

Part A

<<Date>>

<<Master Policyholder's Name>>

<< Master Policyholder's Address>>

<< Master Policyholder's Contact Number>>

Dear << Master Policyholder's Name>>,

Sub: Your Policy no. <<>>

We are glad to inform you that your proposal has been accepted and the HDFC Life Group Poorna Suraksha Policy ("Master Policy") being this Policy, has been issued. We have made every effort to design your Master Policy Document in a simple format. We have highlighted items of importance so that you may recognize them easily.

Cancellation in the Free-Look Period:

In case you are not agreeable to any of the provisions stated in the Master Policy, you have the option to return the Master Policy to us stating the reasons thereof, within 15 days (or 30 days in case the Master Policy has been issued through distance marketing mode) from the date of receipt of the Master Policy. Provided the Scheme Member(s) has not made any claim during the Free-Look Period, upon receipt of your letter along with the original Master Policy document, we shall arrange to refund the Premium paid by you, subject to deduction of the proportionate risk Premium for the period on cover and stamp duty (if any). For administrative purposes, all Free-Look requests should be registered by you, on behalf of Scheme Member.

Contacting us:

The address for correspondence is specified below. To enable us to serve you better, you are requested to quote your Master Policy number in all future correspondence. To contact us in case of any grievance, please refer to Part G.

Thanking you for choosing HDFC Life Insurance Company Limited and looking forward to serving you in the years ahead,

Yours sincerely,

<< Designation of the Authorised Signatory >>

Branch Address: <<Branch Address>>

Agency/Intermediary Code: <<Agency/Intermediary Code>>

Agency/Intermediary Name: <<Agency/Intermediary Name>>

Agency/Intermediary Telephone Number: <<Agency/Intermediary mobile & landline number>>

Agency/Intermediary Contact Details: <<Agency/Intermediary address>>

Address for Correspondence: HDFC Life Insurance Company Limited, 11th Floor Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai-400011.

Registered Office: HDFC Life Insurance Company Limited, Lodha Excelus, 13th Floor, Apollo Mills Compound, Mahalaxmi Mumbai- 400 011. CIN: L65110MH2000PLC128245, www.hdfclife.com email id: cpgroupops@hdfclife.com, Contact number: +91 22 6751 6218/ +91 22 6751 6215

MASTER POLICY DOCUMENT- HDFC Life Group Poorna Suraksha

Unique Identification Number: <<>>

Your Master Policy is a Non-Linked Non-Participating Group Term Insurance Policy. This document is the evidence of a contract between HDFC Life Insurance Company Limited ('We') and the Master Policyholder ('You') as described in the Policy Schedule given below who shall hold the same and all Benefits payable thereunder upon trust for the benefit of the persons to whom the said Benefits are payable (i.e. Scheme Members, or their nominees). The Master Policy is issued pursuant to a proposal made to the Insurer by the Master Policyholder on the date shown in the Policy Schedule for the benefit of Scheme Members ("Proposal").

Upon and subject to timely receipt of Premium by the Insurer from the Master Policyholder, the Insurer shall pay the Benefits described in the Master Policy to the Master Policyholder/Nominee of the Scheme Member, as applicable, subject to the terms of the Master Policy. This Master Policy is written under and will be governed by the applicable laws in force in India and all monies payable under the Master Policy to the Insurer, shall be payable in Indian Rupees.

Notwithstanding the date of the Proposal and the date on which the Master Policy is signed, the Master Policy shall have effect or be deemed to be effective from the date shown in the Policy Schedule as the Effective Date.

In witness whereof, this Master Policy is signed at the end of the Policy Schedule by a person duly authorised by the Insurer.

POLICY SCHEDULE

1. **Master Policy Number:**<< system/operations generated>>
2. **Date of Proposal:**<<<< system/operations generated>>
3. **Date of Inception:** <<Date of Inception>>
4. **Effective Date:**<< system/operations service generated>>
5. **Master Policyholder:**<<Name of Company/Group>>
6. **Name of the Scheme:**<<NAME of Scheme>>
7. **Scheme Type:**<<Compulsory/Voluntary>>
8. **Plan option:**<<Name of Plan option>>
9. **Eligibility to join the Scheme for the Scheme Member:**

Eligibility	Age (Last Birthday) (in years)		
Minimum Age at Entry	< 18 >		
Maximum Age at Entry	Single Premium Payment	Life Option	<79 >
		Extra Life Option & Accelerated Critical Illness Option	<74>
	Limited Premium Payment	Life Option	<74 >
		Extra Life Option & Accelerated Critical Illness Option	<69>
	Regular Premium Payment	Life Option	<78 >
		Extra Life Option & Accelerated Critical Illness Option	<73>
Minimum Maturity Age	<18>		
Maximum Maturity Age	Life Option		<80>
	Extra Life Option & Accelerated Critical Illness Option		<75>

10. **Minimum Number of Members:** <<5>>
11. **Mode / Frequency of Premium Payment:**<<Single/Limited/Regular>> <<Annual / Half-Yearly / Monthly>>
12. **Cover Term**

Mode of Premium Payment	Plan Option		
	Life Option	Extra Life Option	Accelerated Critical Illness Option
Single	1 month – 30 years	1 month – 30 years	1 month – 30 years
Limited	6 years – 50 years	6 years – 50 years	6 years – 30 years
Regular	2 years – 50 years	2 years – 50 years	2 years – 30 years

13. **Underwriting Office:**
14. **Servicing Office:**
15. **Office at which Monies are payable:**

Signed at Mumbai on <<>>
For HDFC Life Insurance Company Limited

Authorised Signatory

Note: Kindly note that name of the Company has changed from "HDFC Standard Life Insurance Company Limited" to "HDFC Life Insurance Company Limited".

In case you notice any mistake, you may return the Master Policy document to us for necessary correction.

SPACE FOR ENDORSEMENTS

Part B

Definitions

The following capitalized terms wherever used in this Policy shall have the meaning given hereunder:

