GROUP HOSPI SHIELD

PART II OF THE POLICY SCHEDULE

I. PREAMBLE

This Policy is a contract of insurance issued by ICICI Lombard General Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium

II. DEFINITIONS

Certain words are used in the policy and this Policy Schedule, which have a specific meaning and are shown below. They have this meaning wherever they appear in the Policy. Where the context so permits, references to the singular shall also include references to the plural and references to the male gender shall also include references to the female gender, and vice versa in both cases.

A. STANDARD DEFINITIONS

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

3. **AYUSH Day Care Centre:** AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

   (Explanation: Medical Practitioner referred in the definition of "AYUSH Hospital" and "AYUSH Day Care Centre" shall carry the same meaning as defined in the definition of "Medical Practitioner")

4. "**Break in policy**" means the period of gap that occurs at the end of the existing policy term / instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

5. "**Grace period**" means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

6. "**Migration**" means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

7. "**Portability**" means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

8. "**Pre-existing disease (PED)**" means any condition, ailment, injury or disease:
   1. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

9. "**Specific waiting period"** means a period up to 24 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

10. **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

11. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

12. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
    Deductible shall be applicable per year, per life or per event as stated in the policy certificate and specific benefit based deductible shall be applied if specified in the policy certificate.

13. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health

14. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    i. Has qualified nursing staff under its employment round the clock;
    ii. Has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
    iii. Has qualified medical practitioner(s) in charge round the clock;
    iv. Has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

    '**Hospital'** includes AYUSH Hospital.

15. **AYUSH Hospital:** An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
    a. Central or State Government AYUSH Hospital; or

    b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

    c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and

is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

16. Hospitalization means admission in a Hospital for aminimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours.

17. Illness means a sickness or disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

Acute condition - is a disease, illness or injury that is likely

to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

Chronic condition - A chronic condition is defined as a disease, illness, or Injury that has one or more of the following characteristics

a) It needs ongoing or long-term monitoring through consultations, examinations, checkups, and / or tests
b) it needs ongoing or long-term control or relief ofsymptoms
c) it requires rehabilitation for the patient or for thepatient to be specially trained to cope with it
d) it continues indefinitely
e) It recurs or is likely to recur.

18. Intensive Care Unit: means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

19. Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

20. Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of **Illness** or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

21. Medical Practitioner is a person who holds a valid registration from Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license. The term Medical Practitioner would include physician, specialist, anesthetist and surgeon but would exclude the Insured Person and his/her Family Members.

22. Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

a. is required for the medical management of the illness or injury suffered by the insured
b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
c. must have been prescribed by a medical practitioner;
d. must conform to the professional standards

widely accepted in international medical practice or by the medical community in India.

23. Network Provider means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.

24. Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

25. Reasonable and Customary Charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / Injury involved .

26. Renewal means the terms on which the contract of insurance may be renewed with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

27. Unproven/Experimental treatment means the treatment including drug experimental therapy which is not **based** on established medical practice in India, is treatment experimental or unproven

STANDARD DEFINITIONS

1. **Age** means the completed years on last birthday as per the English calendar calculated on the day of inception of cover under the Policy.

2. **Ambulance** Charges means transportation costs incurred by the insured person towards availing ambulance services from the site of Accident to the nearest Hospital or from the site of first treatment to the nearest higher center of care in case of life threatening emergency conditions.

3. **Child** means dependent child/children including adopted and step child/children of the Insured Person up to the age of twenty five (25) years and dependent on the insured person for maintenance and financial support.

4. **EMI** or EMI Amount means and includes the amount of monthly payment required to repay the principal amount of Loan and interest by the Insured Person as set forth in the amortization chart. For the purpose of claim settlement against any coverage under this Policy the amortization schedule prepared by the financier as on the loan disbursal date or risk inception date (whichever is later) shall be considered wherever applicable.

5. **Family** Member means an Insured Person's legally wedded spouse, children, ward, step or adopted children, parents, stepparents , mother in law, father in law, children in law, legal guardian, siblings, and siblings in law.

6. **Franchise** means a per Insured event provision in the policy whereby the insurer will not pay unless damage (or loss) exceeds the specified number of days/hours/months as defined in the Policy Certificate. Once a franchise is met, the Sum Insured subject to the Benefit is payable as per terms and conditions.

Illustration: If the customer opts for a Franchise of two days and he is admitted in a hospital for one day the benefit shall not be triggered. However, if the customer is hospitalized for more than two days the customer shall be entitled for a benefit for all days of hospitalization (up to the sum insured and subject to policy T&Cs).

7. **Immediate** Family Member means spouse, children, step or adopted children, brother(s), sister(s) and parent(s) or stepparents of the Insured Person.

8. **Insured** Event means any event specifically mentioned in the Policy Certificate as covered under this Policy for which premium is received by the Company.

9. **Insured** Person(s) means the persons named as insured persons in the Policy Schedule who are insured for the applicable Benefits

under this Policy.

10. **Loan** means the sum of money lent at an interest or otherwise to the Insured Person by any bank/financial institution as identified by the Loan Account Number specified in the Policy Certificate or certified in writing by the bank/financial institution.

11. **Nominee** means the person(s) nominated by the Insured Person to receive the Benefits payable under this Policy on death.

12. **Permanent** Total Disablement means any of the following:
    - Total and irrevocable loss of sight in both eyes, or
    - Total and irrevocable physical separation of two entire hands or two entire feet, or
    - Total and irrevocable loss of one entire hand and one entire foot, or
    - Total and irrevocable loss of sight of one eye and physical separation of one entire hand or physical separation of one entire foot, or Total and irrevocable loss of use of two hands or two feet, or
    - Total and irrevocable loss of use of one hand and one foot, or
    - Total and irrevocable of loss of sight of one eye and loss of use of one hand or one foot.
    - For the purpose of this definition:
        - Physical separation of a hand or foot means separation of the hand at or above the wrist, and of the foot at or above the ankle.
        - Loss of use or Loss of sight means total paralysis of one or more limb, or loss of vision respectively, which is certified in writing by a Medical Practitioner to be permanent, complete and irreversible and substantiated by physical examination and investigation to be permanent, complete and irreversible.

13. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or Benefits attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured Person, what is excluded from the cover and the terms & conditions on which the Policyis issued to the Insured Person.

14. **Policy Period** means the period commencing from the Policy Start Date, Time and ending at the Policy End Date, Time of the Policy and as specifically appearing in the Policy Schedule during which the policy is valid and Insured Person is liable to get a claim subject to waiting periods and policy terms and conditions

15. **Period of Cover** means the period specified in the Policy Certificate during which the Insured Person is covered under the Policy

16. **Policy Schedule** means the Policy Schedule attached to and forming part of the Policy.

17. **Post-hospitalization Medical Expenses** means medicalexpenses incurred during pre-defined number of daysimmediately after the insured person is discharged from the hospital provided that:
    a) Such Medical Expenses are incurred for the same condition for which the insured person's Hospitalization was required, and
    b) The In-patient Hospitalization claim for such Hospitalization is admissible by the InsuranceCompany.

18. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
    a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    b) The In-patient Hospitalization claim for such Hospitalization is admissible by the InsuranceCompany.

19. **Proposal** and Declaration Form means any initial or subsequent declaration made by the policyholder and is deemed to be attached

and which forms a part of this Policy.

a) While filling the proposal form, you are expected to provide all information pertaining to your health and to the cover you would be opting/buying in this policy

Any non-declaration of information which insurance Company should have known for underwriting this policy can lead to cancellation of policy and Company will have a right to forfeit the premium.

20. **Service Provider** means any person, organization, institution, company providing services in individual capacity or through aggregation that has been empaneled with the Insurance Company to provide services specified under the benefits (including add-ons) to the Insured Person on cashless or reimbursement basis. These shall also include providers empaneled to form a part of network other than hospitals

21. **Sum Insured** means the amount specified in the Policy Certificate against a Benefit or set of Benefits that represents Our maximum, total and cumulative liability for any and all claims made in respect of that Insured Person during the Period of Cover under that Benefit/set of Benefits.

22. **You / Your** means person or the entity named as the policyholder in the Policy Schedule and **who** is responsible for payment of premium.

23. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Certificate which shall be served before a claim related to such condition becomes admissible.

24. **We/ Our / Us** means the ICICI Lombard General Insurance Company Limited.

III. BENEFITS COVERED UNDER THE POLICY

This Policy is a contract of insurance between the Policyholder and Us which is subject to the receipt of premium against each Benefit in full (first installment in case the customer has opted for Periodic Premium Payment option) in respect of the Insured Persons and the terms, conditions and exclusions of this Policy. The customer may opt for any one or more base benefits under one or more sections. Extensions may be opted only if a base benefit under the respective section has been opted. The Policy Certificate will specify which of the following Basic Benefits and Extensions are applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Benefit applicable to the Insured Person shall be subject to the availability of the Sum Insured, applicable sub-limits for the Benefit claimed as specified in the Policy Certificate and the terms, conditions and exclusions of this Policy.

All claims shall be made in accordance with the procedures set out in this Policy. Admitted claims will be payable to the Insured Person or the Nominee (as applicable).

SECTION A - HOSPITAL DAILY CASH

A.1.1 Base Benefit: HOSPITAL DAILY CASH BENEFIT

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate for each continuous and completed day of Hospitalization.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each period of Hospitalization within the Period of Cover.
iii. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.
iv. We shall not be liable to make any payment

under this Benefit, if Hospitalization commenced prior to the commencement of the Period of Cover or within the waiting period specified in the Policy Certificate.

v. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, solely at our discretion We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

A.1.2 Base Benefit: EMI BENEFIT

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in a manner specified in the Policy Certificate in respect of the Insured Person upon his/her suffering an Illness or Accident that occurs during the Period of Cover which solely and directly results in hospitalization of the insured person for the minimum number of days mentioned in the policy certificate so to cover under this benefit.

This Benefit shall be payable subject to the following:

We will accept multiple claims under this Benefit during the Period of Cover in respect of the Insured Person. However, our maximum, total and cumulative liability for claims arising in respect of the Insured Person under this Benefit during the Period of Cover shall be the Sum Insured as specified against this Benefit in the Policy Certificate.

i. Our maximum liability under this cover shall be the sum insured mentioned against this benefit in the policy certificate

A.1.3 Base Benefit: DAYCARE TREATMENT BENEFIT

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to undergo a Day Care Treatment during the Period of Cover We will pay the per event amount specified in the Policy Certificate against this Benefit.

For the purpose of this Extension, Day Care Treatment and Day Care Centre may be defined as under:

Day Care Treatment means medical treatment, and/or surgical procedure which is:

undertaken under general or local anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and which would have otherwise required a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under -

i. has qualified nursing staff under its employment;
ii. has qualified medical practitioner/s in charge;
iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

This shall be payable subject to the following:

i. The Day Care Treatment is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. We shall not be liable to pay the event amount for more than 5 times for each Insured Person during the Policy Year.

iii. We shall not be liable to make any payment

under this Extension, if the Day Care Treatment was taken prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

A.1.4 Base Benefit: CANCER CASH BENEFIT

If an Insured Person contracts 'Cancer of Specified Severity' during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Cancer of Specified Severity.

For the purpose of this Extension, Cancer of Specified Severity means-

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

The following are excluded -

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond; iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukaemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

This shall be payable subject to the following:

- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability to make any payment under this Extension shall be in excess of the per event Deductible / per event Franchise stated in the Policy Certificate, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate.

A.2.1 Extension Benefit: ICU CASH BENEFIT

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized in an Intensive Care Unit, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of confinement of the Insured Person in the Intensive Care Unit.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same Illness/Injury in respect of which the Insured Person was Hospitalized in the Intensive Care Unit.
ii. The Hospitalization in the Intensive Care Unit is for Medically Necessary Treatment and is

commenced and continued on the written advice of the treating Medical Practitioner.

iii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person, during the Policy Year.

iv. Our liability to make any payment under this Extension Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable. However, the Deductible/Franchise will not apply to the extent of days in respect of which the Insured Person has already been admitted in the Hospital in a non- ICU room.

v. We shall not be liable to make any payment under this Extension, if the Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

A.2.2 Extension Benefit: BRAIN & STROKE HOSPITALIZATION CASH BENEFIT

If an Insured Person contracts any of the Brain Ailment or Stroke listed below during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount, specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Brain Ailment or Stroke. For the purpose of this Extension, Brain Ailment and Stroke shall mean the following:

A. Benign Brain Tumor

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

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

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

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

The following conditions are excluded:

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

B. Stroke Resulting in Permanent Symptoms

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

The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

C. Permanent Paralysis of Limbs

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

D. Motor Neuron Disease With Permanent Symptoms

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment

with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

E. Multiple Sclerosis With Persisting Symptoms

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

i. Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis; and
ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE are excluded.

F. Major Head Trauma

i. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

ii. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons.

For the purpose of this Benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:

a. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
d. Mobility: the ability to move indoors from room to room on level surfaces;
e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
f. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

I. Spinal cord injury.

This Extension shall be payable subject to the following:

I. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
II. The Hospitalization is for a Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
III. Our liability to make any payment under this Extension Benefit shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.
IV. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.
We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate.

