Edelweiss | GENERAL INSURANCE

POLICY WORDING

YOUR POLICY IN DETAIL

Edelweiss | GENERAL INSURANCE

EDELWEISS HEALTHPLUS POLICY

POLICY WORDINGS

1. Preamble

This is a contract of insurance between the Company and the Policyholder which is subject to the realization of the full premium in advance and the terms, conditions and exclusions to this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by Policyholder in respect of the Insured Persons in the Proposal and the Policy Schedule.

Please inform the Company immediately of any change in the address, or any other changes affecting You or any Insured Person.

2. Definitions

For the purpose of interpretation and understanding of this Policy, the Company has defined below some of the important words used in this Policy. Words not defined below are to be construed in the usual English language meaning as contained in Standard English language dictionaries. The words and expressions defined in the Insurance Act 1938, IRDA Act 1999, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate:

1. Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. Age means the completed age of the Insured Person as on his last birthday.
3. Ambulance means a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
4. Any one illness means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
5. Appendix means a document attached and marked as Appendix to this Policy.
6. Associate medical expenses means proportionate deductions of the medical expenses when a higher room category is chosen than the category that is eligible as per terms and conditions of the policy. Proportionate deduction are not applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category.

Associate Medical expenses applicable to below categories/ Expenses incurred during Hospitalization-

a) Room Rent
b) Nursing charges for Hospitalization as an Inpatient excluding private nursing charges;
c) Medical Practitioners' fees,
d) Physiotherapy
e) Operation theatre charges;

This shall not apply to the below categories:
a) Cost of pharmacy and consumables, b. Cost of implants and medical devices, c) Cost of diagnostics, d) ICU Charges

7. AYUSH Treatment refers to hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems
8. AYUSH Hospital:

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

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

9. AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

10. **Break in Policy** occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

11. **Cashless facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

12. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of the specified Benefits in respect of the Insured Person.

13. **Claimant** means a person who possesses a relevant and valid Insurance Policy which is issued by the Company and is eligible to file a Claim in the event of a covered loss.

14. **Company** (also referred as We/Us/EGIC) means Edelweiss General Insurance Company Limited.

15. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

16. **Congenital anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

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

ii. External congenital anomaly - Congenital anomaly which is in the visible and accessible parts of the body.

17. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A Co-payment does not reduce the Sum Insured.

18. **Day care centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner and must comply with all minimum criterion as under –

i. has qualified nursing staff under its employment;

ii. has qualified medical practitioner/s in charge;

iii. has fully equipped operation theatre of its own where surgical procedures are carried out;

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

19. **Day care treatment** means medical treatment, and/or surgical procedure which is:

i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and

ii. which would have otherwise required hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

20. **Deductible** - Deductible means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured:

i. **Deductible (Top Up)** - We are not liable for any payment unless the Medical Expenses exceed the Deductible. Deductible shall be applicable for each and every Hospitalisation except claims made for Any One Illness.

ii. **Deductible (Super Top Up)** - We are not liable for any payment unless the Medical Expenses exceed the Deductible (as opted on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy). Deductible shall be applicable per Policy Year basis. The deductible is applicable in aggregate towards hospitalisation expenses (admissible under policy) incurred during the policy period by insured (individual policy) or insured family (in case of family floater).

21. **Diagnostic Tests** means investigations, such as X-Ray or blood tests, etc to determine the cause of symptoms and/or medical conditions.

22. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or

ii. the patient takes treatment at home on account of non-availability of room in a hospital.

23. **Diagnosis** means pathological conclusion drawn by a registered medical practitioner, supported by acceptable Clinical, radiological, histological, histopathological and laboratory evidence wherever applicable.

24. **Edelweiss Group** means and includes any company wherein Edelweiss Financial Services Limited wholly owns the shares in that Company or is the majority shareholder

25. **Emergency care** (Emergency) means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

26. **Family Floater Policy** means a Policy described as such in the Policy Schedule where the family members (two or more) named in the Policy Schedule are insured under this Policy. Only the following family members can be covered under a Family Floater Policy:

i. Insured Person; and/or

ii. Insured Person's legally married spouse (for as long as they continue to be married); and/or

iii. Insured Person's children who are less than 26 years of Age on the commencement of the Policy Period (maximum 3 children can be covered).

27. **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.

28. Hazardous Or Adventurous Sports;

Hazardous sports (also known as extreme sports or adventure sports) consist of activities having a high level of danger. These activities normally consist of speed, height, elevated levels of physical exertion, combined with highly specialized gear or spectacular stunts.

A list of some extreme sports includes but not limited to:

Racing like racing on wheels, horseback, base jumping, blathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, climbing/ trekking , cycle racing, cyclo cross, drag racing, endurance testing, hang gliding, harness racing, hell skiing, high diving , hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, manual labour, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, mountaineering/ rock climbing, parachuting, paragliding/ parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river boarding, river boardings, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling , mountaineering, winter sports, Skydiving, Scuba Diving, bungee jumping, skiing, ice hockey, ballooning, hand gliding, diving or under-water activity river rafting, canoeing involving rapid waters, polo, yachting or boating outside coastal waters

29. 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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:

i. has qualified nursing staff under its employment round the clock;

ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii. has qualified medical practitioner(s) in charge round the clock;

iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;

v. maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

31. Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

i. Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

ii. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests

b. it needs ongoing or long-term control or relief of symptoms

c. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it

d. it continues indefinitely

e. it recurs or is likely to recur

32. Indemnity/Indemnify means compensating the Policy Holder/Insured Person up to the extent of expenses incurred, on occurrence of an event which results in a financial loss and is covered as the subject matter of the insurance cover.

33. Individual Policy means a Policy described as such in the Policy Schedule where the individual named in the Policy Schedule is insured under this Policy.

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

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

36. Insured Person (also referred as Insured) means person named as insured in the Policy Schedule.

37. Intensive care unit means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

38. ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

39. Maternity expenses means:

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);

ii. Expenses towards lawful medical termination of pregnancy during the policy period.

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

41. Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

42. **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.

43. **Medically necessary treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
i. is required for the medical management of the illness or injury suffered by the insured;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a medical practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

44. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group Health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer

45. **Material facts** for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

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

47. **Newborn baby** means baby born during the Policy Period and is aged up to 90 days.

48. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.

49. **Cumulative Bonus (No Claim Bonus)** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

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

51. **OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

52. **Pandemic** - A pandemic is an epidemic occurring on a scale which crosses international boundaries, usually affecting a large number of people. The World Health Organization (WHO) declare to be a pandemic when it became clear that the illness was severe and that it was spreading quickly over a wide area.

53. **Pre-Existing Disease** means any condition, ailment or injury or disease
a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement
or
b) For which medical advice or treatment was recommended by, or received from, a Physician within 48 months Prior to the effective date of the policy issued by the insurer or its reinstatement

54. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

55. **Policy** means these Policy terms and conditions and Appendices thereto, the Proposal Form, Policy Schedule and Optional Cover (if applicable) which form part of the Policy and shall be read together.

56. **Policyholder** (also referred as You) means the person named in the Policy Schedule as the Policyholder.

57. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specified in the Policy Schedule.

58. **Policy Period Start Date** means the date on which the Policy commences, as specified in the Policy Schedule.

59. **Policy Period End Date** means the date on which the Policy expires, as specified in the Policy Schedule.

60. **Policy Schedule** means the certificate attached to and forming part of this Policy.

61. **Policy Year** means a period of 12 consecutive months commencing from the Policy Period Start Date or any anniversary thereof.

62. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

63. **Post-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:
i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

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

65. **Reasonable and Customary charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

66. **Reimbursement** means settlement of claims paid directly by the Company directly to the Policyholder/Insured Person.

67. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose

of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

68. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

69. **Standard Single Private Room** means an air conditioned room in a Hospital where a single patient is accommodated and which has an attached toilet (lavatory and bath). Such room type shall be the most basic and the most economical of all accommodations available as a Single room in that Hospital.

70. **Sum Insured** means the amount specified in the Policy Schedule, for which premium is paid by the Policyholder.

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

72. **Third Party Administrator or TPA** means any person who is licensed under the IRDAI (Third Party Administrators-Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an Insurance Company, for the purposes of providing health services.

73. **Total Sum Insured** is the sum total of Sum Insured and the Sum Insured accrued under optional cover chosen by the Policyholder. It represents the Company's maximum, total and cumulative liability for in respect of the Insured Person for any and all Claims incurred during the Policy Year. If the Policy Period is more than 12 months, then it is clarified that the Sum Insured shall be applied separately for each Policy Year in the Policy Period.

74. **Unproven/Experimental** treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

75. **Critical Illnesses:**

1. Cancer of Specified Severity:

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

The following are excluded:

- All tumors which are histologically described as Carcinoma In Situ, benign, premalignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour, or non-invasive, including but not limited to: carcinoma in situ of breasts, cervical dysplasia CIN-1, CIN - 2 and CIN -3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a GLEASON score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- All thyroid cancers histologically classified as T1N0M0 (TNM classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as tan0m0 or of a lesser classification,
- All gastro-intestinal stromal tumors histologically classified as T1N0M0 (TNM classification) or below and with mitotic count of less than or equal to 5/50 hpfs,
- all tumors in the presence of HIV infection.

2. 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.

3. Multiple Sclerosis With Persisting Symptoms

The unequivocal diagnosis of definite multiple sclerosis confirmed and evidenced by all of the following:

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

Other causes of neurological damage such as SLE and HIV are excluded.

4. Major Organ/Bone Marrow Transplant:

I. The actual undergoing of a transplant of:

i) One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii) Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i) Other stem-cell transplants

Where only Islets of Langerhans are transplanted.

5. 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.

6. Open Chest CABG

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.

The following are excluded: Angioplasty and/or any other intra-arterial procedures.

7. 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.

8. Myocardial Infarction (First Heart Attack Of Specific Severity):

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

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

The following are excluded:

- Other acute coronary syndromes
- Any type of angina pectoris
- A rise in cardiac biomarkers or troponin t or i in absence of overt ischemic heart disease or following an intra-arterial cardiac procedure.

9. Stroke Resulting In Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in ct scan or mri of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

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

10. Benign Brain Tumor

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

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

- Permanent neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

The following conditions are excluded:

Cysts, granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

11. 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.

12. Coma Of Specified Severity

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

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

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

13. End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

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

Liver failure secondary to drug or alcohol abuse is excluded.

14. Primary (Idiopathic) Pulmonary Hypertension

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.

The NYHA classification of cardiac impairment are as follows:

- Class III: marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- Class IV: unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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.

15. Surgery of Aorta

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of “aorta” shall mean the thoracic and abdominal aorta but not its branches.

You understand and agree that we will not cover:

- Surgery performed using only minimally invasive or intra-arterial techniques.
- Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

16. Third Degree Burns

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

17. Deafness

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

18. Loss Of Speech

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

All psychiatric related causes are excluded.

19. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterized by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a registered doctor who is a consultant neurologist. The condition must result in the inability of the life insured to perform (whether aided or unaided) at least 3 of the 6 “activities of daily living” for a continuous period of at least 6 months.

Activities of daily living:

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

20. Alzheimer’s Disease

Alzheimer’s (Pre-senile Dementia) disease is a progressive degenerative disease of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive Histopathological changes. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer’s disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the insured person. The diagnosis must be supported by the clinical confirmation of a neurologist and confirmed by our appointed medical practitioner.

The following conditions are however not covered:

- Non-organic diseases such as neurosis and psychiatric illnesses;
- Alcohol related brain damage; and
- Any other type of irreversible organic disorder/dementia

21. Parkinson’s Disease

The unequivocal diagnosis of progressive, degenerative Idiopathic Parkinson’s disease by a neurologist acceptable to us.

The diagnosis must be supported by all of the following conditions:

- The disease cannot be controlled with medication;
- Signs of progressive impairment; and
- Inability of the insured person to perform at least 3 of the 6 activities of daily living as listed below (either with or without the use of mechanical equipment, special devices or other aids and

adaptations in use for disabled persons) for a continuous period of at least 6 months:

Activities of daily living:
• Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
• Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
• Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
• Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
• Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
• Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence

Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

22. Pulmonary Artery Graft Surgery
The undergoing of surgery requiring Median Sternotomy on the advice of a cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

23. Medullary Cystic disease
Medullary cystic disease where the following criteria are met:
a. The presence in the kidney of multiple cysts in the Renal Medulla accompanied by the presence of Tubular Atrophy and Interstitial Fibrosis;
b. Clinical manifestations of Anaemia, polyuria and progressive deterioration in kidney function; and
c. The diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.
d. Isolated or benign kidney cysts are specifically excluded from this benefit.

24. Systemic Lupus Erythematous with Lupus Nephritis:-
A multi-system autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. In respect of this policy, Systemic Lupus Erythematous will be restricted to those forms of Systemic Lupus Erythematous which involve the kidneys (Class III To Class V Lupus Nephritis, established by renal biopsy, and in accordance with the who classification). The final diagnosis must be confirmed by a registered doctor specializing in Rheumatology and Immunology. The WHO classification of lupus nephritis:

Class I Minimal Change Lupus Glomerulonephritis
Class II Mesangial Lupus Glomerulonephritis.
Class III Focal Segmental Proliferative Lupus Glomerulonephritis.
Class IV Diffuse Proliferative Lupus Glomerulonephritis.
Class V Membranous Lupus Glomerulonephritis.

25. Pneumonectomy
The undergoing of surgery on the advice of an appropriate medical specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.
The following conditions are excluded:
• Removal of a lobe of the lungs (Lobectomy)
• Lung Resection or incision

3. Benefits:

General conditions applicable to all benefits and optional covers:
A. This Policy covers Reasonable and Customary Charges incurred towards medical treatment taken by the Insured Person, during the Policy Period, for an Illness, Injury or conditions described in the sections below, if it is contracted or sustained by an Insured Person during the Policy Period.
B. On a floater basis, the maximum, total and cumulative liability of the Company, in respect of all Insured Persons, for any and all Claims incurred under the Policy, during the Policy Year, shall not exceed the total Sum Insured for that Policy.
C. The Company shall provide reimbursement against loss, arising out of covers described in any of the benefits mentioned herein, that occurs during the Policy Period. Each benefit is subject to its Sum Insured, but the Company's liability to make payment in respect of any and all benefits (including optional benefits) shall be limited to the total Sum Insured, unless expressly stated to the contrary.

