



ICICI Lombard Complete Health Insurance- Health Elite

Customer Information Sheet/ Know Your Policy

This document provides key information about your policy. You are advised to go through your policy document.

Sr. No	Description (Please refer to applicable Policy Clause Number in next column)	Policy Clause Number
1.	<u>Name of Insurance Product/Policy</u> ICICI Lombard Complete Health Insurance-Health Elite	
2.	<u>Policy Number</u> XXXXX	
3.	<u>Type of Insurance Product/Policy</u> Both Indemnity and Benefit	
4.	<u>Sum Insured</u> Basis- Individual Sum Insured ₹ XXXX - where each member has a separate sum insured under the policy Floater Sum Insured- ₹ XXXX – where all members under the policy have a single sum insured limit which may be utilized by any or all members	
5.	<u>Policy Coverage</u> (What the policy covers?) Expenses in respect of: i. Basic Covers :- 1. In-patient Treatment: Up to the Annual Sum Insured for admission longer than 24 consecutive hours. 2. Day Care Procedures/Treatment –For a continuous period of less than 24 hours. 3. Technological advancements and Treatments –During policy period up to the annual Sum Insured. 4. Pre Hospitalization Medical expenses - 30 days before hospitalization up to the Annual Sum Insured 5. Post Hospitalization Expenses –60 days after discharge from hospital up to the Annual Sum Insured 6. In Patient AYUSH Hospitalization- Up to Annual sum insured.	d. benefits covered under the Policy Section d. A. 1 Section d. A. 2 Section d. A. 3 Section d. A. 4 Section d. A. 5 Section d. A.