- (1) **Accident**- means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
- (2) **Accidental Death** - means death by or due to a bodily injury caused by an Accident, independent of all other causes of death and must be caused within 180 days of any bodily injury.
- (3) **Actively at work**- An employee of the Company is said to be 'Actively at Work' if he/she meets both the following conditions: i) he/she is not absent on the grounds of ill health or maternity leave at the time of joining the Scheme and ii) he/she has not have availed any leave on the grounds of ill-health for a continuous period of fifteen (15) days or more in the year preceding his/her admission into the Scheme as applicable.
- (4) **Appointee** – means the person named by the Scheme Member and registered with us in accordance with the Nomination Schedule, who is authorized to receive the Death Benefit under this Policy on the death of the Scheme Member while the Nominee is a minor
- (5) **Assignee** – means the person to whom the rights and benefits under this Policy are transferred by virtue of assignment under section 38 of the Insurance Act, 1938, as amended from time to time
- (6) **Assignment**– means a provision wherein the Scheme Member can assign or transfer a Policy in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time
- (7) **Certificate of Insurance(COI)** -means the certificate issued to the Scheme Member under this Master Policy evidencing proof of insurance and containing details regarding the validity period of cover, benefits and name of Nominee etc.
- (8) **Company/Group/Master Policyholder**- means the Company/Group named in the Policy Schedule as the Master Policyholder.
- (9) **Compulsory Participation**- Under Compulsory participation it is mandatory that all the employees/members of the Company/Group are covered under this Master Policy provided they satisfy the eligibility criteria set out in Part F Clause 5 (Eligibility) of the Master Policy.
- (10) **Coverage Term** - means the period for which insurance cover is provided to individual Scheme Member at the Entry Date.
- (11) **Date of Inception** – means the date, as stated in the Policy Schedule, on which the Policy is first issued
- (12) **Death Benefit** - means the amount which is payable on death of Scheme Member in accordance with Part C.
- (13) **Distance Marketing** - includes every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) Voice mode, which includes telephone-calling; (ii) Short Messaging service (SMS); (iii) Electronic mode which includes e-mail, internet and interactive television (DTH); (iv) Physical mode which includes direct postal mail and newspaper & magazine inserts; and, (v) Solicitation through any means of communication other than in person.
- (14) **Effective Date**- means the date from which the Scheme shall first commence as set out in the Schedule.
- (15) **Eligible Person**- means, any person who has satisfied the eligibility criteria set out Part F Clause 5 (Eligibility) in the Master Policy.
- (16) **Entry Date**- in relation to a Scheme Member shall mean the actual date on which an Eligible Person is admitted by the Insurer as a Scheme Member.
- (17) **Exit Date**- means the date on which the insurance cover of the Scheme Member ceases due to occurrence of any of the following events: a) Death of the Scheme Member; b) Master Policy being terminated; c) End of Coverage Term; d) Surrender of Master Policy/Certificate of Insurance; e) Free Look Cancellation
- (18) **Free Look Period** - means the period specified under Part D clause 9 from the receipt of the Policy during which Master Policyholder/Member can review the terms and conditions of this Policy and where if the Master Policyholder/Member is not agreeable to any of the provisions stated in the Policy, he/ she has the option to return this Policy.
- (19) **Grace Period** - means the time granted by the insurer from the due date for the payment of premium, without any penalty / late fee, during which the policy is considered to be in-force with the risk cover without any interruption as per the terms of this policy.
- (20) **Hospital**- mean any institution established for in-patient care and day care treatment of Illness and/or Injuries and which has been registered as a hospital with the local authorities under 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 towns 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;

- (21) **Illness**-means a sickness or a disease or pathological condition leading to the impairment of normal physiological condition which manifests itself during the Cover Term and requires medical treatment.
- i. 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
 - ii. Chronic condition - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:
 - a. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
 - b. It needs ongoing or long-term control or relief of Symptoms
 - c. It requires Scheme Member's rehabilitation or to be specially trained to cope with it
 - d. It continues indefinitely
 - e. It recurs or is likely to recur
- (22) **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.
- (23) **Insurer, Us, We**- means HDFC Life Insurance Company Limited.
- (24) **Master Policy**- means this Policy.
- (25) **Master Policyholder, You, you, Your, your**- means the institution which has entered into a contract with the Company for providing insurance cover to Members of this Policy, as defined in the Schedule.
- (26) **Medical Advice**: means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
- (27) **Medically Necessary**: shall mean 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 Scheme Member; 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.
- (28) **Medical Practitioner** -is a person who holds a valid registration from the Medical Council of any State or Medical Council of Indian or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. The person must be qualified in allopathic system of medicine and shall not be the Scheme Member himself/herself.
- (29) **Nomination** - is the process of nominating a person(s) who is (are) named as "Nominee(s)" in the member information form or subsequently included/ changed by an endorsement. Nomination should be in accordance with provisions of Section 39 of the Insurance Act, 1938 as amended from time to time.
- (30) **Nominee**-means the person nominated by the Scheme Member under this policy and registered with us in accordance with the Nomination Schedule, to whom money secured by the Policy as mentioned under the Death Benefit shall be paid in event of the death of the Scheme Member.
- (31) **Other Entities** shall mean to include the entities other than Regulated Entities
- (32) **Other Levies**- means any statutory tax or charge that the Insurer incurs when administering this Master Policy in the future due to changes in law.
- (33) **Pre-existing Disease**-means any **condition, ailment, injury** or disease: that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement
- (34) **Regulated Entities** shall mean to include the following:
- a. Reserve Bank of India ("RBI") regulated Scheduled Commercial Banks (including co-operative Banks),
 - b. NBFCs having Certificate of Registration from RBI or
 - c. National Housing Bank ("NHB") regulated Housing Finance Companies
 - d. National Minority Development Finance Corporation (NMDFC) and its State Channelizing Agencies
 - e. Small Finance Banks regulated by RBI
 - f. Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies
 - g. Microfinance Companies registered under Section 8 of the Companies Act, 2013
 - h. Any other category as approved by the Authority
- (35) **Revival** - means restoration of the Policy by the Company, which was discontinued due to the non-payment of Premium, with all the benefits mentioned in the Policy document, upon the receipt of all the Premiums due and other charges/ late fee, if any, as per the terms and conditions of the Policy, upon being satisfied as to the continued insurability of the Scheme Member on the basis of the information, documents and reports furnished by the Master Policyholder.
- (36) **Scheme**- means the Scheme named in the Schedule.

- (37) **Scheme Member**- means an Eligible Person who is included in the Scheme as per the Scheme rules as member of that Scheme.
- (38) **Sum Assured**- means the amount payable under this Master Policy per Scheme Member upon death & diagnosis of any one of the covered 29 critical illness during Coverage Term subject to terms, conditions and provisions of this Master Policy.
- (39) **Service**- means the period of continuous service rendered by the Scheme Member as an employee of the Master Policyholder.
- (40) **Surrender** - means complete withdrawal/ termination of the Certificate of Insurance at the request of the Scheme Member.
- (41) **Voluntary Participation**- Under Voluntary Participation, an Eligible Person as defined above is allowed an option to seek Insurance cover under this Master Policy.

SAMPLE

Part C

1. Benefits:

(1) Benefits on Death or diagnosis of contingency covered –

Plan Option	Events	Benefit
Life	Death	In the event of the death of the Scheme Member, the benefit payable shall be the Sum Assured.
Extra Life Option	Death	In the event of the death of the Scheme Member, the benefit payable shall be the Sum Assured.
	Accidental Death	In event of the Scheme Member's death due to Accident, an additional death benefit equal to the Sum Assured will be payable. This is in addition to the death benefit mentioned above
Accelerated Critical Illness Option	Death	In the event of the death of the Scheme Member, the benefit payable shall be the Sum Assured.
	Diagnosis of a Critical Illness	In the event of Scheme Member being diagnosed with any of the covered Critical Illnesses during the Policy Term, the benefit payable shall be the Sum Assured and the policy will terminate.