I. Section I -Basic covers
1. In Patient Hospitalization
If an Insured Person is diagnosed with an Illness or suffers an Injury contracted during the Policy Period which requires hospitalization in a hospital, on the advice of a medical practitioner then We will pay You, Reasonable and Customary charges/Medical Expenses incurred as below
i. Room Rent.
ii. Nursing charges for Hospitalization as an Inpatient excluding private nursing charges.
iii. Medical Practitioners' fees..
iv. Physiotherapy, investigation and diagnostics procedures directly related to the current admission;
v. Medicines, drugs as prescribed by the treating Medical Practitioner.
vi. Intravenous fluids, blood transfusion, injection administration charges and /or consumables.
vii. Operation theatre charges.
viii. The cost of prosthetics and other devices or equipment, if implanted internally during Surgery.
ix. Intensive Care Unit charges.

2. Pre-hospitalization: -

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy immediately before the Insured Person was hospitalised, provided that:

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's subsequent Hospitalisation was required, and

ii. There is a valid claim admissible under Section I.1, (In-patient Hospitalization), I.4 (Day Care Treatment), I.5 (AYUSH), I.6 (Domiciliary Hospitalization) of the Policy.

3. Post-hospitalization: -

The Medical Expenses incurred during the Policy Period, for the period as specified in the Schedule to this Policy, immediately after the Insured Person was discharged following Hospitalisation, provided that:

i. Such Medical Expenses were incurred for the same condition for which the Insured Person's earlier Hospitalisation was required, and

ii.There is a valid claim admissible under Section I.1, (In-patient Hospitalization), I.4 (Day Care Treatment), I.5 (AYUSH), I.6 (Domiciliary Hospitalization) of the Policy.

4. Day Care Treatment

The Company will Indemnify the Policy Holder/Insured Person for the expenses incurred which falls under the definition of Day Care Treatment mentioned under the definition of Day Care Treatment.

5. AYUSH

The Company will Indemnify the Policy Holder/Insured Person, the Reasonable and Customary Charges, up to the amount specified against this Benefit, for medical expenses incurred on the Insured Person's medically necessary and medically advised Inpatient Hospitalization during the Policy Period, on treatment taken under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) in AYUSH Hospital or AYUSH Day Care Centre.

6. Domiciliary Hospitalization

The Company will Indemnify the Policy Holder/Insured Person, , up to the Sum Insured, for the Medical Expenses incurred towards Domiciliary Hospitalization, i.e. coverage extended when Medically Necessary treatment is taken at home, subject to the conditions specified below:

1. This benefit covers pre and post domiciliary hospitalization medical expenses as specified in Clause 3.I.2 Benefit 3.I.3: Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses
2. The Medical Expenses are incurred during the Policy Year.
3. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or the patient takes treatment at home on account of non-availability of room in a hospital

7. Cumulative Bonus

At the end of each Policy Year, the Company will enhance the Sum Insured, on a cumulative basis, as a Cumulative Bonus for each completed and continuous Policy Year, provided that no Claim has been lodged or paid by the Company in the expiring Policy Year, subject to the conditions specified below:

1. If you renew your Policy with Us without any break in the Policy Period and there has been no claim in the preceding year, then We will increase the Limit of Indemnity by 50% of Sum Insured per annum as Cumulative Bonus. The maximum cumulative increase in the Limit of Indemnity will be limited to 100% of Sum Insured as cumulative bonus.
2. In case no claim is made in a particular Policy Year, No Claims Bonus would be credited automatically to the subsequent Policy year, even in case of multi-year Policies (with policy term of 2 years and 3 years).
3. In case a claim is made during the Policy Year, the No Claims Bonus will reduce at the same rate at which it is allotted for every claim-free year, but in no case shall the Total Sum Insured be less than the Sum Insured.
4. This clause does not alter the Company's right to decline renewal or cancellation of the Policy for reasons as specified in Clause 12.4 (Disclosure to Information Norm).

Other Covers – (applicable for section II to Section VIII)

The benefits below are optional and stand to be effective only if shown in the Policy Schedule as being effective. Our maximum liability will be limited to the amount specified in the Policy Schedule within the basic sum insured of the Policy or which is over and above the basic Sum Insured.

II. SECTION II - Optional Covers

1. Hospital Cash Benefit

If, during the Policy Period, an Insured Person sustains bodily Injury or illness which, directly , results in the Insured Person being in a Hospital as an In-patient. The Company will pay the amount as specified in the Policy Schedule for each continuous and completed period of 24 hours subject to Company has accepted the Insured Person's claim under section I. 1 (In Patient Hospitalization).

We will not make payment for the deductible period per event, as mentioned in the Policy Schedule.

This Benefit shall not be payable for more than the number of days per Policy Year, as specified in the Policy Schedule.

This cover is applicable if it is shown on your schedule.

Our maximum liability will be limited to the Sum Insured mentioned for this cover in the Policy Schedule which is within basic Sum Insured.

2. Convalescence Benefit

The Company will pay a fixed amount, as specified against this Benefit, up to a maximum number of days of Hospitalization during the Policy Year for each continuous and completed period of 24 hours of Hospitalization for recovery of the Insured Person, subject to the conditions specified below:

1. The Hospitalization period exceeds number of continuous days as specified in policy schedule.
2. The Company will be liable to pay from a block of number days of continuous Hospitalization arising from Any One Illness or Accident.
3. The Company has accepted the recipient Insured Person's claim under Benefit 3.I.1 In Patient Hospitalization.

This cover is applicable if it is shown on your schedule.

Our maximum liability will be limited to the Sum Insured mentioned for this cover in the Policy Schedule which is within basic Sum Insured.

3. Restoration

The Company will restore 100% of the Sum Insured once in a policy year on indemnity basis in case the Total Sum Insured inclusive of earned cumulative Bonus (if any) is exhausted due to claims paid or accepted as payable during the Policy Year, subject to the conditions specified below:

1. This restored Sum Insured can be utilized only for illness / disease / Injury unrelated to the illness / diseases for which claim/s was / were made in the particular policy year.
2. The Restoration Benefit will be triggered by Section I.1 (In-Patient Hospitalization), Section I.2, I.3 (Pre Hospitalization and Post Hospitalization), Section I.6 (Domiciliary Hospitalization), Section I.4 (Day Care treatment), Section II.6 (Emergency Ambulance if opted), Section II.7 (Organ Donor if opted), Section I.5, (AYUSH), Section VI.1 (Maternity if opted)
3. Restoration will not trigger on the first claim.
4. In case the Restored Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.
5. Any restored Sum Insured will not be used to calculate the Cumulative Bonus (No claim Bonus).
6. Cumulative Bonus shall not be considered while calculating restored Sum Insured.
7. For Individual policies, restored Sum Insured will be available on individual basis whereas in case of a Family Floater policy it will be available on floater basis.
8. For any single claim during a policy year, the maximum claim amount payable shall be sum of:
i. The Sum Insured
ii. Cumulative Bonus (if earned).
9. During a Policy Year, the aggregate claim amount payable, subject to admissibility of the Claim, shall not exceed the sum of:
i. The Sum Insured
ii. Cumulative Bonus (if earned)
iii. Restored Sum Insured.
10. In case of Portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring policy, including Restoration.
11. This benefit would be applicable if specially opted for by the Insured.
12. Deductibles if any will stay as per this Policy.

4. Recharge

The Company will replenish 100% of the Sum Insured on indemnity basis once in a policy year in case the Total Sum Insured inclusive of earned Cumulative Bonus (No Claim Bonus)(if any) is insufficient due to claims paid or accepted as payable during the Policy Year, subject to the conditions specified below:

1. The Recharge Benefit will be triggered by Section I.1 (In-Patient Hospitalization), Section I.2, I.3 (Pre Hospitalization and Post Hospitalization), Section I.6 (Domiciliary Hospitalization), Section I.4 (Day Care treatment), Section II.6 (Emergency Ambulance if opted), Section II.7 (Organ Donor if opted), Section I.5 and (AYUSH), Section VI.1 (Maternity if opted)
2. Recharge Benefit can be utilized even for the same hospitalization or for the treatment of diseases / illness / injury related /unrelated to claim for which claim was paid / payable under the policy.
3. In case the Recharge Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.
4. Any Recharge Sum Insured will not be used to calculate the Cumulative Bonus (No Claim Bonus).
5. Cumulative Bonus (No Claim Bonus) shall not be considered while calculating the Recharge Sum Insured.
6. For Individual policies, Sum Insured will be available on individual basis whereas in case of a Family Floater policy it will be available on floater basis.
7. In case of Portability, the credit for continuity in Sum Insured would be available only to the extent of Sum Insured of the expiring policy.

5. Emergency Ambulance

The Company will indemnify the Policy Holder/Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit, for the Reasonable and Customary Charges necessarily incurred on availing Ambulance services offered by a Hospital or by an Ambulance service provider for the Insured Person's necessary transportation, provided that the necessity of such Ambulance transportation is certified by the treating Medical Practitioner, subject to the conditions specified below:

1. Such Transportation is from the place of occurrence of Medical Emergency of the Insured person, to the nearest Hospital; and/or
2. Such Transportation is from one Hospital to another Hospital for the purpose of providing better Medical aid to the Insured Person, following an Emergency.
3. The Company will not make a payment under this Benefit if the insured person is transferred to a Hospital or diagnostic centre for

evaluation purposes only and not for treatment purpose.
4. The Company has accepted the recipient Insured Person's claim under Section I.1 (In-patient Hospitalization) of the Policy.

This cover is applicable if it is shown on your schedule.
Our maximum liability will be limited to the Sum Insured mentioned for this cover in the Policy Schedule which is within basic Sum Insured.

6. Organ Donor Cover

The Company will Indemnify the Policy Holder/Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit, for the Medical Expenses incurred for an organ donor's in-patient treatment for the harvesting of the organ donated, subject to the conditions specified below:
1. The donation conforms to The Transplantation of Human Organs Act 1994 and amendments thereafter and the organ is for the use of the Insured Person.
2. We only pay for transplants carried out and also the organ procurement is in accordance with applicable laws of particular country.
3. The recipient Insured Person has been Medically Advised to undergo an organ transplant.
4. The Company has accepted the recipient Insured Person's claim under section I.1 (In Patient Hospitalization).

The Company shall not be liable to make any payment in respect of below:
1. Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the organ donor.
2. Screening or Medical Expenses of the organ donor.
3. Costs directly associated with the acquisition of the donor's organ.
4. Expenses related to organ transportation or preservation.
5. Medical treatment or complication in respect of the donor, consequent to harvesting.

6. We do not pay for any– Stem cell harvesting,
– Tissue transplants including those from the patient's own body (other than bone marrow transplants),

This cover is applicable if it is shown on your schedule.
Our maximum liability will be limited to the Sum Insured mentioned for this cover in the Policy Schedule which is within basic Sum Insured.

III. Section III- Special optional Covers

1. Unlimited Restoration

Unlimited restoration is extension of Restoration (Benefit section II .4) , hence all the provisions are mentioned under Section II.4 will be applicable to this cover except that the restoration will be available unlimited during the policy year.

In case of unlimited restoration is opted, restoration benefit can not be opted for.
In case of single claim maximum liability of company shall not exceeds the sum insured.

2. worldwide cover

On payment of additional premium, coverage of this policy will be extended to world wide except Domiciliary Hospitalization (Section I.6).
This cover will be applicable only if mentioned in policy schedule.

Terms and conditions for Worldwide coverages for Assistance Services are as per the "Section 3.II.X -Assistance Services – Within India & Worldwide

If the insured has opted for worldwide coverage on Renewal, then waiting period will apply afresh for any treatment taken outside India.

3. 241 Optional Cover

On receipt of additional premium, we agree to waive the first renewal premium of this Policy, provided:
1. There is no claim paid/ admissible to you during the term of this optional coverage .
2. There is no claim paid/admissible against the policy in particular policy year. In Individual policy, the claim paid/admissible will be considered on respective member who has made the claim. For other members who have not made a claim, premium waiver will be applicable in case of renewal.
3. There is no claim paid/admissible against any members in a floater policy. In case if any member has made a claim, premium will be applicable for all the members in a floater policy in case of renewal
4. This optional benefit has been purchased with this policy for the first time (Individual + Floater), and not an existing policy.
5. This premium waiver benefit is applicable only for the first renewal of the policy and not available at subsequent renewals.
6. This optional benefit is offered only once at the time of initial entry of the insured of this Policy.
7. This optional cover is applicable for 1 year policy term only

Specific conditions for this Optional cover:
1. This coverage can be taken only with this Policy that we've issued you.
2. If you make a claim under this Policy and/or other optional covers (except Dental Benefit and Vaccination Cover) that you've taken, it will be considered as a Claim even for the purpose of this cover. The benefits of this cover will end once you make such a Claim.
3. In case of claim in first policy year is reported by insured in a renewal policy where premium is waived, then we will communicate the insured for payment of requisite premium in renewal policy and policy will continue with continuity benefit. If premium

is not received within 15 days of receipt of communication from client, then renewal policy will get cancelled ab Initio, Company will not be on risk during the period when the premium is not received by us.

4. You can't cancel only this cover in between the policy year , the entire policy needs to be cancelled, but if the policy is within free look period, then customer can cancel this cover without this Edelweiss HealthPlus Insurance Policy being canceled.Similarly, if you cancel Edelweiss HealthPlus Insurance Policy, this cover is also cancelled automatically.

5. You can't include new members for this cover in the middle of your policy term. It has to be taken only at the start.

6. This cover is subject otherwise to the terms, exceptions, conditions and limitations of Edelweiss HealthPlus Insurance Policy

This benefit is subject otherwise to the terms, exceptions, conditions and limitations of this Policy.

4. Policy Extension

By opting this optional cover, the coverage for the Insured Person shall be extended for period, insured no longer resides in India subject to the conditions specified below:

i) Policy will get extended till the time insured has applied for an extension.

ii) The policy holder needs to intimate us of the period of extension to enable us to provide the necessary documents to the customer. (Endorsement).

iii) we will require a documented details confirming you travel abroad.

iv) If this add on is selected then Section III.2 (World wide cover) cannot be opted for

v) If customer has opted for this optional cover, then he/she will be covered for the extended period taken beyond the policy expiry date. The customer will not be covered for the period of extension availed and intimated to us during the policy period.

vi) The applicable waiting period under the policy would continue after the completion of period of extension opted by the customer. The waiting period will be extended for the same days for which extension was taken and continuity of waiting period and policy cover will not be applicable/available during availed extension period.

vii) Minimum continuous extension period cannot be less than 30 days and more than 180 days during the policy year.

viii) Total extension period cannot be more than 180 days during policy year and this option can be opted only once in a policy year.

ix) Extension cannot be permitted prior to 30 days from policy expiry date.

x) This coverage is applicable only for individual basis policy.

xi) Other members of the policy which is issued on Individual basis and who are not eligible for this benefit will get the same policy period as mentioned in base policy and the policy will renew for such members excluding the member who has utilized this benefit.

xii) Extension of the policy will be allowed subject to Policy period corresponding to the member exit date and re-entry date in India as shown in the passport copy.

xiii) Voluntary extension of policy not related to traveling abroad is not allowed.

xiv) Grace period in policies with extension cover opted will commence after the policy end period including the extension period.

xv) This option can be opted for during the policy inception or at renewal only

5. Adventure Sports Cover

By selecting this Cover, participation in Adventurous sports will be included in the cover that you have opted for (all or any of the following), provided participation is under the supervision of a trained professional:

The coverages, terms & conditions, exclusions mentioned in benefit Section I.1 (In Patient Hospitalization) , I.2 (Pre-hospitalization) , I.3 Post Hospitalization , I.4 (Day care treatment), II.6 (Emergency Ambulance) , Section VII Personal Accident will be applicable in this benefit.

