CUSTOMER INFORMATION SHEET – APNE, SAPNE SURAKSHIT

Description is illustrative and not exhaustive

Sl No	Title	Description	Policy Clause Number
1	**Product Name**	Apne, Sapne Surakshit	
2	**What am I covered for**	• **Accidental Death [AD]** - A lumpsum payment would be made in the event of the Death due to an accident. OR • **Permanent Total Disablement [PTD]** - A lumpsum payment would be made as per scale provided in policy in the event of Permanent Total Disablement due to an accident. **Optional benefits -** • **Permanent Total Disablement [PTD]-** A lumpsum payment would be made as per scale provided in policy in the event of Permanent Total Disablement due to an accident. • **Critical Illness** – A lumpsum amount would be paid to the Insured Person mentioned in schedule of benefits for the identified critical illness, medical event or surgical procedure listed below. 1. Cancer of specified severity 2. First Heart Attack – of Specified Severity 3. Open Chest CABG 4. Open Heart Replacement or Repair of Heart Valves 5. Coma of Specified Severity 6. Kidney Failure Requiring Regular Dialysis 7. Stroke 8. Major Organ / Bone Marrow Transplant 9. Permanent Paralysis of Limbs 10. Motor Neuron Disease with Permanent Symptoms 11. Multiple Sclerosis with Persisting Symptoms 12. Alzheimer's Disease 13. Aorta Graft Surgery 14. Loss of Hearing 15. Loss of Sight 16. Aplastic Anemia 17. End Stage Lung Disease 18. End Stage Liver Failure 19. Major Burns 20. Primary Pulmonary Hypertension 21. Benign Brain Tumor 22. Apallic Syndrome	Section 1.1 Section 1.2 Optional Benefit No. 1 Optional Benefit No. 2

		23. Parkinson's Disease 24. Medullary Cystic Disease 25. Muscular Dystrophy 26. Loss of Speech 27. Systemic Lupus Erythematous 28. Major Head Trauma 29. Poliomyelitis 30. Encephalitis 31. Progressive scleroderma 32. Cardiomyopathy 33. Chronic Pancreatitis 34. Amyotrophic Lateral Sclerosis **35.** Terminal Illness • **Permanent Partial Disablement (PPD)** - A lumpsum payment would be made as per scale provided in policy in the event of Permanent Total Disablement due to an accident. • **EMI Cover:** **1. Hospitalization due to an Illness:** EMI against loan would be paid for a maximum period of upto [x] months depending on [x] no. of days Insured Person was continuously hospitalized as mentioned in policy. **2. Hospitalization due to an Accident:** EMI against loan would be paid for a maximum period of upto [x] months depending on the no. of days Insured Person was continuously hospitalized as mentioned in policy. **3. Permanent Partial Disablement (PPD) or Temporary Total disablement (TTD):** EMI against loan would be paid for a maximum period of upto [x] months.	Optional Benefit No. 3 Optional Benefit No. 4.1 Optional Benefit No. 4.2 Optional Benefit No. 4.3
3	**What are the major exclusions in the policy:**	We will not pay for any claim which is caused by, arising from or in any way attributable to any of the following, including their associated complications, unless expressly stated to the contrary in this Policy. - Special Exclusions to Accidental death [AD], Permanent Total Disablement [PTD], Permanent Partial Disablement [PPD], Temporary Total Disablement [TTD] and Hospitalization due to Accident - Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound). - Medical or surgical treatment except as necessary solely and directly as a result of an Accident. - Hernia. **General Exclusions applicable to all Benefits** i) War or similar situations: Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed	Section 2.B

forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

ii) Any Insured Person committing or attempting to commit a breach of law with criminal intent.

iii) Intentional self injury or attempted suicide while sane or insane.

iv) Dangerous acts (including sports):
An Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing in a professional or semi professional nature.

v) Treatment of illness or injury as a consequence of the use of alcohol, tobacco, narcotic or psychotropic substances.

vi) Prosthetic and other devices which are self detachable /removable without surgery involving anaesthesia

vii) Treatment at a healthcare facility which is NOT a Hospital.

viii) Treatment of obesity and any weight control program.

ix) Treatment for correction of eye sight due to refractive error

x) Cosmetic, aesthetic and re-shaping treatments and surgeries:
   a. Plastic surgery or cosmetic surgery or treatments to change appearance unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.
   b. Circumcisions (unless necessitated by Illness or injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.

xi) Types of treatment, defined Illnesses/ conditions/ supplies:
   a. Non allopathic treatment.
   b. Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation.
   c. Charges related to peritoneal dialysis, including supplies
   d. Admission primarily for administration of monoclonal antibodies or IV immunoglobulin infusion.
   e. Experimental, investigational or unproven treatment devices and pharmacological regimens.
   f. Admission primarily for diagnostic and evaluation purposes only
   g. Any diagnostic expenses related to illnesses which we do not cover under this Policy
   h. Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long-term nursing care, custodial care, safe confinement, de-addiction, general debility or exhaustion ("run-down condition").
   i. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment);
   j. Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements
   k. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia,

		baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products. l. Psychiatric and mental disorders (including mental health treatments) m. Sleep-apnoea. n. External congenital diseases, defects or anomalies. o. Stem cell therapy or surgery, or growth hormone therapy. p. Venereal disease, sexually transmitted disease or illness; q. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis. r. Any expense attributable directly or indirectly to pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or child birth (including caesarean section), except in the case of ectopic pregnancy in relation to a claim under 1a) for In-patient Treatment only. s. Treatment for sterility, infertility (primary or secondary), assisted conception or other related conditions and complications arising out of the same. t. Birth control, and similar procedures including complications arising out of the same. u. The expense incurred by the Insured Person on organ donation. v. Treatment for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. xii) Healthcare providers (Hospitals /Medical Practitioners) a. Any Medical Expenses incurred using facility of any Medical Practitioners or institution that We have told You/Insured Person (in writing) is not to be used at the time of renewal or at any specific time during the Policy Period. This exclusion is not applicable for life saving emergency situations and in such cases claims will be settled on reimbursement basis only. b. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.	

4	**Waiting period**	• 30 day waiting period for all conditions from date of inception of policy, except for the claims arising due to an accident. • EMI Cover- Hospitalization due to an Illness - Pre-existing diseases are covered after a waiting period of 48 months • Critical Illness - 90 day waiting period in the first year. - Survival period of [x] days.	Section 2.A Optional Benefit No. 4.1
5	**Payment basis**	• Fixed amount on the occurrence of a covered event for XX benefit.	Section 1
6	**Loss Sharing**	Not Applicable	

7	**Renewal Conditions**	• Your Policy is ordinarily renewable provided that the renewal premium in full has been received by the due dates and subject to realization of premium by Us. Grace period of 30 days for renewing the policy is provided. To avoid any confusion any claim incurred during Grace period will not be payable under this policy.	Section 3.K
8	**Renewal Benefits**	Not Applicable	
9	**Cancellation**	This policy would be cancelled on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation by any Insured Person, upon giving 30 days' notice without refund of premium. In other exceptional cases, premium will be refunded on pro-rata basis.	Section 3.G, 3.H, 3.P
10	**Claims**	Time limit for intimation and submission of claim documents is as follows: **Accident:** Intimation – Within 30 days of event or occurrence **Hospitalization due to Illness:** 48 hours prior to an event which might give rise to a claim In case of Emergency – No later than 24 hours of the event Submission of Claim Documents – The duly signed claim form and all the information/documents required to be submitted to us within 15 days of the completion of the treatment. **Critical Illness:** Intimation – Within 14 days of the diagnosis of the first occurrence of the Critical Illness Submission of Claim Documents – Within 45 days of getting diagnosed with any of the specified Critical illness.	Section 3.D, 3.E.

11	**Policy Servicing/ Grievances/Complaints**	• **Please contact Us for Policy Servicing / Grievances / Complaints at any of our Branches. You can also reach us on:** Toll Free – 1800 102 0333 Email – customerservice@apollomunichinsurance.com • **IRDAI/(IGMS/Call Centre):** For complaint registration – login at http://www.igms.irda.gov.in/ • **Ombudsman** Refer Section 6 for details.	Section 6
12	**Insured's Rights**	• **Implied renewability** -This Policy is ordinarily renewable unless the Insured Person or anyone acting on behalf of an Insured Person has acted in a dishonest or in a fraudulent manner or there has been any misrepresentation under or in relation to this Policy or the renewal of the Policy poses a moral hazard	
13	**Insured's Obligations**	• Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may result in claim not being paid and / or cancellation of the Policy.	
Legal Disclaimer Note: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document, the terms and conditions mentioned in the policy document shall prevail.			

