

Surrogacy Care

Prospectus

Introduction

Surrogacy Care covers surrogate mother or oocyte donor for complications arising out of surrogacy procedure or oocyte retrieval.

Key Features

This Policy covers only Allopathic treatments taken in India for

- Surrogate mothers covering complications arising out of pregnancy through surrogacy and post-partum delivery complications during the Policy Period.
- Oocyte Donor covering complications arising due to oocyte retrieval during the Policy Period.

Product Details

Sum Insured Options – 5 lacs, 10 lacs

Policy Type – Individual Sum insured

Eligibility	Oocyte Donor (Section 1)	Surrogate Mother (Section 2)
Age	Min-21 yrs Max-55 yrs	Min-21 yrs Max- 55 yrs
Insured Relationship	Self , Oocyte Donor	Surrogate Mother
Proposer	Intending Couple Intending Woman	Intending Couple Intending Woman
Policy Tenure	1 year	3 years

Note – The eligibility criteria may get updated as per the applicable surrogacy laws / ART rules in India from time to time.

Benefit Details

Benefit Details	Section 1 - Oocyte Donor	Section 2 - Surrogate Mother
In-Patient Treatment	Covered upto the opted Sum Insured	Covered upto the opted Sum Insured
Day Care Treatment	Covered upto the opted Sum Insured	Covered upto the opted Sum Insured
Pre-Hospitalization Medical Expenses	30 days	30 days
Post Hospitalization Medical Expenses	60 days	60 days
Ambulance Cover	Upto 2000/- per hospitalisation	Upto 2000/- per hospitalisation

COVERS AVAILABLE UNDER THE POLICY

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

- availability of Sum Insured and
- the terms, conditions and exclusions of this Policy and
- any sum insured or sub-limits specified in respect of that Cover and any limits applicable for the Insured Person as specified in the Policy Schedule

Section 1 - Oocyte Donor Cover

1.1 In-patient Treatment

We will indemnify the Medical Expenses incurred up to the limit specified in Policy Schedule if the Insured Person (Oocyte Donor) is hospitalized for complications arising due to oocyte retrieval during the Policy Period provided that:

- The Hospitalisation is for a minimum and continuous period of 24 hours
- the Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
- the Medical Expenses incurred are Reasonable and Customary and may be for one or more of the following:
 - Room Rent and other boarding charges;
 - ICU Charges;
 - Operation theatre expenses;
 - Medical Practitioner's fees including fees of specialists and anaesthetists treating the Insured Person;
 - Qualified Nurses' charges;
 - 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;

1.2 Day Care Treatment

We will indemnify the Medical Expenses incurred up to the limit specified in Policy Schedule if the Insured Person (Oocyte Donor) is hospitalized for Day Care Treatment for complications arising due to oocyte retrieval during the Policy Period provided that:

- a) the Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
- b) the Medical Expenses incurred are Reasonable and Customary;

Further,

- a) We will not cover any OPD Treatment under this Benefit.

1.3 Pre-Hospitalization Medical Expenses and Post-Hospitalization Medical Expenses

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses that occurs during the Policy Period provided that:

- a) We have accepted a Claim for In-patient Treatment or Day Care Treatment 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 30 days preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;
- b) We will pay Post-Hospitalisation Medical Expenses up to 60 days following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment

1.4 Ambulance Cover

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

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

Further,

- a) We will also provide cover under this benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such

facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.

Section 2 - Surrogate Mother Cover

2.1 In-patient Treatment

We will indemnify the Medical Expenses incurred up to the limit specified in Policy Schedule if the Insured Person (Surrogate Mother) is hospitalized for complications arising out of pregnancy through surrogacy and post-partum delivery complications during the Policy Period provided that:

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

2.2 Day Care Treatment

We will indemnify the Medical Expenses incurred up to the limit specified in Policy Schedule if the Insured Person (Surrogate Mother) is hospitalized for Day Care Treatment for complications arising out of pregnancy through surrogacy and post-partum delivery complications during the Policy Period provided that:

- a) the Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
- b) the Medical Expenses incurred are Reasonable and Customary;

Further,

- a) We will not cover any OPD Treatment under this Benefit.