This cover is applicable if it is shown on your schedule.

Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within basic sum insured of policy.

Exclusion IX. Hazardous or Adventure sports: Code- Excl09 is not applicable if this cover is opted.

Special Conditions

1. Such extension will not result into any increase in Sum Insured of the respective Coverage.

2. You shall follow/adhere to all safety measures and guidelines laid down by the instructors/trainers/coaches/the organization conducting the adventure sports while engaged in the adventure sports.

What Is Not Covered

Non-adherence to the guidelines / instructions of the organizers of Adventurous sports.

Participation in Adventurous sports without supervision of trained professional.

6. Prosthetics Cover:
By Opting this cover, we will indemnify the cost towards external prosthetic equipment required during hospitalization, towards theinitial or replaced prosthetic device when all of the following criterias are met:
A) The prosthetic device replaces a limb or a body part, limited to:
• Artificial arms, legs, feet, and hands.
• Artificial face, eyes, ears, and nose.
• Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras.

B) The prosthetic device is ordered by or under the direction of a medical Practitioner
C) The prosthetic device is Medically Necessary.
D) The Company has accepted the recipient Insured Person's claim under Benefit 3.I.1 **In Patient Hospitalization.**

This cover is applicable if it is shown on your schedule.
Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within basic sum insured of policy.

7. Reconstructive Surgery
If, during the Policy Period, the Insured Person sustains bodily injury/ Accident , which requires reconstructive surgery (for cosmetic purpose) within six months from the date of loss, the Company agrees to pay the actual cost of reconstructive surgery upto the limit specified in the Policy Schedule.

For this cover **Reconstructive surgery** means surgery to reconstruct cutaneous or underlying tissue changed/damaged by an accident, prescribed as necessary by the Medical Practitioner.

This cover is applicable if it is shown on your schedule.
Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within basic sum insured of policy.

Claim arising out of pre-existing injuries will not be covered under this benefit
Exclusion VIII Cosmetic or plastic Surgery: Code- Excl08 will not applicable if this cover opted.

8. Accidental Booster
The Company will replenish upto 100% of the basic Sum Insured on indemnity basis in case the Basic Sum Insured is completely/ partially utilised due to claims paid or accepted as payable for hospitalization arising out of an accident during the Policy Year, subject to the conditions specified below:
1. The Accidental Booster Benefit will be triggered due to admissible claim arise out of an accident under Section I.1 (In-Patient Hospitalization), Section I.2, I.3 (Pre Hospitalization and Post Hospitalization), Section I.4 (Day Care treatment), Section II.6 (Emergency Ambulance if opted), Section II.7 (Organ Donor if opted)
2. The replenished amount would be equal to admissible claim amount but not exceeding the basic insured in the policy.
3. This cover would trigger even in cases of multiple accidental claims, however the total amount (inclusive of all accidental claims) replenished would not exceed the basic insured taken.
4. This Accidental Booster Sum Insured can be utilized only for illness / disease/injury unrelated to the injuries for which claim/s was / were made in the particular policy year.
5. Accidental Booster will be triggered only for the accident occurred during the same policy year.
6. In case the Accidental Booster Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.
7. Any Accidental Booster sum Insured will not be used to calculate the Cumulative Bonus (No Claim Bonus).
8. Cumulative Bonus (No Claim Bonus) shall not be considered while calculating the Accidental Booster Sum Insured.
9. For Individual policies, Sum Insured will be available on individual basis whereas in case of a Family Floater policy it will be available on floater basis.

9. Pre-existing Disease Waiting Period Reduction
On payment of additional premium pre-existing waiting period shall be reduced.
This cover will be applicable only if specified in the policy Schedule.
Waiting period will be Reduced only for the disclosed pre-existing diseases which has been accepted by Us at the inception of policy.
By opting this cover, Exclusion clause 5.1.I will be altered

This cover will not be applicable for any permanent exclusions which are specified in the Policy Schedule
This cover will not be applicable for Section VIII.2 Critical Illness Benefit and Section VII -Personal Accident cover section of the policy.

IV. Section IV - Pandemic Benefit Cover-

1) Pandemic Disease Benefit Cover –
By Opting this cover , in addition to the basic cover we will pay the Lump sum benefit equal to amount specified under this cover shall be payable on positive diagnosis of pandemic disease requiring hospitalization for a minimum continuous period of 72 hours. The positive diagnosis of disease shall be from a government authorized diagnostic centre.

Note:
i. Payment will be made only on Hospitalisation for a minimum

continuous period of 72 hours following positive diagnosis for pandemic disease.
ii. This is onetime benefit applicable for the entire tenure of the Policy and shall terminate upon payment of this benefit.

Pandemic -
A pandemic is an epidemic occurring on a scale which crosses international boundaries, usually affecting a large number of people. The World Health Organization (WHO) declare to be a pandemic when it became clear that the illness was severe and that it was spreading quickly over a wide area.
This cover is applicable if it is shown on your schedule.
Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule over and above the basic sum insured of policy.

2) Home Care Treatment Expenses:
Home Care Treatment means Treatment availed by the Insured Person at home for pandemic disease on positive diagnosis in a Government authorized diagnostic Centre, which in normal course would require care and treatment at a hospital but is actually taken at home maximum up to 14 days per incident provided that:
a) The Medical practitioner advices the Insured person to undergo treatment at home.
b) There is a continuous active line of treatment with monitoring of the heal.th status by a medical practitioner for each day through the duration of the home care treatment.
c) Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained .
d) Insured shall be permitted to avail the services as prescribed by the medical practitioner. Cashless or reimbursement facility shall be offered under homecare expenses subject to claim settlement policy disclosed in the website.
e) In case the insured intends to avail the services of non-network provider claim shall be subject to reimbursement, a prior approval from the Insurer needs to be taken before availing such services.

In this benefit, the following shall be covered if prescribed by the treating medical practitioner and is related to treatment of Pandemic disease,
a. Diagnostic tests undergone at home or at diagnostics centre
b. Medicines prescribed in writing
c. Consultation charges of the medical practitioner
d. Nursing charges related to medical staff
e. Medical procedures limited to parenteral administration of medicines
f. Cost of consumables

This cover is applicable if it is shown on your schedule.
Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within basic sum insured of policy.

V. Section V Outpatient Expenses

1. Out-Patient Consultation
We will cover OutPatient consultation taken by insured person during policy period provided that
i. We will cover the number of consultations as specified in the Policy Schedule.
ii. This benefit can be availed either through a Cashless Facility or on Reimbursement basis.
iii. In case of Reimbursement, a maximum amount limit as specified in the Policy Schedule shall be applicable under this benefit.
iv. The number of consultations will be applicable for all Insured Persons on a cumulative basis for the Policy year.
Any unutilized number of consultations cannot be carried forwarded to the next Policy Year.
This cover is applicable if it is shown on your schedule.
Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule over and above the basic sum insured of policy

2. Out-Patient Dental
Under this Benefit, We will pay Reasonable and Customary Charges to cover the fees of a dental practitioner and associated costs for carrying out the following routine Dental Treatment procedures in respect of an Insured Person:
- Clinical Oral examinations;
- Palliative treatment for dental pain;
- Root canal Treatment
- Normal compound fillings; or
- Simple non-surgical extractions.

This cover is applicable if it is shown on your schedule.
Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule over and above the basic sum insured of policy

Exclusions Applicable to Dental Benefit

We will not pay benefit for the following treatment:
a) Bite registration
b) request for Treatment or dental surgery which is not advised and/or recommended by a Dentist, including any Dental Services which are not Medically Necessary
c) any Dental Service solely for cosmetic and/or aesthetics purposes.
d) medications that need to be taken post treatment, expenses for toothbrushes, toothpaste, dental floss, mouthwash.

VI. Section VI- Infertility , Maternity & Baby care

1. Maternity Cover

On Payment of additional premium we will pay the In-Patient Medical Expenses related to pregnancy, childbirth or medically recommended and lawful termination of pregnancy, limited to maximum 2 deliveries or termination(s) or either, during the lifetime of the insured person as below:-.

i. We will cover the Medical expenses for maternity including complications of maternity which requires hospitalization.

ii. We will also cover expenses towards lawful medical termination of pregnancy which requires hospitalization during the Policy period.

iii. In patient Hospitalization Expenses of pre-natal and post-natal hospitalization

Conditions:

i. Waiting Period of 12 months from the date of inception of this cover with us. However this 12 months exclusion would not be applicable in case of continuous renewal of this cover and without break in cover.

ii. Medical Expenses for ectopic pregnancy are not covered under this Benefit. However, these expenses are covered under Section I.1(In-Patient Hospitalization) as opted.

iii. This benefit is available for Self or Spouse (as may be applicable) under this policy.

iv. The Insured Person must have been covered as an Insured under this Policy for a period of 12 months continuously and without any break,

This cover is applicable if it is shown on your schedule.

Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within basic sum insured of policy.

Exclusion XVIII will get waived by opting this cover.

2. Pre-Natal and Post natal

By Opting this cover we will pay the out-Patient Pre-natal & Post natal Expenses limited to maximum 2 children or termination(s) or either, during the lifetime of the insured person as below –

- Consultation related to maternity
- Medicine and vaccination charges related to maternity insured
- Diagnostic test related to maternity of insured person

Condition –

i) We will cover the Medical expenses for pre-natal and post natal on Out Patient basis.

ii) We will also cover expenses towards lawful medical termination of pregnancy on out patient basis .

iii) Waiting Period of 12 months from the date of inception of this cover with us. However this 12 months exclusion would not be applicable in case of continuous renewal of this cover and without break in cover.

Note- Here Prenatal would mean complete antenatal period, and Post natal would mean up to six weeks after date of delivery.

This cover is applicable if it is shown on your schedule.

Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within basic sum insured of policy.

Exclusion XVIII will get waived by opting this cover.

3. Infertility

By Opting this cover the Company will indemnify the expenses incurred on hospitalization for infertility, Under Section 3,I,1 (In Patient Hospitalization) , 3.I.2 (Pre-hospitalization), 3.I.3 (Post-hospitalization).

Claim under this cover is acceptable only for in vitro fertilization procedure.

Definition -

For this coverage infertility is defined as ONE of the following:

- The inability of opposite-sex partners to achieve conception after at least one year of unprotected intercourse.
- The inability of opposite-sex partners to achieve conception after six months of unprotected intercourse when the female partner trying to conceive is age 35 or older.
- The inability of a woman, with or without an opposite-sex partner, to achieve conception after at least six trials of medically supervised artificial insemination over a one-year period.
- The inability of a woman, with or without an opposite-sex partner, after at least three trials of medically supervised artificial insemination over a six-month period of time when the female partner trying to conceive is age 35 or older.

In the absence of a diagnosis of infertility, in-vitro fertilization (IVF) services are considered not medically necessary.

Conditions

- This benefit is available for Self or Spouse (as may be applicable) under this policy.
- The coverage under this Add-on shall be given to legally married couple
- The Insured Person must have been covered as an Insured under this Policy for a period of 24 months continuously and without any break.
- Waiting Period of 24 months from the date of inception of this cover with us. However this 24 months exclusion would not be applicable in case of continuous renewal of this cover and without break in cover.

Our Maximum Liability will be within the basic sum insured mentioned in the policy.

Exclusion XVIII will get waived by opting this cover.

4. Surrogacy (Surrogate Mother)
The Company will Indemnify the Policy Holder/Insured Person, through Cashless or Reimbursement Facility, up to the amount specified against this Benefit, for the Medical Expenses incurred for an surrogate mother as an in-patient treatment for the child birth, as the insured person and/or legally wedded partner is unable to conceive pregnancy subject to the conditions specified below:
1) The donation conforms to The surrogacy Act
2) Health issues or any other related health conditions prevent a self or legally wedded spouse from getting pregnant or carrying a pregnancy to term.
3) Infertility issues prevent self or legally wedded spouse from either getting or staying pregnant, like recurrent miscarriages.
4) A prior approval should be taken from us before the surrogacy procedure is performed.
5) Waiting Period of 24 months from the date of inception of this cover with us. However this 24 months exclusion would not be applicable in case of continuous renewal of this cover and without break in cover
6) Documentary evidences and reports for the reason leading to need of surrogacy is required.
7) The coverage under this option shall be applicable to only one child per policy year.
8) If self or spouse is not insured then details of their documents certifying infertility issues will be required.

The Company shall not be liable to make any payment in respect of below:
1) Same-sex couples wish to have children.
2) Single people want to have biological children.
3) Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses of the surrogate mother.
4) Screening or any other Medical Expenses of the surrogate mother.
5) Costs directly associated with the compensation / pay out to the surrogate mother .
6) Medical treatment or complication in respect of the surrogate mother, consequent to surrogacy.
7) Without any Medical necessity

Our Maximum Liability will be within the basic sum insured mentioned in the policy.

Exclusion XVIII will get waived by opting this cover.

5. New Born Baby cover –
New born babies of the policy holder/Insured shall be covered from day one i.e. from day of baby's birth or delivery and the maximum limit of liability under this cover as opted by insured / policy holder, allowed maximum up to two children.
Sum insured options are as below:
1) Baby covered from day one limited to maternity sum insured
2) Baby covered from day one up to sum insured opted by members

Coverage-
We will cover the baby's in-patient hospitalization for an Illness or Injury during the Policy Period which needs hospitalization in a hospital , on the advice of a medical practitioner.
Pre-Post hospitalization expenses for Your baby will be payable as per the basic cover under this Policy, upto maternity limit/full Sum Insured as opted by You.
Policy period / coverage for Newborn Care is for a period of 90 days i.e. from date of birth to 90 days of baby's age any time during the policy period.
Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is within the basic Sum Insured of the policy.