	7. Reset Benefit – The Sum Insured will be reset up to 100% once a policy year for same illness and Unlimited times for different illness, in case the Annual Sum insured including any Loyalty Bonus(if any), Super Loyalty Bonus(if any), sum insured protector (if any) is insufficient as a result of previous claims 8. Domestic Road Ambulance Cover – For transfer to the nearest Hospital. In case of cashless claim; the same will be covered as per actuals. It will be limited to 1% of Annual Sum Insured maximum up to ₹ 10,000 in case ambulance services are reimbursed. 9. Domestic Air Ambulance Cover - Covers expenses during emergencies up to the annual Sum Insured. 10. Donor Expenses - Covers hospitalization expenses for an organ donor, donating to the Insured Person up to the Annual Sum Insured. 11. Domiciliary Hospitalization – Up to the Annual Sum Insured. 12. Home Care Treatment- Up to 5% of Annual Sum Insured subject to a maximum of ₹ 25,000 13. Wellness Program: - Wellness Program - Health Assistance - Ambulance Assistance - Discounts on services and products a. Wellness points earned by the Insured Person can be redeemed by availing services such as out-patient consultations, purchase of pharmaceutical drugs/ medicines, undergoing diagnostic tests, purchase of health supplements etc. through our mobile application 14. Loyalty Bonus- Get a 20% Cumulative Bonus of the Annual Sum Insured, up to a max of 100% if the policy is continuously renewed with us. No reduction to the cumulative bonus even in case of a claim. 15. Preventive Health Check Up – Insured person(s) aged 21 years and above can avail a preventive health check-up as per the plan eligibility. One coupon will be provided per insured person subject to maximum of 2 coupons for floater policy 16. Teleconsultation(s) – Unlimited tele-consultations will be provided; 24 * 7 and 365 days a year	6Section d. A. 7 Section d. A. 8 Section d. A. 9 Section d. A. 10 Section d. A. 11 Section d. A. 12 Section d. A. 13 Section d. A. 14 Section d. A. 15 Section d. A. 16 Section d. A. 17
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	17. Incentives associated with vaccination against Pneumococcal disease - Discount of 2.5% on premium in case all adult members in the policy have been vaccinated with the conjugate pneumococcal vaccine in the one year prior to policy start date Optional Covers 1.Hospital Daily Cash- A daily cash allowance of ₹ xxx per day for hospitalization, up to 3 consecutive days and a maximum of 10 days per policy year. 2. Convalescence Benefit - A lump sum allowance of Rs 10,000 will be provided once every Policy year, for Hospitalization for a minimum of 10 consecutive days. 3. Nursing at Home post hospitalisation – For medical services of a qualified Nurse at the Insured Person's residence up to ₹ xxxx per day subject to a maximum of 15 days post hospitalization. 4. Compassionate Visit – If the insured, is hospitalized for at least 5 consecutive days, up to ₹ 20,000 for an economy class airfare for an immediate family members travel, will be provided from and to their home/place of origin. This coverage is limited to India. 5.Critical Illness - A fixed amount of ₹ xxxxx will be paid at the diagnoses of one or more of the listed Critical Illnesses occurring for the first time, during the Policy period 6.Personal Accident – Up to Annual Sum Insured; subject to a maximum limit of ₹ 50 Lakhs on occurrence of the following insured events ○ Death ○ Permanent Total Disablement (PTD) 7.Outpatient Treatment cover - Covers Out-patient expenses for doctor consultations, prescribed diagnostic procedures or prescribed pharmaceutical drugs up to ₹ xxxx 8.Maternity Cover– For a maximum of 2 deliveries/terminations after a waiting period of 3 consecutive year(s) up to ₹ xxxx. Pre-natal and post-natal expenses shall be covered up to ₹ 2,000 each within the above limits	Section d.B.1 Section d.B.2 Section d.B.3 Section d.B.4 Section d.B.5 Section d.B.6 Section d.B.8 Section d.B.9 Section d.B.10 Section d.B.11 Section d.B.12 Section d.B.13 Section d.B.14 Section d.B.15
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	9.New Born Baby Cover –Up to 90 days from date of birth if a Maternity Benefit claim has been accepted, subject to the maximum sum insured of ₹ xxxx 10. Voluntary Co-payment - Of xx% for every claim opted. 11. Super Loyalty Bonus- provides 50% increase in the Annual Sum insured, up to a maximum of xx%. 12. Sum Insured Protector – Protects the sum insured against the rising inflation by linking the Sum insured under the base plan to the consumer price index (CPI). 13.Claim Protector- If claim has been accepted under “Inpatient treatment” or “Daycare procedure”, then items included in the list of ‘excluded items’ which are not payable in that particular claim will become payable up to Annual Sum Insured. 14.Worldwide Cover- Including planned hospitalization outside India and anywhere in the world up to the annual Sum Insured subject to the terms & conditions specified. A 7 day advance intimation (from travel) along with approval from the insurer will be required in case of planned hospitalization.	
6.	<u>Exclusions (What does the policy not cover)</u> i. Standard Exclusion 1.Code- Excl01- Pre-Existing Diseases a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months 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 relevant regulatory prescriptions, then waiting period for the same would be reduced to the extent of prior coverage Coverage after the expiry of specified months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer. 2. Code- Excl02- Specified Disease/Procedure waiting period/Specific Waiting Period	e. Exclusions under the policy i. Standard exclusions

