Kotak Complete Cover Group Plan
UIN- 107N018V06

PART B

DEFINITIONS

a) **"Accident":** Means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

b) **"Accidental Total/Partial and Permanent Disability" or " ATPD" :** Means the occurrence of any of the following conditions as a result of accidental bodily injury within 180 days of such Accident:

i. Physical severance at or above wrists or permanent loss of use of both the hands
ii. Physical severance at or above ankles or permanent loss of use of both feet
iii. Total and irrecoverable loss of sight of both eyes
iv. Physical severance at or above wrist or permanent loss of use of one hand and physical severance at or above ankles or loss of use of one foot
v. Physical severance at or above wrist or permanent loss of use of one hand total and irrecoverable loss of sight of one eye
vi. Physical severance at or above ankle or permanent loss of use of one foot and total and irrecoverable loss of sight of one eye

c) **"Act":** means Insurance Act, 1938, as amended from time to time.

d) **"Activities of Daily Living:** Means the following**:**

i. **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
ii. **Dressing** : the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances
iii. **Transferring** : the ability to move from a bed or an upright chair or wheelchair and vice versa
iv. **Mobility** : The ability to move indoors from room to room on level surfaces
v. **Toileting :** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene
vi. **Feeding:** the ability to feed self once food has been prepared and made available

e) **"Age":** means the age of the Member on his/her last birthday (as per the English calendar).

f) **"Assignee"**: Means the person to whom the Policy is assigned and the notice of which is endorsed on the Policy by the Insurer.

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g) **"Beneficiary":** Means the Member; or the nominee; or the legal heir of the Member or the nominee, as the case may be.

h) **"Benefit Multiplier":** Means the option available with the Member to choose the Insured benefit equal to 100%, 110% or 120% of the Outstanding Loan Amount for all the Plan Options. This must be chosen at inception by the Member. Benefit Multiplier does not provide any separate cover, it only determines the amount payable under this Policy with reference to the outstanding loan amount.

i) **"Board":** Means the board of directors of the Insurer.

j) **"Certificate of Insurance" or "COI"**: means: the certificate issued to the Member to confirm his/her coverage under the Policy.

k) **"Cover " or "Insured Benefit":** Means the cover available to the Member as per the terms of this Policy Document and shall be calculated as follows:
Cover / Insured Benefit = Outstanding Loan Amount x Benefit Multiplier

l) **Critical Illness:** Means any of the below mentioned illnesses:

1. Cancer of specified severity:

I. 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 leukaemia, lymphoma and sarcoma.

II. **The following are excluded**

i. All tumours 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 & 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 tumours 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

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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

ix. All tumours in the presence of HIV infection

2. Myocardial Infarction (First Heart Attack - of specified 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

3. 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

4. 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.

5. 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.

6. 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 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

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.

7. 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 end-stage 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

8. Permanent Paralysis of Limb

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.

9. Loss of Limbs

I. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded

10. Third Degree Burns

I. 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

11. Blindness

I. Total permanent and irreversible loss of all vision in both eyes as a result of illness or accident

II. The blindness is evidenced by:
i. corrected visual acuity being 3/60 or less in both eyes or ;

ii. the field of vision being less than 10 degrees in both eyes

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure

12. 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

13. Benign Brain Tumour

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.

14. 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.

II. All psychiatric related causes are excluded.

15. Motor Neuron Disease with Permanent Symptoms

I. 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.

16. Major Surgery of Aorta

I. The actual undergoing of surgery via thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta, a coarctation of the aorta or a traumatic rupture of the aorta. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. There must have been excision and replacement of a portion of diseased aorta with a graft. Stent-grafting is not covered

17. Parkinson's Disease

I. Unequivocal Diagnosis of Parkinson's Disease by a Registered Medical Practitioner who is a neurologist where the condition:

i. cannot be controlled with medication;

ii. shows signs of progressive impairment; and

iii. Activities of Daily Living assessment confirms in a permanent inability to perform at least three (3) of the 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).

II. Drug-induced or toxic causes of Parkinson's disease are excluded.

m) "Date of Commencement of Policy": means the date when the Policy is deemed to have commenced..

n) "Date of Inception of Risk/Cover": means the date from which the risk on the life of Member is assumed by the Insurer.

o) "Declaration of Good Health" or "DOGH": Means declaration provided by the Member regarding his Cover details and medical condition at the inception of the cover in the format prescribed by the Insurer commonly known as Membership Form- cum-Declaration of Good Health

p) **"Grace Period":** Means the time granted by the Insurer i.e. 30 days from the due date for the payment of Premium for yearly, half-yearly and quarterly mode and 15 days for monthly mode without levy of any interest or penalty during which time the cover is considered to be in-force without any interruption as per the terms of the Policy. Grace Period is not applicable to Single Premium cover.

q) **"Group":** Means a group of Members who assemble together with a purpose of engaging in a common activity and not formed with the main purpose of availing insurance cover. Such members are accepted by the Insurer as constituting a Group for the purposes of this Policy.

r) **"IRDAI":** Means the Insurance Regulatory and Development Authority of India;

s) **"Lapse":** Means a suspension of insurance cover for a Member for non-payment of Premiums where Premium is not paid within Grace Period. Such suspension shall be deemed effective from the date of the first unpaid Premium.

t) **"Life Insured":** means the Member as defined below.

u) **Medical Practitioner:** Means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction and is acting within the scope and jurisdiction of his license.

v) **"Member":** Means a person:

- who is resident in India or a citizen of India;
- who has taken loan from the Policy holder
- who is in good health and being eligible to complete the Declaration of Good Health (Evidence of Good Health), if applicable, in the Insurer's format, and who has duly completed and submitted the same to the Policyholder and the Insurer has agreed to provide cover to him/her on the basis of any other evaluation as the Insurer, may deem fit; and
- who falls within the age range indicated by the Insurer for this Policy
- who is included in the Member data submitted by the Policyholder in the format as prescribed in Annexure 1
- in respect of whom the premiums have been received by the Insurer and
- in respect of whom cover has not been declined by the Insurer.