III. Special conditions for this Optional cover (Other than those of this Policy)
1. This cover can be opted only at first policy inception or at the renewal of the Policy.
2. You can't cancel this cover solely in between the policy year, the Policy needs to be cancelled, except at the time of renewal of the Policy, but if the policy is within free look period, then the customer can cancel this cover without base policy being cancelled. If you cancel your base insurance Policy, this coverage shall also stand cancelled along with it.
3. This optional cover should be available in your Policy on the date of loss.
4. This coverage will be rendered effective on and from your baby's date of birth, provided this coverage has been opted for prior to the said date of birth of Your baby. First 30 days waiting period and pre-existing condition exclusion will not be applicable for the baby.
5. No matter what the waiting period of the maternity benefit in Your existing Policy, the baby will be covered from day one as per the Sum Insured option chosen.
6. This benefit is given for one's self and/or spouse, as mentioned in a family floater under this Policy.
7. This coverage shall cease to be in effect once the baby reaches 91 days of age. The Insured can apply for a fresh Policy for the baby, as per the underwriting guidelines of the Company.
8. The coverage under this option shall be applicable to only one child per policy year.
9.The coverage under this option shall be given to a baby of a legally married couple, up to a maximum of any two children.
10. No charges will be paid for umbilical cord occult blood preservation.
11. This cover can be opted only at the time of purchase/ renewal of this Policy and prior to birth of the baby subject to underwriting guidelines of the Company.
12. Pre-post benefit for this cover will be available as per this Policy.

13. All other terms & conditions, exclusions & deductibles stay as per this Policy.

6. Vaccination cover

We will cover vaccinations of dependent child/children Immunization expenses for the amount of Sum Insured mentioned in the policy schedule until the dependent child completes 12 years of age.

To avail this benefit dependent child(ren) must be insured person under the policy.

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is over and above the basic Sum Insured as opted and mentioned in policy schedule.

List of Vaccines

Sr	Age	Vaccine
1	Birth	BCG+ OPV Hep B1
2	6th Weeks	DTwp1/DTap1
		OPV1+IPV1+Hib1
		Hep B2
		Rotavirus
		Pneumococal (PCV10/13)
3	10th weeks	DTwp2/DTap2
		OPV2+IPV2+Hib2
4	14th weeks	DTwp3/DTap3
		OPV3+IPV3+Hib3
5	6th month	Hep B3 +OPV4
6	> 6 month	Flu vaccine
7	9th month	MMR1
8	> 9 months	Typbar TCV (conjugated typhoid) (1 year Apart)
9	> 1 year	Varicella (Chikenpox) 6 months aprt
10	> 1 year	Hepatitis A
11	15-18 month	DTwpB1/DTapB1
		OPV5+IPVB+Hib B1
		MMR2
12	2 Years	Typhoid polysaccharide
13	5 Years	DTwPB2/DTapB2
		MMR B
14	10 years	Tdap
15	15 years	TT
16	Girls- 9 yrs-14 yrs (2 doses)	Cervical cancer Vaccine

VII. Section VII – Personal accident cover –

General conditions applicable to all benefits

i. This Policy covers an Injury or conditions described in the sections below, if it is contracted or sustained by an Insured Person during the Policy Period.

ii. The sum insured under this cover can utilized on an individual basis only.

iii. For a Family Floater policy , this cover is applicable for the Proposer who is an earning member and covered as an Insured under the policy. This cover is not applicable for the other members covered under the floater policy. The maximum, total liability of the Company, , for any and all Claims arising out of/incurred under this section, during the Policy Year, shall not exceed the total Sum Insured for accidental death of that Policy.

iv. In case of an individual policy, this cover is applicable for an Insured who is an earning member specified in Proposal form.

v. The Company shall provide reimbursement against accidental injury , arising out of a covered event or occurrence described in any of the benefits mentioned herein, that occurs during the Policy Period. Each benefit is subject to its Sum Insured, but the Company's liability to make payment in respect of any and all benefits under this section shall be limited to the Sum Insured against Accidental Death.

vi. Children between 4 years to 18 years of age can be covered only if either parent is covered under the same or different policy with reference to covers Accidental Death Benefit (ADB), Permanent Total Disability (PTD, Permanent Partial Disability (PPD). Temporary Total Disability is applicable only for earning persons above 18 years.

vii. Income tax benefit is not applicable on premium paid for Personal Accident Cover.

1. Accidental Death Benefit (ADB) –

If an Insured Person suffers an Accidental bodily Injury during the Policy Period, which is the sole and direct cause of his death within 365 days from the date of such Accident, then the Company will pay the Sum Insured, as specified in the Policy Schedule against this benefit, to the Claimant, subject to the terms & conditions of this Policy.

Upon making payment against a Claim under this benefit, the Policy shall terminate for the Insured Person, in favour of whom such payment has been made.

Our maximum liability will be limited to the amount specified in the Policy Schedule.

2. Permanent Total Disability (PTD)

I. If an Insured Person suffers an Accidental bodily Injury, during the Policy Period, which is the sole and direct cause of his permanent total disablement, occurring within 365 days from the date of such Accident in one of the ways detailed in the table below, then we will pay the percentage of the Sum Insured shown in the table.

Permanent Total Disability	
Table of Benefits	Percentage of Capital Sum Insured Payable
i) Loss of sight of both eyes	100%
ii) Loss of, by physical separation of two entire hands or two entire feet	100%
iii) Loss of one entire hand and one entire foot	100%
iv) Loss of sight of one eye and such loss of one entire hand or one entire foot	100%
v) Complete loss of hearing of both ears and complete loss of speech	100%
vi) Complete loss of hearing of both ears and loss of one limb/loss of sight of one eye	100%
vii) Complete loss of speech and loss of one limb/loss of sight of one eye	100%

II) In this Benefit:

a) Limb means a hand at or above the wrist or a foot above the ankle;

b) Loss of Limb means:

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.

c) Includes cover for paralysis, including paraplegia and quadriplegia with loss of functional use of Limbs.

d) Once a claim has been accepted and paid under this Benefit, the cover under this Benefit shall immediately and automatically cease to be effective in respect of that Insured Person.

e) The degree of disablement shall be assessed by an independent medical practitioner.

Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within the basic sum insured of the Policy.

Any payment made under this benefit shall be deducted from any Accidental Death and/or Permanent Partial Disability and/or Temporary Total Disability, if opted for under this Policy, which ultimately becomes payable under this Policy as a result of the Accident.

3. Permanent Partial Disability (PPD)

If an Insured Person suffers an Accidental bodily Injury during the Policy Period, which is the sole and direct cause of his permanent partial disablement within 365 days from the date of such Accident in one of the ways detailed in the table below, then we will pay the percentage of the Sum Insured shown in the table.

Permanent Partial Disability	
i) Sight of one eye	50%
ii) One hand or One foot	50%
iii) Loss of toes-all	20%
iv) Loss of Toes Great - both phalanges	5%
v) Loss of Toes Great - one phalanges	2%
vi) Loss of Toes Other than great, if more than one toe lost, each	1%
vii) Loss of hearing-both ears	50%
viii) Loss of hearing –one ear	15%
ix) Loss of speech	50%
x) Loss of four fingers and thumb of one hand	40%
xi) Loss of four fingers	35%
xii) Loss of thumb –both phalanges	25%
xiii) Loss of thumb- one phalanx	10%
xiv) Loss of index finger-three phalanges	10%
two phalanges	8%
one phalanx	4%
xv) Loss of middle finger-three phalanges	6%
two phalanges	4%
one phalanx	2%
xvi) Loss of ring finger-three phalanges	5%
two phalanges	4%
one phalanx	2%
xvii) Loss of little finger-three phalanges	4%
two phalanges	3%
one phalanx	2%
xviii) Loss of metacarpals-first or second,	3%
third, fourth or fifth	2%

In this Benefit:
a) 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 and We are satisfied at the expiry of the 365 days that there is no reasonable medical hope of improvement.

b If an Insured Person suffers a Loss not mentioned in the table above, then the degree of disablement shall be assessed by an independent medical practitioner
c) 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.
d) Any claim made under this benefit will not terminate the Policy.
e) If more than one Loss results from any one Accident, it will be paid on cumulative basis .

Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within the basic sum insured of the Policy.

Any payment made under this benefit shall be deducted from any Accidental Death and/or Permanent Total Disability and/or Temporary Total Disability, if opted for under this Policy, which ultimately becomes payable under this Policy as a result of the Accident.

4. Temporary Total Disability (TTD)
If an Insured suffers an accidental injury during the Policy Period which is the sole and direct cause of such disability , which completely prevents him/her from performing each and every duty pertaining to his/her employment or occupation, it shall qualify to be Temporary Total Disability.

Where an Insured has opted for an Elimination Period, a Claim against the circumstances described in a Hazard, as above, shall lie only after completion of such Elimination Period, as shall be shown in the Policy Schedule, provided that:
a) The temporary total disability is certified by the independent medical practitioner.
b) such period of disability commences within the Elimination Period shown in the Policy Schedule after the date of the Accident causing such Injury of any description whatsoever, then We will pay a weekly benefit post completion of Elimination period, provided that
c) such amount shall be payable as stated in the Policy Schedule, as applicable to such Insured Person; and the maximum period for which such amount shall be payable for any one such period of disability shall not exceed the maximum number of weeks payable as stated in the Policy Schedule
d) This Benefit is payable provided that the minimum absence (No of weeks as opted by the customer) from work must be for the consecutive days mentioned in policy schedule, post which if the Insured Person is disabled for a part of the period selected, then only a proportionate part of the weekly benefit will be payable.
e) This Benefit will be payable at the completion of the duration of temporary total disability. In case the temporary total disability continues for a period of more than 30 days then We will make payment of the amount due at the end of every calendar month provided the person continues to suffer from the temporary total disability at end of such period, the main claim is admissible and 'Fitness Certificate' issued by independent Medical Practitioner clearly states duration of rest &/or rehabilitation required.
f) We will not pay more than the Insured Person's gross weekly wage for the Temporary Total Disability benefit.
g) Our maximum liability will be upto the number of weeks specified in the Policy Schedule or the number of days/weeks through which the Insured Person is disabled above the Elimination Period, whichever is earlier.

Elimination Period means the number of consecutive days of Temporary Total Disability that must elapse before weekly benefit amounts become payable. The Elimination Period is shown in the Policy Schedule. Weekly benefit amounts are neither payable nor do they accrue during the Elimination Period.

Gross Weekly Wage - means the Insured Person's base weekly earnings in his or her occupation at the time of the Accident causing the Injury for which benefits are claimed under this cover, but does not include overtime, bonuses, tips, commissions, and special compensations.

Our maximum liability will be limited to the Sum Insured mentioned in the Policy Schedule within the basic sum insured of the Policy.

Any payment made under this benefit shall be deducted from any Accidental Death and/or Permanent Total Disability and/or Permanent Partial Disability, if opted for under this Policy, which ultimately becomes payable under this Policy as a result of the Accident.

VIII. Section VIII – Critical Illness

1. Double Sum insured for critical illness
By opting this cover the Company will indemnify the Policy Holder/Insured Person, through Cashless/Reimbursement facility, double the basic sum insured which is specified in the policy schedule for the payment under the basic covers of the policy (Section I) as opted. If the Double Sum Insured for Critical Illness option is not chosen, then the insured will be indemnified upto base SI as per the terms and conditions under section-I as opted by customer.

The conditions are as specified below:

1. The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period,
2. The basic sum insured – excluding Cumulative Bonus (No Claim Bonus) will be reinstated in case of opted critical illness is triggered.
3. In case the additional Critical Illness Sum Insured is not utilized in a Policy Year, it shall not be carried forward to subsequent Policy Year.
4. The Policy shall not cover the expenses if under double sum insured benefit if :
   i. The Insured Person is first diagnosed as suffering from a Critical Illness within 90 days of the commencement of the Policy Period and the Insured Person has not previously been insured continuously and without interruption under a Policy.
   ii. The Insured Person has already made a claim for the same Critical Illness.
   iii. All other terms & conditions, exclusions & deductibles stay as per your basic Policy
5. Waiting Period of 90 days from the date of inception of this cover with us. However this exclusion would not be applicable in case of continuous renewal of this cover and without break in cover.
6. If double Sum Insured option is not opted by the insured, then the waiting period applicable for these Critical illnesses would be as per the base sum insured . However this exclusion would not be applicable in case of continuous renewal of the policy without break in cover.
7. When the insured is admitted for any other illness other than the defined critical illness and in this course of admission and he has been diagnosed subsequently of the defined critical illness he shall be indemnified under this coverage

List of Critical illnesses plans for Double Sum Insured as below

Section VIII table 1

Sr. No.	Particulars	Plan name				
		(09 CI) Standard	(12 CI) Enhance	(15 CI) Premium	(18 CI) Elite	(25 CI) Ultima
1	Cancer Of Specified Severity	Yes	Yes	Yes	Yes	Yes
2	Kidney Failure Requiring Regular Dialysis	Yes	Yes	Yes	Yes	Yes
3	Multiple sclerosis With Persisting Symptoms	Yes	Yes	Yes	Yes	Yes
4	Major organ/Bone marrow transplant	Yes	Yes	Yes	Yes	Yes
5	Open heart replacement or repair of heart valves	Yes	Yes	Yes	Yes	Yes
6	Open chest coronary artery bypass graft (CABG)	Yes	Yes	Yes	Yes	Yes
7	Permanent Paralysis of limbs	Yes	Yes	Yes	Yes	Yes
8	Myocardial infarction (First heart attack of specific severity)	Yes	Yes	Yes	Yes	Yes
9	Stroke resulting in permanent symptoms	Yes	Yes	Yes	Yes	Yes
10	Benign brain tumour	x	Yes	Yes	Yes	Yes
11	Motor neuron disease with Permanent Symptoms	x	Yes	Yes	Yes	Yes
12	Coma of specified severity	x	Yes	Yes	Yes	Yes
13	End stage liver failure	x	x	Yes	Yes	Yes
14	Primary (idiopathic) pulmonary hypertension	x	x	Yes	Yes	Yes
15	Surgery of aorta	x	x	Yes	Yes	Yes
16	Third degree burns	x	x	x	Yes	Yes
17	Deafness	x	x	x	Yes	Yes
18	Loss of speech	x	x	x	Yes	Yes
19	Muscular dystrophy	x	x	x	x	Yes
20	Alzheimer's disease	x	x	x	x	Yes
21	Parkinson’s disease	x	x	x	x	Yes
22	Pulmonary artery graft surgery	x	x	x	x	Yes
23	Medullary cystic disease	x	x	x	x	Yes
24	Systemic Lupus Erythematous with lupus nephritis	x	x	x	x	Yes
25	Pneumonectomy	x	x	x	x	Yes

2. Critical Illness Benefit

Benefits under this Section are subject to the terms, conditions and exclusions of this Policy. The Sum Insured for the Benefit under this Section is specified in the Policy Schedule . Payment of the Benefit will be subject to the Sum Insured for this Benefit. If insured person is diagnosed as suffering from opted critical illness during the policy period then we will pay the lump sum amount as specified in the policy schedule , provided that

Critical illness which insured person is suffering from, and diagnosed as a critical illness '' during the policy period as first incidence

Upon admission of the first claim under this Section in respect of an Insured Person in any Policy Period, the cover under the Policy shall automatically terminate in respect of that Insured Person and no further Renewals will be allowed for that Insured Person under this Benefit. However basic policy can be renewed without this cover.