- a. The Policy Term, Sum Assured, Cover option, and Mode of Premium Payment will be chosen by Scheme Member and these may vary from one Scheme Member to another.
- b. The Certificate of Insurance issued to a Scheme Member will set out the benefit payable in respect of that Scheme Member during the Coverage Term.
- c. The benefits specified in the Certificate of Insurance are payable provided the Scheme Member's death or Accidental Death has occurred during the Coverage Term of the Scheme Member or in case of diagnosis of any one of the Critical Illnesses or undergoing any of the covered surgeries during the coverage term, subject to Master Policy being in force and all due Premiums, Taxes and any Other Levies been paid and subject to any restrictions or qualifications referred to in these Clauses.
- d. If Accelerated Critical Illness Option is chosen, in the event of the Scheme Member being diagnosed on first occurrence of any of the Critical Illness or undergoing any of the covered surgeries listed below during the coverage term, the Accelerated Critical Illness Benefit shall be payable under the Master Policy. After payment of the Accelerated Critical Illness Benefit, the coverage of the Scheme Member shall cease and all benefits shall expire.
- e. The covered Critical Illnesses under the Accelerated Critical Illness option are listed herein below and defined under Annexure IV of this Master Policy:

List of covered Critical Illnesses and surgeries			
1. Myocardial Infarction (First Heart Attack of specific severity)	2. Open Heart Replacement or Repair of Heart Valves	3. Cancer of Specified Severity	4. Kidney failure requiring regular dialysis
5. Stroke resulting in permanent symptoms	6. Alzheimer's Disease	7. Apallic Syndrome	8. Coma of specified severity
9. End Stage Liver Failure	10. End Stage Lung Failure	11. Loss of Independent Existence	12. Blindness
13. Third Degree Burns	14. Major Head Trauma	15. Parkinson's Disease	16. Permanent paralysis of limbs
17. Multiple Sclerosis with persisting symptoms	18. Motor Neuron Disease with permanent	19. Benign Brain Tumour	20. Major Organ Transplant (as recipient)

	symptoms		
21. Progressive Scleroderma	22. Muscular Dystrophy	23. Poliomyelitis	24. Loss of Limbs
25. Deafness	26. Loss of Speech	27. Medullary Cystic Disease	28. Systematic Erythematous Involvement with lupus Renal
29. Aplastic Anaemia			

- f. If a claim is made for Open Heart Replacement or Repair of Heart Valves, in addition to satisfying the definitions and exclusion criteria, the procedure or surgery must be determined to be Medically Necessary by a Consultant Cardiologist / Surgeon and must be supported by relevant imaging findings & evidenced by established diagnostic reports.
- g. Upon the payment of the benefits as mentioned above with respect to the plan option availed, the cover for that Scheme Member shall cease.
- h. Subject to Clause (n) below, the benefit as set out in the Scheme Member's Certificate of Insurance shall be paid to the Nominee of the deceased Scheme Member for Single Life cases and for Joint Life cases, to the surviving life. If the benefit is in the form of an acceleration of the death benefit and the Scheme Member is alive, then the benefit shall be payable to the Scheme Member.
- i. The Death Benefit/Accelerated Critical Illness Benefit is subject to exclusions provided under Part F of the Master Policy.
- j. The Insurer shall be responsible to honour any valid claims brought under this policy in instances wherein the Master Policyholder has collected/ deducted the Premium but has failed to pay the same to the Insurer within the Grace Period due to administrative reasons.
- k. The payment of Death Benefit to the Master Policyholder may be made by the Insurer subject to the below mentioned conditions and in compliance with guidelines set forth by IRDAI in this regard:
- The Master Policyholder is a Regulated Entity as defined in Part B.
 - Scheme Members have specifically authorised the Insurer in a format provided by the Insurer to make payment of outstanding loan balance amount to the Master Policyholder from the total Death Benefit claim amount otherwise payable to the Nominee of the Scheme Member;
 - The Master Policyholder has collected written authorization from the Scheme Member and submitted the same to the Insurer;
 - Credit Account Statement has been provided by the Master Policyholder with details of Scheme Member as required by the Insurer and in formats provided by the Insurer;
 - The Death Benefit claimed by the Master Policyholder is only to the extent of the outstanding loan balance; and
 - Where the Death Benefit is greater than the outstanding loan balance of the Scheme Member, the excess of the Death Benefit over such outstanding loan balance is paid to the Nominee of the Scheme Member.
- l. In case of Other Entities, the Death Benefit shall be payable to the Nominee, in the event of the Scheme Member's demise.
- m. **Option to extend the insurance cover to the spouse:** The Master Policyholder has an option to extend the insurance cover to the spouse of the Scheme Members. The terms of cover for spouse will be consistent with the terms applicable for Scheme Members of the Scheme.
- n. For Joint Life cases, the benefits will be payable on a first-claim basis and upon the payment of benefit in respect of the first claimant, the cover for the other life will cease and Certificate of Insurance shall terminate. For the avoidance of doubt, it is clarified that in respect of Accelerated Critical Illness option, if the Accelerated Critical Illness claim has been made in respect of one of the lives, both the Accelerated Critical Illness cover and Death Benefit cover will cease for both the lives and Certificate of Insurance shall terminate.

(2) **Maturity Benefit –**

No maturity benefit is payable under this Policy.

(3) **Benefits on Surrender-**

A Scheme Member may surrender the Certificate of Insurance anytime during the Coverage Term and obtain the Surrender Value, which shall be calculated in the following manner:

- Single Pay

$$50\% \times \text{Single Premium} \times \left(1 - \frac{M}{P}\right)$$

The single premium used in the above formula will be excluding any statutory levies and any underwriting extra premium.

- Limited Pay

In case if the Scheme Member surrenders the Certificate of Insurance anytime during the Coverage Term, surrender value will be calculated as given below:

$$50\% \times \text{Total Premiums Paid} \times \left(\frac{T}{N} - \frac{M}{P} \right)$$

Where,

Term	Definition
M	Elapsed months since coverage inception, any part of month shall be counted as full.
N	Number of months for which premiums are payable
P	Policy Term in months
T	Number of months for which premiums are paid
Total Premiums Paid	Total premiums paid means total of all premiums received, excluding any extra premium, any rider premium and taxes.
Original Sum Assured	The Sum Assured specified for the Member at inception.
Current Sum Assured	The Sum Assured applicable in the policy month of surrender as per the repayment schedule set at inception. This will be equal to the Original Sum Assured for level term assurance coverage.

Upon payment of surrender benefit the cover for that Scheme Member (Single Life or Joint Life) terminates and no further benefits are payable.

In case of surrender of the Master Policy / Scheme Member leaving the group, the Scheme Members will be given an option to continue the policy as an individual policy till the expiry of member coverage term.

- Regular Pay

No surrender benefit is payable.

(4) Benefits on Paid-Up

- Limited Pay

If premiums are discontinued at any time before the premium payment term, the policy shall acquire a paid-up status on expiry of the grace period for the last unpaid premium and the cover shall continue for the paid-up Sum Assured as defined below:

$$\text{Current Sum Assured} \times \left(\frac{T}{N} \right)$$

Where T & N are as defined above.