	a) Expenses for listed conditions, surgeries/treatments are excluded until the expiry of 24 months of continuous coverage after inception of the first policy with us. Not applicable for claims arising due to an accident. In case of enhancement of sum insured the exclusion reapplies for increased sum insured. b) If specified disease/procedure falls under the waiting period specified for pre-existing diseases, the longer waiting period shall apply. c) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion. d) If the Insured Person is continuously covered without any break as defined by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage. List of specific diseases/procedure: • Cataract • Benign Prostatic Hypertrophy • Myomectomy, Hysterectomy unless because of malignancy • All types of Hernia, Hydrocele • Fissures &/or Fistula in anus, haemorrhoids/piles • Arthritis, gout, rheumatism and spinal disorders • Joint replacements unless due to accident • Sinusitis and related disorders • Stones in the urinary and biliary systems • Dilatation and curettage , Endometriosis • All types of Skin and internal tumors/ cysts/nodules/ polyps of any kind including breast lumps unless malignant • Dialysis required for chronic renal failure • Surgery on tonsils, adenoids and sinuses • Gastric and Duodenal erosions & ulcers • Deviated Nasal Septum • Varicose Veins/ Varicose Ulcers * 2 years after Policy inception, the maximum liability arising from a cataract treatment claim shall be restricted to a maximum of 10% of the Annual Sum	
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	Insured subject to a maximum of ₹1 Lakh per eye. 3. For treatment of the following illness within 90 days from the first policy commencement date unless they are pre-existing and disclosed at the time of underwriting i. Hypertension ii. Diabetes iii. Cardiac Conditions a) This exclusion does not apply if the Insured Person has continuous coverage for more than twelve months. b) The waiting period also applies to increased sum insured with higher coverage later on. 4.Code- Excl03-30-day waiting period 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 referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently. ii. Permanent Exclusions i. Code- Excl04: Investigation & Evaluation a) Admission primarily for diagnostics and evaluation purposes only are excluded. b) Excludes diagnostic expenses unrelated or not incidental to the current diagnosis and treatment. ii. Code- Excl05: Exclusion Name: Rest Cure, rehabilitation and respite care a) Excludes expenses for admission primarily for enforced bed rest and not for receiving treatment. This also includes: I. Custodial care at home or in a nursing facility for personal assistance by skilled nurses or non-skilled persons. Any services for people who are terminally ill to address their physical, social, emotional and spiritual needs.	
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	iii. Code- Excl06: Obesity/ Weight Control a) Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions: 1) Surgery to be conducted is based on Doctor advice. 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); >= 40 or >= 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss: - o Obesity-related cardiomyopathy - o Coronary heart disease - o Severe Sleep Apnea - o Uncontrolled Type2 Diabetes iv. Code- Excl07: Change of Gender treatments a. Including surgery, to change body characteristics to the opposite sex. v. Code- Excl08: Cosmetic or plastic Surgery a. Excluded unless for reconstruction due to an accident, burn(s), cancer, or as part of medically necessary treatment. It must be certified by the attending medical practitioner to remove a direct health risk vi. Code- Excl09: Hazardous or Adventure sports a. 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. vii. Code- Excl10: Breach of law a. Expenses for or consequent to committing or attempting to commit a breach of law with criminal intent. viii. Code- Excl11: Excluded Providers a. Expenses incurred towards treatment in any hospital/by a Medical Practitioner or other provider specifically excluded by the Insurer, disclosed on the website and notified to the policyholders are not admissible.	
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	However, in case of life threatening situations or an accident, only expenses up to the stage of stabilization are payable. Click here for the list of delisted hospital as on the website https://www.icicilombard.com/docs/default-source/apps/healthclaims/assets/files/delisted-hospital-list.pdf. ix. Code- Excl12: Treatment for, alcoholism, drug or substance abuse or any addictive condition and consequences thereof. x. Code- Excl13: Treatments received in health spas, 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. xi. Code- Excl14: Dietary supplements and substances that can be purchased without prescription, not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalisation claim/ day care procedure. xii. Code- Excl15: Refractive Error: Expenses related to correction of eye sight due to refractive error less than 7.5 dioptries xiii. Code- Excl16: Unproven Treatments- 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. xiv. Code- Excl17: Sterility and Infertility: Expenses related to, sterility and infertility. This includes: - Any type of contraception, sterilization - Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI - Gestational Surrogacy - Reversal of sterilization xv. Code- Excl18: Maternity: - Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy.	
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	ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period ii. Specific Exclusion - Any ailment/ illness/ injury/ condition or treatment or service that is specifically excluded in the Policy Schedule under Special Conditions - Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or cost of cochlear implant(s) unless necessitated by an accident or required surgery. - Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and gingiva except if required due to an Accident. - Personal comfort, cosmetics, convenience and hygiene related items and services - Acupressure, acupuncture, magnetic and other therapies - Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident. - Expenses for venereal disease or any sexually transmitted disease, except HIV. - Screening, counselling or treatment relating to external birth defects and external congenital Illnesses or defects or anomalies - Treatment taken outside the country, unless Worldwide Cover has been opted for. - Intentional self-injury (whether arising from an attempt to commit suicide or otherwise) - Any injury or illness arising from/ attributed to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, 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	ii. Specific Exclusions (Other than those as specified under e.i. above)
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	I. For illness or injury not limited to the likes of nuclear weapons/materials or ionizing radiation, contamination by radioactivity or similar events.	
7.	<u>Waiting period</u> • <u>Time period during which specified diseases/treatments are not covered</u> • <u>It is counted from the beginning of the policy coverage</u> • Initial waiting period: 30 days for all illnesses (except hospitalization due to injury) • Specific waiting periods: First 24 months, for specific illness and treatment. (please refer to the policy wordings for the complete list) • Pre-Existing Diseases: Declared & accepted pre-existing diseases will be covered after 24 months of continuous coverage. • Expense related to hypertension, diabetes and cardiac conditions within 90 days from policy inception unless they are PED (Below waiting periods are applicable only if these covers are opted for) • Maternity Cover: 36 months, provided both Insured Person and Spouse are covered under the same Policy. • Critical Illness : 90 days • Worldwide Cover : 24 months • Outpatient Treatment: 90 days	e.i.4 Standard exclusions e.i.2 e.i.1 e.i.3 Section d.B.9 Section d.B.5 Section d.B.15 Section d.B.8
8.	<u>Financial limits of coverage</u> <u>Sub-limit (It is a pre- defined limit and the insurance company will not pay any amount in excess of this limit)</u> The policy will pay only up to the limits specified hereunder for the following diseases/procedures:	