- Minimum Age at entry and Maximum Age at entry of the Member shall be dependent on the Plan option Chosen:

  i. For Life Cover Option:

  Minimum Age at entry shall be 15 years for education loans and 18 years for all other loans

Maximum Age at entry shall be: 73 years for single premium payment term and 70 years for Limited premium payment term and regular premium payment term

ii. For rest of the Plan Options:

Minimum Age at entry shall be 18 years

Maximum Age at entry shall be: 70 years

- Maximum Age at Maturity of the Member for all Plan options shall be: 75 years.

The Policyholder shall always inform the Insurer in writing about the termination of such Member within 30 (Thirty) days from the date such Member ceases to be a Member

w) "Moratorium Period": Means the option available to the Member at inception to choose from a period of i. 1 to 7 years; or ii. 10 years; or iii. 12 years, wherein the Sum Assured shall not reduce and remain level during such period. After the expiry of Moratorium Period, the benefit will reduce as per the benefit schedule based on interest rate and frequency chosen at the inception.

x) "Non-Medical Limit": Means the amount of the Sum Assured granted on the life of the Member on submission of declaration of good health and without undergoing any medical examination/underwriting as per the underwriting rules of the Insurer.

y) "**Policy**": shall mean the contract of insurance entered into between the Policyholder and the insurer as evidenced by the Policy Document.

z) "Policy Document": Shall mean this agreement, any supplementary contracts or endorsements therein, whenever executed, any amendments thereto agreed to and signed by the Insurer and the individual enrolment forms, if any, of the insured Members, which together constitute the entire contract between the parties.

aa) "Outstanding Loan Amount": Means the loan outstanding calculated from the Loan Cover schedule, determined basis the interest rate, loan repayment frequency, term of the Cover, and Moratorium period chosen at inception and as mentioned in the COI at issuance.

bb) "**Revival**": Means reinstatement of the lapsed benefits of the Cover in accordance with the provisions of the COI. Revival may be of the following two types and the same may be made by a Member within the timelines indicated below:

a. 'Minor Revival': means revival made within six months from the due date of the first unpaid Premium causing the insurance cover to Lapse; and

b. Major Revival': means revival made after six months but within two years from the due date of the first unpaid Premium causing the insurance cover to Lapse.

cc) "Sum Assured": Means the outstanding loan amount at the inception of the Cover.

dd) "Surrender": Means the termination of the Policy/Cover by the Policyholder/Member before expiry of Policy/Cover Term, in accordance with the provisions of the Policy Document/COI.

ee) "Terminal Illness": Means a non-correctable/non-curable medical condition or a non-response to specific disease therapy (which is very likely to culminate in death within a year – to be certified by the treating specialist).

ff) Words importing the masculine gender shall include the feminine gender and vice versa.

gg) Words in the singular shall include the plural and vice versa

PART C

1. BENEFITS PAYABLE:

Benefits under the Policy shall be payable to the Beneficiary /Policyholder (as mentioned under point F of this Section) and depending upon the Plan option chosen and shall be determined basis the date of incident.

Except for the Life Cover Option, all other options include accelerated benefit as more specifically mentioned in the relevant sections. An accelerated benefit is not an additional benefit and it only facilitates earlier payment of the Insured Benefit under the option upon occurrence of the covered event. No maturity benefit is available under the Policy:

A. Benefits available under Life Cover Option:

i. Upon death of the Member during the Cover Term while the cover for the concerned Member is in force, Insured Benefit shall be payable. This benefit shall be payable in lump sum and the Cover shall cease.

ii. In case of occurrence of the covered event, during the Grace Period, the unpaid due Premium shall be deducted from the Insured Benefit payable.

B. Benefits available under Life Cover Plus Accelerated Terminal Illness Benefit Option:

i. Upon the earlier of death of the Member or on diagnosis of Terminal illness during the Cover Term, while the cover for the concerned Member is in force, Insured Benefit shall be payable. This benefit shall be payable in lump sum and the cover shall cease.

ii. In case of occurrence of the covered event, during the Grace Period, the unpaid due Premium shall be deducted from the Insured Benefit payable.

iii. The benefit for Terminal Illness shall be subject to the conditions and exclusions mentioned below:

Conditions for Terminal Illness Benefit:

The illness shall be considered as terminal in case following criteria are met:

- The medical condition should be incurable as per independent medical practitioner (based on consultation with relevant medical specialist). The prognosis of the disease is explained to the insured by the treating specialist.
- There is no improvement in the condition of the insured for last 6 months and with the current treating specialist opines that with treatment modalities, the possibility of improvement is remote and is likely to culminate into death within a year.

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Terminal Illness should be established and confirmed in writing and with reasonable certainty; in the opinion of both the Member's attending physician/ Medical Practitioner (based on consultation with relevant medical specialists) as well as the Insurer's Chief Medical Officer. The decision of the Insurer's Chief Medical Officer shall be final in this regard.

The Insurer's Chief Medical Officer shall study the case in line with medical papers and certificate from treating physician and give the final decision on the claim. The Insurer reserves the right for independent assessment.

Exclusions under Terminal Illness Benefit:

The Member will not be entitled to Terminal Illness benefits if it is caused directly or indirectly due to occasioned, accelerated or aggravated by any of the following:

a. Terminal Illness diagnosis in the presence of HIV infection or conditions due to any Acquired Immune Deficiency Syndrome (AIDS)
b. Terminal illness arising from self-inflicted injuries or attempted suicide within the one year from the inception of Member Cover/ date of revival of Member Cover, whichever is later.