A.2.3 Extension Benefit: ORGAN TRANSPLANT HOSPITALIZATION CASH BENEFIT

If an Insured Person undergoes Organ Transplant during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized for the procedure for transplantation, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and

completed day of Hospitalization of the Insured Person for transplantation of the organ.
For the purpose of this Extension, Organ Transplant shall meanthe following:

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

The following are excluded:
Other stem cell transplants;
Where only islets of langerhans are transplanted

This Extension shall be payable subject to the following:
We have accepted a Claim under the Base Benefitin respect of that Insured Person for the same period of Hospitalization.
i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
iii. We shall not be liable to make any payment under this Extension in respect of any organ transplantation that is not carried out in accordance with the Transplantation of Human Organs Act 1994, as amended.
Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the PolicyCertificate, if applicable.
We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Personduring the Policy Year.
We shall not be liable to make any payment under this Extension, if Hospitalization commenced priorto the commencement of the Period of Cover orwithin the Waiting Period specified in the PolicyCertificate, unless due to an Accident.

A.2.4 Extension Benefit: HEART AILMENT HOSPITALIZATION CASH BENEFIT

If an Insured Person contracts any of the Heart Ailments listed below during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will paythe daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of that HeartAilment.

For the purpose of this Extension, Heart Ailments mean the following:

A. Myocardial Infarction (First Heart Attack of specificseverity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis for Myocardial Infarction should be evidencedby all of the following criteria:
i. A history of typical clinical symptoms consistent with thediagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins orother specific biochemical markers.

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

B. Open Chest CABG

The actual undergoing of heart surgery to correct blockage ornarrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breastbone) or minimally invasive key hole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to beconfirmed by a cardiologist.
The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

C. Open Heart Replacement or Repair of Heart Valves

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

D. Angioplasty

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

E. Primary (Idiopathic) Pulmonary Hypertension

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

The NYHA Classification of Cardiac Impairment are as follows:

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

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

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

We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.

iii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

iv. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate.

A.2.5 Extension Benefit: FRACTURE & BURNS CASH BENEFIT

If an Insured Person suffers a Fracture and/or Second Degree Burns and/or Third Degree Burns during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of that Fracture, Second Degree Burns or Third Degree Burns.

For the purpose of this Extension the following definitions will apply:

Fracture means a medical condition in which there is a damage in the continuity of the bone. A bone fracture may be the result of high force

impact or stress, or a minimal trauma Injury as a result of certain medical conditions that weaken the bone, such as Osteoporosis, bone cancer, or osteogenesis imperfect, where the fracture is then properly termed a pathologic fracture.

Second Degree (partial thickness) Burns means burns which involves the epidermis and part of the dermis layer of skin.

Third Degree (full thickness) Burns means burns which affects and destroys the epidermis and the dermis.

This Extension shall be payable subject to the following:

We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.

We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate.

A.2.6 Extension Benefit: AMBULANCE COVER BENEFIT

If an Insured Person contracts an Illness or suffers an Injury that occurs due to an Accident during the Period of Cover and that Illness or Injury solely and directly requires the Insured Person to be transported to a Hospital for Medically Necessary Treatment, We will pay the event amount specified against this Extension in the Policy Certificate in respect of any Ambulance Services used for transportation of the Insured Person from the site of the Accident/ Illness to the nearest Hospital or from the site of first treatment to a higher centre of care.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
ii. The transportation in case of movement from the site of first treatment to a centre of higher care is recommended in writing by the treating Medical Practitioner.
iii. We shall not be liable to pay the event amount for more than 5 times for each Insured Person during the Policy Year.
iv. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

A.2.7 Extension Benefit: CHILD CARE CASH BENEFIT

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified against this Extension for the purpose of providing care to the Insured Person's Dependent Child/Children.

For the purpose of this Extension, Dependent Child/Children means:

Child/Children (including step child/children) of the Insured Person up to the age of 25 years who are dependent on the Insured Person for maintenance and financial support.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
iii. Our liability under this Extension shall not

increase if the Insured Person has more than one Dependent Child.
We shall not be liable to make any payment under this Extension if the Insured Person has no Dependent Children on the date of the Insured Event giving rise to the Claim under this Extension.
Our liability to make any payment under this Extension shall be in excess of the per event Deductible/Franchise as stated in the Policy Certificate, if applicable.
We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.
We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

A.2.8 Extension Benefit: HOSPITAL ATTENDANT CASH BENEFIT

If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate against this Extension in respect of each continuous and completed day of Hospitalization of the Insured Person which requires a Hospital Attendant to be present.

For the purpose of this Extension, Hospital Attendant means the Insured Person's family member / relative / acquaintance / any other registered third party service provider who would be available to take care of the Insured Person during his/ her Hospitalization.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Certificate, if applicable.
iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each Insured Person during the Policy Year.
v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

A.2.9 Extension Benefit: COMPASSIONATE VISIT CASH BENEFIT

If an Insured Person contracts an Illness or suffers an Injury that occurs during the Period of Cover that Illness or Injury solely and directly requires the Insured Person to be Hospitalized for at least 3 continuous days at a location outside the Insured Person's city of residence, We will pay the amount specified against this Extension in the Policy Certificate towards the expenses incurred on the travel of the Insured Person's Immediate Family Member(s) to the place of Hospitalization.

This Extension shall be payable subject to the following:

i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
iii. The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence. iv. The Medical Practitioner treating the Insured Person recommends in writing the personal attendance of an Immediate Family Member.
v. The Insured Person has not be Hospitalized for any planned treatment or Surgery.
vi. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the

Policy Certificate, if applicable.
We shall be liable to pay the Benefit amount under this extension, only once per policy period.
Our liability under this Extension shall not increase if more than one Immediate Family Member of the Insured Person travels to the Insured Person's place of Hospitalization.
We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Period of Cover or within the Waiting Period specified in the Policy Certificate (unless due to an Accident).

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION A

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

I. STANDARD EXCLUSIONS

1. 30-day waiting period (Code - Excl 03) - Any hospitalization falling within the initial waiting period as specified in the policy certificate subject to a maximum of 30 days-

a) Expenses related to the treatment of any illness within the initial waiting period 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 shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

2. Pre-existing Disease (Code - Excl - 01) - (Unless specifically covered and mentioned in the policy certificate)

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 the portability norms of the, then waiting period for the same would be reduced to the extent of prior coverage
d) Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3. Unproven Treatment (Code - Excl 16) - 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.

4. Maternity (Code - Excl 18) - (Unless specifically covered and mentioned in the policy certificate)

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

5. Sterility and Infertility (Code - Excl 17) - 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.

6. Cosmetic or Plastic Surgery (Code - Excl 08) - 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.

7. Refractive Error (Code - Excl 15) - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

8. Investigation & Evaluation (Code - Excl 04) -

   (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.

9. Obesity/Weight Control (Code - Excl 06) - Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
   a) Surgery to be conducted is upon the advice of the Doctor
   b) The surgery/Procedure conducted should be supported by clinical protocols
   c) The member has to be 18 years of age or older and
   d) Body Mass Index (BMI);
      i. greater than or equal to 40 or
      ii. 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:

   Obesity-related cardiomyopathy Coronary heart disease
   Severe Sleep Apnea Uncontrolled Type2 Diabetes

10. Change of Gender Treatment (Code - Excl 07)-Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

11. Hazardous or Adventure Sport (Code - Excl 09) (unless specifically covered and mentioned in Policy certificate) - 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.

