito-urinary system unless necessitated by malignancy
9) All types of Hernia & Hydrocele
10) Hysterectomy for menorrhagia or Fibromyoma or prolapse of uterus unless necessitated by malignancy
11) Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
12) Kidney Stone / Ureteric Stone /Lithotripsy / Gall Bladder Stone
13) Myomectomy for fibroids
14) Varicose veins and varicose Ulcers
15) Parkinson's or Alzheimer's disease or Dementia

3.4 Permanent Exclusions

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

1. Investigation & Evaluation (Code- Excl04)

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

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

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

3. Obesity/ Weight Control (Code – Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
   i. Obesity-related cardiomyopathy
   ii. Coronary heart disease
   iii. Severe Sleep Apnea
   iv. Uncontrolled Type2 Diabetes

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

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

5. Cosmetic or plastic Surgery (Code – Excl08)

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

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

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

7. Breach of law (Code – Excl10)

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

8. Excluded Providers: (Code- Excl11)

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

9. Code- Excl12

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

10. Code- Excl13

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

11. Code- Excl14

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

12. Refractive Error (Code- Excl15)

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

13. Unproven Treatments (Code – Excl16)

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

14. Sterility and Infertility (Code- Excl17)

Expenses related to sterility and infertility. This includes:

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

15. Maternity (Code- Excl18)

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

16. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II to Policy Terms & Conditions).

17. Taking part or is supposed to participate in a naval, military, air force operation or aviation in a professional or semi-professional nature.

18. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

19. Charges incurred in connection with routine eye examinations and ear examinations, dentures, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment

20. Any expenses incurred on external prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walkers, glucometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.

21. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.

22. Screening, counseling or treatment of any external Congenital Anomaly, Illness or defects or anomalies or treatment relating to external birth defects.

23. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability.

24. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

25. All preventive care (except eligible and entitled for Benefit: 'Annual Health Check-up'), Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics.

26. Expenses incurred for Artificial life maintenance, including life support machine use, post confirmation of vegetative state or brain dead by treating medical practitioner where such treatment will not result in recovery or restoration of the previous state of health under any circumstances.

27. Non - Allopathic Treatment, Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or treatment related to any unrecognized systems of medicine.

28. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds

29. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs, alcohol or hallucinogens.

30. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness.

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31. Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies.

32. Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head or transportation charges by visiting consultant.

33. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

    a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

    b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

    c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro – organisms and / o r biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

34. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner.

35. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions.

36. Remicade, Avastin or similar injectable treatment which is undergone other than as a part of In- Patient Care Hospitalisation or Day Care Hospitalisation is excluded.

37. Expenses related to any kind of Modern Treatment Methods other than mentioned in the Clause 2.A.1.3

38. Hormone replacement therapy.

39. Any other exclusion as specified in the Policy Schedule.

Note: In addition to the foregoing, any loss, claim or expense of whatsoever nature arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above Permanent Exclusions shall also be excluded.

4) CLAIM ADMINISTRATION

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

i. 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;
ii. If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim. Such medical examination will be carried out only in case of reimbursement claims with prior consent of the Insured Person;
iii. 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;
iv. If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

5) CLAIMS PROCEDURE

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

1.1 For Cashless Facility

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

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

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

(v) Photo ID
(vi) Address proof, and photo to comply with KYC norms

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

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

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

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

In the event of claims, please send the relevant documents to:
<Details of the TPA>

(b) Pre-authorization for Emergency Care:

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

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

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

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

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determine the admissibility of the request for pre-authorisation, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

Turn Around Time (TAT) for settlement of Reimbursement is within 15 days from the receipt of the complete documents.

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

1.2 For Reimbursement Claims

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

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

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

1.3 Utilisation of Sum Insured

The sequence for utilisation of Total Sum Insured in the event of claim will be done as per below order depending on the terms and conditions of the respective Covers:

i. Base Sum Insured
ii. Cumulative Bonus (if any)
iii. Cumulative Bonus Booster (if opted)
iv. Double Cover (if opted)
v. Unlimited Restoration Benefit (Inbuilt)

6) CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which

the use of Cashless Facility has been approved, We will be provided with these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

i. Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);
ii. Hospital discharge summary;
iii. First consultation and follow up treatment papers;
iv. Original bills and receipts from the Hospital/Medical Practitioner;
v. Original bills from chemists supported by proper prescription;
vi. Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
vii. Indoor case papers, if available;
viii. Implant Invoice/ Sticker, if available;
ix. Ambulance Invoice, if applicable;
x. FIR (if done) or MLC (if conducted) for Accident cases;
xi. Post mortem report (if conducted);
xii. KYC documents viz. Photo ID and address proof along with duly completed form.
xiii. Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

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

i. Original Pre – authorization request
ii. Copy of Pre – authorization approval letter
iii. Copy of the photo identity document of the Insured Person;
iv. KYC documents obtained at the time of cashless facility.

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

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

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

(b) All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need

to send Medical Expenses being incurred along with the following information and documentation:

(i) Duly Completed Claim Form
(ii) Original bills and receipts from the Hospital/Medical Practitioner;
(iii) Investigation Payment Receipt
(iv) Original Investigation Report
(v) Original Pharmacy Bills
(vi) Original Pharmacy Prescription
(vii) Copy of Discharge Summary

7) General Terms and Clauses

1. Disclosure of Information

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

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

2. Condition Precedent to Admission of Liability

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

3. Complete Discharge

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

4. Multiple Policies

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

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured

is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

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

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

5. Fraud

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

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

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

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

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

6. Free Look Period

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

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

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

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

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

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

7. Cancellation

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-
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.