POLICY WORDING – APNE, SAPNE SURAKSHIT

Apollo Munich Health Insurance Company Limited will cover all the Insured Persons under this Policy upto the **Sum Insured**. The insurance cover is governed by and subject to the terms, conditions and exclusions of this Policy.

Section 1: Base Benefit

Accidental Death

If an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his death within 365 days from the date of the Accident, then We will pay the Sum Insured as mentioned in the below table.

Benefit	Static Sum Insured	Reducing Sum Insured
Accidental Death [AD]	100% of disbursed loan amount	100% of Principal outstanding

In case of an admissible claim under this benefit, coverage under this policy for the Insured Person shall automatically terminate. However in case of borrower and co-borrower loans following shall apply

Both borrower and co-borrower are insured for 100% of disbursed loan amount	Policy shall terminate for both Insured Persons
Borrower and co-borrower are insured for proportion of loan amount	Policy shall terminate only for the Insured Person against whom claim has been made to the extent of his proportion of the loan amount

OR

Permanent Total Disablement*

If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident this is the sole and direct cause of his permanent total disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table below.

	Static Sum Insured	Reducing Sum Insured
Loss of 2 Limbs (both hands or both feet or one hand and one foot)	100% of disbursed loan amount	100% of Principal outstanding amount
Loss of a Limb and an eye		
Complete and irrecoverable loss of sight of both eyes		
Complete and irrecoverable loss of speech & hearing of both ears		

In this Benefit:

a) Limb means a hand at or above the wrist or a foot above the ankle.
b) Loss of Limb means:

Important terms You should know

Sum Insured means the sum shown in the Schedule/Certificate of Insurance which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.

Static Sum Insured means Sum Insured opted by Insured Person shall remain constant throughout the policy term.

Reducing Sum Insured means Sum Insured opted by Insured Person shall keep on reducing on monthly basis. This monthly reduction is equal to monthly EMI amount, as per the amortization schedule prepared by Bank/ Financial Institution.

Insured Person means You and the persons named in the Schedule/ Certificate of Insurance

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

i. the physical separation of a Limb above the wrist or ankle respectively, or
ii. the total loss of functional use of a Limb for at least 365 days from the date of onset of such disability provided that We must be satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

In case of an admissible claim under this benefit, coverage under this policy for the Insured Person shall automatically terminate. However in case of borrower and co-borrower loans following shall apply

Both borrower and co-borrower are insured for 100% of disbursed loan amount	Policy shall terminate for both Insured Persons
Borrower and co-borrower are insured for proportion of loan amount	Policy shall terminate only for the Insured Person against whom claim has been made to the extent of his proportion of the loan amount

OPTIONAL BENEFITS

On payment of additional premium the following benefits shall be added to the Policy coverage

Optional Benefit No. 1 – Permanent Total Disability [PTD]

If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident this is the sole and direct cause of his permanent total disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table.

	Static Sum Insured	Reducing Sum Insured
Loss of 2 Limbs (both hands or both feet or one hand and one foot)	100% of disbursed loan amount	100% of Principal outstanding amount
Loss of a Limb and an eye		
Complete and irrecoverable loss of sight of both eyes		
Complete and irrecoverable loss of speech & hearing of both ears		

In this Benefit:

c) Limb means a hand at or above the wrist or a foot above the ankle.
d) Loss of Limb means:
iii. the physical separation of a Limb above the wrist or ankle respectively, or
iv. the total loss of functional use of a Limb for at least 365 days from the date of onset of such disability provided that We must be satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement

In case of an admissible claim under this benefit, coverage under this policy for the Insured Person shall automatically terminate. However in case of borrower and co-borrower loans following shall apply

Both borrower and co-borrower are insured for 100% of disbursed loan amount	Policy shall terminate for both Insured Persons
Borrower and co-borrower are insured for proportion of loan amount	Policy shall terminate only for the Insured Person against whom claim has been made.

Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in

special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include but is not limited to the following:

i. Our claim form, duly completed and signed for on behalf of the Insured Person.
ii. All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries.
iii. Death/Disability certificate.
iv. A precise diagnosis of the treatment for which a claim is made.
v. A detailed list of the individual medical services and treatments provided.
vi. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
vii. All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
viii. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
ix. Copy of settlement letter from other insurance company or TPA
x. Stickers and invoice of implants used during surgery
xi. Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xii. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xiii. Legal heir certificate (not required if valid nomination exists)
xiv. Certificate from Bank/Financial Institution stating the amortization schedule, the EMI amount, Principal Outstanding, etc

Optional Benefit No. 2 – Critical Illness

We will pay the Insured Person the Sum Insured as a lump sum amount for the listed Critical Illness, provided

i. it occurs or manifests itself during the policy period as a first incidence and
ii. the insured survives [x] days survival period.
iii. specific etiology for the defined critical illness is not among the general and specific exclusions of this policy

Benefit	Static Sum Insured	Reducing Sum Insured
Critical Illness	100% SI	100% of Principal outstanding

Waiting Period

90 days waiting period shall apply from the commencement of the policy period to all claims under the policy, this waiting period shall not be applicable to subsequent renewals.

Note:

- If any Critical Illness is diagnosed in first 90 days of policy inception, then we will cancel the policy and refund the premium in full.
- In case of an admissible claim under this benefit, coverage under this policy for the Insured Person shall automatically terminate. However in case of borrower and co-borrower loans following shall apply

Both borrower and co-borrower are insured for 100% of disbursed loan amount	Policy shall terminate for both Insured Persons
Borrower and co-borrower are insured for proportion of loan amount	Policy shall terminate only for the Insured Person against whom claim has been made.

Definitions:

1. **Activities of Daily Living are:**
   i) Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   ii) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii) Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   iv) Mobility: the ability to move indoors from room to room on level surfaces;
   v) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   vi) Feeding: the ability to feed oneself once food has been prepared and made available
2. **Critical Illness** means any one of the following illnesses or conditions that occurs or manifests itself during the policy period as a first incidence

I. CANCER OF SPECIFIED SEVERITY

a) 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.

b) The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below

vi. Chronic lymphocytic leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs

ix. All tumors in the presence of HIV infection

II. MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

a) The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers

b) The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

III. OPEN CHEST CABG

a) The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

b) The following are excluded:

i. and/or any other intra-arterial procedures

IV. 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.

V. COMA OF SPECIFIED SEVERITY

a) A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

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

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

VI. 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.

VII. STROKE RESULTING IN PERMANENT SYMPTOMS

a) 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.

b) The following are excluded:

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

VIII. MAJOR ORGAN /BONE MARROW TRANSPLANT

a) The actual undergoing of a transplant of:

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

b) The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

IX. 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.

X. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

XI. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

a) The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
b) Other causes of neurological damage such as SLE and HIV are excluded.

XII. Alzheimer's Disease

a) A definite diagnosis of Alzheimer's disease evidenced by all of the following:
   i. Loss of intellectual capacity involving impairment of memory and executive functions (sequencing, organizing, abstracting, and planning), which results in a significant reduction in mental and social functioning
   ii. Personality change
   iii. Personality change Gradual onset and continuing decline of cognitive functions
   iv. No disturbance of consciousness
   v. Typical neuropsychological and neuroimaging findings (e.g. CT scan)
b) The disease must require constant supervision (24 hours daily). The diagnosis and the need for supervision must be confirmed by a Consultant Neurologist.
c) For the above definition, the following are not covered:
   i. Other forms of dementia due to brain or systemic disorders or psychiatric conditions

XIII. Aorta Graft Surgery

a) The undergoing of surgery to treat narrowing, obstruction, aneurysm or dissection of the aorta. Minimally invasive procedures like endovascular repair are covered under this definition. The surgery must be determined to be medically necessary by a Consultant Surgeon and supported by imaging findings.
b) For the above definition, the following are not covered:
   i. Surgery to any branches of the thoracic or abdominal aorta (including aortofemoral or aortoiliac bypass grafts)
   ii. Surgery of the aorta related to hereditary connective tissue disorders (e.g. Marfan syndrome, Ehlers–Danlos syndrome)
   iii. Surgery following traumatic injury to the aorta

The actual undergoing of surgery of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta

but not its branches. Realisation of the aortic surgery has to be confirmed by a specialist Medical Practitioner (Cardiologist/Cardiac Surgeon).