- Regular Pay

If payment of Premium on behalf of a Scheme Member is discontinued at any time before the completion of the Premium Payment Term the Insurance cover shall cease and no benefits shall be paid.

- Single Pay

Not Applicable

(5) Grace Period

There will be a grace period of 30 days for non-monthly premium paying mode and 15 days for monthly mode under Regular and Limited pay policies.

The policy is considered to be in-force with the risk cover during the grace period without any interruption.

If a premium is not paid within the grace period, then all benefits will lapse.

The Insurer shall be responsible to honour any valid claims brought under this policy in instances wherein the Master Policyholder has collected/ deducted the Premium but has failed to pay the same to the Insurer within the Grace Period due to administrative reasons.

Part D

1. Additional Sum Assured option:

The Scheme Member can opt to increase his/her cover during the Coverage Term.

This option will be available subject to the following conditions:

- The option cannot be taken in the event of any claim by the Scheme Member.
- An additional premium will be charged for the increase in the Sum Assured. The maximum Sum Assured will be as per BAUP.
- This option is available subject to Scheme Member satisfying the eligibility criteria set out in Part F Clause 5 (Eligibility) in the Master Policy at the time of availing this option.
- The Scheme Member has the option to surrender the availed additional Sum Assured option at any time during the remaining Coverage term. The Surrender Value shall be calculated in accordance with Part C Clause 1 sub-clause (3) (Benefits on Surrender).

2. Settlement Option:

- (1) Under this option, the Nominee/Scheme Member can choose to receive the plan benefit in instalments over the chosen period of 5 to 15 years instead of a lump sum amount. This option can be opted for anytime before the claim for full or part of claim proceeds payable under the policy.
- (2) The instalment shall be paid in advance based on the frequency chosen by the Nominee / Scheme Member, which can be either yearly, half-yearly, quarterly or monthly. The instalment amount shall be calculated such that the present value of the instalments, using a given interest rate, shall equal the lump-sum payable under the policy. This amount shall be a level amount and once chosen by the Nominee / Scheme Member shall remain fixed over the instalment period.
- (3) The interest rate used to compute the instalment amount shall be equal to the annualized yield on 10-year G-Sec (over last 6 months & rounded down to nearest 25bps) less 25 basis points. The interest rate shall be reviewed half-yearly and any change in the interest rate shall be effective from 25th February and 25th August each year. The interest rate shall be revised every time there is a change as per the above formula. In case of a revision in interest rate, the same shall apply until next revision. The source of 10-year benchmark G-sec yield shall be RBI Negotiated Dealing System-Order Matching segment (NDS-OM). The current rate of interest is 6.25%.
- (4) At any time during the instalment phase, the Nominee / Scheme Member can choose to terminate the instalment payment in exchange for a lump-sum, in which case, the lump-sum payable shall be equal to the discounted value of all the future instalments due. The interest rate used to calculate the discounted value will be that as applicable on date of termination, using the above mentioned formula. The current rate of interest is 6.25%.

3. Lapsed and Paid-Up Policy:

- a. In case of regular Premium paying Policy, if the Premium is not received on behalf of a Scheme Member, within the Grace Period, Insurance cover will lapse for such Scheme Member and no benefits shall be payable under the Certificate of Insurance.
- b. In case of limited Premium paying Policy, if the Premium is not received on behalf of a Scheme Member within the Grace Period, at any time before the completion of the Premium Payment Term, Insurance cover will be altered to paid-up status and paid-up Benefits shall be payable under the Certificate of Insurance.
- c. The Insurer shall be responsible to honour any valid claims brought under this policy in instances wherein the Master Policyholder has collected/ deducted the Premium but has failed to pay the same to the Insurer within the Grace Period due to administrative reasons.
- d. The Insurer would consider requests from Master Policyholder to revive lapsed or paid-up Certificates of Insurance. The revival shall be subject to the Board Approved Underwriting Policy of the Insurer and payment of unpaid Premiums with interest as applicable from time to time.
- e. This Certificates of Insurance may be revived within five (5) years from the date on which the Certificates of Insurance have lapsed or become paid-up.

1. Termination of Insurance:

The Insurance on the life of a Scheme Member shall immediately terminate upon the happening of any of the following events and no benefits will be payable thereafter:

- a. Master Policy being terminated
- b. End of Coverage Term
- c. Surrender of Certificate of Insurance
- d. Free Look Cancellation
- e. Payment of Plan Benefit
- f. Refund of premium under Suicide Clause

2. Assignment or Transfer

Assignment shall be as per the provisions of Section 38 of the Insurance Act, 1938, as amended from time to time. Simplified version of the provisions of Section 38 is enclosed in Annexure I for reference.

3. Nomination:

The Scheme Members covered under this Master Policy can nominate a person/ persons in accordance with Section 39 of the Insurance Act, 1938 as amended from time to time. Simplified version of the provisions of Section 39 is enclosed in Annexure II for reference

4. Terms and Conditions:

- a. The Insurer has the right to close the Scheme for the new members at its sole discretion after providing a notice of not less than 30 days to the Master Policyholder.
- b. In the instance where the Insurer has exercised such right to close the Scheme for the new members, the Insurer shall continue to provide the insurance cover for the existing Scheme Members for their respective unexpired Cover Term.
- c. Scheme Members shall not be allowed to alter or amend benefits once their respective Certificate of Insurance has been issued except to correct any factual error.
- d. The Insurer shall conduct a surprise inspection of the records of the Master Policyholder to ensure compliance with these Policy Provisions and Scheme Rules or the Master Policyholder's auditors will certify compliance.

5. Other Provisions:

- a. The Master Policyholder will act for and on behalf of the Scheme Members in all matters relating to the Scheme and every act done by the Master Policyholder shall be binding on the Scheme Members.
- b. The Insurance effected in favour of the Master Policyholder has no maturity values. Any statutory levy or charges including any tax may be charged to the Master Policyholder either now or in future by the Insurer.

6. Revival

In case of Regular pay and Limited pay policies, if the payment is not received even after the completion of the grace period, the policy lapses. The company shall consider requests from Master Policyholder to revive lapsed Certificates of Insurance, provided such requests are received within the revival period of 5 years from the date of first unpaid premium. Any agreement to revive would be subject to the BAUP and payment of unpaid premiums with interest. The current rate of interest is 9.5% p.a.

The revival interest shall be reviewed half-yearly and it will be reset to: Average Annualized 10-year benchmark as provided by RBI Negotiated Dealing System-Order Matching segment (NDS-OM) G-Sec Yield (over last 6 months & rounded upto the nearest 50 bps) + 2%. The change in revival rate shall be effective from 25th February and 25th August each year. Any change on basis of determination of interest rate for revival will be done only after prior approval of the Authority.

Any medical cost pursuant to the Revival shall be borne by the Scheme Member.

7. Loans:

There is no facility of loan available from us under this Master Policy.