C. Benefits available under Life Cover Plus Accelerated Critical Illness –A /B/C Options:

i. Upon earlier of the death of the Member or diagnosis of the first Critical illness or the Member having to undergo any of the covered surgery during the Cover Term while the Cover for the concerned Member is in force, Insured Benefit shall be payable. This benefit shall be payable in lump sum and the cover shall cease.

ii. In case of occurrence of the covered event, during the Grace Period, the unpaid due Premium shall be deducted from the Insured Benefit payable.

iii. Critical Illness Benefit Term

Under Option A: It shall be equivalent to the Cover Term or 5 years, whichever is lower.
Under Option B: It shall be equivalent to the Cover Term or 10 years, whichever is lower.
Under Option C: It shall be equivalent to the Cover Term.

iv. The benefit for Critical Illness shall be subject to the conditions and exclusions mentioned below:

Conditions for Critical Illness:

- The benefit is payable in full on the first ever occurrence of any one of the Critical Illnesses and only if the Policy is in force at the time of diagnosis of the Critical Illness.

- The Member should notify the Insurer within 90 days from the date of diagnosis of Critical Illness; giving the following details such as date of diagnosis of Critical Illness, nature and extent of Critical Illness and details thereof, including medical reports and investigations; the Member's address etc.

- The benefit is payable only if the Life Insured is willing to be examined by a Medical Practitioner nominated by the Insurer.

- The decision of Insurer's Chief Medical Officer (CMO) would be final in all regards.

- An initial 90-day waiting period is applicable for all conditions covered under Critical Illness Benefit. No benefit shall be payable if diagnosis of any Critical Illness first occurs or diagnosis is first made and/or hospitalization and/or treatment (availed or advised) related to the Critical Illness occurs within the 90 days from Date of Inception of Risk or last reinstatement date, whichever is later.

Exclusions under Critical Illness Benefit:

Apart from the exclusions specified in each of the diseases, there are exclusions for Critical Illness benefit where the life assured will not be entitled to Critical Illness benefit if a Critical Illness results either directly or indirectly from any one of the following causes or within 90 days (during the waiting period) from the date of inception of the coverage or date of reinstatement, whichever is later.

No benefits will be payable under this Policy if a claim or event suffered by the Life Insured is directly or indirectly attributed to or exacerbated as a result of any of the following :

- Pre-Existing disease: Pre-Existing disease shall mean any condition, ailment or injury or related condition(s) for which the Member had signs or symptoms, and / or was diagnosed, and / or received medical advice / treatment within 48 months prior to the first Cover issued by the Insurer and renewed continuously thereafter.
- Diseases in the presence of an HIV infection
- Intentional or self-inflicted injury, attempted suicide while sane or insane.
- Alcohol or Solvent abuse or taking of Drugs, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
- War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, strikes.

- Taking part in any naval, military or air force operation during peace time.
- Participation in any flying activity, except as a bona fide, fare-paying passenger, pilot, air crew of a recognized airline on regular routes and on a scheduled timetable.
- Participation in a criminal or unlawful act with a criminal intent.
- Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to, diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping.
- Disability due to psychiatric illnesses, post-traumatic stress disorder, chronic fatigue, chronic pain, and fibromyalgia are excluded
- Any congenital anomaly: Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position. External Congenital Anomaly which is in the visible and accessible parts of the body is called External Congenital Anomaly.
- Failure to seek or follow medical advice where a "medical advice" means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
- Nuclear Contamination; the radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.

D. Benefits available under Life Cover Plus Accelerated Accidental Disability Benefit:

i. Upon earlier of death of the Member or Accidental Total and Permanent Disability(ATPD) during the Cover Term while the cover for the concerned Member is in force, Insured Benefit shall be payable. This benefit shall be payable in lump sum and the cover shall cease.

ii. In case of occurrence of the covered event, during the Grace Period, the unpaid due Premium shall be deducted from the Insured Benefit payable.

iii. The benefit for ATPD shall be subject to the conditions and exclusions mentioned below:

Conditions for Accidental Total and Permanent Disability (ATPD) Benefit:

- The disability should have lasted for at least 180 days without interruption from the date of disability and must be deemed permanent by medical practitioner empanelled by the Insurer.
- ATPD must be caused due to the Accident
- The Accident shall result in bodily injury or injuries to the Member independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the Accident, directly and independently of any other means cause the ATPD of the Life Assured. In the event of ATPD of the Life Assured after 180 days of the occurrence of the Accident, the Insurer shall not be liable to pay this benefit.

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- The Policy/Cover must be in-force at the time of Accident.

Exclusions under Accidental Total and Permanent Disability Benefit:

Accidental Total and Permanent Disability due to Accident should not be caused by the following:

- Member takes part in any hazardous sport or pastime activities like extreme climbing (soloing), ice climbing, extreme altitude climbing, cave diving, internal exploration of wrecks, ballooning, parachuting without a static line, diving at depths greater than 30 m, motorized racing (speed contests), boxing (including kick boxing), base jumping, sky surfing, aerobatic flying, parasailing , employment as a mine-blaster and other similar activities.
- Member flies in any kind of aircraft other than as a bonafide passenger on an aircraft of a licensed airline.
- Self-inflicted injury, suicide or attempted suicide-whether sane or insane
- An act of any person acting on their own or on behalf of or in connection with any group or organization to influence by force any group, corporation or government by terrorism, kidnapping or attempted kidnapping, attack, assault, or any other violent means.
- Under the influence or abuse of drugs, alcohol, narcotics or psychotropic substance not prescribed by a registered medical practitioner
- Participation in any armed force or peace keeping activities
- War or hostilities (whether war be declared or not), civil war, rebellion, revolution, civil unrest or riot wherein the Life Assured is an active participant in such activities
- Deliberate participation of the Life Assured in an illegal or criminal act with criminal intent
- Nuclear fusion, nuclear fission, nuclear waste or any radioactive or ionising radiation

E. Benefit available in case of Joint Life Cover:

i. In case of joint life cover, the benefit (based on the option chosen as described above) shall be payable only on the first occurrence of covered events, and thereafter the policy will cease and cover on the other member will terminate.

ii. On payment of Benefit, the cover will terminate and all rights, benefits and interests under the policy will cease.

iii. If the claim is repudiated / rejected for any reason whatsoever for one of the Lives Insured, the cover for the other member will continue for the remaining term.

iv. The joint life coverage would be offered to a maximum of two lives (only where there is an insurable interest between the lives.