XIV. Loss of Hearing

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.

XV. Loss of Sight

a) Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident. The Blindness is evidenced by:
   i. corrected visual acuity being 3/60 or less in both eyes or ;
   ii. The field of vision being less than 10 degrees in both eyes.
b) The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

XVI. Aplastic Anaemia

a) A definite diagnosis of Aplastic anaemia resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition must be treated with blood transfusions and, in addition, with at least one of the following:
   i. Bone marrow stimulating agents
   ii. Immunosuppressant
   iii. Bone marrow transplantation
b) The diagnosis must be confirmed by a Consultant Haematologist and evidenced by bone marrow histology.
c) Temporary or reversible aplastic anemia is excluded and not covered in this Policy.

XVII. END STAGE LUNG FAILURE

a) End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
   i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
   ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
   iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
   iv. Dyspnea at rest.

XVIII. END STAGE LIVER FAILURE

a) Permanent and irreversible failure of liver function that has resulted in all three of the following:
   i. Permanent jaundice; and
   ii. Ascites; and
   iii. Hepatic encephalopathy.
b) Liver failure secondary to drug or alcohol abuse is excluded.

XIX. THIRD DEGREE BURNS/ Major Burns

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

XX. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

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

b) The NYHA Classification of Cardiac Impairment are as follows:

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

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

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

XXI. BENIGN BRAIN TUMOR

a) 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.

b) 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.

XXII. Apallic Syndrome

a) A vegetative state is absence of responsiveness and awareness due to dysfunction of the cerebral hemispheres, with the brain stem, controlling respiration and cardiac functions, remaining intact.

b) The definite diagnosis must be evidenced by all of the following:

i. Complete unawareness of the self and the environment

ii. Inability to communicate with others

iii. No evidence of sustained or reproducible behavioural responses to external stimuli

iv. Preserved brain stem functions

v. Exclusion of other treatable neurological or psychiatric disorders with appropriate neurophysiological or neuropsychological tests or imaging procedures

vi. The diagnosis must be confirmed by a Consultant Neurologist and the condition must be medically documented for at least one month without any clinical improvement.

XXIII. Parkinson's Disease

a) A definite diagnosis of primary idiopathic Parkinson's disease, which is evidenced by at least two out of the following clinical manifestations:

i. Muscle rigidity

ii. Tremor

iii. Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses)

b) Idiopathic Parkinson's disease must cause neurological deficit resulting in the permanent and irreversible inability of the Life Assured to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 6 months despite adequate drug treatment.

c) The diagnosis must be confirmed by a Consultant Neurologist.

d) For the above definition, the following are not covered:
   i. Secondary parkinsonism (including drug- or toxin-induced parkinsonism)
   ii. Essential tremor
   iii. Parkinsonism related to other neurodegenerative disorders

XXIV. Medullary Cystic Disease

a) A definite diagnosis of medullary cystic disease evidenced by all of the following:
   i. Ultrasound, MRI or CT scan showing multiple cysts in the medulla and corticomedullary region of both kidneys
   ii. Typical histological findings with tubular atrophy, basement membrane thickening and cyst formation in the corticomedullary junction
   iii. Glomerular filtration rate (GFR) of less than 40 ml/min (MDRD formula)
   iv. The diagnosis must be confirmed by a Consultant Nephrologists.
b) For the above definition, the following are not covered:
   i. Polycystic kidney disease
   ii. Multicystic renal dysplasia and medullary sponge kidney
   iii. Any other cystic kidney disease

XXV. Muscular Dystrophy

a) A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle without involvement of the nervous system. The diagnosis must be confirmed by a company appointed Registered Medical Practitioner who is a neurologist based on all the following conditions:
   i. Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
   ii. Characteristic Electromyogram; or
   iii. Clinical suspicion confirmed by muscle biopsy.
b) The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.
c) The diagnosis must be confirmed by a Consultant Neurologist and supported by electromyography (EMG) and muscle biopsy findings

XXVI. LOSS OF SPEECH

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

XXVII. Systemic Lupus Erythematosus

a) The Systemic Lupus Erythematosus (SLE) is a systemic autoimmune disease. It can affect any part of the body. The immune system erroneously attacks the body´s cells and tissue resulting in inflammation and damage. It can be diagnosed by typical laboratory findings and associated symptoms, the so-called butterfly rash being the most known, and has to be treated with corticosteroids or other immunosuppressants .
b) A definite diagnosis of systemic lupus erythematosus evidenced by all of the following:
   i. Typical laboratory findings, such as presence of antinuclear antibodies (ANA) or anti-dsDNA antibodies
   ii. Symptoms associated with lupus erythematosus (butterfly rash, photosensitivity, serositis)

iii. Continuous treatment with corticosteroids or other immunosuppressants

c) Additionally, one of the following organ involvements must be diagnosed:
   i. Lupus nephritis with proteinuria of at least 0.5 g/day and a Glomerular filtration rate of less than 60 ml/min (MDRD formula)
   ii. Libman-Sacks endocarditis or myocarditis
   iii. Neurological deficits or seizures over a period of at least 3 months and supported by cerebrospinal fluid or EEG findings. Headaches, cognitive and psychiatric abnormalities are specifically excluded.
d) The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologists.
e) The other form of lupus erythematosus the Discoid lupus erythematosus or subacute cutaneous lupus erythematosus or a lupus erythematosus that is drug-induced are not covered.

XXVIII. MAJOR HEAD TRAUMA

a) 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.
b) 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.
c) The following are excluded:
   i. Spinal cord injury;

XXIX. Poliomyelitis

a) A definite diagnosis of acute poliovirus infection resulting in paralysis of the limb muscles or respiratory muscles. The paralysis must be medically documented for at least 3 months from the date of diagnosis.
b) The diagnosis must be confirmed by a Consultant Neurologist and supported by laboratory tests proving the presence of the poliovirus.
c) For the above definition, the following are not covered:
   i. Poliovirus infections without paralysis
   ii. Other enterovirus infections
   iii. Guillain-Barre syndrome or transverse myelitis

XXX. Encephalitis

a) A definite diagnosis of acute viral encephalitis resulting in a persistent neurological deficit documented for at least 3 months following the date of diagnosis. The diagnosis must be confirmed by a Consultant Neurologist and supported by typical clinical symptoms and cerebrospinal fluid or brain biopsy findings.
b) For the above definition, the following are not covered:
   i. Encephalitis in the presence of HIV
   ii. Encephalitis caused by bacterial or protozoal infections
   iii. Myalgic or paraneoplastic encephalomyelitis

XXXI. Progressive scleroderma

a) A definite diagnosis of systemic sclerosis evidenced by all of the following:
   i. Typical laboratory findings (e.g.anti-Scl-70 antibodies)

ii. Typical clinical signs (e.g. Raynaud's phenomenon, skin sclerosis, erosions)
iii. Continuous treatment with corticosteroids or other immunosuppressants

b) Additionally, one of the following organ involvements must be diagnosed:
i. Lung fibrosis with a diffusing capacity (DCO) of less than 70% of predicted
ii. Pulmonary hypertension with a mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterization
iii. Chronic kidney disease with a glomerular filtration rate of less than 60 ml/min (MDRD-formula)
iv. Echocardiographic signs of significant left ventricular diastolic dysfunction

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

d) For the above definition, the following are not covered:
i. Localized scleroderma without organ involvement
ii. Eosinophilic fasciitis CREST-Syndrome