	- For Cataract Treatment, a sub-limit of 10% of Annual Sum insured subject to a maximum of ₹ 1 Lakh per eye is applicable. Basic Covers - Domestic Road Ambulance Cover - 1% of Annual Sum Insured maximum up to ₹ 10,000 - Home Care Treatment - 5% of Annual Sum Insured subject to a maximum of ₹ 25,000 - Loyalty Bonus -20% of Annual Sum Insured maximum up to 100% - Incentives associated with vaccination against Pneumococcal disease- discount of 2.5% will be provided on premium Optional Covers - Hospital Daily Cash- A daily cash allowance of ₹ xxx - Convalescence Benefit- lump sum allowance of ₹10,000 - Nursing at home post hospitalisation- up to ₹ xxxx for each day subject to a maximum of 15 days. - Compassionate Visit- maximum up to ₹ 20,000 - Critical Illness- A fixed amount of ₹ xxxxx will be paid under this benefit. - Personal Accident- payment of a fixed lump sum amount up to Annual Sum Insured; subject to a maximum limit of ₹ 50 Lakhs. - Outpatient Treatment cover- up to ₹ xxxx - Maternity Cover- up to ₹ xxxx. Pre-natal and post-natal expenses shall be covered up to ₹ 2,000 each within the above mentioned limits - New Born Baby Cover - subject to the maximum sum insured of ₹ xxxx - Super Loyalty Bonus- 50% increase in the Annual Sum insured subject to maximum of 200% of the Annual sum insured. <u>Co-payment (It is a specified amount /percentage of the admissible claim amount to be paid by policyholder/insured)</u>	
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	Voluntary co-payment opted- XX% will be applicable for each and every claim Zone Based Pricing- Premium depends on your chosen zone. If treatment is conducted in a higher zone, co-payment applies. There will be no zone based co-payment for Zone A and Zone D <table border="1"> <thead> <tr> <th>Zone</th><th>Treatment taken in zone</th><th>Zone based</th></tr> </thead> <tbody> <tr> <td rowspan="4">Zone B</td><td>Zone A</td><td>8%</td></tr> <tr> <td>Zone B</td><td>Nil</td></tr> <tr> <td>Zone C</td><td>Nil</td></tr> <tr> <td>Zone D</td><td>8%</td></tr> <tr> <td rowspan="4">Zone C</td><td>Zone A</td><td>16%</td></tr> <tr> <td>Zone B</td><td>8%</td></tr> <tr> <td>Zone C</td><td>Nil</td></tr> <tr> <td>Zone D</td><td>16%</td></tr> </tbody> </table> <u>Deductible (It is a specified amount:</u> - <u>Up to which an insurance company will not pay any claim, and</u> - <u>Which will be deducted from total claim amount (if claim amount is more than the specified amount)</u> Not Applicable <u>Any other limit (as applicable)</u> Not Applicable	Zone	Treatment taken in zone	Zone based	Zone B	Zone A	8%	Zone B	Nil	Zone C	Nil	Zone D	8%	Zone C	Zone A	16%	Zone B	8%	Zone C	Nil	Zone D	16%	
Zone	Treatment taken in zone	Zone based																					
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9.	<u>Claims/claims procedures</u> <u>Claims Procedure-</u> Cashless (Pre-Authorization) Procedure; Step 1 – Get your treatment at our network hospital, submit a copy of health card and photo ID proof at Hospital Insurance desk during admission	g.1. Claims Procedure (Other terms and conditions)																					