This cover is applicable for policies issued on individual basis only.

Waiting Period

We shall not be liable to make any payment in respect of any Critical Illness diagnosed within the first 90 days from the Inception Date.

Plans / list of Critical illnesses will be as per Section VIII table 1 above

Our maximum liability will be limited to the amount mentioned in the Policy Schedule, which is over and above the basic Sum Insured as opted and mentioned in policy schedule.

IX. Discount Covers

1. Room rent capping –

By opting this cover policy schedule will specify the eligibility of room rent or room rent category applicable for the insured under the policy.

If the actual room rate is more than the policy's per day limit, then associated medical expenses will be paid in the same proportion of the difference between the approved room rate/ room category and the actual room rate

The room rent category option available under this cover.

Percentage of sum insured basis -

If the policy schedule states the percentage of sum insured per day as eligible room rent and/or ICU, it means maximum eligible room rent and or ICU rent of insured person is limited to specified percentage of sum insured per day of hospitalization.

In case of opted room rent/ ICU are lower than eligible room / ICU then we will pay the room/ICU charges as per actuals.

2. Voluntary Co-pay –

1. If the insured opts for a Co-payment of percentage mentioned in the policy schedule, he is eligible for a corresponding premium discount;

2. Co-payment is applicable on each and every claim, which means the insured shall bear co-pay percentage (as opted by him) of each and every admissible claim for the sections mentioned in the policy schedule;

3. This Voluntary co-pay is not applicable on Hospital Cash Benefit, Convalescence Benefit, Section IV Pandemic Benefit Cover, Out Patient Expenses Cover, Maternity Cover, Vaccination Cover, Section VII Personal Accident cover, Maternity Cover, Vaccination Cover, Section VII Personal Accident cover, Section VIII Critical Illness

4. Eligible Insured person will get discount on premium on opting this optional cover.

3. Voluntary Deductible-

a) Top Up Deductible-

Claims made in respect of any of the benefits below will be subject to the Sum Insured

If any Insured Person suffers an Illness or Accident during the Policy Period that requires that Insured Person's Hospitalisation as inpatient, then We will pay for the Medical Expenses for the benefits mentioned below, in excess of the Deductible stated in the Schedule.

Our maximum liability for a continuous period of Illness, including relapses within 45 days from the last date of discharge from the Hospital or nursing home where treatment has been taken, shall be limited to the amount mentioned in the Schedule. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

This Voluntary Deductible is not applicable on Hospital Cash Benefit, Convalescence Benefit, Section IV Pandemic Benefit Cover, Section V Out Patient Expenses Cover, Maternity Cover, Vaccination Cover, Section VII Personal Accident cover, Maternity Cover, New Born baby Cover for sum insured within maternity limit , Vaccination Cover, Section VII Personal Accident cover, Section VIII Critical Illness .

b) Super Top Up Deductible -

Claims made in respect of any of the benefits below will be subject to the Sum Insured.

If any Insured Person suffers an Illness or Accident during the Policy Period that requires that Insured Person's Hospitalisation as inpatient, then We will pay for the Medical Expenses for the benefits opted by the Insured, in excess of the Deductible stated in the Schedule. Any claim under this Policy shall be payable by Us only if the aggregate of covered Medical Expenses in respect to Hospitalisation(s) of Insured Person (on Individual basis in case of Individual Policy and on Family Floater basis in case of Family Floater Policy) exceeds the Deductible applicable on per Policy Year basis.

Our maximum liability for a continuous period of Illness, including

relapses within 45 days from the last date of discharge from the Hospital or nursing home where treatment has been taken, shall be limited to the amount mentioned in the Schedule of Benefits. Occurrence of the same Illness after a lapse of 45 days as stated above will be considered as fresh Illness for the purpose of this Policy.

This Voluntary Deductible is not applicable on Hospital Cash Benefit, Convalescence Benefit, Section IV Pandemic Benefit Cover, Section V Out Patient Expenses Cover, Maternity Cover, Vaccination Cover, Section VII Personal Accident cover, Maternity Cover, New Born baby Cover for sum insured within maternity limit , Vaccination Cover, Section VII Personal Accident cover, Section VIII Critical Illness.

4. Increase in Pre-existing disease waiting period

By opting this cover, pre-existing disease waiting period would be increased from 36 months to 48 months

1. By opting this cover Pre-existing disease waiting period will be changed to 48 months from 36 months as mentioned in exclusion 5.1.I of the policy
2. Waiting period will be calculated from first policy inception
3. This option will be applicable only for the new business policies with Edelweiss General Insurance Company Limited at the time of inception only.
4. This waiting period will be applicable only on pre-existing diseases disclosed at the time of policy inception.
5. This cover will not be applicable for Section VIII.2 Critical Illness Benefit and Section VII -Personal Accident cover section of the policy

X. Assistance Services - Within India & Worldwide

Here the Eligible Domestic or Global Participant means "Insured person who is covered under this policy"

All the below mentioned assistance services would be provided by Us /through our appointed service provider. No claims for reimbursement will be applicable for this service. Hence to avoid any discomfort to insured it is advisable that insured should inform/intimate us in advance to utilize this services, the details of which are mentioned in the policy schedule.

1. Medical Referrals- On Assistance Services basis

Insured Person(s) will have tele-access to an operations center of Our Service Provider, who with their multilingual staff on duty will provide reference of doctors in the vicinity where the insured person is located for medical consultation.

Insured Person(s) will have telephone access to operations centre staff 24 hours a day every day of the year with multi lingual personnel for medical referral.

This cover is applicable if it is shown on your schedule.

2. Emergency Medical Evacuation - On Assistance service basis

Definitions:

Emergency Evacuation means:

(a) Your/ Insured Person(s) medical condition warrants immediate Transportation from the place where You/ Insured Person(s) are injured or sick to the nearest Hospital where appropriate medical treatment can be obtained; or (b) after being treated at a local Hospital, Your/ Insured Person(s) medical condition warrants Transportation to the place where the Trip commenced to obtain further medical treatment or to recover; or (c) both (a) and (b) above.

Transportation - means any land, water or air conveyance required to transport You during an Emergency Evacuation.

When an adequate facility is not available proximate to the Insured Person(s) , as determined by service providers consulting physician and Insured Person(s) attending physician, our service provider will arrange transportation under appropriate medical supervision, by an appropriate mode of transport to the nearest medical facility capable of providing the required care

This cover is applicable if it is shown on your schedule.

3. Medical Repatriation - On Assistance Services basis

Our service provider will arrange for transportation under medical supervision to the Insured Person(s) residence in India or to a medical or rehabilitation facility near such residence when our service provider's consulting physicians and the attending physician determines that transportation is medically necessary, at such time the Insured Person(s) is medically cleared for travel by our service provider's consulting physician and attending physician.

This cover is applicable if it is shown on your schedule.

4. Compassionate Visit – On Assistance service basis

When an Insured Person(s) will be hospitalized for more than 7 consecutive days and is travelling without a companion, service provider will arrange for a family member or friend to travel to visit the Insured Person(s) by providing an appropriate means of transportation via economy carrier transportation as determined by our service provider. The family member or friend is responsible to meet all VISA and travel document requirements if applicable.

This cover is applicable if it is shown on your schedule.

5. Medical Monitoring – On Assistance service basis

Medical Personnel will monitor Insured Person(s) condition and will i) Stay in regular communication with the attending Physician and / or Hospital and ii) Relay necessary and legally permissible information to family members.

This cover is applicable if it is shown on your schedule.

6. Second Medical Opinion – On Assistance service basis
Our appointed service provider will arrange for second medical opinions for Insured Person(s) for such services upon request in the following instances: i) When a Participant's medical condition is undiagnosed by a treating physician; ii) when a Participant seeks an additional medical opinion following an original diagnosis; and iii) when the determination of the most appropriate course of medical treatment is required based on a current diagnosis. The participant may contact our Assistance Service Provider's s operation centre to initiate the request for a medical consultation and the Participant is responsible for gathering, obtaining, and submitting to our Assistance Service Provider all required medical reports, charts, data, and medical history pertaining to the Participant's condition and responding to follow up requests for additional information. All information provided to Assistance Service Provider must be legible. The medical review will be undertaken by a physician / medical practitioner licensed to practice medicine and within a discipline that relates to the condition / diagnosis.
The second medical opinion will be provided to the Insured Person(s) in the electronic format and such opinion will be reached and rendered within 5 business days after all required medical history, data, reports, charts are properly submitted for consultation and review. The services solely relate to the provision of a medical opinion and does not include personal visits or follow-up for discussions for the implementation of course of treatment. If the Insured Person(s) seeks further involvement from the physician rendering the opinion or seeks to converse with or visit the Physician, such must be arranged on a fee for service basis with Assistance Service Provider facilitating such arrangements. All opinions rendered by the physician are the opinions of the physician and neither Edelweiss General Insurance Company Limited nor Assistance Service Provider is responsible or liable for the content of such opinions.

Exclusions:
Second Medical Opinion is not included for any health related claim where the second medical opinion will serve as a means to evaluate the Insured Person(s) claim in connection with coverage determination.

This cover is applicable if it is shown on your schedule.

7. Return of Mortal Remains – On Assistance Service basis
In the case of Insured Person(s) death , our service provider will arrange and pay for the return of mortal remains to an authorized funeral home proximate to the Insured Person(s) legal residence..

This cover is applicable if it is shown on your schedule.

Exclusion applicable to all Assistance services – applicable to coverage both within India and worldwide:

Service provider will not provide any of these services to an Insured Person(s) if i) the eligible participant undertook travel for the purpose of obtaining medical treatment, ii)injuries are sustained as a result of participation in acts of war or insurrection iii) injuries are incurred while participating in criminal activity or as a result of unlawful consumption of drugs iv)injuries are sustained as a result of attempted suicide
Service provider will not repatriate or evacuate an Insured Person(s) if the Insured Person(s) has i) no medical authorization ii) mild lesions, simple injuries such as sprain, simple fractures or mild sickness which can be treated by local doctors and do not prevent the Insured Person(s) from continuing the trip and returning home iii)if Insured Person(s) is pregnant and beyond the end of 28th week and with respect to the child born from the pregnancy, service provider will not evacuate or repatriate a child born while the Insured Person(s) was traveling beyond 28th week or Service provider will not provide services for trips exceeding 90 days from legal residence.

Claims Process Note for Availing services for Medical Referral, Emergency Medical Evacuation, Medical Repatriation, Compassionate Visit, Return of Mortal Remains:
1. Insured / Nominee calls our Assistance Service Provider operations to avail the medical assistance service.
2. Our empanelled Assistance Service Provider will do the validation and proceed with the case for the eligible member.
3. If member is eligible as defined, our Assistance Service Provider will activate the service.
4. If member is not eligible, explanation will be given to insured in a courteous manner.
5. Our Assistance Service Provider will inform to EGIC about the case and the case will be dealt with accordingly.

Claims Process Note for Availing services for Second Medical Opinion:

Option 1
1) Insured will call for SMO to our empanelled Assistance Service Provider operations centre
2) Our empanelled Assistance Service Provider will verify member eligibility based on enrolment data and send the Second Medical Opinion portal link to the member via email with a unique reference of EGIC.
3) Once the case is registered in service provider's portal, our empanelled Assistance Service Provider sends an auto mailer to member about the documents received.
4) Followed by notification email by our empanelled Assistance Service Provider to insured stating that your request has been received and proceed with the request.

5) Any further information required if any, our empanelled Assistance Service Provider to call the member directly/send email asking for additional information.
6) Once the insured submits the addition requested information, our empanelled Assistance Service Provider will begin working on Second Medical Opinion & from that date of the receipt of the medical report, Second Medical Opinion will be ready usually within five (5) to seven (7) business days.
7) Insured will receive the direct link on registered email address once report is ready. Insured can download the report can access in e-format or print it.
8) If insured wishes to teleconsult / televideo / consult with opinion-providing doctor, for any further diagnostic tests and/or line of treatment or discuss on opinion personally, the insured will directly pay to the doctor. for any such additional services.

Option 2
1) Insured will call/email for Second Medical Opinion to our empanelled Assistance Service Provider Operations centre and our empanelled Assistance Service Provider will verify member eligibility based on enrolment data.
2) In case the Insured is unable to upload report on the Second Medical Opinion portal, our empanelled Assistance Service Provider's coordinator to fill the details on portal on behalf of the insured member and request insured member for the reports either by scan copy via email and in case of hard copy will instruct the member to send the reports to address of our empanelled Assistance Service Provider operations centre.
3) Post updation of details and once the case is registered in service provider's portal, our empanelled Assistance Service Provider sends an auto mailer to member about the documents/-details updated on the portal.
4) Followed by notification email by our empanelled Assistance Service Provider to insured stating that your request has been received and proceed with the request.
5) Our empanelled Assistance Service Provider to check the report and revert in case of any deficiency to member.
6) Once the insured submits the addition requested information, the SMO team may begin working on SMO opinion & from that date report will be ready within five (5) to seven (7) business days.
7) Our empanelled Assistance Service Provider will send the soft copy of the Report to Member on the registered email address.
8) If insured wishes to teleconsult / televideo / consult with opinion-providing doctor, for any further diagnostic tests and/or line of treatment or discuss on opinion personally, the insured will directly pay to the doctor. for any such additional services.