12. Breach of Law (Code - Excl 10)- Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

13. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (Code - Excl 12)

14. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.(Code - Excl 13)

15. 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. (Code -Excl 14)

16. Excluded providers (Code - Excl 11) -

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.

17. Rest Cure, rehabilitation and respite care (Code - Excl 05)-
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.

18. Specified disease/procedure waiting period (Code - Excl 02) - Two Years Exclusion - (Unless

the waiting period is specifically waived off and mentioned in the policy certificate)

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

List of such specific diseases/procedures

i. Deviated Nasal Septum, CSOM-Chronic Suppurative Otitis Media
ii. Stapedectomy, Mastoidectomy, any treatment for conditions related to tonsils, adenoids, sinuses, turbinates/ concha
iii. Fibroids (fibromyoma), Endometriosis, Uterine Prolapse, Polycysyic Ovarian Syndrome(PCOS)
iv. Dilatation and curettage (D&C), Myomectomy,Hysterectomy
v. Arthritis, Gout and Rheumatism
vi. Stones in gall bladder & Biliary System; Cholecystitis, Fissure/fistula in anus, hemorrhoids, pilonidal sinus, piles, Esophageal Varices & Gastric Varices, Gastritis, Duodenitis & Pancreatitis
vii. Gastric & Duodenal ulcers, Gastro Esophageal Reflux Disorder (GERD)/Acid Peptic Disease, Ulcerative colitis, Crohn's disease, Irritable Bowel Syndrome, Inflammatory Bowel disease
viii. All forms of cirrhosis, Rectal prolapse, Perineal Abscesses, Perianal Abscesses
ix. Cholecystectomy, Endoscopy
x. Stones in Urinary system, all prostate diseases, chronic renal failure or end stage renal failure or chronic kidney disease, dialysis
xi. Dysfunctional uterine bleeding, pelvic inflammatory diseases, stress incontinence,
xii. Hydrocele, varicocele/ rectocele/ spermatocele
xiii. Cataract, Glaucoma, Diseases of the vitreous and retina
xiv. Unless malignant, All Internal/ External tumors, cysts, nodules, polyps, sinus, fistula, adenoma, lumps including teratoma, breast lumps, dermoid cyst, ovarian cyst, desmoid tumour, umblical granuloma, mucous cyst of lip/cheek
xv. Diseases related to thyroid
xvi. All skin ailments
xvii. Ulcers of any kind (whether internal or external) including decubitus ulcers
xviii. Varicose veins & Varicose ulcers
xix. Intervertebral disc disorders , Arthroscopy, Spinal and Vertebral Disorders including diagnosis as low back ache, Surgeries for joint replacements (except if hospitalization is required due to an accidental injury)
xx. All Hernias (except if Hospitalization is required due to an Injury)

II. SFECIFIC EXCLUSIONS

1. All dental treatment or dental surgery of any kind unless necessitated due to an Accident
2. Any treatment received outside India unless specifically covered and specified in the Policy Certificate unless
3. specifically covered and specified in the Policy Certificate.
4. Circumcision unless necessary for treatment of an underlying diseases.
5. Routine medical, dental, eye and ear examinations is not covered unless specifically covered and specified in the Policy Certificate.
6. Treatment of venereal disease.

7. Intentional self-Injury, suicide or attempt to suicide.
8. Any Injury that has occurred prior to the commencementof Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatmenthas been sought. Any Illness, complication or ailment arising out of or connected to such Injury.
9. Any external congenital anomalies.
10. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world
11. Treatment by a Family Member and self-medication or any treatment that is not scientifically recognized.
12. War, invasion, act of foreign enemy hostilities or warlikeoperations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings,police, military, naval or air service, engaging in aviationother than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.
13. Death, disablement (whether of a permanent nature or ofa temporary nature), Injury, Illness or Hospitalization arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel(explosive or hazardous form) or resulting from or fromany other cause or event contributing concurrently or inany other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel,nuclear, chemical or biological attack.

Claim Documents for Section A (All covers under Section A)

1. On the occurrence of an Insured Event which may give rise to a claim under Section A of the Policy, We shall beprovided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 days of the occurrence of the Insured Event: Duly filled claim form
2. Indoor case papers from the Hospital, if available,mentioning the diagnosis, date and time of admission and discharge, past medical and surgical history with duration.
3. Hospital Discharge summary filled and attested by Hospital
4. First Information Report (F.I.R.) copy / Medico-legal case papers - Notarized/ Attested by a gazetted officer in caseof an Injury
5. In case of claim under Ambulance Cover Benefit, Hospital Attendant Cash Benefit, Compassionate VisitCash Benefit - Original bills / receipt confirmingutilization of respective services

SECTION B - SPECIFIC INFECTIOUS DISEASES BENEFIT

SECTION B.1: SPECIFIC VECTOR BORNE DISEASE BENEFIT

For the purpose of benefit under Section B.1 under this policy, Specific Vector-Borne Disease means Malaria, Dengue, Chickungunya, Kala Azar, Japanese encephalitis, Zika Fever and Filariasis

Benefit B.1.1: Base Benefit: Specific Vector Borne Disease related Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in thePolicy Certificate if an Insured Person is diagnosed with aSpecific Vector Borne Disease that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of the Specific Vector Borne Disease andis commenced and continued on the written adviceof the treating Medical Practitioner.
ii. The Insured Person's stay in the Hospital should continue for a minimum period of 48

successive hours.

iii. We shall not be liable to make any payment under this Benefit, if the Insured is first Hospitalized prior to the commencement of the Period of Cover.

iv. We shall not be liable to make any payment under this Benefit, if the Insured Person is Hospitalized due to Specific Vector Borne Disease within a waiting period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.

v. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.

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

Claims Documents for Section B.1.1:

Duly filled claim form

Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization

Indoor case papers of treating hospital, if available Laboratory Reports confirming the diagnosis of Specific

Vector Borne Disease, as follows:

- Dengue - NS1 antigen test or Ig M- Elisa test
- Malaria - Peripheral Smear Test confirming the presence of Malarial parasites
- Chickungunya - Presence of IgM and IgG anti chikungunya antibodies
- Kala-Azar - Direct Agglutination Test or Rapid dipstick test or ELISA for detecting IgG, Anemia, Leucopenia, thrombocytopenia and Hypergammaglobulinemia
- Japanese encephalitis - Ig M antibody detection in serum or cerebrospinal fluid
- Zika Fever - PCR report confirming the diagnosis
- Filariasis - Antigen detection in blood sample or IgG4 antibody detection using routine assays

SECTION B.2: RABIES AND TETANUS BENEFIT

Benefit B.2.1: Basic Benefit: Rabies and Tetanus related Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Rabies or Tetanus occurring on account of an Injury from an Accident that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Rabies or Tetanus and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. The Insured Person's stay in Hospital should continue for a minimum period of 48 successive hours

iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to Rabies or Tetanus is prior to the commencement of the Period of Cover.

iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Rabies or Tetanus is within a waiting period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.

v. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.