	Step 2 – The hospital sends an approval request for your cashless admission along with relevant documents (cashless pre-authorization form, investigation reports, past consultation papers (as applicable), copy of health card and photo ID proof, etc.) Step 3 – Request will be processed as per policy terms and conditions Step 4 – While you avail treatment the claim payment is settled directly to the Provider/Hospital Step 5 – You can check and track your claim status live on IL TakeCare app or WhatsApp If You notify pre authorization request for cashless facility through any of Our empanelled network hospitals along with complete set of documents & information, We will decide within 1 hour of the actual receipt of such pre authorization request. Further, we shall grant final authorization within three hours of the receipt of discharge authorization request from the hospital. . Find our extensive list of hospitals providing cashless services on our website https://www.icicilombard.com/health-insurance/health-claim/partner-hospital or on the IL TakeCare App. List of excluded providers/delisted hospitals is available on our website https://www.icicilombard.com/docs/default-source/apps/healthclaims/assets/files/delisted-hospital-list.pdf. Notify us 48 hours before planned admission or within 24 hours for emergencies when using cashless services. Non-medical and non-payable expenses are your responsibility. You shall be required to furnish the following documents for or in support of a Claim:	
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	1. Duly completed Claim form signed by You and the Medical Practitioner. The claim form can be downloaded from our website www.icicilombard.com 2. Original bills, receipts and discharge certificate/ card from the Hospital/ Medical Practitioner 3. Original bills from chemists supported by proper prescription. 4. Original investigation test reports and payment receipts. 5. Indoor case papers 6. Medical Practitioner's referral letter advising Hospitalization in non-Accident cases. 7. Any other document as required by Us or to investigate the Claim or Our obligation to make payment for it Reimbursement Procedure; Step 1 – Get treatment at a non-network hospital by self-paying all the treatment costs. Collect all treatment and expenses related documents. Step 2 – Send us the claim documents along with the claim form. You can also emboss the original documents and submit an e-claim on the ILTakecare app. if an e-claim is submitted please retain all the original documents and produce if asked by Insurance to submit in original hard copy. Step 3 – The claim will be processed as per policy terms and conditions Step 4 – The approved amount in the claim would be reimbursed to you Insurer needs to be notified of any planned Hospitalization at least 48 hours before admission and 24 hours after admission in the case of emergency hospitalisation. We are to be provided with a duly completed 'Claim Form' and the requisite claim documents, as soon as practicable, latest within 30 days from the date of discharge from the Hospital, failing which we will have the right to treat the claim as inadmissible. The claim will	
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	be processed within 15 days of receipt of claim along with claim form. The relevant documents to be sent to ICICI Lombard Health Care, 1st, 4th (Half), 5th and 6th floors, Varun Towers- II, Opp. Hyderabad Public school, Begumpet, Hyderabad, District Hyderabad, Telangana Pin code -500016 Download the Claim Form here - https://echannel-wf.icicilombard.com/docs/default-source/apps/healthclaims/assets/files/claim-form-greater-than-1-lac.pdf	
10	<u>Policy Servicing</u> You may contact us on our Toll Free no: 1800 2666, or email to customersupport@icicilombard.com or use our IL TakeCare App or send a Hi to RIA, our Responsive Intelligent Assistant on WhatsApp (7738282666) for policy services. For details of Company officials kindly visit our website https://www.icicilombard.com/customer-support.	f. General terms and conditions
11	<u>Grievances/Complaints</u> In case of any grievance the insured person may contact the Company through Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com Address: ICICI Lombard General Insurance Co. Ltd. Ground floor- Interface 11, Sixth floor- Interface 16 , Office no 601 & 602, New linking Road, Malad (West), Mumbai – 400064 There is an interactive voice response (IVR) facility for senior citizens' grievance redressal for easy and faster resolution Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. For branch details, please visit https://www.icicilombard.com/docs/default-source/policy-wordings-product-brochure/final-gro-mapping.pdf.	f.16. General terms and conditions