4. Discounts/Loadings

Discounts Type	Discounts Percentage
1. Family Discount- A discount of 5% on total premium will be given if two or more family members are covered under the same policy under the individual policy option	5%
2. Long Term Discount- A discount of 7.5% and 10% on total premium will be given if a policyholder chooses to pay upfront premium for 2 years and 3 years respectively.	7.5% and 10%
3. Edelweiss Group Employee Discount - A 5% discount on the premium if he/she is an employee of Edelweiss Group	5%
4. Online Discount (A discount of 15% on total premium will be given. Applicable only if taken from Edelweiss website)	15%
6. Edelweiss Customer Discount- A discount of 5%shall be given to any proposer who has a valid and existing Unique Customer Identification Number as issued by the Edelweiss Group. Edelweiss Customer discount shall only be given to the proposer when (a) the person is verified customer of the Edelweiss Group as defined on the date when the proposal is made and (b) it is sold through direct sales mode only and not through the intermediaries Note: The maximum discount under Edelweiss Group Employee Discount and Edelweiss Customer Discount both put together is 5%	5%

Maximum Loading under this policy due to medical conditions will be 100% per year per member in Individual policy and per policy in Floater option.

5. General Exclusion
1 Exclusions Applicable: (Not Applicable for section VIII- personal Accident Cover)

We shall not be liable to make any payment under this Policy directly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically opted:

I. Pre-Existing Diseases - Code- Excl01
a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months (section I) unless specifically opted and 48 months for the Critical Illness benefit cover; of continuous coverage after the date of inception of the first policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 36 months (section I) unless specifically opted and 48 months Critical Illness benefit cover for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.
e) The waiting periods as defined in Section VI. 1 (Maternity Cover), VI. 2 (Pre-Natal and Post natal), VI. 3 Infertility, VI.4 Surrogacy shall be applicable individually as mentioned in respective sections and Claims shall be assessed accordingly.

II.Specified disease/procedure waiting period- Code- Excl02

1.24 months waiting period
a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f) List of specific diseases/procedures
i. Any treatment related to Arthritis (if non-infective), Osteoarthritis and Osteoporosis, Gout, Rheumatism, Spinal Disorders (unless caused by accident), Joint Replacement Surgery (unless caused by accident), Arthroscopic Knee Surgeries/ACL Reconstruction/Meniscal and Ligament Repair
ii. Surgical treatments for Benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to Adenoidectomy, Mastoidectomy, Tonsillectomy and Tympanoplasty), Nasal Septum Deviation, Sinusitis and related disorders
iii. Benign Prostatic Hypertrophy
iv. Cataract
v. Dilatation and Curettage
vi. Fissure / Fistula in anus, Hemorrhoids / Piles, Pilonidal Sinus, Gastric and Duodenal Ulcers
vii. Surgery of Genito-urinary system unless necessitated by malignancy
viii. All types of Hernia & Hydrocele
ix. Hysterectomy, unless necessitated by malignancy
x. Internal tumours, skin tumours, cysts, nodules, polyps including breast lumps (each of any kind) unless malignant
xi. Kidney Stone / Ureteric Stone / Lithotripsy / Gall Bladder Stone
xii. Myomectomy for fibroids
xiii. Varicose veins and varicose ulcers

2. 90 Days Waiting Period
a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 90 days of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific diseases/procedures
i. Diabetes & Related complications include: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot / Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hyper /Hypoglycaemic Shocks.
ii. Hypertension & Related complications include: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal Bleed / Haemorrhages.
iii. Cardiac disorder:

III. 30-day waiting period- Code- Excl03
a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

IV. Investigation & Evaluation- Code- Excl04
a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

V. Rest Cure, rehabilitation and respite care- Code- Excl05

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

VI. Obesity/ Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

- i. Obesity-related cardiomyopathy
- ii. Coronary heart disease
- iii. Severe Sleep Apnea
- iv. Uncontrolled Type2 Diabetes

VII. Change – of – Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

VIII. Cosmetic or plastic Surgery: Code- Excl08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

IX. Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

This exclusion will not be applicable if Benefit section III.5 is opted.

X. Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

XI. Excluded Providers: Code- Excl11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

XII. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12

XIII. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. Code- Excl13

XIV. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. Code- Excl14

XV. Refractive Error: Code- Excl15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

XVI. Unproven Treatments: Code- Excl16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

XVII. Sterility and Infertility: Code- Excl17

Expenses related to sterility and infertility. This includes:

(i) Any type of contraception, sterilization

(ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

(iii) Gestational Surrogacy

(iv) Reversal of sterilization

XVIII. Maternity: Code Excl18

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

XIX. Any Treatment that arises from or is in any way connected with attempted suicide or any injury or illness that the Insured Person inflicts upon himself.

XX. Any Treatment by way of the intentional Termination of Pregnancy.

XXI. Charges incurred in connection with cost of spectacles and contact lenses, routine eye and ear examinations, hearing aids, all other external appliances and /or devices whether for diagnosis or treatment for the complete exhaustive list kindly refer,List I - Items for which coverage is not available in the Policy.

Any expenses relating to OPD treatments are not covered unless specifically opted by customer and mentioned in policy schedule.

XXII. Injury or disability directly caused or contributed to whilst engaging in or taking part in war, invasion, terrorist activities, rebellion (whether war be declared or not), civil war, commotion, military or usurped power, martial law, riot or the act of any lawfully constituted authority, or while the Insured Person(s) is / are carrying out army, naval or air services operations, whether or not war has been declared.

XXIII. Any Treatment availed outside the territorial limits of the policy unless specifically opted for.

XXIV. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

XXV. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness.

XXVI. Alopecia wigs and/or toupee and all hair or hair fall treatment and products.

XXVII . Congenital external diseases, defects or anomalies or in consequence thereof.

XXVIII. Certification by a Medical Practitioner who shares the same residence as the Insured Person or who is a member of the Insured Person's family.

XXIX. Any injury or any disease directly caused by or arising from ionising radiation or contamination by radiation or contamination by radioactivity from the combustion of nuclear fuel claim or expense nuclear waste nuclear, chemical or biological attack.

Definitions

1. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when Suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

2. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) microorganisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

2 Exclusion for Section VII (Personal accident cover)

I. Pre-Existing Diseases- - Code- Excl01

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of the 36 months of continuous coverage as specified in the policy schedule, after the date of inception of the first policy with insurer.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of specified months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer

II. Suicide or attempted suicide, intentional self-inflicted Injury, acts of self-destruction, whether the Insured Person is medically sane or insane.

III. Breach of law: Code- Excl10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

IV. Hazardous or Adventure sports: Code- Excl09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving

V. Voluntary participation in actual or attempted felony, riots or civil commotion.

VI. Felonious assault , riots, terrorism/terror attack, hijacking, kidnapping.

VII. Treatment arising from or consequent upon war or any act of war, invasion, act of foreign enemy, 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.

VIII. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.

IX. Certification by a Medical Practitioner who shares the same residence as the Insured Person or who is a member of the Insured Person's family.

X. Congenital external diseases, defects or anomalies or in consequence thereof.
XI. Any change of profession after inception of the Policy which results in the enhancement of Our risk under the Policy, if not accepted and endorsed by Us on the Policy Schedule .

XII. Death or disablement caused by participation of the Insured Person in any flying activity, except as a bona fide, passenger of a recognized airline on regular routes and on a scheduled timetable.

XIII. Insured Persons involved in naval, military or air force operations.

XIV. Accidental death or Injury occurring after twelve calendar months from the date of the Accident.

XV. Any injury or any disease directly caused by or arising from ionising radiation or contamination by radiation or contamination by radioactivity from the combustion of nuclear fuel claim or expense nuclear waste nuclear, chemical or biological attack.

XVI. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when Suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

XVII. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) microorganisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

XVIII. Participation in any kind of motor speed contest (including trial and training).

XIX. Insurance in respect of underground mining and for contractors specializing in tunnelling.

XX. Air travel except as a passenger on a recognized airline operating on regular scheduled air routes or air travel by charter aircraft duly licensed as a recognise air carrier and flown by professional crews between properly established and maintained airport/routes.

XXI. Accident caused under the influence of , Alcoholism, intoxicating drug or substance abuse or any addictive condition and thereof.

3. Permanent Exclusions

Irrespective of waiting period or Portability, below mentioned disease are permanently excluded under this policy in case where such disease are pre-existing or disclose by the customer in the proposal form at the time of first proposal of this product with us. These pre-existing illnesses will not be covered even if the optional cover Pre-existing Waiting Period Waiver/Reduction has been opted. We will permanently exclude these conditions with due consent of proposer or persons to be insured.

TABLE

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behaviour

Sr. No.	Disease	ICD Code
3	Epilepsy	G40 Epilepsy
4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25) Ischemic heart diseases, I50 Heart failure, I42 Cardiomyopathy; I05-I09 - Chronic rheumatic heart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02 Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory Bowel Diseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn'sdisease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis, unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver disease with fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classified elsewhere. K 70 to K 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure; I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system (Q 60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent and without hepatic coma; B17.0 –Acute delta- (super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B with delta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinating disease	G.35 to G 37

Sr. No.	Disease	ICD Code
13	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified
14	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
15	Avascular necrosis (osteo-necrosis)	M 87 to M 87.9

6. Migration:

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast30 days before the policy renewal date as per IRDAI guide lines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration, kindly refer the link .. .
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1

7. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link ...
https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987&flag=1

8. Claims Procedure and Management

8.1 Pre-requisite for admissibility of claim

Any claim being made by an Insured Person or attendant of Insured Person during Hospitalization on behalf of the Insured person, should comply with the following conditions:

1. The Condition Precedent Clause has to be fulfilled.
2. The medical condition caused, Medical Expenses incurred, subsequently the Claim being made, should be with respect to the Insured Person only. The Company will not be liable to Indemnify the Insured Person for any loss other than the covered benefits and any other person who is not accepted by the Company as an Insured Person.
3. The holding Policy should be in force at the event of the Claim. All the Policy Terms and Conditions, waiting periods and exclusions are to be fulfilled including the realization of premium by their respective due dates.
4. All the required and supportive Claim related documents are to be furnished within the stipulated timelines. The Company may call for additional documents wherever required.

8.2 Duties of a Claimant/ Insured Person in the event of Claim:-

On the occurrence of any loss, within the scope of cover under the Policy

You shall:

1. The Policyholder / Insured Person shall check the updated list of Network Provider before submission of a pre-authorization request for Cashless Facility.
2. Forthwith file/submit a Claim Form in accordance with 'Claim Procedure' Clause as provided in the Policy.
3. Assist and not hinder or prevent Us or any of Our representative from taking any reasonable steps in pursuance of their duties for ascertaining the admissibility of the Claim under the Policy.
4. The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person and shall be provided with complete necessary documentation and information to establish company's/ its liability for the Claim, its circumstances and its quantum.
5. If You do not comply with the provisions of this Clause or other obligations cast upon You under this Policy, in terms of the other clauses referred to herein or in terms of the other clauses in any of the Policy documents, all benefits under the Policy shall be forfeited, at Our option.

8.3. Claims Procedure

Intimation must be given at least 72 hours prior to planned hospitalization. In case of emergency hospitalization, intimation must be given within 48 hours of hospitalization or before discharge whichever is earlier.

We may consider the delay in extreme cases of hardship where it is proved to our satisfaction that under the circumstances in which the insured person was placed it was not possible from him/her or any other person to intimate/ notify / submit / file claim within the prescribed time limit.

I. Cashless Facility

The Company may extend Cashless Facility as a mode to Indemnify the Medical Expenses incurred by the Insured Person at a Network Provider. In order to avail Cashless Facility, the following process must be followed:

1. Submission of Pre-authorization Form: A Pre-authorization form which is available on the Company's Website or with the Network Provider, has to be duly filled and signed by the Insured Person and the treating Medical Practitioner, as applicable, which has to be submitted electronically by the Network Provider to the Company for approval. Only upon due approval from the Company, Cashless Facility can be availed only at Network Hospital. A health card issued to the insured person at the time of Policy purchase, should be preserved and produced at any of the Network Providers in the event of Claim being made, to avail Cashless Facility.

   i. For Planned Treatment: The Company must be contacted to pre-authorize Cashless Facility for planned treatment at least 72 hours prior to the proposed treatment. Once the request for pre-authorization has been granted, the treatment must take place within 10 days of the pre-authorization date at a Network Provider.

   ii. In Emergencies: If the Insured Person has been Hospitalized in an Emergency, the Company must be contacted to pre-authorize Cashless Facility within 48 hours of the Insured Person's Hospitalization or before discharge from the Hospital, whichever is earlier.

   iii. Identification documents: Health Card issued by the company and Valid Photo Identification like Voter ID card, Driving License, Passport, PAN Card, Aadhaar Card or any other identification proof.

2. Company's Approval: The Company will confirm in writing, authorization or rejection of the request to avail Cashless Facility for the Insured Person's Hospitalization.

3. Please note that rejection of a Pre-authorization request is in no way construed as rejection of coverage or treatment. The Insured Person can proceed with the treatment, settle the hospital bills and submit the claim for a possible reimbursement.

4. The Company may modify the list of Network Providers or modify or restrict the extent of Cashless Facilities that may be availed at any particular Network Provider.

Insured can also look upon our website and click on the below link of network hospitals available under cashless facility:

https://www.edelweissinsurance.com/health-insurance/-/section/health-home

II. Re-imbursement Facility

1. It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular coverage is payable only under Reimbursement Facility, the following information details should be provided to the Company within 48 hours of admission to the Hospital or before discharge from the Hospital, whichever is earlier:

i. The Policy Number

ii. Name of the Policyholder

iii. Nature of Illness or Injury and the treatment/Surgery taken

iv. Hospital where treatment/Surgery was taken

v. Date of admission and date of discharge.

2. In the event of death of the Policyholder, the Company will pay the nominee and in case of no nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

8.4. Documents to be submitted for filing a valid Claim

The Company shall be provided with the following necessary information and documentation in respect of all claims at Your/Insured Person's expense within 15 days of the Insured Person's discharge from Hospital (in the case of Pre-hospitalization Medical Expenses and Hospitalization Medical Expenses) or within 15 days of the completion of the Post-hospitalization Medical Expenses period (in the case of Post-hospitalization Medical Expenses). For those claims for which the use of Cashless Facility has been authorized, the Company will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital as follows.

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

1. For In-patient Treatment /Day Care Procedures, the below documents would be required

   a. Duly filled and signed Claim Form.

   b. Photocopy of ID card / Photocopy of current year policy.

   c. Original Detailed Discharge Summary / Day care summary from the hospital. Original consolidated hospital bill with bill no and break up of each Item, duly signed by the insured.

   d. Original payment Receipt of the hospital bill with receipt number

   e. First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from Attending Medical Practitioner / Surgeon demanding such test.

   f. Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts

   g. Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same

h. Original medicine bills and receipts with corresponding Prescriptions.
i. Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.
j. For Road Traffic Accident in addition to in patient treatment documents, below details are required:
k. Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.
l. For Non Medico legal cases: In addition to in patient treatment documents we would require treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)
m. For Accidental Death cases: In addition to in patient treatment documents, Copy of Post Mortem Report (if conducted) & Death Certificate.