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

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses that occurs during the Policy Period provided that:

- a) We have accepted a Claim for In-patient Treatment or Day Care Treatment 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 30 days preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;
- b) We will pay Post-Hospitalisation Medical Expenses up to 60 days following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment

2.4 Ambulance Cover

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

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

Further,

- a) We will also provide cover under this benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic centre for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available/adequate treatment facilities at the existing Hospital.

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:

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.

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 Apnoea
 - 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. 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.

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

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

15. Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services, medical supplies including elastic stockings, diabetic test strips, and similar products.
16. Expenses incurred on all dental treatment;
17. Acupressure, acupuncture, magnetic and such other therapies;
18. Vaccination or inoculation of any kind,
19. Intentional self-injury (whether arising from an attempt to commit suicide or otherwise)
20. Treatment relating to Congenital external Anomalies
21. Any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition;
22. Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;
23. Any treatment taken outside India;
24. Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;
25. Any consequential or indirect loss arising out of or related to Hospitalization;
26. Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority;
27. Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;
28. All non-medical expenses listed in Annexure II (List I) of the Policy.
29. Any OPD treatment will not be covered
30. Treatment and supplies for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities.
31. Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), and Hyperbaric Oxygen Therapy will not be covered unless it forms a part of In-Patient Treatment in case of hospitalisation or part of discharge advice upto the Post hospitalisation period as specified in the Policy Schedule.
32. Any illness, sickness or disease other than complications arising out of pregnancy and post-partum delivery for the surrogate mother or complications arising out of oocyte retrieval for the oocyte donor.
33. Treatment of any pre-existing condition/disease of the Insured including its complications
34. Expenses related to ART, IVF or similar procedure other than those mentioned above will not be covered under this Policy.
35. Surrogacy / Oocyte donation related consultation, diagnostic or pharmacy expenses, Consultations with Fertility Specialist
36. Cost of Oocyte retrieval/ donation procedure including but not limited to expenses related to injections, tests, ultrasound, ovum pick-up
37. Cost of Surrogacy treatment procedure including but not limited to expenses related to injections, tests, ultrasound, ovum pick-up, embryo transfer
38. Delivery Expenses (Normal or Caesarean)

39. Voluntary Termination of Pregnancy / Miscarriage (including miscarriage due to accident) except in case of life-threatening medical condition to the surrogate mother, during the policy period of the Surrogate Mother
40. Any Non-Allopathy Treatment
41. Any expenses arising out of Domiciliary Hospitalization
42. Any Expenses prior to oocyte retrieval process of Oocyte Donor
43. Any Expenses prior to implantation of the embryo in womb of surrogate mother
44. Any expenses incurred for fetal reduction
45. Expenses arising during pregnancy of surrogate mother related to fetal wellbeing not affecting surrogate mother
46. Any claim arising due to non-compliance of the provisions stated in the respective Surrogacy law, The Surrogacy (Regulation) Act, 2021, The Surrogacy (Regulation) Rules, 2022, the Assisted Reproductive Technology Law, The Assisted Reproductive Technology (Regulation) Act, 2021, The Assisted Reproductive Technology (Regulation) Rules, 2022 and any subsequent additions / modifications to the Law / Act / Rules.
47. Complications of pregnancy resulting from:
 - i. the Surrogacy procedure conducted in a Clinic which is not registered as per the provisions of The Surrogacy (Regulation) Act, 2021
 - ii. Surrogacy which is for commercial purposes or for commercialization of surrogacy or surrogacy procedures
48. Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

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:

1. 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;
2. 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;
3. 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;
4. 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.