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

to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

Claims Documents for Section B.2.1:

Duly filled claim form

Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization

Indoor case papers of treating hospital, if available Certificate from treating doctor confirming the diagnosis

SECTION B.3: SPECIFIC GASTRO INTESTINAL INFECTIONS BENEFIT

For the purpose of benefit under Section B.3 under this policy, Specific Gastro Intestinal Infections mean the following:

Acute Inflammatory Diarrhoea - Acute onset, caused by invasive or noninvasive pathogens and their enterotoxins characterized by the following:

Watery Stools containing blood and pus cells, Clinical signs of dehydration

High grade fever

Typhoid Fever - An infection from Salmonella Typhi characterized by the following:

Fever for more than 5 days,

Presence of Salmonella Typhi bacteria in the blood and Multi organ involvement

Benefit B.3.1: Base Benefit: Specific Gastro Intestinal Infections Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Specific Gastro Intestinal Infections that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Specific Gastro Intestinal Infections and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in Hospital should continue for a minimum period of 48 successive hours
iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to Specific Gastro Intestinal Infection is prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Specific Gastro Intestinal Infection is within a waiting period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.
v. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
vi. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

Claims Documents for Section B.3.1:

Duly filled claim form

Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization

Indoor case papers of treating hospital, if available Laboratory Reports confirming the diagnosis of Specific

Gastro Intestinal Infections, as follows:

- Acute Inflammatory Diarrhoea - Routine Stool Examination confirming the presence of RBCs and Pus Cells in stools
- Typhoid Fever - Presence of Salmonella Typhi in Blood / Urine / Stool sample

SECTION B.4: SPECIFIC VIRAL INFECTIONS BENEFIT

For the purpose of benefit under Section B.4 under this policy, Specific Viral Infections means Viral Hepatitis (Hepatitis A, B C and E), Measles, Mumps, Poliomyelitis, Avian Influenza and Swine Influenza

Benefit B.4.1: Base Benefit: Specific Viral Infections Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Specific Viral Infection that solely and directly requires the Insured Person to be hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Specific Viral Infection and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in Hospital should continue for a minimum period of 48 successive hours
iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to Specific Viral Infection is prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Specific Viral Infection is within a waiting period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.
v. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
vi. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

Claims Documents for Section B.4.1:

Duly filled claim form
Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization
Indoor case papers of treating hospital, if available Laboratory Reports confirming the diagnosis of Specific Viral
Infections, as follows:

- Viral Hepatitis:

Hepatitis A - Positive HAV IgM antibody test
Hepatitis B - Positive HBsAg Test
Hepatitis C - Positive HCV RNA test
Hepatitis E - IgG / IgM Antibody Test confirming diagnosis

- Measles - IgG / IgM Antibody Test
- Mumps - IgG / IgM Antibody Test
- Poliomyelitis - Throat swab / Stool / CSF culture for Poliovirus
- Avian Influenza: Laboratory test of a Throat Swab confirming the diagnosis
- Swine Influenza: Laboratory test of a Throat Swab confirming the diagnosis

SECTION B.5: SPECIFIC NERVOUS SYSTEM INFECTIONS BENEFIT

For the purpose of benefit under Section B.5 under this policy, Specific Nervous System Infections means Meningitis, Encephalitis, Creutzfeldt-Jakob disease, Guillain-Barré syndrome

Benefit B.5.1: Basic Benefit: Specific Nervous System Infections Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Specific Nervous System Infection that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Specific Nervous System Infection and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in Hospital should continue for a minimum period of 48 successive hours
iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to

Specific Nervous System Infection is prior to the commencement of the Period of Cover.

iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Specific Nervous System Infection is within a waiting period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us.

v. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.

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

Claims Documents for Section B.5.1:

Duly filled claim form

Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization

Indoor case papers of treating hospital, if available Laboratory Reports confirming the diagnosis of Specific

Nervous System Infection, as follows:

- Meningitis: CSF Examination confirming the diagnosis of Meningitis
- Encephalitis: EEG / MRI / CSF / Examination confirming the diagnosis of Meningitis
- Creutzfeldt-Jakob disease: MRI / CSF Examination / Electroencephalography confirming the diagnosis
- Guillain-Barré syndrome: EMG / CSF Examination confirming the diagnosis

SECTION C - ACCIDENTAL INJURY BENEFITS

Our maximum, total and cumulative liability for claims arising in respect of the Insured Person during the Period of Cover under Benefits C.1.1, C.1.2, and C.1.3 shall be the Sum Insured as specified against this set of Benefits in the Policy Certificate.

C.1.1 Base Benefit: Accidental Death Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 365 days from the date of the Accident.

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

Claims Documents for Section C.1.1:

Claim Form MLC or FIR

Cause of Death Certificate and Death Certificate by municipal corporation

Post Mortem Report

Viscera / Chemical Analysis / Forensic Report

Police Final Charge Sheet / Court Final Order

Spot / Inquest Panchnama

Indoor case papers, if available

C.1.2 Base Benefit: Permanent Total Disablement (PTD) Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Benefit C.1.1 (Accidental

Death Benefit), if in force for the Insured Person.

- If the Insured Person suffers Injuries resulting in more than one of the Permanent Total Disablements, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.
- If We have admitted a claim for Permanent Total Disablement in accordance with this Benefit, then We shall not be liable to make any payment under Benefit C.1.1 (Accidental Death Benefit), if the Insured Person subsequently dies (unless the sum insured against death benefit is greater, during which the balance amount shall be paid to the nominee). However, any other applicable Benefits which may get triggered will be considered in accordance with the terms and conditions of the respective Benefits.
- We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit and Benefit C.1.1 (Accidental Death Benefit) & C.1.3 (Permanent Total Disablement (PTD) Benefit) in respect of the Insured Person shall immediately and automatically cease.
- On the acceptance of a claim under this Benefit, insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

Claims Documents for Section C.1.2:

Claim For MLC or FIR
Police Final Charge Sheet / Court Final Order
Spot / Inquest Panchnama
Disability Certificate issued by civil or government Hospital
Indoor case papers, if available Medical Certificate

C.1.3 Base Benefit: Permanent Partial Disablement (PPD) Benefit

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Certificate) in the manner which is specified in the table below if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person (which is of the nature specified in the table below) within 365 days from the date of the Accident.