8. Free Look Cancellation:

By Master Policy Holder:

- (1) In case you, the Master Policyholder, are not satisfied with the terms and conditions specified in the Master Policy Document, you have the option of returning the Master Policy Document to us stating the reasons thereof, within 15 days from the date of receipt of the Master Policy Document, as per IRDAI (Protection of Policyholders' Interests) Regulations, 2017
- (2) In case of the Product is sold through Distance Marketing mode, the period will be 30 days from the date of receipt of the letter along with Master Policy Document
- (3) On receipt of the letter along with the Master Policy Document, we shall arrange to refund the premium paid by you, subject to deduction of the proportionate risk premium for period on cover plus the expenses incurred by us on stamp duty (if any)

By Scheme Member:

- (1) In case the Member is not satisfied with the terms and conditions specified in the Certificate of Insurance, he/she has the option of returning the Certificate of Insurance to us stating the reasons

thereof, within 15 days from the date of receipt of the Certificate of Insurance, as per IRDAI (Protection of Policyholders' Interests) Regulations, 2017

- (2) In case of the Product is sold through Distance Marketing mode, the period will be 30 days from the date of receipt of the letter along with Certificate of Insurance
- (3) On receipt of the letter along with the Certificate of Insurance, we shall arrange to refund the premium, subject to deduction of the proportionate risk premium for period on cover plus the expenses incurred by us on stamp duty (if any)

For administrative purposes, all Free-Look requests should be registered by you, on behalf of Scheme Member.

SAMPLE

Part E

- 1. Additional Servicing Charges**
Nil

SAMPLE

Part F

1. Waiting Period and Exclusions:

i. 90 Days Waiting Period for Accelerated Critical Illness Benefit

No benefit shall be paid in case the Scheme Member is diagnosed with any of the applicable listed Critical Illnesses or surgeries within 90 days from the date of commencement of the Coverage term except in cases where the Critical Illness occurs as a result of an Accident (such as Major Head Trauma).

ii. Suicide exclusion (Single & Joint Life)

- For employer-employee groups, sum Assured will be payable to the nominee in case of death due to Suicide.
- In case of non employer-employee schemes, if the Scheme Member dies due to suicide within 12 months from the date of joining the scheme or from the date of revival of the policy, as applicable, the nominee or beneficiary of the Scheme Member shall be entitled to at least 80% of the total premiums paid till the date of death or the surrender value available as on the date of death whichever is higher, provided the policy is in force, where total premiums paid refers to total of all the premiums received, excluding any extra premium, any rider premium and taxes
- For both employer-employee and non employer-employee schemes, in case of Joint Life, on first death due to suicide, the above mentioned respective benefits will be payable to the surviving Scheme Member

Additional sum assured, if opted for, will be treated in the same manner as applicable for Sum Assured.

iii. Permanent Exclusions for Accelerated Critical Illness Benefit

A. General Permanent Exclusions

Unless expressly stated to the contrary in this Master Policy, we will not make any payment for any claim in respect of any Scheme Member if it is directly or indirectly caused by, arises from or is in any way attributable to any of the following:

1. Treatment which is not medically necessary;
2. 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
3. Directly or indirectly arising from or consequent upon war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, terrorism, rebellion, active participation in strikes, riots or civil commotion, revolution, insurrection or military or usurped power;
4. Nuclear disaster, radioactive contamination and/or release of nuclear or atomic energy;
5. Intentional self-inflicted injuries; or any attempts of suicide while sane or insane; or deliberate exposure to exceptional danger (except in an attempt to save human life);
6. Violation or attempted violation of the law or resistance to arrest or by active participation in an act with criminal intent;
7. Engaging in or taking part in professional sport(s) or any hazardous pursuits, power boat racing, sky diving, para gliding, parachuting, scuba diving, skydo riding, winter sports, sky jumping, ice hockey, ice speedway, ballooning, hand gliding, river rafting / bugging, black water rafting, yachting / boating outside coastal waters, motor rallying, power lifting, quad biking, rodeo and roller hockey
8. Aviation, gliding or any form of aerial flight other than on a scheduled commercial airline as a bona fide passenger (whether fare paying or not), pilot or crew member.
9. Any sickness classified as an epidemic by the Central or State government.
10. Treatment to relieve symptoms caused by ageing, puberty, or other natural physiological cause, such as hearing loss caused by maturing or ageing.
11. Treatment of abnormalities, deformities, or Illnesses present only because they have been passed down through the generations of the family.
12. Failure to seek or follow medical advice as recommended by a Medical Practitioner
13. Delaying of medical treatment in order to circumvent the waiting period

B. Specific Permanent Exclusions

In addition to the General Permanent exclusions listed above:

1. No Critical Illness Benefit (or any variant of Critical Illness benefit) will be payable for any of the following:
 - The coverage shall terminate for the Critical Illness benefit for any critical illness having occurred within 90 days of the commencement or date of revival of cover, whichever is later. A refund of premium relating to Critical Illness Benefit would be payable subject to a deduction of proportionate risk premium for the duration of cover. However, the coverage for death benefit shall continue.
 - Critical Illness Benefit, where death occurs within 30 days of the date of diagnosis of covered critical illness
 - Any more than one claim in respect of Critical Illness Benefit

- Any Pre-existing condition

Note: For the purpose of waiting period, Date of commencement or inception of coverage for a benefit option shall mean the date from which the member is covered under that benefit option.

iv. Accidental Death Benefit Exclusions:

1. No Accidental Death Benefit will be payable if the death of the Scheme Members occurs after 180 days from the date of Accident.

Specific Exclusions for this benefit are listed below

We will not pay Accidental Death Benefit, if Accidental Death is caused from or due to any of the following:

- Intentionally self-inflicted injury or 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.
- Engaging in or taking part in professional sport(s) or any hazardous pursuits, power boat racing, sky diving, para gliding, parachuting, scuba diving, skydo riding, winter sports, sky jumping, ice hockey, ice speedway, ballooning, hand gliding, river rafting / bugging, black water rafting, yachting / boating outside coastal waters, motor rallying, power lifting, quad biking, rodeo and roller hockey.
- War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
- Taking part in any flying activity, other than as a passenger in a commercially licensed aircraft.
- Participation by the life assured in a criminal or unlawful act.

2. Claims Procedure:

- (1) The Master Policyholder shall inform the Insurer within 30 days of the death/ illness of a Scheme Member and shall file a claim with the Insurer on behalf of the Nominee of the deceased Scheme Member in the form prescribed by the Insurer and accompanied by all relevant documents as may be required by the Insurer, within 90 days from the date of death/ /illness.

However, the Insurer will condone the delay caused in intimation of claim where the claim is genuine and the delay is proved to be for reasons beyond the control of the claimant.

- (2) Subject to Part C Clause 1 sub-clause (1)(n), the Insurer shall pay the Claim amount in relation to the Death Benefit to the Nominee of the deceased Scheme Member in Single Life cases and to the surviving life in the Joint Life cases, who shall give a valid discharge/receipt for the same. If the benefit is in the form of an acceleration of the death benefit and the Scheme Member is alive, then the benefit shall be payable to the Scheme Member.