XXXII. Cardiomyopathy

a) A definite diagnosis of one of the following primary cardiomyopathies:
i. Dilated Cardiomyopathy
ii. Hypertrophic Cardiomyopathy (obstructive or non-obstructive)
iii. Restrictive Cardiomyopathy
iv. Arrhythmogenic Right Ventricular Cardiomyopathy

b) The disease must result in at least one of the following:
i. Left ventricular ejection fraction (LVEF) of less than 40% measured twice at an interval of at least 3 months.
ii. Marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain (Class III or IV of the New York Heart Association classification) over a period of at least 6 months.
iii. Implantation of an Implantable Cardioverter Defibrillator (ICD) for the prevention of sudden cardiac death

c) The diagnosis must be confirmed by a Consultant Cardiologist and supported by echocardiogram or cardiac MRI. The implantation of an Implantable Cardioverter Defibrillator (ICD) must be determined by a Consultant Cardiologist.

d) For the above definition, the following are not covered:
i. Secondary (ischemic, valvular, metabolic, toxic or hypertensive) cardiomyopathy
ii. Transient reduction of left ventricular function due to myocarditis
iii. Cardiomyopathy due to systemic diseases
iv. Implantation of an Implantable Cardioverter Defibrillator (ICD) due to primary arrhythmias (e.g. Brugada or Long-QT-Syndrome)

XXXIII. Chronic Pancreatitis

a) A definite diagnosis of severe chronic pancreatitis evidenced by all of the following:
i. Exocrine pancreatic insufficiency with weight loss and steatorrhoea
ii. Endocrine pancreatic insufficiency with pancreatic diabetes
iii. Need for oral pancreatic enzyme substitution

b) These conditions have to be present for at least 3 months. The diagnosis must be confirmed by a Consultant Gastroenterologist and supported by imaging and laboratory findings (e.g. faecal elastase).

c) For the above definition, the following are not covered:
i. Chronic pancreatitis due to alcohol or drug use
ii. Acute pancreatitis

XXXIV. Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)

a) A definite diagnosis of amyotrophic lateral sclerosis. Should be characterized by muscular weakness and atrophy, evidence of anterior horn cell dysfunction, visible muscle fasciculations, spasticity, hyperactive deep tendon reflexes and exterior plantar reflexes, evidence of corticospinal tract involvement, dysarthric and dysphagia. Appropriate neuromuscular testing such as Electromyogram (EMG) must be present.

b) The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no chance of recovery.

c) The diagnosis must be confirmed by a Consultant Neurologist and supported by nerve conduction studies (NCS) and electromyography (EMG).

d) For the above definition, the following are not covered:

i. Other forms of motor neurone disease
ii. Multifocal motor neuropathy (MMN) and inclusion body myositis
iii. Post-polio syndrome
iv. Spinal muscular atrophy
v. Polymyositis and dermatomyositis

XXXV. Terminal Illness

A definite diagnosis of an advanced or rapidly progressing disease, which, in the opinion of the consulting physician* and an independent physician appointed by the insurance company, is not curable and will lead to death within 6 months. The insured must no longer receive active treatment other than that of palliative therapy (reducing the severity of disease symptoms).

Supporting Documentation & Examination

The Insured Person or someone claiming on the Insured Person`s behalf shall provide Us with all documentation, information and medical records We may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 45 days of getting diagnosed with any of the Critical illness as mentioned in section 4.2 . In the event of any of Our request for specific information, same shall be submitted within 15 days of our Request. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured. Such documentation will include but is not limited to the following

i) Our claim form duly completed (along with captioned documents) and signed by/ on behalf of the Insured Person.
ii) Original Discharge Summary.
iii) Medical certificate confirming the diagnosis/treatment of Critical Illness from Medical Practitioner.
iv) A precise diagnosis of the treatment for which a claim is made.
v) Treating doctors certificate regarding the duration & etiology
vi) KYC documents
vii) Certificate from Bank/Financial Institution stating the amortization schedule, the EMI amount, Principal Outstanding, etc.

The Insured Person shall have to undergo medical examination by Our authorised Medical Practitioner, as and when We may reasonably require, to obtain an independent opinion for the purpose of processing any claim. We will bear the cost towards performing such medical examination (at the specified location) of the Insured person.

Optional Benefit No. 3 – Permanent Partial Disablement (PPD)

a. If an Insured Person suffers an Accident during the Policy Period and within 365 days from the date of the Accident this is the sole and direct cause of his permanent partial disablement in one of the ways detailed in the table below, then We will pay the percentage of the Sum Insured shown in the table**.**

Loss of:	Static Sum Insured	Reducing Sum Insured
Each arm at the shoulder joint	50% of disbursed Loan amount	50% of outstanding Principal Amount
Each leg above centre of the femur		
Each arm to a point above elbow joint		

Each leg up to a point below the femur		
Each arm below elbow joint		
Each hand at the wrist		
Each eye		
Each leg to a point below the knee		
Each leg up to the centre of tibia		
Each foot at the ankle.		

b. In this Benefit Loss means:

I. the physical separation of a body part, or

II. the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disability provided that We are satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

c. If an Insured Person suffers a Loss not mentioned in the table above, then We will assess the degree of disablement with an independent medical advisor and determine the amount of payment to be made.

If a claim in respect of a whole member (any organ, organ system or a limb) also encompasses some or all of its parts, Our liability to make payment will be limited to the member only and not any of its parts or constituents.

Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include but is not limited to the following:

i. Our claim form, duly completed and signed for on behalf of the Insured Person.
ii. All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries.
iii. Death/Disability certificate.
iv. A precise diagnosis of the treatment for which a claim is made.
v. A detailed list of the individual medical services and treatments provided.
vi. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
vii. All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
viii. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
ix. Copy of settlement letter from other insurance company or TPA
x. Stickers and invoice of implants used during surgery
xi. Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xii. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xiii. Legal heir certificate (not required if valid nomination exists)
xiv. Certificate from Bank/Financial Institution stating the amortization schedule, the EMI amount, Principal Outstanding, etc

Optional Benefit No. 4 – EMI Cover

1. **Hospitalization due to an illness**: If an Insured person, during policy period, is continuously hospitalized due to an illness for more than [X]* weeks and is unable to perform duties pertaining to his/her employment, then We will pay the amount as mentioned in below table.

Benefit	Static Sum Insured	Reducing Sum Insured
Hospitalization due to an illness	EMI payments for a period of [Y]* months.	

Each opted option can be utilized only once per Policy Year. If Policy Period is more than 1 year, then this benefit can be utilized once per Policy Year for every year of Policy Period.
If this benefit is not utilized in a Policy Year, then it shall not be carried forward to any subsequent Policy Year.
Waiting period: 30 days for all illnesses (except accident) in the first year and is not applicable in subsequent renewals.
For this benefit Pre-existing Diseases will be covered after a waiting period of 48 months.

Supporting Documentation & Examination
The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include but is not limited to the following:

i. Our claim form, duly completed and signed for on behalf of the Insured Person.
ii. All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries.
iii. A precise diagnosis of the treatment for which a claim is made.
iv. A detailed list of the individual medical services and treatments provided.
v. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
vi. All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
vii. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
viii. Copy of settlement letter from other insurance company or TPA
ix. Stickers and invoice of implants used during surgery
x. Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xi. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xii. Legal heir certificate (not required if valid nomination exists)
xiii. Certificate from Bank/Financial Institution stating the amortization schedule, the EMI amount, Principal Outstanding, etc

2. **Hospitalization due to an accident**: If an Insured person, during policy period, is continuously hospitalized due to an accident for more than [X]* weeks and is unable to perform each and every duties pertaining to his/her employment, then We will pay the amount as mentioned in below table.

Benefit	Static Sum Insured	Reducing Sum Insured
Hospitalization due to an accident	EMI payments for a period of [Y]* months.	

Each opted option can be utilized only once per Policy Year. If Policy Period is more than 1 year, then this benefit can be utilized once per Policy Year for every year of Policy Period.
If this benefit is not utilized in a Policy Year, then it shall not be carried forward to any subsequent Policy Year**.**

Supporting Documentation & Examination
The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include but is not limited to the following:

i. Our claim form, duly completed and signed for on behalf of the Insured Person.
ii. All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries.
iii. A precise diagnosis of the treatment for which a claim is made.
iv. A detailed list of the individual medical services and treatments provided.
v. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
vi. All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
vii. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
viii. Copy of settlement letter from other insurance company or TPA
ix. Stickers and invoice of implants used during surgery
x. Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xi. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xii. Legal heir certificate (not required if valid nomination exists)
xiii. Certificate from Bank/Financial Institution stating the amortization schedule, the EMI amount, Principal Outstanding, etc

3. **Permanent Partial Disablement (PPD) or Temporary Total disablement (TTD):**
   a. If an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his permanent partial disablement within 365 days from date of Accident in one of the ways detailed in the table below, then We will pay the amount as mentioned in the table below.