For the purpose of this Benefit, Permanent Partial Disablement means total and/or partial irrecoverable loss of use or the actual loss by physical separation of the body parts as specified in the table below:

SR No.	LOSSES COVERED	% OF SUM INSURED payable
1	Loss of one entire hand	70
2	Loss of one entire foot	70
3	Loss of use of one eye	50
4	Loss of all toes	20
5	Loss of great toe - both phalanges	5
6	Loss of great toe - one phalanx	2
7	Other than great toe if more than one toe lost each	5
8	Loss of use of both ears	75
9	Loss of use of one ear	30
10	Loss of four fingers and thumb of one hand	40
11	Loss of four fingers	35
12	Loss of thumb - both phalanges	25
13	Loss of thumb - one phalanx	10
14	Loss of index finger - three phalanges	10
15	Loss of index finger - two phalanges	8
16	Loss of index finger - one phalanx	4
17	Loss of middle finger - three phalanges	6
18	Loss of middle finger - two phalanges	4
19	Loss of middle finger - one phalanx	2
20	Loss of ring finger - three phalanges	5
21	Loss of ring finger - two phalanges	4

22	Loss of ring finger - one phalanx	2
23	Loss of little finger - three phalanges	4
24	Loss of little finger - two phalanges	3
25	Loss of little finger - one phalanx	2
26	Loss of metacarpus - first or second (additional)	3
27	Loss of metacarpus - third, fourth or fifth (additional)	2

considered under Benefit C.1.1 (Accidental Death Benefit, if opted).

ii. If a claim is accepted under this Benefit and the amount due under this claim and claims already admitted in respect of the Insured Person cumulatively leads to the Sum Insured being exceeded, then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this Benefit and the Policy shall continue, subject to the availability of the Sum Insured and the terms, conditions and exclusions of this Policy.

Claims Documents for Section C.1.3:

Claim Form MLC or FIR
Police Final Charge Sheet / Court Final Order
Spot / Inquest Panchnama
Disability Certificate issued by civil or government Hospital
Indoor case papers, if available Medical Certificate

C.1.4 Base Benefit: Temporary Total Disablement (TTD) Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the incapacitation of the Insured Person which prevents the Insured Person from engaging in any employment or occupation on a temporary basis, then We will pay upto the weekly amount specified against this Benefit in the Policy Certificate for the duration that the Temporary Total Disablement continues.

This Benefit shall be payable subject to the following:

vi. We shall not be liable to make any payment under this Benefit in respect of the Insured Person for more than the total number of weeks specified in the Policy Certificate for any and all claims arising within the Period of Cover under this Benefit.

This Benefit shall be payable subject to the following:

Such period of disability is within 30 days after the date of Accident causing such Injury

vii. If the Injury is sustained to or suffered in relation to the spine and its muscular girdle, ligamentous system, cartilage, nervous system and blood supply to the spine which is not detectable by means of radiological scanning, imaging, or neurological fallout testing, then Our liability under this Benefit shall extend for a maximum period of five (5) weeks.

viii. We shall not be liable to make any payment which is more than the Insured Person's Gross Weekly Income

ix. In the event of any dispute as to the date when the Temporary Total Disablement ceased, such date shall be finally determined by an external Medical Practitioner approved by Us who certifies either:

a) the date upon which the Insured Person recovered; or

If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be the date upon which the Insured Person recovered as far as he/she will ever recover.

vi. If the Insured Person is disabled for a part of a week, then only a proportionate part of the weekly amount will be payable in respect of that week.

Gross Weekly Income means the Insured Person's base weekly earnings in his or her occupation at the time of the Accident causing the Injury for which benefits are claimed under this coverage, but not including, overtime,

bonuses, tips, commissions, and special compensation.

Claims Documents for Section C.1.4:

Claim Form MLC or FIR
Medical Certificate Fitness Certificate
Income Documents (ITR/Form 16, as applicable)

C.1.5 Base Benefit: Children's Education Grant Benefit

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

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

If the Insured Person's Dependent Children also die in the same Accident or due to any event occurring after the death of the Insured Person and before the claim amount payable under this Benefit can be paid in full, the amount payable shall be paid to the Dependent Child's legal heirs in the manner specified in the Policy Certificate.

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

This Benefit shall be payable subject to the following:

Our maximum, total and cumulative liability under this Benefit is the Sum Insured specified against this Benefit, irrespective of the number of surviving Dependent Children of the Insured Person.

Claims Documents for Section C.1.5:

- Documentation requirement mentioned against Benefit
- C.1.1 (Accidental Death Benefit) or Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of Injury) Bonafide Certificate from the educational institute certifying the enrolment of the Insured Person's child in his/her educational course
- Proof of relationship of children with Insured Person such as passport/Aadhar card with full DOB /election card / PAN card
- Age proof of children such as passport,/Aadhar card with full DOB /election card / PAN card

C.1.6 Base Benefit: Accidental Hospitalization Expenses Reimbursement Benefit

We will reimburse the Medical Expenses incurred in respect of the Insured Person for treatment of Injury sustained by the Insured Person in an Accident which occurs within the Period of Cover and solely and directly requires the Insured Person to be Hospitalized.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person is admitted to the Hospital within 7 days of the occurrence of the Accident.
iii. We will reimburse only those Medical Expenses that are Reasonable and Customary Charges.
iv. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the

Policy Certificate, if applicable

v. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

Claims Documents for Section C.1.6:

Claim Form
Indoor Case Papers, if available MLC or FIR
All Diagnostic Reports Complete Hospital bills
Discharge Summary

C.1.7 Base Benefit: Accidental Hospitalization Daily Cash Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate for each continuous and completed day of Hospitalization.

This Benefit shall be payable subject to the following:

The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

The Insured Person is admitted to the Hospital within 7 days of the occurrence of the Accident.

iii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each period of Hospitalization within the Period of Cover.

Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.

If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured and the maximum number of days as mentioned against this Benefit in the Policy Certificate.

vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

Claims Documents for Section C.1.7:

Claim Form
Indoor Case Papers, if available MLC or FIR
All Diagnostic Reports Complete Hospital bills
Discharge Summary
Certificate from Medical Practitioner

C.1.8 Base Benefit: Loss Of Job Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in the manner specified in the Policy Certificate if the insured person loses his job on account of an Injury due to an Accident resulting in Permanent Total Disablement or Permanent Partial Disablement during the Policy Period

This Benefit shall be payable subject to the following:

- The Insured Person is employed on the direct payroll of an organization or entity having a registered office in India or of an Indian branch of such organization or entity, for a minimum of six continuous months before the Risk Inception Date
- Loss of Job is involuntary in nature and not on account of self-resignation
- The onus of establishing that the loss of Job was due to an involuntary reason (resulting from the Insured Person suffering an injury during the Policy Period, solely and directly resulting in the Insured Person's suffering Permanent Total Disablement or Permanent Partial Disablement)

and providing proof of such reason where required by Us, shall lie on the Insured Person/claimant. Any form of self resignation shall not be admissible.

- Once a claim has been considered admissible and payable by Us under this Section, any subsequent Renewal of the cover under this Section will be solely as per Our discretion, on a case to case basis.

Claims Documents for Section C.1.8:

- Documentation requirement mentioned against Benefit
  - (Permanent Total Disablement (PTD) Benefit) or
  - (Permanent Partial Disablement (PPD) Benefit) (As per the nature of injury)
- Certificate from the employer of the Insured confirming the termination, dismissal, temporary suspension or retrenchment from employment of the Insured furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured with the reasons for the same. In case of temporary suspension the period of suspension should also be mentioned in such certificate.