	If Insured person is not satisfied with the redressal of grievance ,insured person may contact the Grievance Redressal Officer of the Company at the details provided in the below link: https://www.icicilombard.com/grievanceredressal.com If Insured person is not satisfied with the redressal of grievance, the insured person may also approach Insurance Regulatory and Development Authority of India (IRDAI) through the Bima Bharosa Portal - https://bimabharosa.irdai.gov.in/ or IRDAI Grievance Call Centre(IGCC) at their toll free no. 1800 4254 732 / 155255 • • Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDAI website: www.irdai.gov.in, or on the Company's website at www.icicilombard.com or on https://www.cioins.co.in/Ombudsman	
12	<u>Things to remember</u> Free Look cancellation: Every insured of new health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty charges (Please refer to the Policy Wordings and the Prospectus for more details) If You wish to cancel the Policy, You may contact us through Our website www.icicilombard.com (Customer Support section) or call us at toll Free no: 1800 2666, or email to customersupport@icicilombard.com.	f. General terms and conditions-15 f.General terms and conditions-10 f.General terms and

	Policy Renewal- We shall ordinarily renew the Policy except on grounds of , misrepresentation or established fraud or non-disclosure by the Insured, provided the policy is not withdrawn and also subject to moratorium conditions. Migration and Portability – - The insured has the choice to port his / her policies from one Insurer to another. - The insured is entitled to transfer the credits gained to the extent of the sum insured and the benefits available in the previous policy, subject to the underwriting policy of the Company - The company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines. - This benefit is not applicable for enhanced sum insured. The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months. - In case You are keen on migrating or outward porting kindly contact us at customersupport@icicilombard.com Change in Sum Insured- Sum Insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the company. For increase in SI, the waiting period if any shall start afresh only for the enhanced portion of the sum insured. Zone Based Pricing - Premium will be computed basis zone chosen by Insured Person. Zone based co-payment will be applicable in case treatment is taken in a higher zone Moratorium Period- After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is	conditions-8 and 9 f.General terms and conditions-28 f.ii.Specific Terms and Clauses-18 f.General terms and conditions-12
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	enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits..	
13	<u>Your Obligations</u> • Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may affect the claim settlement. • If there is misrepresentation, non-disclosure of material facts, fraud, or non-cooperation in the proposal form, personal statement, medical history, or claim documents, the policy becomes void. In such cases, any benefits obtained through fraudulent means result in the forfeiture of all paid premiums.	f.l.1. Disclosure of Information f.l.4. Fraud

Declaration by the Policy Holder:

I have read the above and confirm having noted the details.

Place:

Date: _____

Signature of the Policy Holder

NOTE: In case of any conflict, the terms and conditions mentioned in the policy document shall prevail.

Benefit Illustration