Corona Rakshak Policy, Aditya Birla Health Insurance Co. Limited
Policy wordings

1. PREAMBLE

This Policy is a contract of insurance issued by **Aditya Birla Health Insurance Co. Limited** (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person named in the schedule (hereinafter called the 'Insured Person'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. OPERATIVE CLAUSE

If during the policy period the Insured Person is diagnosed with COVID and hospitalized for more than seventy-two hours following Medical Advice of a duly qualified Medical Practitioner as per the norms specified by Ministry of Health and Family Welfare, Government of India, the Company shall pay the agreed sum insured towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during the Policy period shall be the Sum Insured) opted and specified in the Schedule.

3. DEFINITIONS

The terms defined below and at other junctures in the Policy have the meanings ascribed to them wherever they appear in this Policy and, where, the context so requires, references to the singular include references to the plural; references to the male includes the female and references to any statutory enactment includes subsequent changes to the same.

3.1 **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.

3.2 **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.

3.3 **COVID:** For the purpose of this Policy, Corona virus Disease means COVID-19 as defined by the World Health Organization (WHO) and caused by the virus SARS-CoV2

3.4 **Diagnosis** means diagnosis by a registered medical practitioner, supported by clinical, radiological, histological, histo-pathological and laboratory evidence and also surgical evidence wherever applicable.

3.5 **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policy holder.

3.6 **Hospital means** any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and

Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company ' s authorized personnel.
vi. For the purpose of this policy any other set-up designated by the government as hospital for the treatment of Covid-19 shall also be considered as hospital.

3.7 **Hospitalisation** means admission in a hospital designated for COVID-19 treatment by Government, for a minimum period of seventy-two (72) consecutive 'In-patient care' hours.

3.8 **In-Patient Care** means treatment for which the insured person has to stay in a hospital continuously for more than 72 hours for treatment of COVID.

3.9 **Insured Person** means person(s) named in the schedule of the Policy.

3.10 **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.11 **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the license.

3.12 **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.

3.13 **Non- Network Provider** means any hospital that is not part of the network.

3.14 **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.

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

3.16 **Policy period** means period of three and half months (3 ½ months), six and half months (6 ½ months) and nine and half months (9 ½ months) i.e., 105 days, 195 days and 285 days respectively as specified in the policy schedule.

3.17 **Policy Schedule** means the Policy Schedule attached to and forming part of

Policy.

3.18 **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum liability for any and all claims made under the Policy, in respect of that Insured Person during the Policy period.

3.19 **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

3.20 **Waiting Period** means a period from the inception of this Policy during which specified disease is not covered. On completion of the period, specified disease shall be covered provided the Policy has been continuously renewed without any break.

4. COVERAGE:

The cover listed below is in-built Policy benefit and shall be available to all Insured Persons in accordance with the procedures set out in this Policy.

4.1 **COVID Cover**

Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of 72 hours. The positive diagnosis of COVID shall be from a government authorized diagnostic centre.

Note:

i. Payment will be made only on Hospitalisation for a minimum continuous period of 72 hours following positive diagnosis for COVID.

ii. This is onetime benefit applicable for the entire tenure of the Policy and shall terminate upon payment of this benefit.

5. WAITING PERIOD:

The Company shall not be liable for any claim arising for COVID within 15 days from the first policy commencement date.

6. EXCLUSIONS

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

6.1 lnvestigation & Evaluation (Code- Excl04)

i. Expenses related to any admission primarily for diagnostics and evaluation purposes.

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

6.2 Any diagnosis which is not related and not incidental to COVID is not covered in this Policy.

6.3 Testing done at a Diagnostic centre which is not authorized by the Government shall not be recognized under this Policy.

6.4 Any claim with respect to COVID manifested prior to commencement date of this

policy or during the waiting period.

6.5 Cover under this Policy shall cease if the Insured Person travels to any country placed under travel restriction by the Government of India.

7. CLAIM PROCEDURE

7.1 **Notification of claim:**

Upon the happening of the covered event, which may give rise to a claim under this policy, notice with full particulars shall be sent to the Company within 15 days from the date of occurrence of the event / diagnosis of COVID.

7.2 **Procedure:**

The insured person may submit the necessary documents to TPA (if applicable) / Company within the prescribed time limit as specified hereunder.