Appointment letter
Last 3 Months Salary Slip Form 16
Contact details of employer-phone no. mobile no., email ID, contact person in HR/Admin/Personnel dept. Appointment letter Employer if Re employed

C.1.9 Base Benefit: RECOVERY BENEFIT

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in a manner specified in the Policy Certificate in respect of the Insured Person upon his/her suffering an Accident that occurs during the Period of Cover which solely and directly results in hospitalization of the insured person for the minimum number of days mentioned in the policy certificate so to cover under this benefit.
This Benefit shall be payable subject to the following:

- We will accept multiple claims under this Benefit during the Period of Cover in respect of the Insured Person. However Our maximum, total and cumulative liability for claims arising in respect of the Insured Person under this Benefit during the Period of Cover shall be the Sum Insured as specified against this Benefit in the Policy Certificate.
- Our maximum liability under this cover shall be the sum insured mentioned against this benefit in the policy certificate

SPECIFIC EXCLUSIONS APPLICABLE TO SECTION C
(Except Benefit C.1.6, C.1.7 and C.1.9)

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

War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.

1. Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution.
2. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world.
3. Breach of law or while being involved in any unlawful activity.
4. Any Injury / Illness arising from intentional self-Injury, suicide or attempted suicide.
5. Any Injury / Illness arising whilst under the influence of alcohol or intoxicating drugs or substance abuse of any kind.

6. Any Injury / Illness occurring whilst working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel

7. Any Accidental Injury / Illness directly or indirectly caused by venereal disease

8. Injury sustained whilst engaging in Adventure Sports (Unless specifically covered and mentioned in the policy certificate

9. Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought.

10. Expenses incurred on eyeglasses, contact lenses, hearing aids and examination for the prescription or fitting thereof.

11. Any Illness, complication or ailment not arising out of or connected to Injury.

12. Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, or illness of the Insured Person resulting directly from, or indirectly caused by, or contributed to or aggravated or prolonged by, childbirth or pregnancy or in consequence thereof.

13. Death, disablement (whether of a permanent nature or of a temporary nature), Injury, or Illness arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

14. Circumcision or strictures, vaccination, inoculation, sex change, beauty treatment of any description, intentional self-Injury, (which expression shall cover also general debility, "run down" conditions), venereal disease, use of intoxicating drugs, or any Illness, Injury, death or disablement directly or indirectly due to any one or more of them.

15. Dental treatment, eye treatment and plastic surgery unless medically necessitated as a consequence of an Injury sustained in an Accident during the Period of Cover.

16. Any Hospitalization not arising out of an Injury sustained in an Accident during the Period of Cover.

17. Routine medical, dental, eye and ear examinations.

18. All cosmetic/aesthetic surgeries including but not limited to lasik surgery.

EXCLUSIONS APPLICABLE TO BENEFITS C.1.6, C.1.7 & C.1.9

We shall not be liable to make any payment for any claim under Benefits C.1.6, C.1.7 & C.1.9 of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in anyway attributable to any of the following:

I. STANDARD EXCLUSIONS

- All dental treatment or dental surgery of any kind unless necessitated due to an Accident
- Unproven Treatment (Code - Excl 16) - 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. Maternity(Code - Excl 18) - (Unless specifically covered and mentioned in the policy certificate)
- Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period;
- Sterility and Infertility (Code - Excl 17) - 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

- Cosmetic or Plastic Surgery (Code - Excl 08) - 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.
- Investigation & Evaluation (Code - Excl 04) -

  Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;

  Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

  Any external congenital anomalies.

  Any Injury / Illness occurring whilst engaging in any Adventure Sports as an Amateur. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world
- Hazardous or Adventure Sport (Code - Excl 09) -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.
- Breach of Law (Code - Excl 10) - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.(Code Excl 12)
- Rest Cure, rehabilitation and respite care (Code - Excl05) -

  Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes: 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.
- Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons (Code - Excl 13)
- 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 a part of hospitalization claim or day care procedure (Code - Excl 14)
- Excluded Providers (Code - Excl 11)

  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 policy holders 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.

II. SPECIFIC EXCLUSIONS

- Routine medical, dental, eye and ear examinations is not covered unless specifically covered and specified in the Policy Certificate.
- Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought. Any Illness, complication or ailment arising out of or connected to such Injury
- War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.
- Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution.
- Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world.
- Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide.
- Any Illness, complication or ailment not arising out of or connected to Injury

BASIS OF ASSESSMENT OF CLAIM

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 procedures and requirements in relation to claims, shall be Conditions Precedent to Our liability under this Policy**.**

We shall be under no obligation to pay as per this policy until we have received all premium payments in full and on time for Insured Person's cover under the Policy.

Claim Procedure:

We shall be given notice of any event that may give rise to a claim on toll free number 1800 2666 or on our website www.icicilombard.com or also in writing at our address specified in the Policy Certificate:

All claims shall be made within the timelines and in accordance with the procedures set out in the relevant Sections of the Policy. All claims documentation must be submitted in full as specified within the relevant Section of the Policy.

Claims made beyond period of 30 days of the Insured Event would be considered to be condoned only on merits if proved that the delay was on account of reasons beyond the claimant's control.

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 for which the Insured person may be called to submit before our nominated medical practitioner for medical examination. If needed, we/our representatives be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's Injury/Illness and treatment in furtherance to verify the facts surrounding the claim.

All claims will be investigated (as required) and settled in accordance with the applicable regulatory guidelines.

Any payment due to You under this Policy shall be paid to You by Us. However, We also reserve

Our right to pay the Claim directlyto the Hospital or to the Nominee (as named in the Policy Schedule).

NOTE:- Please inform us immediately of any change in the address, occupation, state of health, or of any other changes affecting the Insured Person (or his Nominee/ legal heir, as the case may be)

- The scope of cover shall be within the geographical boundaries on India unless specified otherwise.

Terms of Renewal

The Policy may be renewed as as per the relevant regulatory prescription and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an Injury or Accident or Illness or Hospitalization that occurred during the Grace Perio

The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

- You shall on tendering any premium for the Renewal ofthis Policy give notice in writing to Us of any disease, physical defect or infirmity with which any of the InsuredPerson(s) have become affected since the payment ofthe expiring Policy start date.