- (3) The documents required for processing a claim are:

Basic documentation if death is due to Natural Cause:

- a. Completed claim form, (including NEFT details and bank account proof as specified in the claim form);
- b. Original Policy;
- c. Original or copy Death Certificate issued by Municipal Authority/ Gram Panchayat / Tehsildar (attested by issuing authority);
- d. Claimant's identity and residence proof.
- e. Certificate of Insurance as issued to the Scheme Member

Basic Documentation if death is due to un-natural causes:

- a. Completed claim form, (including NEFT details and bank account proof as specified in the claim form);
- a. Original Policy;
- b. Original or copy Death Certificate issued by Municipal Authority/ Gram Panchayat / Tehsildar (attested by issuing authority);
- c. Claimant's identity and residence proof.
- d. Certificate of Insurance as issued to the Scheme Member
- e. Original or copy of First Information Report, Police Panchnama report attested by Police authorities; and
- f. Original or copy of Post mortem report attested by Hospital authority.

Note: Depending on the circumstances of the death, further documents may be called for as we deem fit.

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Critical Illness Benefit Claim:

- a. Completed claim form, (including NEFT details and bank account proof as specified in the claim form)
- b. Member Information/Enrollment Form (MIF)
- c. Separate Member Authorization (if applicable)
- d. All medical reports for diagnosis and treatment of critical Illness
- e. All current and past medical records of Scheme Member
- f. NEFT Details along with supporting Documents of Insured member
- g. Translation of all vernacular documents (if Required)

Note: Depending on the circumstances, further documents may be called for as we deem fit.

3. Issuance of Duplicate Policy:

The Master Policyholder may request for a duplicate copy of the Policy at HDFC Life offices along with relevant documents. While making an application for duplicate Master Policy the Master Policyholder is required to submit a notarized original indemnity bond on stamp paper.

4. Age Admitted

The Company has calculated the Premiums under the Policy on the basis of the age of the Scheme Member as declared in the member enrolment form. In case proof of age of the Scheme Member has not been provided with the member enrolment form, Master Policyholder/Scheme Member will be required to furnish such proof of age of the Scheme Member as is acceptable to us and have the age admitted. In the event the age so admitted ("Correct Age") during the Cover Term is found to be different from the age declared in the member enrolment form, without prejudice to our rights and remedies including those under the Insurance Act, 1938, as amended from time to time we shall deny the cover ab initio, vary the Sum Assured and/or recover/refund excess Premium.

5. Eligibility:

- (1) Any person who satisfies all of the following conditions shall be eligible to participate in the Scheme.
 - a) Person is not aged less than the minimum entry age as set out in the Policy Schedule,
 - b) Person is not aged more than the maximum entry age as set out in the Policy Schedule,
 - c) Person who satisfies further eligibility criteria, as may be specified in the Policy Schedule by the Insurer,
 - d) Person who satisfies the underwriting requirements of the Insurer on his/her Entry Date

6. Commencement of Insurance:

- (1) On the Effective Date, the Insurer shall grant Insurance in accordance with these provisions in respect of each person who is an Eligible Person on that date and who is accepted by the Insurer as a Scheme Member. In the event of any other person becoming an Eligible Person and the requisite Premium, Taxes and any Other Levies being received in full by the Insurer, he/she shall be accepted as a Scheme Member by the Insurer immediately on the Insurer being notified and being satisfied that such person has met all the conditions of eligibility. For this purpose, the Master Policyholder shall notify the Insurer in writing in such form and at such times as shall be prescribed by the Insurer, the names and full particulars of the persons as soon as they meet the eligibility conditions. Accordingly, the Eligible Person shall also not be covered up to the time the requisite Premium, Taxes and any Other Levies are received in full by the Insurer and no benefit would become payable for such period in respect of such person. Separate premiums are payable in respect of every Scheme Member insured under the Master Policy
- (2) Under Voluntary Participation: An Eligible Person is required to pay in part or in full, the Premium payable under the Master Policy.
- (3) Under Compulsory Participation: An Eligible Person is not required to pay any part of the Premium, payable under the Scheme.

7. Provision of information:

- (1) Before assuring any benefit under these provisions in respect of an Eligible Person and to determine the rights and obligations of the Insurer under these provisions, the Master Policyholder must provide the Insurer with such information, data and evidence as the Insurer considers necessary in such form as required/specified by the Insurer.
- (2) In the event of any change in the name or other particulars of a Scheme Member, the Master Policyholder must inform the Insurer of the change within 15 days of being informed of the same by the said Scheme Member or on the Master Policyholder becoming aware of the same, whichever is earlier.
- (3) In the event of a Scheme Member ceasing to meet the eligibility criteria, the Master Policyholder must inform the Insurer of that event, within 30 days of that event. In the event of any person becoming an

Eligible Person after the Effective Date, the Master Policyholder must inform the Insurer within 30 days of that event.

- (4) Subject to Section 45 of the Insurance Act 1938, as amended from time to time if in respect of a Scheme Member any information, data or evidence given to the Insurer proves to be incorrect, the particular Insurance in respect of such Scheme Member shall be rendered voidable, at the instance of the Insurer.
- (5) The Insurer shall not be liable for any loss of benefit resulting from errors in or omissions from any information, data or evidence given to the Insurer by the Master Policyholder. Where a loss of benefit is due to an error or omission by the Master Policyholder and the Insurer is required to pay for the benefit in full, the Insurer will pay the benefit in full and seek compensation for the error from the Master Policyholder.
- (6) The Insurer shall not admit a claim in respect of a Scheme Member under this Master Policy unless it receives the documents specified under Part F Clause of this Master Policy or such other document that the Insurer may decide, within the legal and regulatory framework in the circumstances of a particular case. The Insurer will not accept the aforesaid documents unless it is issued by a person duly authorized to issue the same.
- (7) The Master Policyholder shall arrange to submit to the Insurer evidence of age in respect of each Scheme Member at the time of entry into the Scheme, if required by the Insurer.
- (8) Satisfactory evidence of health as required by the Insurer shall be furnished by every Eligible Person at the time of his entry into the Scheme and on each occasion when an increase in Sum Assured is granted. The terms of acceptance may be varied if in the opinion of the Insurer the evidence of health is not satisfactory or other special hazards exist.

8. Incorrect Information and Non-Disclosure:

Fraud, misrepresentation and forfeiture would be dealt with in accordance with provisions of Section 45 of the Insurance Act 1938 as amended from time to time. Simplified version of the provisions of Section 45 is enclosed in Annexure III for reference

9. Taxes

Indirect Taxes

Taxes and levies shall be levied as applicable from time to time. Any taxes, statutory levy becoming applicable in future may become payable by the Master Policyholder by any method including by levy of an additional monetary amount in addition to Premium and or charges.

Direct Taxes

Tax will be deducted at the applicable rate from the payments made under the Policy, as per the prevailing provisions of the Income Tax Act, 1961 as amended from time to time.