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. For Cashless Facility

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

(a) Pre-authorization for Planned Hospitalization:

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

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

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

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

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

In Case of Claim Contact Us at:

24x7 Toll Free number: 1800 266 4545 or may write an e- mail at care@zurichkotak.com

In the event of claims, please send the relevant documents to:

Family Health Plan Insurance TPA Ltd,
Ground Floor, Srinilaya – Cyber Spazio
Road No. 2, Banjara Hills,
Hyderabad, 500 034.

(b) Pre-authorization for Emergency Care:

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

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

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

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

Turn Around Time (TAT) for settlement of Reimbursement is within 30 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.

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.

CLAIM DOCUMENTS

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

- a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);
- b) Hospital discharge summary;
- c) First consultation and follow up treatment papers;
- d) Original bills and receipts from the Hospital/Medical Practitioner;
- e) Original bills from chemists supported by proper prescription;
- f) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
- g) Indoor case papers, if available;
- h) Implant Invoice/ Sticker, if available;
- i) Ambulance Invoice, if applicable;
- j) FIR (if done) or MLC (if conducted) for Accident cases;
- k) Post mortem report (if conducted);
- l) Certificate from the treating doctor for inability to donate Oocyte by the mother. (If the oocyte donor is other than proposer mother)
- m) Copy of signed contract for the Oocyte donor/Surrogate mother.
- n) KYC documents viz. Photo ID and address proof along with duly completed form.
- o) 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:

- a) Original Pre – authorization request
- b) Copy of Pre – authorization approval letter
- c) Copy of the photo identity document of the Insured Person;
- d) 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

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, if the term of policy up to one-year 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

Portability shall not be applicable under the policy.

9. Migration

Portability shall not be applicable under the policy.

10. Renewal of Policy

Policy shall not be available for Renewal on expiry.

11. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

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

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

13. Moratorium Period

Moratorium Period shall not be applicable under the policy.

14. Nomination

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

15. Redressal of Grievance

In case of any grievance the insured person may contact the company through

Website: www.zurichkotak.com

Toll free: 18002664545

E-mail: care@zurichkotak.com

Courier: Zurich Kotak General Insurance Company (India) Limited (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

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>

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

The details of the Insurance Ombudsman is available at:

<https://www.zurichkotak.com/customer-support/grievance-redressal-process>

The updated details of Insurance Ombudsman offices are also available on the website of Council for Insurance Ombudsmen: www.cioins.co.in/ombudsman

The details of the Insurance Ombudsman is available at Annexure I

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

16. Claim Settlement (Provision for Penal Interest)

- i. The Company shall settle or reject a claim, as the case may be, within 30 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.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(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)

17. Eligibility

Eligibility	Oocyte Donor (Section 1)	Surrogate Mother (Section 2)
Age	Min-21 yrs	Min-21 yrs

	Max-55 yrs	Max--55 yrs
Insured Relationship	Self, Oocyte Donor	Surrogate Mother
Proposer	Intending Couple Intending Woman	Intending Couple Intending Woman
Policy Tenure	1 year	3 years

Note – The eligibility criteria may get updated as per the applicable surrogacy laws / ART rules in India time to time

18. 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.

19. 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.

20. 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.

21. Underwriting and Loadings

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

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

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

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

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

22. 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.

23. 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.

24. 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.

25. 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.

26. 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.

27. ECS/ Auto Debit Payment Facility:

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

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

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

28. 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.

29. 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.

Premium Table

SI	Age of the Insured	Surrogacy Cover		Oocyte Cover	
		without GST	with GST @ 18%	without GST	with GST @ 18%
5 Lacs	21-35	28,473	33,598	4,773	5,632
	36-40	40,020	47,224	6,750	7,965
	41-48	66,990	79,048	11,138	13,143
	49-55	1,47,378	1,73,906	24,503	28,914
10 Lacs	21-35	39,862	47,037	6,682	7,885
	36-40	56,028	66,113	9,450	11,151
	41-48	93,786	1,10,667	15,593	18,400
	49-55	2,06,329	2,43,468	34,304	40,479

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 which may extend to ten lakh rupees.