POLICY WORDING

GROUP SECURE MIND

PART II OF THE POLICY Standard Definitions

1. DEFINITIONS

For the purposes of this Policy, the following words shall have the meanings as set forth below:

Accident: An accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

Any one illness: Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home w here treatment was taken.

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

Cashless facility: Cashless facility means a facility extended by the insurer to the insured w here 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.

Congenital Anomaly: refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

i. Internal Congenital Anomaly - Congenital anomaly which is not in the visible and accessible parts of the body
ii. External Congenital Anomaly - Congenital anomaly which is in the visible and accessible parts of the body

Condition Precedent: shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

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

–Has qualified nursing staff under its employment;
–Has qualified medical practitioner/s in charge;
–Has a fully equipped operation theatre of its own where surgical procedures are carried out;
–Maintains daily records of patients and ill make these accessible to the insurance company's authorized personnel

Day Care Centre includes Ayush Dare Care Centre

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:

- Having qualified registered AYUSH Medical Practitioner(s) in charge;
- Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Break in policy means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.**Day care treatment:** refers to medical treatment, and/or surgical procedure which is:

i. Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs. because of technological advancement, and
ii. Which would have otherwise required a hospitalization of more than 24 hours.
iii. Treatment normally taken on an out-patient basis is not included in the scope of this definition. [Insurers can, in addition, restrict coverage to a specified list

Deductible: is 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.

Emergency care: means management for a severe 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.

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.

Hospital:
A hospital means any institution established for *in-patient care* and *daycare treatment* of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of

Section 56(1) and 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 tow ns having a population of less than 10,00,000 and at least 15 in-patient 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 makes these accessible to the insurance company's authorized personnel.

Hospital includes Ayush Hosiptal

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:
   - Having at least 5 in-patient beds;
   - Having qualified AYUSH Medical Practitioner in charge round the clock;
   - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Hospitalization:
Hospitalization means admission in a Hospital for a minimum period of 24 consecutive *'In-patient Care'* hours except for specified procedures/ treatments, w here such admission could be for a period of less than 24 consecutive hours.

Illness: Means a sickness or disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment

a. **Acute condition** - 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.
b. **Chronic condition** - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
   - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
   - it needs ongoing or long-term control or relief of symptoms
   - it requires your rehabilitation or for you to be specially trained to cope with it
   - it continues indefinitely
   - it recurs or is likely to recur.

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

Inpatient Care: Inpatient care means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

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 w here the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Maternity expenses: Maternity expenses means;
a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
b. Expenses towards lawful medical termination of pregnancy during the policy period.

Medical Advice: means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow -up prescription.

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.

Medical Practitioner:
Medical Practitioner means a person who holds a valid registration from the 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 its scope and jurisdiction of license.

Medically Necessary Treatment:
Medically necessary treatment means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:
i) is required for the medical management of the illness or injury suffered by the insured;
ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii) must have been prescribed by a *medical practitioner*;

iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Migration:
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.

Network Provider: 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.

Non- Network: any hospital, Day Care Centre or other provider that is not part of the network.

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

New born baby means baby born during the Policy Period and is aged upto 90 days.

Portability:
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.
Pre-Hospitalization: Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Post-Hospitalization Medical Expenses: Means Medical Expenses incurred immediately after the Insured Person is Hospitalised, provided that

i. such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Pre-Existing Disease means any condition, ailment, injury or disease:
a) 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
b) 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.

Qualified Nurse: Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

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) i. 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 company shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
ii. 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. No interest will be charged If the instalment premium is not paid on due date.
iv. In case of instalment premium due not received within the grace period, the policy will get cancelled.
v. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vi. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

Reasonable and Customary Charges 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.

Renewal: Renewal means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renew al continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

Surgery or Surgical Procedure: Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or day care centre by a *medical practitioner.*

Unproven/Experimental treatment: 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.

Specific Definitions

Alternative Treatments: are forms of treatments other than treatment Allopathy or modern medicine and includes Ayurveda, Unani, Sidhaand Homeopathy in the Indian context.

Bank: Means a banking company that transacts the business of banking in India or abroad.

Certificate: means Certificate of Insurance issued by the Company to the Insured confirming that the Insured is entitled to insurance coverage under this Policy.

Company: means ICICI Lombard General Insurance Company Limited.

Doctor: Means a person who holds a degree of a recognized medical institute and is registered by Medical Council of India or of the respective States of India, if so required and acting within the scope of the license of registration granted to him/her. The definition would include Physician, Specialist, Anesthetist and Surgeon and specifically excludes doctors / practitioners in non-allopathic fields.

EMI or EMI Amount[1]: Means and includes the amount of monthly payment required to repay the principal amount of Loan and Interest by the Insured as set forth in the amortization chart referred to in the loan agreement (or any amendments thereto) between the Bank/Financial Institution and the Insured prior to the date of occurrence of the Insured Event under this Policy. For the purpose of avoidance of doubt, it is clarified that any monthly payments that are overdue and unpaid by the Insured prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.

Financial Institution: Shall have the same meaning assigned to the term under section 45 I of the Reserve Bank of India Act, 1934 and shall include a Non Banking Financial Company as defined under section 45 I of the Reserve Bank of India Act, 1934

Insured: Means the Individual(s) w hose name(s) are specifically appearing as such in Part I of the Schedule to this Policy. For the purpose of avoidance of doubt it is clarified that the heirs, executors, administrators, successors or legal representatives of the Insured may present a claim on behalf of the Insured to the Company.

Insured Event Means any event specifically mentioned as covered under this Policy.