Each arm at the shoulder joint	Each hand at the wrist
Each leg above centre of the femur	Each eye
Each arm to a point above elbow joint	Each leg to a point below the knee
Each leg up to a point below the femur	Each leg up to the centre of tibia

Each arm below elbow joint	Each foot at the ankle.

In this Benefit Loss means:

i) the physical separation of a body part, or

ii) the total loss of functional use of a body part or organ provided this has continued for at least 365 days from the onset of such disability provided that We are satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

If an Insured Person suffers a Loss not mentioned in the table above, then We will assess the degree of disablement with Our medical advisors and determine the amount of payment to be made.

If a claim in respect of a whole member (any organ, organ system or a limb) also encompasses some or all of its parts, Our liability to make payment will be limited to the member only and not any of its parts or constituents.

b. If an Insured Person suffers an Accident during the Policy Period which is the sole and direct cause of a temporary disability which completely prevents him from performing each and every duty pertaining to his employment or occupation, then We will pay the amount as mentioned in schedule of benefits, provided that the temporary total disablement is certified by a Doctor.

Benefit	Static Sum Insured	Reducing Sum Insured
Permanent Partial Disablement (PPD) or Temporary Total disablement (TTD)	EMI payments for a maximum period of upto 3/6/9/12 months.	

Each opted option can be utilized only once per Policy Year. If Policy Period is more than 1 year, then this benefit can be utilized once per Policy Year for every year of Policy Period.
If this benefit is not utilized in a Policy Year, then it shall not be carried forward to any subsequent Policy Year.

Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include but is not limited to the following:

i. Our claim form, duly completed and signed for on behalf of the Insured Person.
ii. All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries.
iii. Death/Disability certificate.
iv. A precise diagnosis of the treatment for which a claim is made.
v. A detailed list of the individual medical services and treatments provided.
vi. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
vii. All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
viii. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
ix. Copy of settlement letter from other insurance company or TPA
x. Stickers and invoice of implants used during surgery

xi. Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xii. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xiii. Legal heir certificate (not required if valid nomination exists)
xiv. Certificate from Bank/Financial Institution stating the amortization schedule, the EMI amount, Principal Outstanding, etc

Section 2: Special terms and Conditions

A. Waiting Period

We are not liable for any claim arising due to condition for which appearance of signs/symptoms, consultation, investigation, treatment or admission started within 30 days from Policy Commencement Date, except for the claims arising due to an Accident.
Pre-existing Diseases will be covered after a waiting period of 48 months.

If any time period is specifically mentioned in Benefits, then it shall supersede the time periods mentioned above

B. General Exclusions

We will not pay for any claim which is caused by, arising from or in any way attributable to any of the following, including their associated complications, unless expressly stated to the contrary in this Policy.

1. Special Exclusions to Accidental death [AD], Permanent Total Disablement [PTD], Permanent Partial Disablement [PPD], Temporary Total Disablement [TTD] and Hospitalization due to Accident
   a) Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).
   b) Medical or surgical treatment except as necessary solely and directly as a result of an Accident.
   c) Hernia.
2. General Exclusions applicable to all Benefits

Non-Medical Exclusions	xiii) War or similar situations: Treatment directly or indirectly arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind. xiv) Any Insured Person committing or attempting to commit a breach of law with criminal intent. xv) Intentional self-injury, suicide or attempted suicide while sane or insane. xvi) Dangerous acts (including sports): An Insured Person's participation or involvement in naval, military or air force operation, racing, diving, aviation, scuba diving, parachuting, hang-gliding, rock or mountain climbing in a professional or semi professional nature.
Medical Exclusions	xvii) Treatment of illness or injury resulting as a consequence of the use of alcohol, tobacco, narcotic or psychotropic substances. xviii) Prosthetic and other devices which are self detachable /removable without surgery involving anaesthesia xix) Treatment at a healthcare facility which is NOT a Hospital. xx) Treatment of obesity and any weight control program.

xxi) Treatment for correction of eye sight due to refractive error

xxii) Cosmetic, aesthetic and re-shaping treatments and surgeries:

c. Plastic surgery or cosmetic surgery or treatments to change appearance unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, cancer or burns.

d. Circumcisions (unless necessitated by Illness or injury and forming part of treatment); aesthetic or change-of-life treatments of any description such as sex transformation operations.

xxiii) Types of treatment, defined Illnesses/ conditions/ supplies:

w. Non allopathic treatment.

x. Conditions for which treatment could have been done on an outpatient basis without any Hospitalisation.

y. Charges related to peritoneal dialysis, including supplies

z. Admission primarily for administration of monoclonal antibodies or IV immunoglobulin infusion.

aa. Experimental, investigational or unproven treatment devices and pharmacological regimens.

bb. Admission primarily for diagnostic and evaluation purposes only

cc. Any diagnostic expenses related to illnesses which we do not cover under this Policy.

dd. Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long-term nursing care, custodial care, safe confinement, de-addiction, general debility or exhaustion ("run-down condition").

ee. Preventive care, vaccination including inoculation and immunisations (except in case of post-bite treatment);

ff. Admission for enteral feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements

gg. Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

hh. Psychiatric, mental disorders (including mental health treatments)

ii. Sleep-apnoea.

jj. External congenital diseases, defects or anomalies.

kk. Stem cell therapy or surgery, or growth hormone therapy.

ll. Venereal disease, sexually transmitted disease or illness;

mm. "AIDS" (Acquired Immune Deficiency Syndrome) and/or infection with HIV (Human Immunodeficiency Virus) including but not limited to conditions related to or arising out of HIV/AIDS such as ARC (AIDS Related Complex), Lymphomas in brain, Kaposi's sarcoma, tuberculosis.

nn. Any expense attributable directly or indirectly to pregnancy (including voluntary termination), miscarriage (except as a result of an Accident or Illness), maternity or child birth (including caesarean section), except in the case of ectopic pregnancy in relation to a claim under 1a) for In-patient Treatment only.

oo. Treatment for sterility, infertility (primary or secondary), assisted conception or other related conditions and complications arising out of the same.

pp. Birth control, and similar procedures including complications arising out of the same.

	qq. The expense incurred by the Insured Person on organ donation. rr. Treatment for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure; muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities. xxiv) Healthcare providers (Hospitals /Medical Practitioners) c. Any Medical Expenses incurred using facility of any Medical Practitioners or institution that We have told You/Insured Person (in writing) is not to be used at the time of renewal or at any specific time during the Policy Period. This exclusion is not applicable for life saving emergency situations and in such cases claims will be settled on reimbursement basis only. d. Treatments rendered by a Medical Practitioner who is a member of the Insured Person's family or stays with him, however proven material costs are eligible for reimbursement in accordance with the applicable cover.

Section 3 General Conditions

a. Conditions precedent

The fulfilment of the terms and conditions of this Policy including the payment of premium by the due dates mentioned in the Schedule/Certificate of Insurance and the correct disclosures in a complete manner in the proposal form insofar as they relate to anything to be done or complied with by You or any Insured Person shall be conditions precedent to Our liability. The premium for the Policy will remain the same for the Policy Period as mentioned in Policy Schedule/Certificate of Insurance. Policy will be issued between the range of 1 year to 5 years (in interval of 1 year). Sum Insured & benefits will be applicable on Policy Year basis.

b. Geography

This Policy applies to events or occurrences taking place anywhere in the world.

c. Insured Person

Only those persons named as Insured Persons in the Schedule/Certificate of Insurance shall be covered under this Policy. Any eligible person may be added during the Policy Period after his application has been accepted by Us and additional premium has been received. Insurance cover for this person shall only commence once We have issued an endorsement confirming the addition of such person as an Insured Person.