10. Modification, Amendment, Re-enactment of or to the Insurance laws and rules, regulations, guidelines, clarifications, circulars etc. thereunder:

- (1) This Policy is subject to-
 - (i) The Insurance Act, 1938, Amendments, modifications (including re-enactment) as may be made from time to time, and
 - (ii) Other such relevant Regulations, Rules, Laws, Guidelines, Circulars, Enactments etc as may be introduced there under from time to time.
- (2) We reserve the right to change any of these Master Policy Provisions / terms and conditions in accordance with changes in applicable regulations or laws and where required, with IRDAI's approval.
- (3) We are required to obtain prior approval from the IRDAI before making any material changes to these provisions, except for changes of regulatory / statutory nature.
- (4) We reserve the right to require submission by You of such documents and proof at all life stages of the Policy as may be necessary to meet the requirements under Anti- money Laundering/Know Your Customer norms and as may be laid down by IRDAI and other regulators from time to time when the same are notified by the authorities for this/similar plans.

11. Notices:

Any notice, direction or instruction given to Us, under the Policy, shall be in writing and delivered by hand, post, facsimile or from registered electronic mail ID to:

HDFC Life Insurance Company Limited, 11th Floor, Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400011.

Registered Office: Lodha Excelus, 13thFloor, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400011.

E-mail: service@hdfclife.com or any of our HDFC Life Branches and such other address as may be informed by Us.

Similarly, any notice, direction or instruction to be given by Us, under the Policy, shall be in writing and delivered by hand, post, courier, facsimile or registered electronic mail ID to the updated address in the records of the Insurer.

You are requested to communicate any change in address, to the Insurer supported by the required address proofs to enable the Insurer to carry out the change of address in its systems. The onus of intimation of change of address lies with the Master Policyholder. An updated contact detail of the Master Policyholder will ensure that correspondences from the Insurer are correctly addressed to the Master Policyholder at the latest updated address.

12. Jurisdiction:

This Policy shall be governed by the laws of India and the Courts of India shall have the exclusive jurisdiction to settle any disputes arising under this Master Policy.

13. General:

- (1) Any information needed to administer the Policy must be furnished by the Master Policyholder.
- (2) If the information provided by the Master Policyholder in the application form is incorrect or incomplete, the Insurer reserves the right to vary the Benefits which may be payable.
- (3) The Insurer can check/inspect/audit, at any time, if the Benefits are being paid to the correct person as and when due.

Part G

1. Grievance Redressal Process

- (1) The Master Policyholder can contact us on the below mentioned address or at any of our branches in case of any complaint/ grievance:
Grievance Redressal Officer
HDFC Life Insurance Company Limited
11th Floor, Lodha Excelus, Apollo Mills Compound,
N. M. Joshi Marg, Mahalaxmi, Mumbai, Maharashtra - 400011
Helpline number: 18602679999 (Local charges apply)
E-mail: service@hdfclife.com
- (2) All grievances (Service and sales) received by the Company will be responded to within the prescribed regulatory Turn Around Time (TAT) of 15 days.
- (3) Written request or email from the registered email id is mandatory.
- (4) If required, we will investigate the complaints by taking inputs from the Master Policyholder over the telephone or through personal meetings.
- (5) We will issue an acknowledgement letter to the customer within 3 working days of the receipt of complaint.
- (6) The acknowledgement that is sent to the customer has the details of the complaint no., the Policy no. and the Grievance Redressal Officer's name who will be handling the complaint of the Master Policyholder.
- (7) If the Master Policyholder's complaint is addressed within 3 days, the resolution communication will also act as the acknowledgment of the complaint.
- (8) The final letter of resolution will offer redressal or rejection of the complaint along with the appropriate reason for the same.
- (9) In case the Master Policyholder is not satisfied with the decision sent to him or her, he or she may contact our Grievance Redressal Officer within 8 weeks of the receipt of the communication at any of the touch points mentioned in the document, failing which, we will consider the complaint to be satisfactorily resolved.
- (10) The following is the escalation matrix in case there is no response within the prescribed timelines or if you are not satisfied with the response. The number of days specified in the below- mentioned escalation matrix will be applicable from the date of escalation.

Level	Contact	Response Time
1st Level	AVP- Customer Relations	10 working days
2nd Level (for response not received from Level 1)	SVP- Customer Relations	7 working days

You are requested to follow the aforesaid matrix to receive satisfactory response from us.

- (11) 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 IRDAI on the following contact details:
 - a. IRDAI Grievance Call Centre (IGCC) TOLL FREE NO:155255 / 18004254732
 - b. Email ID: complaints@irda.gov.in
 - c. Online- You can register your complaint online at <http://www.igms.irda.gov.in/>
 - d. Address for communication for complaints by fax/paper:
General Manager
Consumer Affairs Department – Grievance Redressal Cell
Insurance Regulatory and Development Authority of India
Sy No. 115/1, Financial District,
Nanakramguda, Gachibowli,
Hyderabad – 500 032

2. In the event the Master Policyholder is dissatisfied with the response provided by us, the Master Policyholder may approach the Insurance Ombudsman of that region. The details of the existing offices of the Insurance Ombudsman are provided below. You are requested to refer to the IRDAI website at “www.irdai.gov.in” for the updated details.

(1) **Details and addresses of Insurance Ombudsman**

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
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	Gujarat , Dadra & Nagar Haveli, Daman and Diu
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 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh & Chhattisgarh
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	Orissa
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	Karnataka
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	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , Chandigarh
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	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
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@ecoi.co.in	Delhi

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@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry
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	Rajasthan
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	Kerala, Lakshadweep, Mahe – a part of Pondicherry
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	West Bengal, Sikkim, Andaman & Nicobar Islands
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@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli,

		Ballia, Sidharathnagar
MUMBAI	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@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
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	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanoj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
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	Bihar, Jharkhand
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	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

(2) Power of Ombudsman-

- 1) The Ombudsman shall receive and consider complaints or disputes relating 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 Company ;
 - (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 insurers and their agents and intermediaries;

- (g) issuance of life insurance policy, general 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; and
 - (i) any other matter resulting from the violation of provisions of the Insurance Act, 1938, as amended from time to time, 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).
- 2) The Ombudsman shall act as counsellor and mediator relating to matters specified in sub-rule (1) provided there is written consent of the parties to the dispute.
 - 3) The Ombudsman shall be precluded from handling any matter if he is an interested party or having conflict of interest.
 - 4) The Central Government or as the case may be, the IRDAI may, at any time refer any complaint or dispute relating to insurance matters specified in sub-rule (1), to the Insurance Ombudsman and such complaint or dispute shall be entertained by the Insurance Ombudsman and be dealt with as if it is a complaint made under Clause (3) provided herein below.
- (3) Manner in which complaint is to be made -
- 1) Any person who has a grievance against the Company, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the Company complained against or the residential address or place of residence of the complainant is located.
 - 2) The complaint shall be in writing, duly signed by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the Company against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.
 - 3) No complaint to the Insurance Ombudsman shall lie unless—
 - (a) the complainant makes a written representation to the Company named in the complaint and—
 - i. either the Company had rejected the complaint; or
 - ii. the complainant had not received any reply within a period of one month after the Company received his representation; or
 - iii. the complainant is not satisfied with the reply given to him by the Company;
 - (b) The complaint is made within one year—
 - i. after the order of the insurer rejecting the representation is received; or
 - ii. after receipt of decision of the Company which is not to the satisfaction of the complainant;
 - iii. after expiry of a period of one month from the date of sending the written representation to the Company if the Company fails to furnish reply to the complainant.
 - 4) The Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the Company against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.
- 5) No complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

Annexure I

Section 38 - Assignment or 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 Insurance Laws (Amendment) Act, 2015. The extant provisions in this regard are as follows:

- (1) This policy may be transferred/assigned, wholly or in part, with or without consideration.
- (2) 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.
- (3) 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.
- (4) The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
- (5) The transfer or 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.
- (6) Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
- (7) 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.
- (8) 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.
- (9) 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 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 policySuch 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.