Loan: Means the sum of money lent at interest or otherwise to the Insured by any Bank/Financial Institution as identified by the Loan Account Number referred to in the Part I of Schedule to this policy

Nominee: Means the person(s) nominated by the Insured to receive the insurance benefits under this Policy payable on the death of the Insured. For the purpose of avoidance of doubt it is clarified that if the Insured is a minor, his guardian shall appoint the Nominee.

Policy Period: Means the period commencing from Policy start date and hour as specified in Part I of the Schedule and terminating at midnight on the Policy end date as specified in Part I of the Schedule to this Policy

Period of Insurance: Means the period commencing from the date of incorporation of the insured under the policy as specifically stated in Part I of Schedule against the Period of Insurance Start Date but not earlier than Policy Start Date and ending on the Period of Insurance End Date as specified in Part I of the Schedule to this Policy.

Physical Separation: Means as regards the hand actual separation at or above the wrists, and as regards the foot means actual separation at or above the ankle.

Policy: Means the Policy booklet, the Schedule, any Extension and applicable endorsements under the Policy. The Policy contains details of the extent of cover available to the Insured, the exclusions under the cover and the terms and conditions of the issue of the Policy

Policy holder: Means the entity, whether a company (including Banks/Financial Institutions), trust, association or other organization, whose name specifically appears as such in Part I of the Schedule to this Policy

Public Authority: Means any governmental, quasigovernmental organization or any statutory body or duly authorized organization with the power to enforce laws, exact obedience, command, determine or judge.

Principal Outstanding: Means the principal amount of the Loan outstanding as on the date of occurrence of Insured Event less the portion of principal component included in the EMIs payable but not paid from the date of the loan agreement till the date of the Insured Event/s. For the purpose of avoidance of doubt, it is clarified that any EMIs that are overdue and unpaid to the Bank prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.

Professional Sports: Means a sport, which would remunerate a player in excess of 50% of his or her annual income as a means of their livelihood.

Schedule: Means this schedule and parts thereof, and any other annexure(s) appended, attached and / or forming part of this Policy.

Sum Insured: Means and denotes the amount of cover available to each Insured, subject to the terms and conditions of this Policy and as stated against such Insured's name in Part I of the Schedule which is the maximum liability of the Company for that respective Insured under this Policy.

Scheduled Airline: Means any civilian aircraft operated by a civilian scheduled air carrier holding a certificate, license or similar authorization for civilian scheduled air carrier transport issued by the country of the aircraft's registry, and which in accordance therewith flies, maintains and publishes tariffs for regular passenger service between named cities at regular and specified times, on regular or chartered f lights operated by such carrier.

2. BENEFITS UNDER THE POLICY

2.1 SECTION I: MAJORMEDICAL ILLNESS & PROCEDURES

Insured event: For the purposes of this Section and the determination of the Company's liability under it, the Insured Event in relation to the Insured, shall mean any illness, medical event or surgical procedure as specifically defined below w hose signs or symptoms first commence more than 90 days after the commencement of Period of Insurance and shall only include:

a) First Diagnosis of the below -mentioned Illnesses more specifically described below:
   1. Cancer of specified severity
   2. Kidney failure requiring regular dialysis;
   3. Multiple Sclerosis with persisting symptoms; or
   4. Benign Brain Tumor
   5. Parkinson's Disease before the age of 50 years
   6. Alzheimer's Disease before the age of 50 years
   7. End Stage Liver Disease

b) Undergoing for the first time of the following surgical procedures, more specifically described below:
   1. Major Organ/ Bone Marrow Transplant;
   2. Open heart replacement or repair of heart valves;
   3. Open chest CABG;
   4. Surgery of Aorta;

c) Occurrence for the first time of the following medical events more specifically described below:
   1. Stroke resulting in permanent symptoms;
   2. Permanent Paralysis of Limbs;
   3. First Heart Attack- of specified severity
   4. Major Burns;
   5. Loss of Speech;
   6. Deafness
   7. Coma of Specified Severity

The Insured Event under this Section I and the conditions applicable to the same are more particularly defined below:

CANCER OF SPECIFIED SEVERITY

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. 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 behaviour, 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;

MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

I. 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 evidenced by all of the following criteria:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. 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.

OPEN CHEST CABG

I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
II. The following are excluded:
   i. Angioplasty and/or any other intra-arterial procedures.

STROKE RESULTING IN PERMANENT SYMPTOMS

I. 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 w ell 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.
II. **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.

PERMANENT PARALYSIS OF LIMBS

i. 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.

KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:
i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible endstage failure of the relevant organ, or ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
II. The following are excluded:

i. Other stem-cell transplants. ii. Where only islets of Langerhans are transplanted.

MULTIPLESCLEROSIS WITH PERSISTING SYMPTOMS

I. 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 orsensory function, which must have persisted for a continuous period of at least 6 months.

III. Neurological damage due to SLE is excluded.

OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. 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.

BENIGN BRAIN TUMOR

I. 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.

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

III. 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.

PARKINSON'S DISEASE BEFORE THE AGE OF 50 YEARS

The occurrence of Parkinson's Disease where there is an associated Neurological Deficit that results in Permanent Inability to perform independently at least three of the activities of daily living as defined below

I. Transfer: Getting in and out of bed without requiring external physical assistance

ii. Mobility: The ability to move from one room to another without requiring any external physical assistance

iii. Dressing: Putting on and taking of all necessary items of clothing without requiring any external physical assistance

iv. Bathing/Washing: The ability to w ash in the bath or shower (including getting in and out of the bath or shower) or wash by other means

v. Eating: All tasks of getting food into the body once it has been prepared Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   i. Permanent jaundice; and
   ii. Ascites; and
   iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is **excluded.**

SURGERY OF AORTA

The actual undergoing of medically necessary surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

Traumatic injury of the aorta is excluded

ALZHEIMER'S DISEASE BEFORE THE AGE OF 50 YEARS

Clinically established diagnosis of Alzheimer's Disease (presenile dementia) resulting in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or resulting in need of supervision and permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months

MAJOR BURNS

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

DEAFNESS

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

2.1.2 BENEFIT PAYABLE UNDER SECTION I

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, General Exclusions stated in this Policy, to pay the Sum Insured in relation to the Insured as stated against Section I under Schedule I on the occurrence of an Insured Event as stated above, under this Section.