If an Insured Person dies other than death due to an accident, he will cease to be an Insured Person upon Us/Administrator receiving all relevant particulars in this regard. We will return a part of the premium (as per cancellation grid in section 3.18) received for such person IF AND ONLY IF there are no claims in respect of that Insured Person under the Policy.

d. Notification of Claim

	Treatment, Consultation or Procedure:	**We must be notified:**
A.	**Accidental death [AD], Permanent Total Disablement [PTD], Permanent Partial Disablement [PPD] or Temporary Total Disablement [TTD] and Hospitalization due to Accident**	
i)	Any event or occurrence that may give rise to a claim	Within 30 days of event or occurrence

B.	**Hospitalization due to Illness**	
i)	Treatment for which a claim may be made is to be taken and it requires Hospitalisation	At least 48 hours prior to the Insured Person's admission.
ii)	Treatment for which a claim may be made is to be taken and it requires Emergency Hospitalisation	Within 24 hours of the Insured Person's admission to Hospital.
C.	**Critical Illness**	
i)	If any event or occurrence that may give rise to a claim under this Benefit	Within 14 days of the diagnosis of the first occurrence of the Critical Illness.

Note:

- The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the insured.
- If any time period is specifically mentioned in Benefits, then it shall supersede the time periods mentioned in above table.

e. Supporting Documentation & Examination

The Insured Person or someone claiming on Your behalf shall provide Us with any documentation, medical records and information. We or Our TPA may request to establish the circumstances of the claim, its quantum or Our liability for the claim within 15 days of the earlier of Our request or the Insured Person's discharge from Hospitalisation or completion of treatment. The Company may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person. Such documentation will include but is not limited to the following:

xv. Our claim form, duly completed and signed for on behalf of the Insured Person.
xvi. All reports and records, including but not limited to all medical reports, case histories/indoor case papers, investigation reports, treatment papers, discharge summaries.
xvii. Death/Disability certificate.
xviii. A precise diagnosis of the treatment for which a claim is made.
xix. A detailed list of the individual medical services and treatments provided.
xx. All pre and post investigation, treatment and follow up (consultation) records pertaining to the present ailment for which claim is being made
xxi. All investigation, treatment and follow up records pertaining to the past ailment(s) since their first diagnoses or detection
xxii. Treating doctor's certificate regarding missing information in case histories e.g. Circumstance of injury and Alcohol or drug influence at the time of accident
xxiii. Copy of settlement letter from other insurance company or TPA
xxiv. Stickers and invoice of implants used during surgery
xxv. Copy of MLC (Medico legal case) records and FIR (First information report), in case of claims arising out of an accident
xxvi. Regulatory requirements as amended from time to time, currently mandatory NEFT (to enable direct credit of claim amount in bank account) and KYC (recent ID/Address proof and photograph) requirements
xxvii. Legal heir certificate (not required if valid nomination exists)
xxviii. Certificate from Bank/Financial Institution stating the amortization schedule, the EMI amount, Principal Outstanding, etc

f. Claims Payment

i. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full in time and all payments have been realised and We have been provided with the documentation and information We has requested to establish the circumstances of the claim, its

quantum or Our liability for it, and unless the Insured Person has complied with his obligations under this Policy.

ii. We shall on admission of a claim make the payment of the principal outstanding amount to the Bank/Financial Institution where the Insured Person has authorized Us for the same. Where the Insured Person has opted for a Static Sum Insured; We shall on admission of a claim make the payment of the principal outstanding amount to the Bank/Financial Institution where the Insured Person has authorized Us for the same and any balance Static Sum Insured shall be payable to the Insured Person or Nominee, as applicable. The Insured Person can authorize for payment of principal outstanding amount to the Bank/ Financial Institution at the time of opting for coverage under this Policy or at a later date.

iii. We will only make payment to Insured Person, Nominee or the Bank/Financial Institution, as applicable, under this Policy. Receipt of payment by Insured Person, Nominee or Master Policyholder shall be considered as a complete discharge of Our liability against the respective/any claim under this Policy. In the event of Insured Person's death, We will make payment to the Nominee (as named in the Schedule/Certificate of Insurance). Payment of the admissible claim to the Bank/Financial Institution shall be as per table below

Sum Insured Type	Sum Insured settlement basis	Claim amount paid to
Reducing Sum Insured	The Principal Outstanding in the books of Bank/Financial Institution as on the date of occurrence of the event minus all the unpaid/ overdue EMI's (if any) payable to Bank/Financial Institution	Bank/Financial Institution
Static Sum Insured	Principal Outstanding as per the amortization schedule prepared by Bank/ Financial Institution minus all the unpaid/ overdue EMI's (if any).	Bank/Financial Institution & Nominee (Amount provided to Nominee shall be the Principal amount settled by Insured Member as on the date of occurrence of covered event)

iv. We shall reject the claim by sending claim rejection letter to Insured Person or settle a claim by making the payment of claim that has been admitted as payable by Us under the Policy terms and conditions within 30 days of receipt of last necessary document(s) / information and any other additional information required for the settlement of the claim. All claims will be settled in accordance with the applicable regulatory guidelines, including IRDAI (Protection of Policyholders Regulation), 2017. In case of delay in payment of any claim that has been admitted as payable by Us under the Policy terms and condition, beyond the time period as prescribed under IRDAI (Protection of Policyholders Regulation), 2017, we shall pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document(s) to the date of payment of claim. For the purpose of this clause, 'bank rate' shall mean the bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

v. Where the circumstances of a clam warrant an investigation in our Opinion, We 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, We shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days , We 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.

vi. The payments under this Policy shall only be made in Indian Rupees within India.

vii. We will only make payment to or at Your direction. If an Insured Person submits the requisite claim documents and information along with a declaration in a format acceptable to Us, this person will be deemed to be authorized by You to receive the concerned payment. In the event of the death of an Insured Person, We will make payment to the Nominee (as named in the Schedule).

viii. If specific etiology for the defined critical illness is among the general or specific exclusions of this policy then the claim would not be payable. Etiology means the cause or origin of a disease or disorder as determined by medical diagnosis.

ix. For Static Sum Insured type policies, claims shall be settled based on the Sum Insured opted at the time of policy inception and last paid EMI amount.

x. For Reducing Sum Insured type policies, claims shall be settled based on least of the following:
   i. The Principal Outstanding in the books of Bank/Financial Institution as on the date of occurrence of the event minus all the unpaid/ overdue EMI's (if any); OR
   ii. Principal Outstanding as per the amortization schedule prepared by Bank/ Financial Institution minus all the unpaid/ overdue EMI's (if any).

xi. This policy does not cover any interest accrued on the Principal Loan amount.

g. Non-Disclosure or Misrepresentation:

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

i. cancelled ab initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, with Your consent, upon 30 day notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance;

ii. the claim under such Policy if any, shall be rejected/repudiated forthwith.

h. Dishonest or Fraudulent Claims

If any claim is in any manner dishonest or fraudulent, or is supported by any dishonest or fraudulent means or devices, whether by You or the Insured Person or anyone acting on behalf of You or an Insured Person, then this Policy shall be:

i. cancelled ab-initio from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, with Your consent, upon 30 day notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance.

ii. all benefits payable, if any, under such Policy shall be forfeited with respect to such claim.

i. Endorsement

This Policy constitutes the complete contract of insurance. This Policy cannot be changed by anyone (including an insurance agent or broker) except Us. Any change that We make will be evidenced by a written endorsement signed and stamped by Us.

j. Change of Plan Type

The policy does not allow to convert plan from Static Sum Insured type to Reducing Sum Insured type or vice versa.

k. Renewal

This Policy is ordinarily renewable unless the Insured Person or anyone acting on behalf of an Insured Person has acted in a dishonest or in a fraudulent manner or there has been any misrepresentation, mis-description or non-disclosure under or in relation to this Policy or the renewal of the Policy poses a moral hazard.

a) We are NOT under any obligation to:

i. Send renewal notice or reminders.

ii. Renew it on same terms or premium as the expiring Policy. Any change in benefit or premium will be done with the approval of the Insurance Regulatory and Development Authority and will be intimated to You atleast 3 months in advance. In the likelihood of this policy being withdrawn in future, we will intimate you about the same 3 months prior to expiry of the policy.

b) All applications for renewal of the Policy must be received by Us before the end of the Policy Period. A Grace Period of 30 days for renewing the Policy is available under this Policy. Any disease/ condition contracted during the Grace Period will not be covered and will be treated as a Pre-existing Condition.

c) For renewal of Reducing Sum Insured type policies, the Sum Insured shall be equal to the outstanding principal amount at the time of renewal and premium shall be charged accordingly.