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F. Payment of Insured Benefit to Policyholder:

If the Policyholder is a regulated entity as follows: 1) Reserve Bank of India (RBI) regulated Scheduled Banks (including Cooperative Banks) 2) NBFCs having Certificate of Registration from RBI or 3) National Housing Bank (NHB) Regulated Housing Finance Company 4) National Minority Development Finance Corporation (NMDFC) and its State Channelizing Agencies 5) Small Finance Banks (SFB) regulated by RBI, the payment of Insured Benefit may be made to the Policyholder, to the extent of loan outstanding as on the date of contingent event, and subject to the conditions laid down by IRDAI under the Circular IRDA/LIFE/CIR/GDL/285/12/2014, dated 29.12.2014, and various other applicable Regulations/ Guidelines/ Circulars or instructions issued from time-to-time and specific authorization obtained from the member concerned. In cases of non-regulated entities, the Insured Benefit shall be payable to the Beneficiary.

G. Rider Benefits:

No riders are available under the Policy.

2. PREMIUMS PAYABLE

Mode of Premium Payment: <<Single/Monthly/Half yearly/ Quarterly/ Annual Premium>>.

The Policyholder/ Member is liable to pay Goods and Services tax, cess and other statutory levies, if any, and as applicable from time to time, on the premiums payable. The premiums payable are calculated based on the Premium rates, and are subject to Goods and Services tax, cess and other levies as may be applicable from time to time. The Insurer reserves the right to review the Premium rates periodically and change the premium rates (from the pre-approved set of premium rates) applicable under the Policy in respect of new entrants at any time, by giving the Policyholder two months' notice in writing.

The Policyholder/ Member must pay in advance a single premium/first instalment of regular / limited premium for a Member, before cover can commence for that Member. This Premium shall be calculated at such premium rates indicated in the COI or such revised rates as notified by the Insurer to the Policyholder from time to time in writing. Grace Period as applicable will be allowed.

The Insurer is liable for any claim if the Premiums in respect of the concerned Member is received by the Insurer/Policyholder, subject to the Member proving that he has paid the Premium and has secured a proper receipt that he was duly insured.

Special Conditions, if any:

< as applicable>

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REGISTERED OFFICE: CIN: U66030MH2000PLC128503, Regd. Office: 2nd Floor, Plot #C-12, G- Block, BKC, Bandra (E), Mumbai- 400051, Website: http://insurance.kotak.com, Email: clientservicedesk@kotak.com, Toll Free No.: 18002098800, Fax No.: +91 22 67425649 / 50

As per the Insurance regulations, no cover shall be extended to any person(s) unless the premium due for such cover has been received in advance by the insurance Insurer.
< To comply with this regulation, Policyholder will need to keep a deposit as per Section 64VB, equivalent of approx premium amount due in next month with Insurer.> OR < Therefore all covers shall commence from the valued credit date in Insurer's account with Policyholder.>

Signed for and on behalf of Kotak Mahindra Life Insurance Company Limited at Mumbai on the <day> of <month>, 20 <year>.

Authorised Signatory

Signed for and on behalf of Kotak Mahindra Life Insurance Company Ltd. at Mumbai on xxxxxxxx

Authorised Signatory

PART D

1. LAPSE:

Under Regular Premium Payment mode, the Cover for Member will lapse if the Premiums are not received by the Insurer/Policyholder within the Grace Period. Single Premium Cover shall not lapse.
Under Limited Premium payment mode policies, Cover will lapse if the premiums are not paid within the Grace Period in the first 3 policy years.

The lapsed cover of the Member can be revived by making an application within two years from the date of the first unpaid premium and before the expiry of the Cover Term as per the clause on 'Revival' mentioned below.

2. Revival:

The lapsed cover of a Member can be revived by making an application within two years from the date of the first unpaid premium and before the Date of Maturity of Cover as per the following conditions:

i. **Minor Revival**:

The Member may exercise Minor Revival without proof of good health and payment of outstanding premiums together with interest (9% p.a. on the due premium). The said rate may be revised from time to time with prior approval from IRDAI.

ii. **Major Revival**

The Member may exercise Major Revival by furnishing satisfactory evidence of health as required.
The arrears of premiums together with interest (9% p.a. on the due premium) may be charged. The said rate may be revised from time to time with prior approval from IRDAI.

iii. The revival of the Cover may be on terms different from those applicable when the cover lapsed, based on Board Approved Underwriting Policy (BAUP).

iv. The revival will take effect only after the Insurer communicates its decision to the Member and the same is accepted by the Member.

v. In case the policy is not revived within the revival period then the surrender value, if any, shall be paid and policy shall be terminated.

3. Surrender :

Master Policyholder surrender:

In case the Policyholder surrenders the Policy, the Members shall be given the option to continue their cover till the end of their respective Cover Term

Members who do not opt to continue with their cover, the Surrender value as defined below shall be payable to them as lump sum.

- No surrender benefit is payable for Regular and Limited Premium paying policies.
- Single Premium paying policies will acquire Surrender Value immediately after the payment of Single Premium.

Surrender value for Single Premium policies is equal to –
60% * Total Premiums Paid to date * (Outstanding Cover Term / Cover Term)* ((Cover term-PPT)/Cover term) * (Outstanding loan amount^ / Initial loan amount^)

^The initial and outstanding loan amount mentioned above will be as per the loan cover schedule issued to the member at inception of the cover.

Member surrender:

The Cover shall continue till the end of the contracted term, unless expressly surrendered by the Member. Surrender value as defined above shall be payable.

Upon Surrender, no benefits shall be available under the Policy and the cover shall stand terminated.

4. Exit Value:

Under limited premium paying policy, if premium is discontinued after 3 policy years – after expiry of the Revival period of 2 years (refer to the Revival section), policies shall acquire Exit Value, as mentioned below:

50% * Total Premiums Paid to date * (Outstanding Cover Term / Cover Term)* ((Cover term-PPT)/Cover term) * (Outstanding loan amount^ / Initial loan amount^)

^The initial and outstanding loan amount mentioned above will be as per the loan cover schedule issued to the member at inception of the cover.