2.1.3 CLAIMS SETTLEMENT PROCESS APPLICABLE TO SECTION I

In the event of a claim arising out of an Insured Event covered under this Section, the Insured Event as described above shall be intimated to the Company within thirty (30) days date of first diagnosis of the Illness, date of surgical procedure or date of occurrence of the medial event as the case may be and the Insured shall arrange for submission of the following documents to the Company:

Common list of documents for all Critical Illness:

1. Certificate from the attending Doctor of the Insured confirming, inter alia,
   a. Name of the Insured;
   b. Name, date of occurrence and medical details of the Insured Event
   c. Confirmation that the Insured Event does not relate to any Pre-Existing Disease or any Illness or Injury which existed within the first 3 months of commencement of Period of Insurance.
2. Certificate, if applicable, from the Bank/Financial Institution stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.
3. Duly completed claim forms;
4. Original Discharge Certificate/ Card from the hospital/ Doctor;
5. Original investigation test reports, indoor case papers.
6. Photo ID Proof of proposer/ nominee
7. Address Proof of proposer/ nominee
8. 2 recent coloured passport size photographs of proposer/ nominee
9. Signed NEFT mandate along cancelled cheque copy of proposer/ nominee
10. Any other documents as may be required by the Company.

Illustrative list for each of the Critical Illness

CANCER OF SPECIFIED SEVERITY

1. Claim form
2. Hospital Discharge Card photocopy
3. Hospital Bills photocopy
4. Pharmacy/Investigations Bills
5. Investigations Reports
6. Details of the Treatment received by the Customer from the inception of the Ailment.
7. Letter from treating consultant stating presenting complaints with duration and the past medical history.
8. Histopathology / Cytology / FNAC / Biopsy / Immunohistochemistry reports.
9. X-Ray / CT scan / MRI scan / USG / Radioisotope / Bone scan Reports.
10. Blood Tests.
11. Any other specific investigation done to support the diagnosis like the PAP Smear/ Mammography, etc.
12. Xerox Policy Certificate
13. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

FIRST HEART ATTACK - OF SPECIFIED SEVERITY

1. Claim form
2. Hospital Discharge Card photocopy
3. Photocopy Hospital Bills.
4. Pharmacy/Investigations Bills
5. Investigations Reports
6. Casualty Medical Officers/Emergency room papers with all details of Presenting Complaints and the Medical Examination by the attending physician.
7. Subsequent Consultation Papers with the Treating Doctor and the treatment received
8. ECG On Admission and subsequent ECG's
9. Stress test/ Tread Mill Test
10. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT, LDH / Electrolytes
11. X-ray / 2D-Echocardiography Report
12. Thallium Scan Report
13. Xerox Policy Certificate
14. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

OPEN CHEST CABG

1. Claim form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills.
4. Pharmacy/Investigations Bills
5. Investigations Reports
6. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
7. ECG at the time of detection of Coronary Artery Disease and Subsequent ECG's
8. Stress test/ Tread Mill Test
9. Letter from treating consultant suggesting Coronary Angiography and CABG
10. Coronary Angiography report / CT Angiography Report
11. Cardiac Enzymes Tests: Troponin T/Troponin I, CPK / CPK-MB, SGOT / SGPT, LDH / Electrolytes
12. X-ray / 2D-Echocardiography Report
13. Thallium Scan Report
14. Xerox Policy Certificate
15. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

STROKE RESULTING IN PERMANENT SYMPTOMS

1. Claim form
2. Hospital Discharge Card photocopy
3. Photocopy Hospital Bills.
4. Pharmacy/Investigations Bills
5. Investigations Reports
6. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
7. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologist/ Physician stating the Neurological deficit.
9. MRI / CT scan/ 2D Echocardiography Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke Blood tests (Lipid profile/Random Blood Sugar / Prothrombin Time/APTT/ Bleeding Time/ Clotting Time/ Homocystiene levels)
10. Xerox Policy Certificate
11. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

PERMANENT PARALYSIS OF LIMBS

1. Claim form
2. Hospital Discharge Card photocopy
3. Photocopy Hospital Bills.
4. Pharmacy/Investigations Bills
5. Investigations Reports

6. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
7. Subsequent details of the Treatment, with the Consultation papers from the Treating Neurologis t/ Physician stating the Neurological deficit and the degree/current status and duration of the Paralysis.
8. Confirmation from the Central/State Government Hospital about the complete, irreversible and permanent loss
9. MRI / CT scan Reports or any other Imaging technique Used during the diagnosis and treatment of the Stroke
10. Electro-myogram Report
11. Xerox Policy Certificate
12. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