l. Notices

Any notice, direction or instruction under this Policy shall be in writing and if it is to:

i. Any Insured Person, then it shall be sent to You at Your address specified in the Schedule and You shall act for all Insured Persons for these purposes.

ii. Us, it shall be delivered to Our address specified in the Schedule.

iii. No insurance agents, brokers or other person or entity is authorised to receive any notice, direction or instruction on Our behalf unless We have expressly stated to the contrary in writing.

m. Dispute Resolution Clause

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian Courts and subject to Indian law.

n. Nomination

You can change the nominee to whom such payment is to be made at any time during the Policy Period, provided that such change shall only be effective when You have notified Us and We have recorded the change by an endorsement to this effect.

o. Termination

i. You may terminate this Policy at any time by giving Us/Administrator a written notice. The cancellation shall be from the date of receipt of such written notice. Premium shall be refunded as per table below IF AND ONLY IF no claim has been made under the Policy:

- For policies with policy term of one year (Static Sum Insured or Reducing Sum Insured):

Length of time Policy in force	Refund of premium
up to 1 month	75%
up to 3 months	50%
up to 6 months	25%
exceeding 6 months	0%

- For policies with policy term of more than one year (Static Sum Insured):

Cancellation year / Policy term	**2**	**3**	**4**	**5**
Year 1	49%	54%	57%	59%
Year 2	-	33%	41%	46%
Year 3	-	-	24%	33%
Year 4	-	-	-	20%
Year 5	-	-	-	-

No refund of premiums will be made under the policy during the last year of insurance (not applicable on one year policy duration)

- For policies with policy term of more than one year (Reducing Sum Insured):

Loan Period	2	3	3	4	4	4	5	5	5	5	6-7	6-7	6-7	6-7
Policy Period	2	2	3	2	3	4	2	3	4	5	2	3	4	5
Cancellation year														
Year 1	44%	46%	49%	47%	51%	53%	47%	52%	54%	55%	48%	53%	55%	56%
Year 2	-	-	23%	-	26%	30%	-	28%	34%	36%	-	29%	36%	40%
Year 3	-	-	-	-	-	14%	-	-	17%	21%	-	-	20%	25%
Year 4	-	-	-	-	-	-	-	-	-	10%	-	-	-	13%
Year 5	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Loan Period	7-10	7-10	7-10	7-10	10-15	10-15	10-15	10-15	>15	>15	>15	>15
Policy Period	2	3	4	5	2	3	4	5	2	3	4	5
Cancellation year												
Year 1	48%	53%	56%	57%	48%	54%	56%	58%	49%	54%	57%	58%
Year 2	-	30%	38%	42%	-	31%	39%	44%	-	32%	40%	45%
Year 3	-	-	21%	28%	-	-	23%	30%	-	-	24%	32%
Year 4	-	-	-	16%	-	-	-	18%	-	-	-	19%
Year 5	-	-	-	-	-	-	-	-	-	-	-	-

No refund of premiums will be made under the policy during the last year of insurance (not applicable on one year policy duration)

ii. We shall terminate this Policy for the reasons as specified under aforesaid section 3 g) (Non Disclosure or Misrepresentation) & section 3 h) (Dishonest or Fraudulent Claims) of this Policy and such termination of the Policy shall be ab initio from the inception date or the renewal date (as the case may be), upon 30 day notice, by sending an endorsement to Your address shown in the Schedule/endorsement/Certificate of Insurance.

iii. The policy shall be cancelled automatically upon full repayment of loan amount.

iv. In case the Insured Person transfers his/her loan to another Bank/ Financial Institution, then We will cancel the Policy and return a part of premium as per the above grid IF AND ONLY IF no claims has been made.

v. If both insured persons are covered for 100% of loan amount disbursed and if the loan amount is repaid in full before the end of Policy Term and same has been intimated to Us, then We shall cancel the Policy and return a part of premium as per the above grid IF AND ONLY IF no claims has been made.

vi. If insured persons are covered for the proportion of loan amount against their name and if any of the insured member repays the his loan amount in full before the end of policy term, then we shall cancel the policy and return a part of premium, as per the above grid, in respect of that insured person only. Return of part of premium shall be made IF AND ONLY IF no claims has been made. The other insured member shall continue to be covered under the policy.

vii. In the event of part prepayment of Loan, no refund of premium shall be made under this policy.

p. Free Look Cancellation

Insured Person has a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of this Policy. If the Insured person has have any objections to any of the terms and conditions, he/she has the option of cancelling the Policy stating the reasons for cancellation. and We will refund the premium paid by Insured Person after adjusting

- the amounts spent on any medical check-up, stamp duty charges and
- Proportionate risk premium.

Insured Person can cancel the Policy only if no claims have been made under the Policy. All rights under this Policy will immediately stand extinguished on the free look cancellation of the Policy. Free look provision is not applicable and available at the time of renewal of the Policy.

Section 4. INTERPRETATIONS & DEFINITIONS

The terms defined below have the meanings ascribed to them wherever they appear in this Policy Document and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same:

2. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
3. **Activities of Daily Living are:**
    i) Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
    ii) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    iii) Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
    iv) Mobility: the ability to move indoors from room to room on level surfaces;
    v) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    vi) Feeding: the ability to feed oneself once food has been prepared and made available.
4. **Age** or **Aged** means completed years as at the Commencement Date.
5. **Commencement Date** means the commencement date of this Policy as specified in the Schedule.
6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
7. **Dental treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
8. **Disclosure of information norm** means the policy shall be void and all premiums paid herein shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
9. **EMI or EMI Amount** means the amount of monthly payment required to repay the loan availed by Insured Person from Bank/Financial Institution prior to the date of event which may give rise to a claim under this Policy. This is as per the amortization chart referred to in the loan agreement (or any amendments thereto) between the Bank/Financial Institution and the Insured Person. For the purpose of avoidance of doubt, it is clarified that any EMIs that are overdue and unpaid to the Bank prior to the occurrence of the Event, which may give rise to claim under this policy, will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.
10. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
11. **Hospital** a hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    I. has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
    II. has qualified nursing staff under its employment round the clock,
    III. has qualified Medical Practitioner(s) in charge round the clock,
    IV. has a fully equipped operation theatre of its own where surgical procedures are carried out,

V. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

12. **Hospitalization** means admission in a hospital for a minimum period of 24 In-patient Care consecutive hours except for specified procedures treatments, where such admission could be for a period of less than 24 consecutive hours.
13. **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.
14. **Insured Person** means You and the persons named in the Schedule.
15. **Loan** means the sum of money lent at interest or otherwise to the Insured by any Bank/Financial Institution as identified by the Loan Account Number referred to in this policy.
16. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
17. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.
18. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which
    I. Is required for the medical management of the Illness or injury suffered by the Insured Person;
    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.
19. **Notification of Claim** means the process of notifying a claim to the insurer or TPA by specifying the timeliness as well as the address / telephone number to which it should be notified.
20. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this policy wording (including endorsements, if any) and the Schedule.
21. **Policy Period** means the period between the Commencement Date and the Expiry Date as specified in the Schedule.
22. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.
23. **Pre-Existing Disease** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.
24. **Principal Outstanding** means the principal amount of the disbursed Loan outstanding excluding interest payable thereon as on the date of occurrence of Event that may give rise to claim under this policy. This shall not include any component of the overdue and unpaid EMI's. For the purpose of avoidance of doubt, it is clarified that any EMIs that are overdue and unpaid to the Bank prior to the occurrence of the Event, which may give rise to claim under this policy, will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.

25. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/ injury involved
26. **Reducing Sum Insured** means Sum Insured opted by Insured Person shall keep on reducing on monthly basis. This monthly reduction is equal to the Principal component of monthly EMI amount, as per the amortization schedule prepared by Bank/ Financial Institution.
27. **Static Sum Insured** means Sum Insured opted by Insured Person shall remain constant throughout the policy term.

28. **Sum Insured** means the sum shown in the Schedule which represents Our maximum liability for each Insured Person for any and all benefits claimed for during the Policy Period.
29. **Survival Period** means the period after an insured event that the insured person has to survive before a claim becomes valid.
30. **Terrorism** shall mean an act, including, but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or Government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear."
31. **We/Our/Us** means the Apollo Munich Health Insurance Company Limited.
32. **You/Your/Policyholder** means the person named in the Schedule who has concluded this Policy with Us.