5. Paid-Up Value:

The Policy does not acquire any Paid-Up Value.

6. Loans:

Loans are not available under the Policy.

7. Cover:

The cover for each member shall be subject to the conditions mentioned in this Policy Document and the Certificate of Insurance issued to the concerned Member.

8. Policyholder Covenants

The Policyholder shall collect the valid and complete DOGH, if applicable, along with such other documents as it may require for the purpose of the insurance cover given to the Member. The Policyholder shall preserve and maintain it as an integral part of such documentation. The Policyholder shall allow the officers of the Insurer (including representatives authorized in writing by the Insurer), to inspect and make copies of all/any relevant records for the purposes of this Policy, at reasonable hours on any day.
Policyholder shall obtain a Certificate of compliance from the Auditor of the Group or the Manager of the Group on every anniversary date of the Policy and submit the same to the Insurer at its request. Renewal of such Policy / cover will be subject to such submission of Certificate of compliance by the Policyholder to the Insurer. OR Alternatively, The Insurer may conduct the inspection of the books and records of the Policyholder to assess whether they are complying with the relevant IRDAI guidelines.
The Policyholder shall assist the Insurer, if the Insurer so requires, in the prosecution of a proceeding or in the matter of recovery of claims which the Insurer has against the third parties.
It shall be the duty of the Policyholder to intimate the Insurer with necessary details on the exclusion of the Member and it shall indemnify the Insurer for all charges and damages incurred due to payment made to ineligible Member.
The Insurer may initiate any suitable action against the Policyholder for incomplete or incorrect data submitted by them without prejudice to the rights of the Members.
The Policyholder acknowledges and agrees that if the Policyholder fails to remit the premiums to the insurer in a timely manner, the Insurer shall not be liable in any manner with respect to the affected cover.

9. Discontinuance

This policy may be discontinued for new entrants at the option of the Insurer or the Policyholder by giving the other party at least one month's prior notice in writing. It is clarified that, in case of single premium payment mode the cover for the existing members will continue even after the discontinuance of the policy. However, for regular / limited premium payment mode, the Members shall be given the option to continue their cover till the end of their respective Cover Term subject to the payment of due Premiums.

10. Member Data

The Policyholder must provide the soft copy of the up-to-date Member Data to the Insurer on or before such date of every month as agreed between the Policyholder and the Insurer to enable the Insurer to update its records and calculate premium. Hard copies of the

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Member Data will not be accepted if the same are not accompanied along with the soft copy of the data. A grace period of 7 days will be allowed for providing the Member data to the Insurer. The Insurer shall not be liable for any claim except as provided for in this document and for only those members whose member data has been provided by the Policyholder to the Insurer. If there is a discrepancy between the soft copy and hard copy of the member data submitted by the Policyholder then in such circumstance the soft copy will be final and will prevail over the hard copy of the member data.

As mentioned above, the Policyholder shall submit the Member Data by such agreed date , however, claim in respect of a member for whom the Member Data is in the process of so being submitted, shall be submitted by the Policyholder to the Insurer and such a claim shall be considered and settled subject to terms and conditions as provided herein. The Policyholder shall arrange to furnish such documents/information as may be required by the Insurer in this regard.

11. Free Look Period:

In case the Policyholder/Member is not agreeable to any of the provisions stated in the Policy, then there is an option of returning the Policy/COI, stating the reasons thereof within 15 days from the date of the receipt of the Policy/COI. The cancellation request should be submitted to nearest Branch of the Insurer or sent directly to the Insurer's Head Office. On receipt of letter along with the original policy document/COI, the Insurer shall refund the Premium paid after deducting the proportionate risk premium, medical charges (if any) and stamp duty. A Policy/COI once returned shall not be revived, reinstated or restored at any point of time and a new proposal will have to be submitted for a new policy.

PART E

NOT APPLICABLE

PART F

1. Suicide Exclusion:

In the event of the Member committing suicide within 12 months from date of Inception of the cover, 80% of the premiums paid will be payable.

In the event of suicide after 12 months from Date of Inception of the Cover, following will be applicable:
In case of suicide within one year of the date of revival of the Cover when the revival is done within 6 months from the date of first unpaid premium, Suicide Exclusion shall not be applicable and the Insured Benefit under the Cover shall be payable.
However, in case of suicide within 1 year of the date of revival, when the revival is done after than 6 months from the date of first unpaid premium, the benefit payable shall be higher of 80% of Premiums Paid or Surrender Value (if any) at the date of claim event.

2. Proof of Age

The Policyholder shall submit a declaration in writing of the Age(s) of the Members covered and persons to be covered under this Policy, at inception and along with every monthly statement of Member Data (for Members added from time to time).

The Insurer shall not be liable for payment of any benefits in respect of a Member for whom such a declaration has not been given.

If at a future date, the Age is found to be different from the Age declared, without prejudice to the Insurer's other rights and remedies including those under the Insurance Act, 1938, and any other laws then prevailing, the Insurer will have the right to recover balance premium without interest for the concerned Member/Life Insured before settling his/her claim. In case of excess Premium, the Insurer shall refund the same without interest, after deducting expenses (if any).

The Insurer may call for proof of age from the Policyholder or the concerned Member/Life Insured and the Policyholder or Member must provide the same when required.