1. Claim form
2. Hospital Discharge Card photocopy
3. Photocopy Hospital Bills.
4. Pharmacy/ Investigations Bills
5. Investigations Reports
6. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
7. Blood Tests- Renal Function Tests specifically: Serum Creatinine, Blood Urea Nitrogen, Serum Electrolytes done in the recent past (Not more than Tw o Week period from the date of intimation of Loss)
8. Dialysis Papers/Receipts done in recent past.
9. Renal scan
10. Letter from the nephrologists stating the diagnosis of End Stage Kidney Failure.
11. Xerox Policy Certificate
12. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

MAJOR ORGAN /BONE MARROW TRANSPLANT

1. Claim form
2. Hospital Discharge Card photocopy
3. Photocopy Hospital Bills.
4. Pharmacy/Investigations Bills
5. Investigations Reports
6. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
7. Scan / Histopathology / Cytology / FNAC/ Biopsy report suggesting irreversible & non-compensatory changes of the particular organ. 8 Bone Marrow Biopsy Reports (Specifically In Case of Bone Marrow Transplant)
8. Letter from a specialist Doctor confirming the need of transplantation (Organs Specified are: Heart , lung, Liver, pancreas, kidney, bone marrow)
9. Xerox Policy Certificate
10. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

MULTIPLESCLEROSIS WITH PERSISTING SYMPTOMS

1. Claim form
2. Hospital Discharge Card photocopy
3. Photocopy Hospital Bills.
4. Pharmacy/Investigations Bills
5. Investigations Reports
6. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
7. MRI / CT Scan Report.
8. Electo-myogram report
9. Biopsy / Cytology Report
10. Specific Blood Tests: Creatinine Phosphokinase /Anti Nuclear Antibodies , C - reactive protein /Autoimmune work up
11. Any other relevant Blood investigations.
12. Confirmation from the Central/State Government Hospital about diagnosis of Multiple Sclerosis and the duration of the same.
13. Xerox Policy Certificate
14. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

1. Claim form
2. Hospital Discharge Card photocopy
3. Photocopy Hospital Bills.
4. Pharmacy/Investigations Bills
5. Investigations Reports
6. Consultation Paper stating the presenting complaints with duration, past medical history with duration, treatment and medication advised.
7. X-ray and 2D-Echocardiography Report.
8. Letter from the Cardiologist/Cardiothoracic Surgeon suggesting valve replacement with the type of valve to be used.
9. Xerox Policy Certificate
10. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

BENIGN BRAIN TUMOR

1. Duly completed Claim Form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills
4. Pharmacy/Investigation Bills
5. Investigation Reports
6. Histopathology / Cytology / FNAC / Biopsy / Immunohistochemistry reports
7. X-Ray / CT Scan / MRI Scan
8. Consultation papers stating the presenting complaints with duration, past medical history with duration, treatment and advised medication and treatment.
9. Subsequent details of the treatment with the consultation papers from the inception of ailment
10. Letter from the neuro-surgeon confirming the diagnosis
11. Blood Tests
12. Any other specific investigation done to support the diagnosis
13. Xerox Policy Certificate
14. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

PARKINSON'S DISEASE BEFORE THE AGE OF 50

1. Duly completed Claim Form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills
4. Pharmacy/Investigation Bills
5. Investigation Reports
6. PET Scan / CT Scan / MRI Scan / EEG

7. Consultation papers stating the presenting complaints with duration, past medical history with duration, treatment and advised medication and treatment.
8. Subsequent details of the treatment with the consultation papers from the treating specialist.
9. Confirmation from the Central/State Government Hospital about the permanent neurological deficit
10. Xerox Policy Certificate
11. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

END STAGE LIVER DISEASE

1. Duly completed Claim Form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills
4. Pharmacy/Investigation Bills
5. Investigation Reports
6. Sonography / Biopsy Reports
7. Consultation papers stating the presenting complaints with duration, past medical history with duration, treatment and advised medication and treatment.
8. Subsequent details of the treatment with the consultation papers from the treating specialist.
9. Blood Tests
10. Xerox Policy Certificate
11. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

SURGERY OF AORTA

1. Duly completed Claim Form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills
4. Pharmacy/Investigation Bills
5. Investigation Reports
6. Consultation papers stating the presenting complaints with duration, past medical history with duration, treatment and advised medication and treatment.
7. Subsequent details of the treatment with the consultation papers from the treating specialist
8. X-Ray and 2D-Echocardiography Report
9. Letter from the Cardiologist/Cardiothoracic Surgeon suggesting Aorta Surgery

10 Xerox Policy Certificate

11. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

ALZHEIMER'S DISEASE BEFORE THE AGE OF 50 YEARS

1. Duly completed Claim Form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills
4. Pharmacy/Investigation Bills
5. Investigation Reports
6. PET Scan / CT Scan/ MRI Scan / EEG
7. Neuropsychological Tests
8. Consultation papers stating the presenting complaints with duration, past medical history with duration, treatment and advised medication and treatment.
9. Subsequent details of the treatment with the consultation papers from the treating specialist.
10. Confirmation from the Central/State Government Hospital about the permanent neurological deficit
11. Xerox Policy Certificate
12. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

MAJOR BURNS

1. Duly completed Claim Form
2. FIR
3. Panchnama
4. Inquest Panchnama
5. Police Final Report/Charge Sheet (Based on FIR)
6. Letter from the treating doctor specifying the degree of burns along with body surface area involved
7. Post-Mortem Report
8. Xerox Policy Certificate
9. Any other supporting documents as required by the company
10. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

LOSS OF SPEECH

1. Duly completed Claim Form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills
4. Pharmacy/Investigation Bills
5. Investigation Reports
6. Consultation papers stating the presenting complaints with duration, past medical history with duration, treatment and advised medication and treatment.
7. Subsequent details of the treatment with the consultation papers from the treating specialist.
8. Confirmation from the Central/State Government Hospital about the total and irreversible loss and duration of the same
9. Xerox Policy Certificate
10. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