2. Pre and Post-hospitalisation expenses
a. Duly filled and signed Claim Form
b. Photocopy of ID card / Photocopy of current year policy.
c. Original Medicine bills, original payment receipt with prescriptions
d. Original Investigations bills, original payment receipt with prescriptions and report
e. Original Consultation bills, original payment receipt with prescription
f. Copy of the Discharge Summary of the main claim
g. Photo copies of documents provided to another insurance company if applicable

Note : We may call for additional documents/ information as relevant to the claim.

8.5. Claim Assessment
1. The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.
2. The Claim amount assessed would be deducted from the following amounts in the following progressive order:
i. Sum Insured
ii. Cumulative Bonus (if applicable)
iii. Double Sum Insured for Critical Illness (if applicable)
iv. Restoration (if applicable)
v. Recharge (if applicable)
Looking at the various covers opted by the Insured, We will apply the benefits which are of maximum beneficial to the Insured. Either before or after settlement of the claim, if the customer feels that the processing of claim is not to his satisfaction, then he/she can request for reconsideration of the processing of claim and we shall process the claim accordingly subject to the applicable coverage conditions.

8.6 Claim Settlement (provision for Penal Interest)
1. This Policy covers only medical treatment taken entirely within India (and worldwide if opted). All payments under this Policy shall be made in Indian Rupees.
2. The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person during the Policy Period, once the Total Sum Insured for that Insured Person is exhausted.
3. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
4. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
5. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
6. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

9. Premium

Payment in Instalments (Wherever applicable)
The policy will be issued for a period of 1 year, 2 year or 3 years. The Sum Insured and Benefit will be applicable on Policy Year basis.
The Insured person can choose to pay Premium for this Policy on any one of the following basis:
i. Single premium
ii. Instalment premium

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)
i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

If You are opting for Instalment premium payment through ECS, then kindly ensure that:
a. Electronic Clearing Service (ECS) Mandate form is completely filled & signed by You.
b. The Premium amount which would be auto debited & frequency of instalment is duly filled in the ECS Mandate form.
c. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.
d. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the ECS facility.
e. Non-payment of premium on due date as opted by You in the mandate form subject to an additional renewal/ revival period will lead to termination of the policy.

10. Tax Benefit
The premium amount paid under this policy qualifies for deduction under Section 80D of the Income Tax Act.

11. Standard Terms and Conditions

12.1. Alterations in the Policy
1. This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company. However, change or alteration with respect to increase/ decrease of the Sum Insured shall be permissible only at the time of renewal of the Policy. On renewal, the policy could be subject to certain changes in terms and conditions including change in premium rate.
2. Where an individual is added to this Policy either by way of endorsement or at the time of Renewal, the Pre-existing Disease clause, exclusions and waiting periods will be applicable considering such Policy Year as the first year of the Policy with Us.

12.2. Cancellation / Termination
1. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

	Refund Percentage		
Cancellation period	1 Year Policy	2 Year Policy	3 Year Policy
Up to 1 Month	75%	87.50%	92.00%
Up to 3 Months	50%	75.00%	83.00%
Up to 6 Months	25%	62.50%	75.00%
Up to 9 Months	NIL	50.00%	67.00%
Up to 12 Months	NIL	42.00%	55.00%
Up to 15 Months	NIL	25.00%	50.00%
Up to 18 Months	NIL	12.50%	42.00%
Up to 24 Months	NIL	NIL	30.00%
Up to 30 Months	NIL	NIL	8.00%
Up to 36 Months	NIL	NIL	NIL

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

2. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

3. In case of demise of the Policyholder,
i. Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policyholder. The premium would be refunded for the unexpired period of this Policy at pro-rata basis.
ii. Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period for the other Insured Persons. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a policyholder provided that:
a) Written notice in this regard is given to the Company before the Policy Period End Date; and
b) A person of Age 18 years or above, who satisfies the Company's criteria applies to become the Policyholder.

12.3. Complete discharge

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

12.4. Disclosure to Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, misdescription or non-disclosure of any material fact by the policyholder.

12.5. Electronic Transactions

The Policyholder and/or Insured Person agree to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

12.6. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

12.7. Limitation of Liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the claim shall not be admissible, unless the Policyholder proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond his control.

12.8. Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk. The Company may adjust the scope of cover and / or the premium paid or payable accordingly.

12.9. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

12.10. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

1. You/the Insured Person at the address specified in the Policy Schedule or at the changed address of which the Company must receive written notice.

2. Us at the following address: :- Edelweiss General Insurance Company Limited, 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai - 400070, Registered Office: Edelweiss House, Off CST Road, Kalina, Mumbai -400 098 .

Toll Free No.: 1800 12000.

3. No insurance agents, brokers or other person/entity is authorized to receive any notice on the Company's behalf.

4. In addition, the Company may send You/the Insured Person other information through electronic and telecommunications means with respect to Your Policy from time to time.

12.11. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

12.12. Nomination

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

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

12.13. Obligations in case of a minor

If an Insured Person is less than 18 years of Age, the legal guardian (in case of all other adult Insured Person's demise in a floater basis) shall be completely responsible for ensuring compliance with all the terms and conditions of this Policy on behalf of that minor Insured Person.

12.14. Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be Condition Precedent to the Company's liability under the Policy

12.15. Overriding effect of Policy Schedule

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Schedule, the information contained in the Policy Schedule shall prevail.

12.16. Premium Loading

1. Based on the Board approved Company's underwriting guidelines , upon the disclosure of the health status of the persons proposed for insurance and declarations made in the Proposal, the Company may apply underwriting loading on the premium payable (excluding statutory levies and taxes) . The maximum underwriting loading applicable will not exceed more than 100% of the premium for a individual member in case of Individual policies and on a policy level in floater policies..
2. These loadings will be applied from inception date of the First Policy including subsequent Renewal(s) with Us.
3. The Company may apply a specific personal waiting period on a medical condition/ailment depending on the past history or additional waiting periods on Pre-existing Diseases as part of the special conditions on the Policy but it will not exceed the 36 months waiting period. However the permanent exclusions can be applied for diseases as mentioned under Clause 3, Subclause Permanent Exclusion.

12.17. Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

12.18. Renewal Terms

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 15 Days for installment premium (i.e. monthly, quarterly and Half Yearly) and 30 days for single premium to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

vi. The Company may carry out underwriting in accordance with its Board approved underwriting policy in relation to any request for change in Sum Insured or Deductible at the time of renewal of the Policy.

vii. This product may be withdrawn / modified by the Company after due approval from the Authority (IRDAI). In case this product is withdrawn / modified by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by the Authority (IRDAI). The Company shall duly intimate the Policyholder at least three months prior to the date of such modification / withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.

viii. The Company may revise the renewal premium payable under the Policy provided that revisions to the renewal premium are in accordance with the Authority's (IRDAI) rules and regulations as applicable from time to time. Change in rates will be applicable from the date of approval by the Authority and shall be applied only prospectively thereafter for new policies and at the date of renewal for renewals.

ix. Loading if applicable on expiring policy will be applicable on subsequent renewals with the Company

13. Geography

This Policy applies to events or occurrences taking place within India and can be extended worldwide as specified in the policy schedule.

Policy Type	Individual	Floater
Relationship covered	Self	Self
	Spouse	Legally wedded Spouse
	Dependent Children	
		Dependent Parent(s)
	Parent(s)	Dependent Parent In Law(s)
	Parent(s)-in-law	Dependent Children(natural or legally adopted) between the age 3 months to 25 years
	Son-in-law	
	Daughter-in-law	
	Grandparent(s)	
	Grand Child/ Children	
	Brother In Law	
	Sister In Law	
	Siblings	
	Niece	
	Nephew	
Minimum Age	91 days (Proposer 18 years)	91 days
Maximum Age	No upper Limit	No upper Limit
Cover ceasing age	No	No

In case of Section VII (personal accident) and section VIII (Critical illness Benefit) opted then Entry age will be restricted to - 4 yrs. to 65 Years

15. Fraud

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

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

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

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

16. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break.

17. Moratorium Period

After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

18. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

19. Zone Classification

Option to select a resident Zone higher or lower than that of the Zone is available on payment of applicable premium at the time of buying the First Policy and on subsequent renewals

Zone Classification
Zone I: Delhi, NCR, Mumbai (including Navi Mumbai) , Kalyan , Thane
Zone II: Bangalore, Kolkata, Hyderabad, Secunderabad, Chennai, Pune, Vadodara, Ahmedabad, Surat
Zone III: All cities apart from Zone I & Zone II.

(a) Persons paying Zone I premium can avail treatment all over India without any Co-pay.
(b) Persons paying Zone II premium.
i) Can avail treatment in Zone II and Zone III without any Co-pay.
ii) Availing treatment in Zone I will have to bear 10% of each and every claim.
(c) Person paying Zone III premium
i) Can avail treatment in Zone III, without any Co-pay.
ii) Availing treatment in Zone II will have to bear 10% of each and every claim.
iii) Availing treatment in Zone I will have to bear 20% of each and every claim.
Aforesaid Co-payments for claims occurring outside of the Zone will not apply in case of Hospitalisation due to Accident and Critical illnesses mentioned in Critical illness section.
The aforesaid Co-payments applicable are in addition to the Voluntary Co-pay under Section IX.2 (voluntary co-pay) (if opted) and section V (Out Patient expenses) (if opted) .
This co-pay will not be applicable on Benefit based covers.
However, Zones can be changed by the Company after informing the Insured 3 months in advance, subject to approval from IRDA.

Not Applicable if world wide Cover is opted.

20. Customer Services and Grievances Redressal:
In case of any grievance the insured person may contact the company through
• Website: www.edelweissinsurance.com, Link:https://www.edelweissinsurance.com/documents/20143/1081704/Service+Parameters+and+Grievance+Mechanism+15-04-21.pdf/114fd592-ad87-457a-d8c6-2e6cc6b9fd91?t=1618577820419
• Toll free: 1800120216216 / 180012000
• E-mail: grievance@edelweissinsurance.com
• Courier: 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai 400 070:
Insured person may also approach the grievance cell at any of the company's branches with the details of grievance
If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at 1800120216216 and grievance@edelweissinsurance.com.
For updated details of grievance officer, kindly refer the link……….
https://www.edelweissinsurance.com/documents/20143/1081704/Service+Parameters+and+Grievance+Mechanism+15-04-21.pdf/114fd592-ad87-457a-d8c6-2e6cc6b9fd91?t=1618577820419
If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.
Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

21. Grievance Mechanism
In case of any Grievance of the Complainant sent in a written communication to the Company at any of the touch points as mentioned, shall be addressed within 14 days of the receipt of the complaint

• For easy and faster response, please feel free to contact us on
Call us at: 180012000 (Toll Free) or 02242312000 (Call charges applicable)
Email us at: support@edelweissinsurance.com

• Please feel free to contact our Grievance Cell on
Call us at: 1800120216216
Email: grievance@edelweissinsurance.com
Contact Details for Senior Citizens:
o Contact number: 02242312001
o Email ID: senior.citizen@edelweissinsurance.com
Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

• The Grievance Redressal Officer
Email: grievanceofficer@edelweissinsurance.com
Call us at: 022 4931 4422
Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

If you are not satisfied with the response or do not receive a response from the Company, within 14 days of your complaint, you may approach the Grievance Cell of the Insurance Regulatory and Development Authority of India ('IRDAI') on the following contact details:

IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255
Email ID: complaints@irda.gov.in
Register online at: http://www.igms.irda.gov.in/

Address for communication for complaints by fax/paper:
Consumer Affairs Department
Insurance Regulatory and Development Authority of India
Sy. No. 115/1, Financial District, Nanakramguda, Gachibowli
Hyderabad – 500032

In case you are not satisfied with the response provided by the company or no response is received, you may approach the Insurance Ombudsman in your region for the resolution post 30 days from the date of registration of the complaint.

Details of the Insurance Ombudsman Offices are available on the link http://www.policyholder.gov.in/Addresses_of_Ombudsmen.aspx

The Complainant may approach the Office of the Insurance Ombudsman established by the Central Government of India as per Rule 13 and Rule 14 of the Insurance Ombudsman Rules, 2017 ('Ombudsman Rules').

The following complaints can be lodged with the Insurance Ombudsman:
1. Any partial or total repudiation of claims by an insurer;
2. Any dispute in regard to premium paid or payable in terms of the policy;
3. Any dispute on the legal construction of the policies in so far as such disputes relate to claims;
4. Delay in settlement of claims;
5. Non-issue of any insurance document to customers after receipt of premium.

Manner in which complaint is to be made Rule 14 of the Ombudsman Rules:-
1. Any person who has a grievance against the Company, may himself or through his legal heirs make a complaint in writing to the Ombudsman within whose jurisdiction the branch or office of the Company complained against is located.
2. The complaint shall be in writing duly signed by the complainant or through his legal heirs and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against which the complaint is made, the fact giving rise to the complaint.
3. No complaint to the Ombudsman shall lie unless:
• the complainant had before making a complaint to the Ombudsman, made a written representation to the Company/insurer named in the complaint and either insurer had rejected the complaint or the complainant had not received any reply within a period of one month after the insurer concerned received his representation or the complainant is not satisfied with the reply given to him by the insurer;
• the complaint is made not later than one year after the insurer had rejected the representation or sent his final reply on the representation of the complainant; and
• the complaint is not on the same subject matter for which any proceedings before any court or Consumer Forum or arbitrator is pending or was so earlier.

Insurance Ombudsman –The insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance.
The contact details of the Insurance Ombudsman offices have been provided as Annexure-A.