3. Nomination and Assignment

i. Nomination is allowed as per Section 39 of the Act, as amended from time-to-time. [A Leaflet containing the simplified version of the provisions of Section 39 is enclosed in Annexure – 4 for reference].

ii. It is mandatory for the Policyholder to have appropriate nomination data and appropriate nomination procedures in place so as to ensure timely and complete discharge to the nominee.

iii. The Policyholder shall ensure that nomination details for all the Members covered under the Policy are obtained, and that the requisite nominations are available/ updated in their records at any point in time. The said details shall be maintained by the Policyholder and will be updated on a regular basis in case of any revisions. The Policyholder shall provide the necessary information and documents to Insurer on demand or as and when required. Further, the nominees' details and records shall be provided by the Policyholder to the Insurer for verification and audit purpose. The Policyholder shall certify the correctness and accuracy of the nomination made by the Member.

iv. In the event of a death claim, the Policy number and the letter from the Policyholder along with the certified information of the nominee details in the Insurer's format shall be provided along with the claim intimation form, proof of address & photo identity of the nominee.

v. Assignment is allowed as per Section 38 of the Act, as amended from time-to-time. [A Leaflet containing the simplified version of the provisions of Section 38 is enclosed in Annexure – 3 for reference.

vi. In case of force majeure event, company may at its sole discretion, waive any or all of the above mentioned documents and settle the claim in favour of the Member's nominee or legal heir provided the Insurer is satisfied after its own investigation.

vii. In case of claims due to exit from the Policy other than death (i.e. termination, surrender etc.), individual details to be submitted to the Policyholder in the prescribed from, for onward transmission to the Insurer.

viii. The benefits shall be limited at all times to the monies payable under this Policy.

4. Issuance of Duplicate Policy Document

The Policyholder may request for issuance of duplicate Policy Document by making a request to the Company in writing or in the prescribed form as the case may be. Issuance of duplicate Policy Document shall be made subject to the following conditions:

i. The Policyholder pays the applicable fee.
ii. The Policyholder submits an affidavit cum indemnity in the format, if any, prescribed by the Company
iii. Free Look clause shall not be applicable with respect to such duplicate Policy Document.

5. Claims:

All death claims must be notified to the Insurer in writing within 3 months from the date of the death along with the original death certificate and the primary documents as herein stated. The Insurer reserves its rights to condone the delay on merit for delayed claims, where the delay is genuine and proved to be for reasons beyond the control of the Beneficiary

The primary documents normally required for processing a death claim are:

- Intimation of the claim event (i.e. death) vide duly filled in claim form in the Insurer's format stamped and signed by the authorised representative of the Policyholder
- Original death certificate issued by the Municipal Authority,
- Proof of age of the Beneficiary (for example attested copy of birth certificate/ school leaving certificate etc.)
- Proof of membership under the policy
- Last attending Doctor's Certificate stating the exact cause of death and all the associated medical documents
- If the death is due to an accident or any other unnatural cause, the following shall be required:

– A certified copy of the FIR filed with the Police authorities
– A certified copy of the Post Mortem Report/Autopsy Report

- Proof of identity of the Nominee, duly certified by the Policyholder
- Member Authorization Form as per prescribed format.
- Original Cancelled cheque showing name of Bank, location of Bank Branch, Name of Account Holder and Account No. In absence of the same the client can even submitted Photocopy of Bank Pass Book/Bank Statement of beneficiary bearing the aforeferred details duly attested by the Concerned Bank.
- Guardian details for minor Nominee

All claims shall be subject to the provisions of this Policy document, such other requirements as stipulated by the Insurer and the legal title of the claimant, satisfactory to the Insurer. The Insurer reserves the right to call for any additional information and documents required to satisfy itself as to the validity of a claim.

All amounts due under this Policy are payable in Indian Currency at the office of the Insurer situated at Mumbai, but the Insurer at its absolute discretion may fix an alternative place of payment for the claim at any time before or after the claim arises. A discharge or receipt by the Nominee shall be a good, valid and sufficient discharge to the Insurer in respect of any payment to be made by the Insurer hereunder.

6. Notice

Any notice, information or instruction to the Insurer must be in writing and delivered to the address intimated by the Insurer to the Policyholder which is currently:

Group Operations
Kotak Mahindra Life Insurance Company Limited
7th Floor, Building No.21,

Infinity Park, Off Western Express Highway,
General A.K. Vaidya Marg,
Malad (E), Mumbai,
Maharashtra -400097, India

The Insurer may change the address stated above and intimate the Policyholder of such change by suitable means.

Any notice, information or instruction from the Insurer to the Policyholder shall be mailed to the following address:

<<....>>

……

……

or to the changed address as intimated to the Insurer in writing.

7. Electronic Transactions

All remote transactions effected through the internet, world wide web, electronic data interchange, call centres, 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 the Insurer or on behalf of the Insurer, for and in respect of this Policy, shall be legally binding on either party and shall be considered as valid transactions as per extant laws applicable and which are done in adherence to and in compliance with the terms and conditions of such facilities, as may be prescribed by the Insurer from time to time.

8. Fraud / Misstatement:

The provisions of Section 45 of the Insurance Act 1938, as amended from time-to-time, will be applicable to this contract and each life cover provided therein. [A Leaflet containing the Simplified Version of Section 45 is enclosed in Annexure for reference]

9. Force Majeure

If the Insurer's performance or any of the Insurer's obligations are in any way prevented or hindered as a consequence of any act of God or State, strike, lock out, legislation or restriction by any government or any other authority or any other circumstances beyond the Insurer's anticipation or control, the performance of this Policy shall be wholly or partially suspended during the continuance of such force majeure. The Insurer will resume its obligations towards this Policy immediately after the Force Majeure event ceases. The Insurer will keep the IRDA informed about the suspension of operations during Force Majeure event and also the resumption of its obligations and undertake to seek IRDA's permission before effecting any of these changes.

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10. Non Disclosure of Policyholder Information

The Policyholder shall follow the Process for sharing data with the insurer if and when communicated to the Policyholder by the Insurer. Process defined for data sharing elaborates and explains about the flow of data and necessary controls put in place to avoid any data leakage.

In case of any failure on part of the Policyholder to comply or adhere to the defined process, the insurer will not be liable to adhere to terms & conditions mentioned in the non- disclosure arrangement, if any. Further, any breach or violation on the part of the Policy holder, shall absolve the Insurer/Company from all liabilities as envisaged under such non-disclosure arrangement.