DEAFNESS

1. Duly completed Claim Form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills
4. Pharmacy/Investigation Bills
5. Investigation Reports
6. Consultation papers stating the presenting complaints with duration, past medical history with duration, treatment and advised medication and treatment.
7. Subsequent details of the treatment with the consultation papers from the treating specialist.
8. Confirmation from the Central/State Government Hospital about the total and irreversible loss by an ENT specialist
9. Audiometry Reports
10. Xerox Policy Certificate
11. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

COMA OF SPECIFIED SEVERITY

1. Duly completed Claim Form
2. Photocopy Hospital Discharge Card
3. Photocopy Hospital Bills
4. Pharmacy/Investigation Bills
5. Investigation Reports
6. Consultation papers stating the presenting complaints with duration, past medical history with duration, treatment and advised medication and treatment.
7. Subsequent details of the treatment with the consultation papers from the treating specialist.

8. Confirmation from the Central/State Government Hospital about the permanent neurological deficit and duration of the same
9. Xerox Policy Certificate
10. Age proof of Insured: Election ID Card / PAN Card / School Leaving Certificate / Copy of Passport

2.1.4 EXCLUSIONS APPLICABLE TO SECTION I

The Company shall not be liable to make any payment directly or indirectly arising out of the following events:

a) Any Pre-Existing Disease- Any Insured Event arising on account of or in connection with any Pre-Existing Disease
b) If the Insured does not submit a medical certificate from the Doctor evidencing diagnosis of Illness or Injury or occurrence of the medical event or the undergoing of the medical / surgical procedure.
c) The Company shall not be liable to make any payment under this Policy in connection with or in respect of any Insured Event, as stated in this Section, occurred or suffered before the commencement of Period of Insurance or arising within first three months of the commencement of the Period of Insurance.
d) Any medical procedure or treatment, which is not medically necessary or not performed by a Doctor.
e) Any physical, medical condition or treatment or service that is specifically excluded in the Policy in Part I of the Schedule under Special Conditions.
f) Treatment relating to birth defects and external congenital Illnesses.
g) Birth control procedures and hormone replacement therapy.
h) Any treatment/surgery for change of sex or any cosmetic surgery or treatment/surgery /complications/illness arising as a consequence thereof.
i) Treatment by a family member and self-medication or any treatment that is not scientifically recognized.

2.1.5 SPECIFIC CONDITIONS APPLICABLE TO SECTION I

1. The cover under this Policy, for the specific Insured, shall terminate in the event of claim in respect of such Insured becoming admissible and accepted by the Company under this Section. In consequence thereof no benefit shall be payable under any other section of this Policy.

2.2 SECTION II: PERSONAL ACCIDENT

Insured event: For the purposes of this Section and the determination of the Company's liability under it, Insured Event in relation to the Insured, shall mean Injury sustained during the Policy Period which shall within twelve months of its occurrence be the sole and direct cause of a) death or b) Permanent Total Disablement (more specifically defined herein below). For the purposes of this Section, Permanent Total Disablement shall mean total and irrecoverable:

i. Loss of sight of both eyes; or
ii. Actual loss by Physical Separation of both hands or both feet or one entire hand and one entire foot; or
iii. Loss of use of both hands or both feet or of one hand and one foot without Physical Separation;

Provided that, such disablement shall as a direct consequence thereof permanently disable the Insured from resuming his normal occupation or engaging in similar gainful employment.

2.2.1 BENEFIT PAYABLE UNDER SECTION II

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, General Exclusions stated in the Policy, to pay the Sum Insured as stated against Section II under Schedule I, on occurrence of the Insured Event as stated above under this Section

2.2.2 CLAIM SETTLEMENT APPLICABLE TO SECTION II

i. Upon the happening of any Injury giving rise or likely to give rise to a claim under this Policy, the Injury as described above shall be intimated to the Company within seven days from the date of its occurrence.

ii. The Insured shall deliver to the Company, within 30 days of the date of occurrence of the Insured Event, a detailed statement in writing as per the claim form and any other material particular, relevant to the making of such claim.

iii. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

iv. Proof satisfactory to the Company shall be furnished in connection with all matters upon which a claim is based. Any medical or other agent of the Company shall be allowed to examine the Insured on the occasion of any alleged Injury when and so often as the same may reasonably be required on behalf of the Company. Such evidence as the Company may from time to time require shall be furnished and a post-mortem examination report wherever applicable, shall be furnished to the Company within a period of thirty days.

The Company shall not be liable to pay any claims under this Section II unless the claim under the Policy is accompanied by the following documents:

Personal Accident - Death

1. Duly completed Claim form
2. FIR
3. Panchanama
4. Inquest Panchanama
5. Police Final Report/Charge Sheet (Based on FIR)
6. PM Report having remark for FSLR or CA Report, the reports are must
7. Death Certificate issued by the Municipal authority
8. Cause of death certificate issued by the hospital
9. Original Policy Certificate
10. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport
11. Doctors Report
12. Certificate, if applicable, from the Bank/Financial Institution stating the amortization schedule, the EMI Amount, Principal Outstanding, etc.
13. Any other supporting documents as required by the company
14. RACT award (In case of Rail Accident)
15. Any other document as required by the Company /TPA to investigate the Claim or Our obligation to make payment for it

Permanent Total Disability

1. Claim form
2. FIR
3. Panchanama
4. Disability Certificate from civil surgeon or from designated govt./competent authority