Annexure A

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email:-**bimalokpal.ahmedabad@cioins.co.in**	State of Gujarat, Union Territory of Dadra & Nagar Haveli & Union Territory of Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No.57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru-560 078. Tel.:- 080-26652048 / 26652049 Email:- **bimalokpal.bengaluru@cioins.co.in**	State of Karnataka
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 033. Tel.:- 0755-2769200/201/202, Fax:- 0755-2769203 Email:- **bimalokpal.bhopal@cioins.co.in**	States of Madhya Pradesh and Chattisgarh
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.:- 0674-2596461 / 2596455, Fax:- 0674-2596429 Email:-**bimalokpal.bhubaneswar@cioins.co.in**	State of Odisha
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/ 2706468 Fax:- 0172-2708274 Email:- **bimalokpal.chandigarh@cioins.co.in**	States of Punjab, Haryana, Himachal Pradesh, Union Territory of Jammu & Kashmir, Union Territory of Ladakh and Union Territory of Chandigarh
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 , Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668 / 24335284 Fax:- 044-24333664 Email:- **bimalokpal.chennai@cioins.co.in**	State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry)
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23232481/23232481 Email:- **bimalokpal.delhi@cioins.co.in**	State of Delhi
ERNAKULAM Office of the Insurance Ombudsman, 2nd floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, Ernakulum - 682 015. Tel.:- 0484-2358759/2359338 Fax:- 0484-2359336 Email:- **bimalokpal.ernakulam@cioins.co.in**	State of Kerala, Union Territory of Lakshadweep and Mahe, a part of Puducherry
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361- 2632204 / 2602205 Email:- **bimalokpal.guwahati@cioins.co.in**	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040- 67504123 / 23312122 Fax:- 040-23376599 Email:- **bimalokpal.hyderabad@cioins.co.in**	States of Andhra Pradesh, Telangana and Union Territory of Yanam - a part of Puducherry

CONTACT DETAILS	JURISDICTION
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi-II Bldg., Ground Floor, Bhawani Singh Marg, Jaipur - 302005. Tel.:- 0141-2740363 Email:- **bimalokpal.jaipur@cioins.co.in**	State of Rajasthan
KOLKATA Office of the Insurance Ombudsman, Hindustan Building Annexe, 4th floor, 4, C.R. Avenue, Kolkata - 700 072. Tel.:- 033-22124339 / 22124340, Fax:- 033-22124341 Email:- **bimalokpal.kolkata@cioins.co.in**	States of West Bengal, Bihar, Sikkim and Union Territory of Andaman and Nicobar Islands
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2231330 / 2231331, Fax:- 0522-2231310. Email:- **bimalokpal.lucknow@cioins.co.in**	Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varansi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sulanpur, Maharajganj, Santkabirnagar, Azamgarh, Kaushinagar, Gorkhpur, Deoria, Mau, Chandauli, Ballia, Sidharathnagar
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022- 26106552/ 26106960, Fax:- 022-26106052 Email:- **bimalokpal.mumbai@cioins.co.in**	State of Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Distt: Gautam Budh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email:- **bimalokpal.noida@cioins.co.in**	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozabad, Gautam Budh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006. Tel.: 0612-2680952 Email:- **bimalokpal.patna@cioins.co.in**	States of Bihar and Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Building, 3rd Floor, CTS Nos. 195 to 198, NC Kelkar Road, Narayan Peth, Pune - 411 030 Tel: 020 -41312555 Email:- **bimalokpal.pune@cioins.co.in**	State of Maharashtra, Area of Navi Mumbai and Thane, excluding Mumbai Metropolitan Region

List I - Items for which coverage is not available in the Policy

Sl. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL/ INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT

Sl. No.	Item
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II - Items that are to be subsumed into Room Charges

Sl. No.	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE/ ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN

Sl. No.	Item
15	FACE MASK
16	FLEX! MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS/ VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES/ MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND/ NAME TAG
37	PULSEOXYMETER CHARGES

List III - Items that are to be subsumed into Procedure Charges

Sl. No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE

Sl. No.	Item
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV - Items that are to be subsumed into costs of treatment

Sl. No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPO EQUIPMENTS
7	INFUSION PUMP- COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTIONISTERILLIUM
17	Glucometer& Strips
18	URINE BAG

Day Care Treatment: All the day care treatments are covered which falls under the definition of Day care treatment mentioned in the policy.

Indicative List of documents required:

In- Patient Hospitalization (limited to India)

- Details of Claim intimation given to Company / TPA together with Copy of policy & premium receipt and / or and ID Card issued to insured.
- Valid Photo ID card.
- Duly filled and signed Claim Form.
- Doctor's referral note for in-patient hospitalization, if applicable
- Hospital Discharge Report/Transfer Summary / Death Summary issued by hospital
- Medical Treatment Notes and Reports & Medical recovery report if applicable
- Original Test Reports (Pathology/X-Rays/Sonography/ECG etc)
- Indoor case papers / Doctor's notes / Nursing notes if applicable
- Details of medical expenses original bills/cash memos receipts along with prescriptions
- Hospital/Nursing Home Registration No. if not registered then treating doctor's certificate about no of beds, availability of qualified doctors, qualified nurses/staff round the clock and fully equipped operation theater in the hospital/Nursing home
- Police report/first information report about accident/MLC, if applicable
- Photographs of the insured showing affected area, if applicable
- Any other document that may be required for assessment of the claim

The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company.

In- Patient Hospitalization (worldwide)

- Details of Claim intimation given to Company / TPA / OSP together with xerox of policy & premium receipt and / or ID card issued to insured.
- Duly filled and signed Claim Form
- Doctor's referral note advising for in-patient hospitalization, if applicable
- Hospital Discharge Report/ Transfer Summary / Death Summary issued by hospital
- Medical treatment notes & Medical recovery report if applicable
- Original Test Reports (Pathology/X-Rays/Sonography/ECG etc.)
- Indoor case papers / Doctor's notes / Nursing notes if applicable
- Details of medical expenses original bills/cash memos receipts along with prescriptions
- Hospital/Nursing Home Registration No. if not registered then treating doctor's certificate about no of beds, availability of qualified doctors, qualified nurses/staff round the clock and fully equipped operation theater in the hospital/Nursing home
- Police report / first information report about accident/MLC, if applicable.
- Photographs of the insured showing affected area, if applicable.
- Any other document that may be required for assessment of the claim

The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company.

Pre-Hospitalization and Post-Hospitalization expenses:

- Duly filled and signed Claim Form
- Details of medical expenses with original bills/cash memo receipts for Pharmacy / Pathology / Radiology reports along with prescriptions / consultations.
- Any other document that may be required for assessment of the claim

Day-Care Treatment:

- Details of Claim intimation given to Company / TPA together with Copy of policy & premium receipt and / or and ID Card issued to insured.
- Valid Photo ID card.
- Duly filled and signed Claim Form.
- Doctor's referral note for in-patient hospitalization as daycare, if applicable
- Hospital Day-Care Discharge Report
- Medical Treatment Notes and Reports
- Original Test Reports (Pathology/X-Rays/Sonography/ECG etc)
- Indoor case papers / Doctor's notes / Nursing notes if applicable
- Details of medical expenses original bills/cash memos receipts along with prescriptions
- Hospital/Nursing Home Registration No. if not registered then treating doctor's certificate about no of beds, availability of qualified doctors, qualified nurses/staff round the clock and fully equipped operation theater in the hospital/Nursing home
- Police report/first information report about accident/MLC, if applicable
- Photographs of the insured showing affected area, if applicable
- Any other document that may be required for assessment of the claim

The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company.

AYUSH Treatment:
• Details of Claim intimation given to Company / TPA together with Copy of policy & premium receipt and / or and ID Card issued to insured.
• Valid Photo ID card.
• Duly filled and signed Claim Form.
• Doctor's referral note for in-patient hospitalization if applicable
• Hospital Discharge Report/Transfer Summary / Death Summary issued by hospital
• Medical Treatment Notes and Reports & Medical recovery report if applicable
• Original Test Reports (Pathology/X-Rays/Sonography/ECG etc)
• Indoor case papers / Doctor's notes / Nursing notes if applicable
• Details of medical expenses original bills/cash memos receipts along with prescriptions
• Hospital/Nursing Home Registration No. if not registered then treating doctor's certificate about no of beds, availability of qualified doctors, qualified nurses/staff round the clock and fully equipped operation theater in the hospital/Nursing home
• Police report/first information report about accident/MLC, if applicable
• Photographs of the insured showing affected area, if applicable
• Any other document that may be required for assessment of the claim

The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company.

Domiciliary Treatment
• Duly filled and signed Claim Form.
• Doctor's referral note for in-patient hospitalization
• Treatment Summary issued by doctor
• Medical Treatment Notes and Reports & Medical recovery report if applicable
• Original Test Reports (Pathology/X-Rays/Sonography/ECG etc)
• Doctor's notes / Nursing notes
• Details of medical expenses original bills/cash memos receipts along with prescriptions
• Any other document that may be required for assessment of the claim

The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company.

Hospital Cash Benefit and Convalescence Benefit:
• Duly filled and signed Claim Form mentioning details of benefit claimed.
• Documents as required for in-patient hospitalization.
• Any other document that may be required for assessment of the claim

Emergency Ambulance:
• Duly filled and signed Claim Form mentioning details of benefit claimed.
• Documents as required for in-patient hospitalization including doctor's certificate with necessary details of requirement of transportation, if available.
• Any other document that may be required for assessment of the claim

Organ Donor
• Duly filled and signed Claim Form mentioning details of benefit claimed.
• Documents as required for the benefit of in-patient hospitalization, of both the donor and the insured.
• Any other document that may be required for assessment of the claim

Adventure Cover
• Details of Claim intimation given to Company / TPA together with Copy of policy & premium receipt and / or and ID Card issued to insured.
• Valid Photo ID card.
• Duly filled and signed Claim Form with self-declaration of the incident which led to injury.
• Doctor's referral note for in-patient hospitalization, if applicable
• Hospital Discharge Report/Transfer Summary / Death Summary issued by hospital
• Medical Treatment Notes and Reports & Medical recovery report if applicable
• Original Test Reports (Pathology/X-Rays/Sonography/ECG etc)
• Indoor case papers / Doctor's notes / Nursing notes if applicable
• Details of medical expenses original bills/cash memos receipts along with prescriptions
• Hospital/Nursing Home Registration No. if not registered then treating doctor's certificate about no of beds, availability of qualified doctors, qualified nurses/staff round the clock and fully equipped operation theater in the hospital/Nursing home
• Police report/first information report about accident, MLC by hospital if applicable
• Photographs of the insured showing affected area, if applicable
• Any other document that may be required for assessment of the claim

Prosthetics Cover
• Duly filled and signed Claim Form mentioning details of benefit claimed.
• Certificate from treating doctor, mentioning medical necessity of prosthetic device.
• Any other document that may be required for assessment of the claim

Reconstructive Surgery cover
• Duly filled and signed Claim Form mentioning details of benefit claimed.
• Documents as required for the benefit of in-patient hospitalization.
• Certificate from treating doctor, mentioning medical necessity of reconstruction.
• Any other document that may be required for assessment of the claim

Pandemic Cover:
• Duly filled and signed Claim Form.
• Copy of Insured Person's passport, if available (All pages).
• Photo Identity proof of the patient (if insured person does not own a passport)
• Medical practitioner's prescription advising admission.
• Discharge summary including complete medical history of the patient along with other details.
• Investigation reports like Insured Person's Test Reports from Authorized diagnostic centre
• NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque.
• KYC (Identity proof with Address) of the proposer, where claim liability is above `1 Lakh as per AML Guidelines.
• Legal heir/succession certificate, wherever applicable.
• Any other relevant document required for assessment of the claim.

Home Care Treatment Expenses:
• Duly filled and signed Claim Form
• Copy of Insured Person's passport, if available (All pages)
• Photo Identity proof of the patient (if insured person does not own a passport)
• Medical practitioners' prescription advising hospitalization
• A certificate from medical practitioner advising treatment at home or consent from the insured person on availing home care benefit.
• Discharge Certificate from medical practitioner specifying date of start and completion of home care treatment.
• Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained
• Any other relevant document required for assessment of the claim.

Out Patient expenses
• Claim Form duly filled in and signed.
• Complete set of outpatient treatment records and prescriptions from treating doctor
• Any other document required for claim processing.

Maternity Cover
• Duly filled and signed Claim Form mentioning details of benefit claimed.
• Documents as required for the benefit of in-patient hospitalization.
• Any other document that may be required for assessment of the claim

Pre/Post Natal Cover:
• Duly filled and signed Claim Form
• Details of medical expenses incurred with original bills/cash memo receipts for Pharmacy / Pathology / Radiology reports along with prescriptions / consultations.
• Any other document that may be required for assessment of the claim

Infertility Cover:
• Duly filled and signed Claim Form
• Documents as required for the benefit of in-patient and pre/post hospitalization.
• Any other document that may be required for assessment of the claim

The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company.

Surrogacy Cover
• Duly filled and signed Claim Form mentioning details of benefit claimed.
• Documents as required for the benefit of in-patient hospitalization of Maternity cover.
• Any other document that may be required for assessment of the claim

New Born Baby cover
• Duly filled and signed Claim Form
• Documents as required for the benefit of in-patient and pre/post hospitalization.
• Any other document that may be required for assessment of the claim

Vaccination cover
• Claim Form duly filled in and signed.
• Complete set of outpatient treatment records and prescriptions from treating doctor and expenses incurred for vaccination.
• Any other document required for claim processing.

Accidental Death Benefit (ADB)
• FIR from police authorities wherever necessary (in case of accidents outside residence)
• Death Certificate from the Municipal Authorities
• Death Summary from the Hospital Authorities if death is confirmed by the Hospital

- First Assessment sheet of the treating doctor while insured was brought to the hospital prior to death
- Post Mortem Report, if conducted
- Documentary proof of accidental death
- Duly filled and signed claim form
- Policy Copy and Annexure
- Inquest / Panchnama Report
- Photographs of the insured
- Coroner's Report and / or Forensic Science Laboratory report
- Any other document that may be required for assessment of the claim.

Permanent Total Disability (PTD)

- FIR from police authorities wherever necessary (in case of accidents outside residence)
- Discharge Summary from the Hospital Authorities
- First Assessment sheet of the treating doctor while insured was brought to the hospital immediately after the accident, hospitalization documents like indoor case papers, doctor's notes, nursing notes.
- Duly filled and signed claim form
- Policy Copy and Annexure
- Photographs of the insured
- Disability /Fitness certificate duly attested by the treating doctor with details of disability
- Any other document that may be required for assessment of the claim.

Permanent Partial Disability (PPD)

- FIR from police authorities wherever necessary (in case of accidents outside residence)
- Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability.
- Duly filled and signed claim form
- Policy Copy and Annexure
- Hospital / Nursing Home Medical Records and Hospitalization documents
- Photographs of the insured showing affected area
- Any other document that may be required for assessment of the claim.

Temporary Total Disability (TTD)

- FIR from police authorities wherever necessary (in case of accidents outside residence)
- Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability including expected timeline for recovery.
- Medical fitness certificate from the Treating consultant indicating duration of rest medically advised
- Duly filled and signed claim form
- Policy Copy and Annexure
- Hospital / Nursing Home Medical Records and Hospitalization documents.
- Salary certificate / income proof
- Photographs of the insured showing affected area
- Any other document that may be required for assessment of the claim