Section 5. Claim Related Information

For any claim related query, intimation of claim and submission of claim related documents, the Insured Person can contact Apollo Munich through:

- Website : www.apollomunichinsurance.com
- Toll Free : 1800-102- 0333
- Fax : 1800- 425- 4077
- Courier : Claims Department,
  Apollo Munich Health insurance Co. Ltd
  Ground floor, Srinilaya – Cyber Spazio
  Suite # 101,102,109 & 110, Ground Floor,
  Road No. 2, Banjara Hills,
  Hyderabad-500 034

  Or

  Claims Department
  Apollo Munich Health Insurance Company Limited
  iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase – III,
  Gurgaon -122016, HARYANA

Section 6. Grievance Redressal Procedure

If You have a grievance that You wish Us to redress, You may contact Us with the details of Your grievance through:

- Our website : www.apollomunichinsurance.com
- E-mail : customerservice@apollomunichinsurance.com
- Toll Free : 1800-102-0333
- Fax : +91-124-4584111
- Courier : Any of Our Branch office or Corporate office

You may also approach the grievance cell at any of Our branches with the details of Your grievance during Our working hours from Monday to Friday.

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may contact Our Head of Customer Service at:

The Grievance Cell, Apollo Munich Health Insurance Company Limited, iLABS Centre, 2nd & 3rd Floor, Plot No 404 - 405, Udyog Vihar, Phase – III, Gurgaon -122016, HARYANA

If You are not satisfied with Our redressal of Your grievance through one of the above methods, You may approach the nearest Insurance Ombudsman for resolution of Your grievance. The contact details of Ombudsman offices are mentioned below.

Office of the Executive Council of Insurers
(Monitoring Body for Offices of Insurance Ombudsman)
3rd Floor, Jeevan Seva Annexe, Santacruz(West), Mumbai – 400054. Tel no: 26106671/6889.
Email id: inscoun@ecoi.co.in website: www.ecoi.co.in
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If you have a grievance, approach the grievance cell of Insurance Company first.
If complaint is not resolved/ not satisfied/not responded for 30 days then
You can approach The Office of the Insurance Ombudsman(Bimalokpal)
Please visit our website for details to lodge complaint with Ombudsman.

Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, Ahmedabad - 380001. Tel nos: 079-25501201/02/05/06 email: bimalokpal.ahmedabad@ecoi.co.in	Office of the Insurance Ombudsman, 2nd Floor, Janak Vihar Complex, 6, Malviya Nagar, BHOPAL-462 003. Tel.:- 0755-2769201/9202 Fax : 0755-2769203 Email: bimalokpal.bhopal@ecoi.co.in
Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.:- 0674-2596455/2596003 Fax : 0674-2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Office of the Insurance Ombudsman, SCO No.101-103,2nd Floor, Batra Building, Sector 17-D, CHANDIGARH-160 017. Tel.:- 0172-2706468/2772101 Fax : 0172-2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. Tel.:- 044-24333668 /24335284 Fax : 044-24333664 Email: bimalokpal.chennai@ecoi.co.in	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg.,Asaf Ali Road, NEW DELHI-110 002. Tel.:- 011-23234057/23232037 Fax : 011-23230858 Email: bimalokpal.delhi@ecoi.co.in
Office of the Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, S.S. Road, GUWAHATI-781 001 . Tel.:- 0361-2132204/5 Fax : 0361-2732937 Email: bimalokpal.guwahati@ecoi.co.in	Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel : 040-65504123/23312122 Fax: 040-23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., M.G. Road, ERNAKULAM-682 015.	Office of the Insurance Ombudsman, Hindustan Building. Annexe, 4th Floor, C.R.Avenue, KOLKATA - 700072

Tel : 0484-2358759/2359338 Fax : 0484-2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Tel No: 033-22124339/22124346 Fax: 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road,Hazaratganj, LUCKNOW-226 001. Tel : 0522 -2231331/2231330 Fax : 0522-2231310 Email: bimalokpal.lucknow@ecoi.co.in	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe,S.V. Road, Santacruz(W), MUMBAI-400 054. Tel : 022-26106960/26106552 Fax : 022-26106052 Email: bimalokpal.mumbai@ecoi.co.in
Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II, Bhawani Singh Road, JAIPUR – 302005. Tel: 0141-2740363 Email: bimalokpal.jaipur@ecoi.co.in	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Darshan, N.C. Kelkar Road, Narayanpet PUNE – 411030. Tel: 020-32341320 Email: Bimalokpal.pune@ecoi.co.in
Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg., JP Nagar, 1st Phase, Ground Floor BENGALURU – 560025. Tel No: 080-26652049/26652048 Email: bimalokpal.bengaluru@ecoi.co.in	Office of the Insurance Ombudsman, 4th Floor, Bhagwan Sahai Palace, Main Road, Naya Bans, Sector-15, NOIDA – 201301. Tel: 0120-2514250/51/53 Email: bimalokpal.noida@ecoi.co.in
Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, PATNA – 800006 Tel No: 0612-2680952 Email id : bimalokpal.patna@ecoi.co.in.	

IRDA REGULATION NO 5: This Policy is subject to regulation 5 of IRDA (Protection of Policyholder's Interests) Regulation.

Apne, Sapne Surakshit - CLAIM PROCEDURE

Please review your Product Name and familiarize yourself with the benefits available and the exclusions.
To help us to provide you with fast and efficient service, We kindly ask you to note the following.

1. We recommend that you keep copies of all documents submitted Apollo Munich.
2. Please quote your member ID/policy number in all your correspondences.

What do I do in case of a claim or any assistance?

	Intimation & Assistance	Claims Procedure
Hospitalization due to Illness	• Please contact us at least 48 hours prior to an event which might give rise to a claim. • For any emergency situations, kindly contact us within 24 hours of the event.	• Please send the duly signed claim form and all the information/documents mentioned* therein to us within 15 days of the completion of the treatment. * Please refer to claim form for complete documentation. • If there is any deficiency in the documents/information submitted by you, We will send the deficiency letter within 7 days of receipt of the claim documents. • On receipt of the complete set of claim documents, we will make the payment for the admissible amount, along with a settlement statement within 30 days. • The payment will be made in the name of the proposer. **Note: Payment will only be made for items covered under your policy and upto the limits therein.**
Accidental Death [AD], Permanent Total Disablement [PTD], Permanent Partial Disablement [PPD], Temporary Total Disablement [TTD], Hospitalization due to Accident	Please contact us within 30 days of an event which might give rise to a claim	• Provide Us a written notice with full particulars immediately. • Collect the claim form available at all our offices. You can also download the form from our website. • Submit Us the dully filled and signed claim form along with the documents mentioned in the claim form. **Note: The essential claim documents in original along with the claim form have to be submitted within 30 days of the occurrence of the incident, at any of our following offices**
Critical Illness [CI]	Please intimate Us of any event or occurrence that may give rise to a claim under this Policy within 14 days of diagnosis of first occurrence of Critical Illness.	• You must intimate us within 14 days of diagnosis of first occurrence of Critical Illness. • You must submit a duly filled claim form along with specified documents within 45 days of completion of survival period for the Critical Illness against which the claim is made. • If there is any deficiency in the documents/information submitted by you, We will send the deficiency letter within 7 days of receipt of the claim documents. • Any additional information requested must be submitted within 15 days of Our request.

		• On receipt of the complete set of claim documents, We will send the payment for the admissible amount, along with a settlement statement within 30 days.

We can be contacted through:

- Website: www.apollomunichinsurance.com
- Fax: 1800- 425- 4077
- Toll Free: 1800-102- 0333
- Courier

Claims Department,
Apollo Munich Health insurance Co. Ltd
Ground floor, Srinilaya – Cyber Spazio
Suite # 101,102,109 & 110, Ground Floor,
Road No. 2, Banjara Hills,
Hyderabad-500 034

OR

Claims Department,
Apollo Munich Health Insurance Co. Ltd.,
2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III,
Gurgaon-122016, Haryana

Please use the Claim Intimation Form for intimation of a claim.

For any doubt or clarifications and/or information, call our Toll Free Line at 1800-1020-333 or log on to our website www.apollomunichinsurance.com or email us at customerservice@apollomunichinsurance.com