5. Hospitalization reports
6. Hospitalization discharge card
7. RACT award (In case of Rail Accident)
8. Police Final Report/Charge Sheet (Based on FIR)
9. Investigation report
10. Xerox Policy Certificate
11. Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport
12. Any other document as required by the Company /TPA to investigate the Claim or Our obligation to make payment for it

2.2.3 EXCLUSIONS APPLICABLE TO SECTION II

The Company shall not be liable under this Section for:

i. Payment under more than one of the categories specified (Death or Permanent Total Disablement) in the Benefit Payable in respect of the Insured.

ii. Payment of compensation in respect of Insured Event which occurs whilst the Insured is operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft, or Scheduled Airlines or is engaging in aviation or ballooning, or whilst the Insured 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;

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

iv. Payment of compensation in respect of death or Permanent Total Disablement arising from or resulting directly or indirectly from any Illness to any Insured.

v. No sum shall be payable under this Section in case of any Permanent Total Disability for which medical care, treatment, or advice was recommended by or received from a Doctor or from which the Insured suffered or which was present before the commencement of the Policy Period.

2.2.4 SPECIAL CONDITIONS APPLICABLE TO SECTION II

The cover under this Policy, for the specific Insured, shall terminate in the event of claim in respect of that Insured becoming admissible and accepted by the Company under this Section. In consequence thereof no benefit shall be payable under any other section of this Policy

2.3 SECTION III LOSS OF JOB

Insured event: For the purposes of this Section and the determination of the Company's liability under it, Insured Event in relation to any Insured, shall mean termination from employment of the Insured or his dismissal, temporary suspension or retrenchment from employment imposed on him by the employer during the Policy Period on account of insured person suffering an Illness or Injury due to an Accident as per the employer's rules/regulations.

2.3.1 BENEFIT PAYABLE UNDER SECTION III The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, General Exclusions stated in the Policy, to pay, on occurrence of the Insured Event as stated above under this Section, in relation to the Insured, either

1) The Sum Insured as mentioned in the Policy Schedule; or
2) The EMI Amount(s) falling due in respect of the Loan (Loan account number as stated in Schedule I of this Policy) after the commencement of the Insured Event till the reinstatement of employment with the same employer or new employer or expiry of Policy Period, whichever is earlier, subject to a maximum of Sum Insured as stated under the Policy Schedule

2.3.2 CLAIM SETTLEMENT APPLICABLE TO SECTION III

In the event of a claim arising out of an Insured Event covered under this Section, the Insured Event as described above shall be intimated by the Insured to the Company within thirty (30) days from the date of termination from employment of the Insured or his dismissal, temporary suspension or retrenchment from employment on account of insured person suffering an Illness or Injury as the case may be and the Insured shall arrange for submission of the following documents to the Company:

1) Duly completed claim form;
2) Certificate if applicable from the Bank stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.
3) Certificate from the employer of the Insured confirming the termination from employment of the Insured with the reasons for the same.
4) Appointment letter
5) Last 3 Months Salary Slip
6) Form 16
7) Contact details of employer-phone no. mobile no., email ID, contact person in HR/Admin/Personnel dept. Appointment letter Employer if Re employed
8) VISA proof and Passport copy in case of Insured is NRI
9) All Treatment Papers, Doctor's Certificate, Discharged Summary, Disability Certificate (in case of loss of job due to a disability), Investigation reports
10) Photo Copy of the policy
11) Age proof of Insured: Election ID Card / PAN Card/ School Leaving Certificate / Copy of passport

12) Any other document as required by the Company /TPA to investigate the Claim or Our obligation to make payment for it

2.3.3 EXCLUSIONS APPLICABLE TO SECTION III

The Company shall not be liable to make any payment under this Section in the event of termination, dismissal, temporary suspension or retrenchment from employment of the Insured being attributed to any reason other than that arising from an Illness or Injury due to an Accident. The Company shall not be liable to make any payment under this Policy in connection with or in respect of: Self-employed persons; Any claim relating to unemployment from a job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer; Any voluntary unemployment; Unemployment at the time of inception of the Policy Period or arising within first three months of inception of the Policy Period. Any unemployment from a job under which no salary or any remuneration is provided to the Insured Any unemployment due to resignation, retirement whether voluntary or otherwise Any unemployment due to non-confirmation of employment after or during such period under which the Insured was under probation.

2.3.4 SPECIFIC CONDITIONS APPLICABLE TO SECTION III

A claim under this section shall become admissible provided the period of termination, dismissal, temporary suspension or retrenchment from employment of the Insured shall not be less 30 consecutive days ("Retrenchment Period"). The benefit is available only for salaried employees.

The cover as described under this Section, for specific Insured, shall terminate in the event one or more claim(s) in respect of that Insured becoming admissible and accepted by the Company under this Section and the Company admitting liability to the extent of the Sum Insured as stated against Section III for the Insured under Schedule I

3. GENERAL EXCLUSIONS APPLICABLE TO THE POLICY:

The Company shall not be liable for any loss or damage under this Policy:

1. Arising or resulting from the Insured committing any breach of the law with criminal intent
2. Due to, or arising out of, or directly or indirectly connected with or traceable to, war, invasion, act of foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of all Heads of State and citizens of whatever nation and of all kinds and acts of terrorism
3. Directly or indirectly caused by or contributed to by or arising from ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission
4. Directly or indirectly caused by or contributed to by or arising from nuclear weapon materials.
5. Directly or indirectly caused by or contributed to by or arising out of usage, consumption or abuse of alcohol and/or drugs.
6. Arising out of or as a result of any act of self-destruction or self-inflicted injury, attempted suicide or suicide.
7. Any consequential or indirect loss or expenses arising out of or related to any Insured Event.
8. Arising out of or resulting directly or indirectly due to or as a consequence of pregnancy or treatment traceable to pregnancy and childbirth, abortion and its consequences, tests and treatment relating to infertility and invitro fertilization.
9. Arising out of or resulting directly or indirectly while serving in any branch of the Military or Armed Forces of any country during war or warlike operations
10. Arising out of or resulting directly or indirectly caused by, resulting from or in connection with any ac t of terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss. The Policy also excludes loss, damage, cost or expenses of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any w ay relating to action taken in respect of any act of terrorism.