11. Governing Laws

1. Anti Money Laundering Provisions:
   The Prevention of Money Laundering Act, 2002, also applies to insurance transactions. As such the Insurer shall enforce the said legislation to the extent it may be applicable to this Policy.
2. Miscellaneous

   This Policy is subject to the Insurance Act 1938, as amended by the Insurance Regulatory and Development Authority Act, 1999, such amendments, modifications as may be made from time to time and such other relevant regulations including IRDAI (Protection of Policyholders' Interest) Regulations, 2017, as may be introduced there under from time to time by that Authority.

3. Entire Agreement:
   This Policy Document along with the documents and agreements referred to herein, supersedes all prior discussions and agreements (whether oral or written, including all correspondence) with respect to the subject matter of this Policy, and this Policy Document (together with any written and mutually agreed amendments or modifications thereof) contain the sole and entire agreement between the Company and the Policyholder with respect to the subject matter hereof.

4. Jurisdiction:

   Without prejudice to the generality of the aforesaid provisions, this Policy shall be governed by the laws of India. The Courts in India shall have the exclusive jurisdiction to settle any disputes arising under this Policy.

12. General

1. The cover for a Member will cease on the earliest of:

a. The date on which any one of the option benefits are paid.
b. The date on which the Policyholder/Member discontinues payment of regular due premiums.
c. he/she ceases to be member of the group
d. the scheduled date of expiry of loan as per member data submitted in the manner herein mentioned
e. The Member attaining the Maximum Age at maturity as mentioned in the synopsis provided by the Insurer.

2. Any information needed to administer the Policy must be furnished by the Policyholder. Any information pertaining to the Policy shall be accepted by the Company only if it is received from the authorized signatory /e-mail ID of the Policyholder.

3. The Insurer can check/inspect, at any time, if the Benefits are being paid to the correct person as and when due

PART G

Query/Complaint Resolution

1. In case you have any query or complaint/grievance, you may approach our office at the following address:

   Group Operations,
   Kotak Mahindra Life Insurance Company Ltd.,
   7th Floor Zone IV, Building No.21, Infinity Park, Off Western Express Highway, General A.K. Vaidya Marg, Malad (E), Mumbai – 400097".
   Telephone: 18001207856 (Monday-Friday (excluding public holidays) between 10.00 a.m. to 6.00 p.m)
   Email: kli.groupoperations@kotak.com

2. In case you are not satisfied with the decision of the above office, or have not received any response within 10 days, you may contact the following official for resolution:

   Chief Grievance Officer
   Kotak Mahindra Life Insurance Company Ltd,
   Kotak Towers, 7th Floor, ZoneIV,
   Building No. 21, Infinity Park, Off Western Express Highway,
   General A.K. Vaidya Marg, Malad East, Mumbai 400097
   Toll Free: 1800 209 8800
   Email ID: kli.grievance@kotak.com

3. If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India (IRDAI) on the following contact details:

   IRDA Grievance Call Centre (IGCC) TOLL FREE NO: 1800 4254 732

   Email ID: complaints@irda.gov.in

   You can also register your complaint online at http://www.igms.irda.gov.in/

   Address for communication for complaints:

   Consumer Affairs Department

   Insurance Regulatory and Development Authority

   Sy.No.115/1,Financial District, Nanakramguda,

   Gachibowli, Hyderabad-500032

4. In case you are not satisfied with the decision/resolution of the Insurer, you may approach the Insurance Ombudsman at the address given below ~~for~~ if your grievances pertains to:

   (a) delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;

(b) any partial or total repudiation of claims by the Insurer;
(c) disputes over premium paid or payable in terms of insurance policy;
(d) misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
(e) legal construction of insurance policies in so far as the dispute relates to claim;
(f) policy servicing related grievances against Insurer and their agents and intermediaries;
(g) issuance of life insurance policy, including health insurance policy which is not in conformity with the proposal form submitted by the proposer;
(h) non-issuance of insurance policy after receipt of premium in life insurance including health insurance; and

(i) any other matter resulting from the violation of provisions of the Insurance Act, 1938 or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the policy contract, in so far as they relate to issues mentioned at clauses (a) to (f).

5. The complaint should be made in writing duly signed by the complainant or by his legal heirs with full details of the complaint and the contact information of complainant.
6. As per Insurance Ombudsman Rules, 2017, notification no. GSR 413(E) [F.NO.14019/22/2010-INS.II], dated 25-4-2017 the complaint to the Ombudsman can be made:

- Only if the grievance has been rejected by the Grievance Redressal Machinery of the Insurer
- Within a period of one year from the date of rejection by the Insurer
- If it is not simultaneously under any litigation.

List of Insurance Ombudsman

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@ecoi.co.in	**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@ecoi.co.in
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202	**BHUBANESHWAR** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in

Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	**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@ecoi.co.in
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 2323481/23213504 Email: bimalokpal.delhi@ecoi.co.in	**GUWAHATI** Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in
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 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
ERNAKULAM 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@ecoi.co.in	**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@ecoi.co.in
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331	**MUMBAI** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960

Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in
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.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	**PATNA** Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
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@ecoi.co.in	**GOVERNING BODY OF INSURANCE COUNCIL,** 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106889 / 671 / 980 Fax: 022 - 26106949 Email: inscoun@ecoi.co.in

Annexure 1: Member Data

Field Description
Customer Full Name :
Customer ID:
Certificate No. :
Location:
Plan Option:
Issuance Status of COI:
Branch Name:
Branch Code:
Agreement Date:
Customer Type (industry):
Gender:
Date Of Birth:
Date of commencement of Risk/Cover:
Cover Amt:
Premium Payment Term
Premium Payment Mode
Tenure in Years
Premium amount (excluding Goods and Services tax and cess)
Goods and Services Tax and cess
Premium with Goods and Services Tax and cess
Confirmation for underwriting status (MQ/DOGH)
Remarks
Address of the customer (to be provided as Address 1, Address 2….. in excel file)
Pincode
Email ID of the Customer
Mobile no. of the Customer

The above format may be altered by the Insurer from time to time with prior written notice to the Policyholder.