POLICY RELATED TERMS AND CONDITIONS

- It is the responsibility of the Insured to provide satisfactory proof substantiating the claim within the prescribed period. Also to provide support to ourmedical practitioner and agent/investigating team toenable them to carry out all medical examination and investigation relating to the claim.
- That notice of change of business or occupation of the Insured person be intimated immediately as per the terms & conditions.
- Any compliance of a claim request on cashless basis shall be at the sole discretion of ICICI Lombard General Insurance Company Ltd.
- Any change in the policy terms and conditions including but not limited to sum insured and/or coverage shall not be permitted within the Period of Cover.
- In case the customer chooses to pay the premium in installments then he/she shall not be able to change thefrequency of payments within the Period of Cover.
- In case the customer has opted for auto renewal, the policy can be renewed but, subject to such alterations which may be in respect to sum insured, coverage, premium and such other conditions upon intimation to the Insured.
- We shall make payment to assignee/partial assignee/conditional assignee, as the case may be or in the absence of assignee to the Insured Person or theInsured Person's nominee. If there is no assignee or nominee and the Insured Person is incapacitated ordeceased, We will pay to the Insured Person's heir, executor or validly appointed legal representative.
- Policy certificate means Certificate of Insurance and viceversa

For Section A & B, the Insured Person shall have the right to migrate from this Policy to a similar individual health insurance policy, if available with Us.

PART III OF THE POLICY SCHEDULE STANDARD 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

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) under this 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. 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.

5. Cancellation

a) The policyholder may cancel this policy by giving 7 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

i) Refund Grid applicable to Policies having Policy Period lesser than or equal to 1 year:

Day of cancellation	**Rate of Premium refunded**
Within 30 days*	70%
31 - 90 days	60%
91 days - 6 months	45%
Exceeding 6 months	Nil

* Not applicable for policies with freelook period; Premium refund for cancellations during the freelook period will be provided as per the Free look clause

ii) Refund Grid Applicable to policies having Policy Period greater than 1 year:

% of Premium refund				
Day of cancellation	**Policy Period**			
	2 years	**3 years**	**4 years**	**5 years**
Within 180 Days*	60%	65%	70%	75%
181 - 365 days	40%	52%	57%	61%
366 - 730 days	NIL	26%	38%	46%
731 - 1095 days		NIL	20%	30%
1096 - 1460 days			NIL	15%
More than 1460 days	NIL			

Not applicable for policies with freelook period; Premium refund for cancellations during the

freelook period will be provided as per the Free look clause

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

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.

6. Migration

In case of migration of indemnity based health insurance policy (except Personal Accident and Travel Policies) with the same Insurer, the insured can transfer the credits gained to the extent of the Sum Insured and benefits available in the previous policy to the migrated policy. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months

7. Portability

a. The insured has the choice to port his / her policies from one Insurer to another. An Insured desirous of porting his/her policy to another insurer shall apply 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 due date for renewal.

b. 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

c. The Company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines .

d. This benefit is not applicable for enhanced sum insured.

8. Renewal of Policy

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

- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- No loading shall apply on renewals based on individual claims experience

9. Withdrawal of Policy

- 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.
- 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

10. 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 company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. except for proven fraud and permanent exclusions specified in the policy

contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract

11. Premium Payment in Installments

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)

a) Grace Period of 15 days would be given to pay the instalment premium due for the policy.

b) During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

c) 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.

iii. iv. No interest will be charged If the instalment premium is not paid on due date In case of instalment premium due not received within the grace period, the policy will get cancelled.

iv. In the event of a claim, all subsequent premium instalments shall immediately become due and payable

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

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

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

13. Free Look Period

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.

14. 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 periodas per regulatory prescriptions, provided the policy has been maintained without a break.

15. Redressal of Grievance

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
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.

If insured person is not satisfied with the

redressal of grievance ,insured person may contact the grievance redressal officer 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 IRDA 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

Office of the Insurance Ombudsman	**Area of Jurisdiction**
AHMEDABAD Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
BHOPAL Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESWAR Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha
CHANDIGARH Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.

CHENNAI Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).
DELHI Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141-2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
KOCHI Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
KOLKATA Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Insurance Ombudsman Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road,	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur,

Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Insurance Ombudsman Office of the Insurance	Bihar, Jharkhand.

Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	
PUNE Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).
THANE Shri Umesh Sinha Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604 Email:bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https:/ligms. irda.qov. in/

The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org, on the website of General Insurance Council: www. generalinsurancecouncil.org.in , website of the company www.icicilombard.com or from any of the offices of the Company or For updated list of ombudsman details kindly visit https://www.cioins.co.in/Ombudsman

16. 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.

SPECIFIC TERMS AND CLAUSES

1.Incontestability and Duty of Disclosure

The Policy shall be null and void and no benefit shall be payable in the event a Claim being fraudulent or any fraudulent means or devices being used by the Insured Person or any one acting on his behalf to obtain any benefit under this Policy.

2.Material Change

The Insured Person shall immediately notify Us in writing of any material change in the risk and cause at his own expense such additional precautions to be taken as circumstances may require to ensure safe operation, trade or business practices thereby containing the circumstances that may give rise to the Claim and We may, adjust the scope of cover and / or premium, if necessary, accordingly.

3.Records to be maintained

The Insured Person shall keep an accurate record containing all relevant particulars and shall allow Us to inspect such record.

4.Notice of charge

We shall not be bound to take notice or be affected by any notice of any trust, charge, lien,

assignment or other dealing with or relating to this Policy, but the payment by Us to the Insured Person, Nominee, assignee or his legal heirs of any amount under the Policy shall in all cases be an effectual discharge to Us.

5.Overriding effect of Part II of the schedule

The terms and conditions contained herein and in Part II of the Schedule to this Policy shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Schedule to this Policy, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in Part II of the Schedule to this Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be adjudicated or interpreted in accordance with Indian Laws and only competent Indian courts 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.

6.Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to: In case of the Insured Person, at the address specified in the Policy Certificate.

In case of Us:

ICICI Lombard General Insurance Company Limited, ICICI Lombard House,
414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

7.Customer Service

If at any time the Insured Person (or his Nominee/ legal heir, as the case may be) requires any clarification or assistance, they may contact Our offices at the address specified below, during normal business hours.

ICICI Lombard General Insurance Company Limited ICICI Lombard House 414, Veer Savarkar Marg, Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025.

OTHER TERMS AND CONDITIONS

ENDORSEMENTS AVAILABLE UNDER THIS POLICY

Endorsement I: Premium Installment Clause

We will accept payment of the premium applicable taxes, charges, etc. in monthly/quarterly/semi- annual/annual installments as specified in the Policy Certificate provided that the Policyholder continues to perform and observe all their obligations hereunder.

Endorsement II: Auto Renewal Clause

We will automatically renew the Policy for the Policy Period as opted by the policyholder. However, after completing its entire auto Renewal period on expiry of the Policy on the Policy End Date,

Every Renewal premium shall be paid and accepted as per the terms of Renewal specified under this Policy and upon the distinct understanding that no alteration has taken place in the facts contained in the Proposal and Declaration Form herein before mentioned and that nothing is known to the Insured Person that may result to enhance the risk of We under the guarantee hereby given. Any change in the risk will be intimated to the Company by the Policyholder/ Insured Person. Nothing herein or otherwise shall affect Our right to impose any additional terms and conditions on Renewal or restrict any Renewal terms as to premium or otherwise.

No Renewal receipt shall be valid unless it is on the printed form of Our and signed by Our authorized official.