4. GENERAL CONDITIONS APPLICABLE TO THE POLICY

4.1 AGE LIMIT

Entry in the policy is allowed till the age of 65 years. The Policy provides for life-long renewability.

4.2 OTHER CONDITIONS

At any time during the Policy Period the Company shall be entitled to inspect any or all records of the Insured that may be relevant to this Policy. The Company shall also have the right of interaction with any and or all those agencies or agents of the Insured as may be relevant for examination/verification of the data/documents in connection with the process and disposal of any claims under this Policy. The Insured shall provide reasonable support to the Company in this regard.

If so required by the Company, the Insured will have to submit to a medical examination by the Company's nominated Doctor or undergo diagnostic or other medical tests as often as the Company considers necessary, in its sole discretion.

4.3 PAYMENTS

The Company shall be duly discharged of its obligations under this Policy and the Insured the shall hold the Company harmless , upon making the payment of the claim to the Insured or his nominee/ legal heirs as the case may be

4.4 REFUND OF PREMIUM
The company shall refund the premium as per the Company's short period scales in case of receipt of notice of cancellation from the Insured, provided there is no claim under the policy

4.5 Terms of Renewal
The Policy can be renewed under then the prevailing Group Secure Mind Policy or its nearest substitute (in case the product Group Secure Mind Policy is withdrawn by the Company) offered by the Company.
1. A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium conditions as provided in the policy.

2. 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.

Renewal Premium – Premium payable on renewal and on subsequent continuation of cover are subject to change.

Maximum Renewal Age - There will be life-long renewal without any age restriction for the cover.

4.6 Settlement/Rejection of Claim -The settlement of claims would be done by the Company within 15 days of receipt of claim along with claim form, any rejections if done, would be provided with proper reasons by the Company. The role of the TPA (if any) would be limited to facilitate the f low of information between the Company and Insured.

PART III OF SCHEDULE

Standard Terms and Conditions

1. Incontestability and Duty of Disclosure
The Policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis- description or on non-disclosure in any material particular in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being fraudulent or any fraudulent means or devices being used by the Insured or any one acting on his behalf to obtain any benefit under this Policy.

2. No constructive Notice
Any of the circumstances in relation to these conditions coming to the know ledge of any official of the Company shall not be construed as notice to or be held to bind or prejudicially affect the Company not withstanding subsequent acceptance of any premium.

3. Notice of charge etc.
The Company shall not be bound to notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy but the receipt of the Insured or his legal personal representative shall in all cases be an effectual discharge to the Company.

4. Special Provisions
Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

5. Overriding effect of Part II of the Schedule The terms and conditions contained herein and in Part II of the Schedule 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 s cope of cover contained in Part II of the Schedule, 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 and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

6. Electronic Transactions
The Insured agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time. The Insured agrees that the Company may exchange, share or part with any information to or with other ICICI Bank Group Companies or any other person in connection with the Policy, as may be determined by the Company and shall not hold the Company liable for such use/application.

7. Right to inspect
If required by the Company, an agent/representative of the Company including a loss assessor or a Surveyor appointed in that behalf shall in case of any loss or any circumstances that have given rise to the claim to the Insured be permitted at all reasonable times to examine into the circumstances of such loss. The Insured shall on being required so to do by the Company produce all books of accounts, receipts, documents relating to or containing entries relating to the loss or such circumstance in his possession and furnish copies of or extracts from such of them as may be required by the Company so far as they relate to such claims or will in any w ay assist the Company to ascertain in the correctness thereof or the liability of the Company under the Policy.

8. Fraudulent claims
If any claim 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, or anyone acting on his behalf to obtain any benefit under this Policy, or if a claim is made and rejected and no court action or suit is commenced within twelve months after such

rejection or, in case of arbitration taking place as provided therein, within twelve(12) calendar months after the Arbitrator or Arbitrators have made their award, all benefits under this Policy shall be forfeited.

9. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law. Each party agrees to submit to the jurisdiction of the Courts in India and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

10. Arbitration clause

If any dispute or difference shall arise as to the quantumto be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties to the dispute/difference, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators. Arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is clearly agreed and understood that no difference or dispute shall be referable to arbitration, as hereinbefore provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

11. Cancellation/ Termination

a) Disclosure to information norm- The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or non-disclosure of any material fact.

b) The Insured may also cancel this policy by giving 15 days notice in writing to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice cancel the policy and retain the premium for the period his policy has been in force at the Company's short period scale as mentioned in the Policy provided that no refund of premium shall be made if any claim has been made under the policy by or on behalf of the insured.

12. 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.