All the above member details are mandatory. The Insurer shall not accept data received from the Policyholder without the above details
The above format may be altered by the Insurer from time to time with prior written notice to the Policyholder.

Annexure (MU):-

Medical Underwriting Limits:

<<Based on group details and underwriting rules>>

Annexure (FU):-

Financial Underwriting:

<<Based on group details and underwriting rules>>

Annexure 2: List of valid age proofs:

- Birth Certificate/
- School / College Leaving Certificate, provided – it specifies Date of Birth, States that Date of Birth is extracted from School / College Records, Stamped and signed by College / School
- Passport
- Driving license
- Aadhar Card
- PAN Card
- Ration Card, which specifies the Date of Issue of the Ration Card and the Date of Birth or Age of the Life to be Insured
- Election ID card (also called voters ID) issued by the Election Commission of India can be accepted as valid age proof provided it was issued at least 2 years before the date of the insurance proposal.
- Extract from service register in case of:
    - Government and semi-government employees
- In case of defense/central government/ state government personnel, identity card issued respectively by the defense department /central government/ state government to their personnel showing, inter alias, the date of birth or age
- Marriage certificate in the case of Roman Catholics issued by Roman Catholic Church
- Domicile certificate in which the date of birth stated was proved on the strength of the school certificate or birth certificates

NOTE: Any of the abovementioned Age Proof document submitted should have been issued atleast 1 year prior to the date of the cover. In other words, any age proof document which has been issued by the respective issuing authority within a span of 1 year before the risk commencement date, then the same shall not be acceptable.

Annexure 3

Section 38 - Assignment and Transfer of Insurance Policies

Assignment or transfer of a Policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended by the Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

01. This Policy may be transferred/assigned, wholly or in part, with or without consideration.
02. An Assignment may be effected in a Policy by an endorsement upon the Policy itself or by a separate instrument under notice to the Insurer.
03. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
04. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
05. The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer.
06. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
07. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
08. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the Policy is being serviced.
09. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
    a. not bonafide or
    b. not in the interest of the Policyholder or
    c. not in public interest or
    d. is for the purpose of trading of the insurance Policy.
10. Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of Policyholder giving a notice of transfer or assignment.
11. In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.
12. The priority of claims of persons interested in an insurance Policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates

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of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.

13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except

    a. where assignment or transfer is subject to terms and conditions of transfer or assignment OR

    b. where the transfer or assignment is made upon condition that

    i. the proceeds under the Policy shall become payable to Policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR

    ii. the insured surviving the term of the Policy

    Such conditional assignee will not be entitled to obtain a loan on Policy or surrender the Policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person

    a. shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and

    b. may institute any proceedings in relation to the Policy

    c. obtain loan under the Policy or surrender the Policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings

15. Any rights and remedies of an assignee or transferee of a life insurance Policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by this section.

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Annexure 4

Section 39 - Nomination by Policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

01. The Policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the Policy shall be paid in the event of his death.
02. Where the nominee is a minor, the Policyholder may appoint any person to receive the money secured by the Policy in the event of Policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.
03. Nomination can be made at any time before the maturity of the Policy.
04. Nomination may be incorporated in the text of the Policy itself or may be endorsed on the Policy communicated to the insurer and can be registered by the insurer in the records relating to the Policy.
05. Nomination can be cancelled or changed at any time before Policy matures, by an endorsement or a further endorsement or a will as the case may be.
06. A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the Policy or in the registered records of the insurer.
07. Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
08. On receipt of notice with fee, the insurer should grant a written acknowledgement to the Policyholder of having registered a nomination or cancellation or change thereof.
09. A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will not get cancelled to the extent of insurer's or transferee's or assignee's interest in the Policy. The nomination will get revived on repayment of the loan.
10. The right of any creditor to be paid out of the proceeds of any Policy of life insurance shall not be affected by the nomination.
11. In case of nomination by Policyholder whose life is insured, if the nominees die before the Policyholder, the proceeds are payable to Policyholder or his heirs or legal representatives or holder of succession certificate.
12. In case nominee(s) survive the person whose life is insured, the amount secured by the Policy shall be paid to such survivor(s).
13. Where the Policyholder whose life is insured nominates his
    a. parents or
    b. spouse or
    c. children or

d. spouse and children

e. or any of them

the nominees are beneficially entitled to the amount payable by the insurer to the Policyholder unless it is proved that Policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14. If nominee(s) die after the Policyholder but before his share of the amount secured under the Policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act, 2015.
16. If Policyholder dies after maturity but the proceeds and benefit of the Policy has not been paid to him because of his death, his nominee(s) sh

all be entitled to the proceeds and benefit of the Policy.

17. The provisions of Section 39 are not applicable to any life insurance Policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act, 2015, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the Policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be sp/cifically mentioned on the Policy. In such a case only, the provisions of Section 39 will not apply.

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Annexure 5

Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding Policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended by Insurance Laws (Amendment) Act, 2015, are as follows:

01. No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 yrs from
    a. the date of issuance of Policy or
    b. the date of commencement of risk or
    c. the date of revival of Policy or
    d. the date of rider to the Policy
    whichever is later.
02. On the ground of fraud, a Policy of Life Insurance may be called in question within 3 years from
    a. the date of issuance of Policy or
    b. the date of commencement of risk or
    c. the date of revival of Policy or
    d. the date of rider to the Policy
    whichever is later.
    For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.
03. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance Policy:
    a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
    b. The active concealment of a fact by the insured having knowledge or belief of the fact;
    c. Any other act fitted to deceive; and
    d. Any such act or omission as the law specifically declares to be fraudulent.
04. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
05. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / 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 mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the Policyholder, if alive, or beneficiaries.

06. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which Policy was issued or

revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the Policy of life insurance is based.

07. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on Policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.
08. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance Policy would have been issued to the insured.
09. The insurer can call for proof of age at any time if he is entitled to do so and no Policy shall be deemed to be called in question merely because the terms of the Policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

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