Disclaimer: This is only the relevant extract of the Insurance Laws (Amendment) Act, 2015. Policy Holders are advised to refer to Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 for complete and accurate details.

Annexure II

Section 39 - Nomination by member of the policy

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) Ordinance dtd 26.12.2014. The extant provisions in this regard are as follows:

- (1) The member of 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.
- (2) Where the nominee is a minor, the member of policyholder may appoint any person to receive the money secured by the policy in the event of member's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.
- (3) Nomination can be made at any time before the maturity of the policy.
- (4) 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.
- (5) 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.
- (6) 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.
- (7) Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
- (8) On receipt of notice with fee, the insurer should grant a written acknowledgement to the member of the policyholder of having registered a nomination or cancellation or change thereof.
- (9) 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 member of the policyholder whose life is insured, if the nominees die before the member, the proceeds are payable to member of the 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 member of 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 themthe nominees are beneficially entitled to the amount payable by the insurer to the member of the policyholder unless it is proved that member of the 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 member of 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) Ordinance, 2014 (i.e 26.12.2014).
- (16) If member of the 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) shall 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 (Ordinance) 2014, 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 specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

Disclaimer: This is only the relevant extract of the Insurance Laws (Amendment) Act, 2015. Policy Holders are advised to refer to Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 for complete and accurate details.

Annexure III

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) Ordinance dtd 26.12.2014 are as follows:

1. 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 policywhichever is later.
2. 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 policywhichever 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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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Annexure IV
Definitions of covered Critical Illnesses and surgeries

1. **Myocardial Infarction (First Heart Attack of specific severity)** - 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:

- A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
- New characteristic electrocardiogram changes
- Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

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

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

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

The following are excluded:

- All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- 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
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- 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

4. **Kidney Failure Requiring Regular Dialysis** - 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.

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

The following are excluded:

- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

6. **Alzheimer's Disease** - Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's Disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Life Assured. This diagnosis must be supported by the clinical confirmation of an appropriate Registered Medical practitioner who is also a Neurologist and supported by the Company's appointed doctor.

The following are excluded:

- Non-organic disease such as neurosis and psychiatric illnesses; and
- Alcohol-related brain damage.

7. **Apallic Syndrome** - Universal necrosis of the brain cortex with the brainstem remaining intact. Diagnosis must be confirmed by a neurologist acceptable to the Company and the condition must be documented for at least one month.

8. **Coma Of Specified Severity** - 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:

- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

9. **End Stage Liver Failure** - Permanent and irreversible failure of liver function that has resulted in all three of the following:

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

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

10. **End Stage Lung Failure** - End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($\text{PaO}_2 < 55\text{mmHg}$); and
- Dyspnea at rest.

11. **Loss of Independent Existence** - Confirmation by a consultant physician acceptable to the Company of the loss of independent existence due to illness or trauma, which has lasted for a minimum period of 6 months and results 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) as mentioned below. For the purpose of this benefit, the word "permanent", shall mean beyond the hope of recovery with current medical knowledge and technology.

Activities of Daily Living are:-

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

12. **Blindness**- Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

The Blindness is evidenced by:

- corrected visual acuity being 3/60 or less in both eyes or ;
- the field of vision being less than 10 degrees in both eyes.

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

13. **Third Degree 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.

14. **Major Head Trauma** - Accidental head injury resulting in permanent neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

The following are excluded:

- Spinal cord injury

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

- cannot be controlled with medication;
- shows signs of progressive impairment; and
- Activities of Daily Living assessment confirms the inability of the Life Assured to perform at least three (3) of the Activities of Daily Living as defined in the Policy, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons, for a continuous period of six months.

Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinson's Disease are excluded.

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

17. **Multiple Sclerosis With Persisting Symptoms** - The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

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

Other causes of neurological damage such as SLE is excluded.

18. **Motor Neurone Disease With Permanent Symptoms** - Motor neurone 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.

19. **Benign Brain Tumour** - Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist:

- 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.

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.

20. **Major Organ Transplant (as recipient)** - The actual undergoing of a transplant of:

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

The following are excluded:

- Other stem-cell transplants
- Where only islets of langerhans are transplanted

21. **Progressive Scleroderma** -

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The systemic involvement should be evidenced by any one of the following findings -

Lung fibrosis with a diffusing capacity (DCO) of less than 70% of predicted

- Pulmonary hypertension with a mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterisation
- Chronic kidney disease with a GFR of less than 60 ml/min (MDRD-formula)
- Echocardiographic findings suggestive of Grade III and above left ventricular diastolic dysfunction

The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist.

The following are excluded:

- Localised scleroderma (linear scleroderma or morphea);
- Eosinophilic fasciitis; and
- CREST syndrome.

22. **Muscular Dystrophy** - Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions:

- Family history of other affected individuals;
- Clinical presentation including absence of sensory disturbance, normal cerebro- spinal fluid and mild tendon reflex reduction;
- Characteristic electromyogram; or
- Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Scheme member to perform (whether aided or unaided) at least three of the six "Activities of Daily Living" as defined earlier, for a continuous period of at least six months.

23. **Poliomyelitis** - The occurrence of Poliomyelitis where the following conditions are met:

- Poliovirus is identified as the cause and is proved by Stool Analysis,
- Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

24. **Loss of Limbs** - 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.

25. **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.

26. **Loss of Speech** - 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, and Throat (ENT) specialist. All psychiatric related causes are excluded.

27. **Medullary Cystic Disease** - Medullary Cystic Disease where the following criteria are met:

- The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
 - Clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
 - The Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.
- Isolated or benign kidney cysts are specifically excluded from this benefit.

28. **Systematic Lupus Erythematosus with Renal Involvement** - Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of “Critical Illness”, SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.

Abbreviated ISN/RPS classification of lupus nephritis (2003):

Class I - Minimal mesangial lupus nephritis

Class II - Mesangial proliferative lupus nephritis

Class III - Focal lupus nephritis

Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis

Class V - Membranous lupus nephritis

Class VI - Advanced sclerosing lupus nephritis the final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

29. **Aplastic Anaemia** - Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

- Blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.