13. Renewal notice

a) A health insurance policy shall be renewable provided the product is not withdrawn, except in case of established fraud or non-disclosure or misrepresentation by the Insured. If the product is withdrawn, the policyholder shall be provided with suitable options to migrate.

b) Every renewal premium (which shall be paid and accepted in respect of this Policy) shall be so paid and accepted upon the distinct understanding that no alteration has taken place in the facts contained in the proposal or declaration herein before mentioned and that nothing is known to the insured that may result to enhance the risk under the guarantee hereby given. Any change in the risk will be intimated by the insured to The Company. Nothing herein or otherwise shall affect The Company right to impose any additional terms and conditions on renewal or restrict any renewal terms as to premium or otherwise.

c) The Policy may be renewed by mutual consent and in such event the renewal premium shall be paid to The Company on or before the date of expiry of the Policy and in no case later than Grace Period of 30 days from the expiry of the Policy.

d) An Insurer shall not resort to fresh underwriting unless there is an increase in sum insured. In case increase in sum insured is requested by the policyholder, the Insurer may underwrite only to the extent of increased sum insured

14. Notices

Any notice, direction or instruction given under this Insured shall be in writing and delivered by hand, post, or facsimile to In case of the Insured, at the address specified in Part 1 of the Schedule.

In case of the Company:
ICICI Lombard General Insurance Company Limited,
ICICI Lombard House,
414, Veer Savarkar Marg,
Near Siddhi Vinayak Temple, Prabhadevi,
Mumbai 400025,
Toll-free number: 1800-2666

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.

15. Customer Service

If at any time the Insured requires any clarification or assistance, the Insured may contact the offices of the Company at the address specified, during normal business hours.

16. Withdrawal of Policy

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

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."

17. **Migration:**

In case of migration of this policy with the Company, 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.

18. **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.

19. Grievances

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.

SN	Center	Address & Contact
1	AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in Jurisdiction : Gujarat, Dadra & Nagar Haveli, Daman and Diu.

2	BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in Jurisdiction :Karnataka.
3	**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 Jurisdiction : Madhya Pradesh, Chhattisgarh.
4	BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in Jurisdiction : Odisha.
5	CHANDIGARH	Mr Atul Jerath 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 Jurisdiction : Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.
6	CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in Jurisdiction : Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
7	DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in Jurisdiction : Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
8	GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in Jurisdiction : Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

9	HYDERABAD	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in Jurisdiction : Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
10	JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in Jurisdiction : Rajasthan.
11	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 Jurisdiction : Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry. Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in
12	KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in Jurisdiction : West Bengal, Sikkim, Andaman & Nicobar Islands.
13	LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in Jurisdiction : Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
14	MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in

		Jurisdiction : Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
15	NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in Jurisdiction : 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.
16	PATNA	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in Jurisdiction : Bihar, Jharkhand.
17	PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in Jurisdiction : Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).
18	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 Jurisdiction :Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/ West, N, S and T.

The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org, on the web site www.generalinsu rancecouncil.org.in, website of the company www.icicilombard.com or from any of the offices of the Company or on https://www.cioins.co.in/Ombudsman.

Additional Clauses

AC1: FOR REDUCING SUM INSURED COVERS:

Notwithstanding anything contrary stated in the Policy, the Sum Insured under the Policy on the date of the Insured Event covered under Sections I & II for the purpose of calculation of claim shall be the least of the following:

1. The Principle Outstanding in the books of the Bank/Financial Institution as on the date of occurrence of the Insured Event; or
2. The Principle Outstanding as per the amortization schedule prepared by Bank/Financial Institution. In the event the Sum Insured as appearing against Section I & II of the Schedule I of the Policy is less than the total of the actual Loan disbursed up to the date of the occurrence of the Insured Event, then the Amortization schedule shall be calculated as if the actual Loan disbursed was equivalent to the Sum Insured. ; or
3. The Sum Insured as appearing against Section I & II of the Schedule I

AC2 PREMIUM REFUNDS:

Notwithstanding anything to the contrary contained in the Policy, the refund of premium under the Policy shall be as under In the event of full prepayment of the Loan by the Insured, the Company shall refund a portion of the premium subject to the terms and conditions of the Policy as per the rates mentioned below:

% Return Premium (Fixed SI Basis)

	Period of insurance (Years)			
Year of cancellation	2	3	4	5
Year 1*	25%	45%	57%	78%

Year 2		11%	26%	57%
Year 3			6%	37%
Year 4				18%

Premium Refund (Reducing SI Basis)

Policy	2	3	4	5	5	5	5	5	5	5	5	5	5	5
Loan	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Year 1*	25%	45%	57%	65%	70%	73%	74%	75%	76%	77%	77%	78%	78%	78%
Year 2		11%	26%	37%	45%	49%	51%	53%	54%	55%	56%	56%	57%	57%
Year 3			6%	17%	24%	28%	31%	33%	34%	35%	36%	36%	37%	37%
Year 4				4%	9%	12%	14%	15%	16%	16%	17%	17%	18%	18%
5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
78%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	80%	80%	80%
57%	58%	58%	58%	58%	59%	59%	59%	59%	59%	59%	59%	59%	59%	59%
37%	38%	38%	38%	38%	39%	39%	39%	39%	39%	39%	39%	39%	39%	39%
18%	18%	19%	19%	19%	19%	19%	19%	19%	19%	19%	19%	19%	20%	20%

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

In event of part prepayment of the Loan, no refunds of premium shall be made under this Policy. No refunds of premium will be made under the Policy during the last year of the Policy Period.

Upon making any refund of premium under this Policy in accordance with the terms and conditions hereof in respect of the Insured, the cover in respect of that Insured shall forthwith terminate and the Company shall not be liable hereunder.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Insured w here any claim has been admitted by the Company or has been lodged with the Company.

Notwithstanding anything to the contrary stated herein the Company shall not be liable to make any payment arising out of any claim under Section I for any Insured if the Insured does not survive a period of at least ____ days after the date of occurrence Insured Event.