Sl. No.	Type of Claim	Prescribed Time limit
1	COVID Cover	Within thirty days of date of discharge from hospital following positive diagnosis for COVID

7.3 **Documents to be submitted:**

The claim is to be supported with the following documents and submitted within the prescribed time limit.

Benefits	Claims Documents Required
Covid-19 Cover	i. Duly filled and signed Claim Form ii. Copy of Insured Person's passport, if available (All pages) iii. Photo Identity proof of the patient (if insured person does not own a passport) Medical practitioner's prescription advising admission iv. Medical practitioner's prescription advising admission v. Discharge summary including complete medical history of the patient along with other details. vi. Investigation reports including Insured Person's Test reports from Authorized diagnostic centre for COVID. vii. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque viii. CKYC form duly filled with KYC (Identity proof with Address) of the proposer / nominee (where applicable), where claim liability is above Rs 1 Lakh as per AML Guidelines ix. Legal heir / succession certificate, wherever applicable x. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted.
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company.
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

7.4 **Claim Settlement (provision for Penal Interest)**

1. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
2. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
3. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
4. In case of delay beyond stipulated 45 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

7.5 **Payment of Claim**

All claims under the policy shall be payable in Indian currency only. On payment of 100% of sum insured the policy will be terminated.

8. GENERAL TERMS & CONDITIONS

8.1 **Disclosure of information:**

The Policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of m is representation, mis-description or non-disclosure of any material fact by the policyholder.

8.2 **Condition Precedent to Admission of Liability:**

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

8.3 **Material Change:**

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

8.4 **Records to be Maintained**

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company

may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

8.5 **Complete Discharge**

Any payment to the policyholder, insured person or his/ her nominees or his / her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

8.6 **Notice & Communication**

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
ii. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
iii. The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

8.7 **Territorial Limit**

The company ' s liability to make any payment under the policy will be within India only.

8.8 **Fraud**

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his /her behalf to obtain any benefit under this policy, all benefits under this policy shall be forfeited.

Any amount already paid against claims made under the policy which are found fraudulent later under this policy shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;
b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;
c) any other act fitted to deceive; and
d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer.

8.9 **Cancellation:**

The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person, by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8.10 **Automatic termination:**

This policy shall terminate for the Insured immediately on the earlier of the following events irrespective of the expiry date mentioned in the policy schedule

- Upon the demise of the covered person.
- Upon payment of an admissible claim and settlement of 100% of Sum Insured specified in the Policy Schedule.

8.11 **Territorial Jurisdiction**

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

8.12 **Arbitration**

i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

ii. It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.

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

8.13 **Endorsements (Changes in Policy)**

This policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall be evidenced by a written endorsement signed and stamped.

8.14 **Terms and conditions of the Policy**

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

8.15 **Nomination**

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in

writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule le/Policy Certificate /Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

9. REDRESSAL OF GRIEVANCE

In case of any grievance the insured person may contact the company through

Website: https://www.adityabirlacapital.com/healthinsurance
Toll Free: 1800 270 7000
Email: care.healthinsurance@adityabirlacapital.com
Courier: Aditya Birla Health Insurance Co. Limited 9th Floor, Tower 1, One Indiabulls Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013

lnsured person may also approach the grievance cell at any of the company's branches with the details of grievance

lf lnsured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer.
For updated details of grievance officer, refer the link
https://www.adityabirlacapital.com/healthinsurance/#!/homepage

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

Insurance Ombudsman - lf lnsured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices are provided on Our website and in this Policy at Annexure A

10. TABLE OF BENEFITS

Name	**Corona Rakshak Policy, Aditya Birla Health Insurance Co. Limited**
Product Type	Individual
Category of Cover	Benefit based
Sum insured	INR 50,000 / INR 1,00,000/ INR 1,50,000 /INR 2,00,000 / INR 2,50,000
Policy Period	Three and half months (3 ½ months), six and half months (6 ½ months) and nine and half months (9 ½ months) i.e, 105 days, 195 days and 285 days respectively
Eligibility	Policy can be availed by persons between the age of 18 years and 65 years. Proposer with higher age can obtain policy for adult members of the family, without covering self.
Coverage	COVID Cover Lump sum benefit equal to 100% of the Sum Insured shall be payable on positive diagnosis of COVID, requiring hospitalization for a minimum continuous period of 72 hours. The positive diagnosis of COVID shall be from a government authorized diagnostic centre.