8. Portability

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

9. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person.

i. The Company shall endeavour 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 at least 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

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

11. Withdrawal of Policy

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

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as

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cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

12. Premium Payment in Instalments

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

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

ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date.

v. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable. (This clause will not apply to claims arising under 'Unlimited E-consultations', 'Health Services', 'Annual Health Check-up', 'Value Added Services' and 'Wellness Benefit')

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

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

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

14. Moratorium Period

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

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sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

15. Nomination

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

16. Redressal of Grievance

In case of any grievance the insured person may contact the company through
Website: www.zurichkotak.com
Toll free: 18002664545
E-mail: care@zurichkotak.com
Courier:
Zurich Kotak General Insurance Company (India) Limited, 401, 4th Floor, Silver Metropolis, Jai Coach Compound, Off Western Express Highway, Goregaon (East), Mumbai- 400063. Maharashtra, India.

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievanceofficer@zurichkotak.com
For updated details of grievance officer, kindly refer the link:
https://www.zurichkotak.com/customer-support/grievance-redressal-process

For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at seniorcitizen@zurichkotak.com

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

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

The details of the Insurance Ombudsman is available at Annexure I

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

17. Claim Settlement (Provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 15 days from the date of receipt of 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)

18. Eligibility

Family Floater policy - A family floater policy can cover a maximum of 2 adults and 3 dependent children under a single policy
Relationships covered - Self, Spouse / Partner, Your natural or adopted dependent children

Individual Policy - Self, Spouse / Partner, Your natural or adopted dependent children, Your parents, Your parents-in-law, Your siblings, Brother in Law, Sister in Law, Grandparents, Grandchild(ren).

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

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

19. Material Change

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

20. No constructive Notice

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

21. Terms and condition of the Policy

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

22. Zone Classification

Zone I – Delhi NCR, Mumbai Metropolis Area (Including Mumbai Suburban, Thane, Palghar, Raigad, any other city defined by government), Gujarat, Aligarh, Mathura
(Delhi NCR includes Delhi, Baghpat, Bulandshahr, Gautam Buddh Nagar, Ghaziabad, Hapur, Meerut, Muzaffarnagar, Shamli, Charkhi Dadri, Faridabad, Gurugram, Jhajjar, Jind, Karnal, Mahendragarh, Nuh, Palwal, Panipat, Rewari, Bhiwani, Alwar, Bharatpur, Rohtak, Sonipat, any other city defined by government)

Zone II – Rest Of India

- Identification of Zone will be based on the city of the Proposer.
- A single Zone shall be applicable to all members covered under the Policy.
- You also have an option of selecting another Zone from the applicable Zones of any of the Insured Person(s) in the Policy.
- Option to select a Zone higher than that of the actual Zone is available on payment of relevant premium at the time of buying the Policy or at the time of Renewal.
- Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to an Accident.
- In case of treatment taken in a city, in a Zone higher than the eligible Zone for the Insured Person, the Co-payment percentages as below shall apply:

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

23. Underwriting and Loadings

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

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

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

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

In case policies are accepted with loadings, waiting period for Pre-Existing Disease (Section 3.1) as well as Specified disease/ procedure (Section 3.3) shall continue to be applicable.

Alterations such as increase/ decrease in Base Sum Insured or change in covers or addition/deletion of Insured Persons will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. Underwriting in relation to acceptance of request for changes will be based mainly as per underwriting policy of the company. The terms and conditions of the existing policy will not be altered. Increase/ Enhancement of Base Sum Insured shall be allowed up to maximum Base Sum Insured available under the Policy.

On Renewal of the Policy if an increased Base Sum Insured is requested then the elapsed period for existing diseases/ illness / injury shall be limited to the Base Sum Insured of the immediately completed Policy Period. Further, the waiting periods will apply afresh in relation to the amount by which the Base Sum Insured has been enhanced.

24. Cause of Action/ Currency for payments

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

25. Policy Disputes

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

26. Special Provision for Insured Person who are Senior citizen

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

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27. Communications & Notices

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

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

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

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

28. Customer Service

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

29. ECS/ Auto Debit Payment Facility:

You are eligible for availing the ECS / Auto Debit payment facility for your premium payments under this Policy. This facility can be opted for automatic premium payment under this Policy for such premium paying term as availed by you under this Policy by submitting a duly signed ECS / Auto Debit mandate form. You may opt for any premium payment term as per your convenience but in accordance with the Policy terms and conditions. Please note that this facility may not be available for all the Banks at present however and you are requested to kindly visit website: www.zurichkotak.com to check the updated list of all partner banks facilitating the ECS /Auto Debit facility from time to time. Additionally, the following conditions shall apply in case of ECS / Auto Debit facility opted by you –

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

The term ECS / Auto Debit herein shall be governed by the Electronic Clearing Service (Debit) Procedural Guidelines issued by the Reserve Bank of India (as may be amended from time to time)

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and shall mean an electronic facility for effecting periodic insurance premium payment transactions in an automated manner.

30. Electronic Transactions

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

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

31. Automatic change in Coverage under the policy

The coverage for the Insured Person(s) shall automatically terminate in the case of any Insured Person's demise during the policy period/year:

Termination of cover takes place on account of death of the insured person and pro-rata refund of premium of deceased insured person is processed for the unexpired policy period, provided no claim has been made. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other insured persons may also apply to renew the policy. In case, the other insured person is minor, the policy shall be renewed only through any one of his/her natural guardian or guardian appointed by court. All relevant particulars in respect of such person (including his/her relationship with the insured person) must be submitted to the company along with the application.

Statutory Warning - Prohibition Of Rebates (Under Section 41 of Insurance Act 1938)

1) No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property, in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.
2) Any person making default in complying with the provisions of this section shall be liable for a penalty

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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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