Edelweiss | GENERAL INSURANCE

POLICY WORDING

YOUR POLICY IN DETAIL

EDELWEISS GROUP TOTAL PROTECT POLICY

POLICY WORDING

1. Preamble

Upon receipt of the premium amount from you (the policyholder named in the policy schedule) and realization thereof by us (Edelweiss General Insurance Co. Ltd.) and believing that all the information provided to us by you is accurate and truthful, we agree to provide You with an insurance cover, as is described in the Policy Schedule and subsequent endorsements, against a loss You may sustain to the extent and limits contained in the terms below.

2. Definitions

The words and phrases defined in the Insurance Act 1938 (as amended from time to time), IRDA Act 1999 (as amended from time to time), the regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority will keep their original meaning.

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

1. Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. Adventurous Sports -

Sporting activities (also known as extreme sports or adventure sports) that are hazardous in nature and consist of activities having a high level of danger. These activities normally involve speed, height and elevated levels of physical exertion of above-average magnitude, combined with highly specialized gear or spectacular stunts.

The said extreme or adventure sports include following:

Racing on wheels or horseback, big game hunting, mountaineering, winter sports, sky diving, parachuting, scuba diving, riding or driving in races or rallies, mountain climbing, hunting or equestrian activities, rock climbing, pot holing, 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, racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, caving, 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, parachuting, paragliding/ parapenting, piloting aircraft, powerlifting, power boat racing, quad biking, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling.

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

4. 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.

5. Any one illness means an illness continuing over a period of time and includes its relapse within 45 days from the date of last consultation with the Hospital where treatment was received.

6. Appendix means a document attached and marked as an appendix to this Policy.

7. Assistance Service Provider (ASP) means such person or persons or a juristic person as may be appointed by the Company from time to time in order to provide worldwide assistance to the Insured Persons, as per the terms of this Policy

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

9. 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

10. 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

11. Break-in Policy occurs at the end of an expiring policy term, when the premium due for renewal of such policy is not paid on or before the premium renewal date or within 30 days therefrom.

12. 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.

13. Claim means a demand made to the Company, in accordance with the terms of this Policy, for payment of the specified benefits in respect of the Insured Person.

14. Claimant means a person who possesses a relevant and valid Policy/Certificate of Insurance issued by the Company under this Policy, or the nominee of an Insured Person or a legal heir of an Insured Person, who is eligible to file a Claim in the event of a covered loss.

15. Company (also referred to as we/us/EGIC/Insurer) means Edelweiss General Insurance Company Limited.

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

17. 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.

18. 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.

19. 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.

20. 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.

21. Deductible is 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. This is to clarify that a deductible does not reduce the sum insured. Deductible shall be applicable per year, per life or per event as stated in schedule.

22. Dental Treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery.

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

24. Diagnostic Test means investigations, such as X-ray or blood tests, etc., to determine the cause of symptoms and/or medical conditions.

25. 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.

26. Edelweiss Group means a company or a legal entity, in which Edelweiss Financial Services Limited has a direct or indirect holding or management control.

27. 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.

28. Endorsement means written evidence of modification on the Policy, including but not limited to increase or decrease in the period, extent and nature of the cover agreed to by us, in writing.

29. Family means and includes the primary Insured Person, whose name appears first on a Policy Schedule or Certificate of Insurance as one covered under this Policy, his/her lawful spouse, child/children, dependent parents/ parents-in-law and such other persons who are specifically mentioned in the Policy Schedule or Certificate of Insurance, and wherein all persons so named are family members.

30. 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
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 upto the age of 25 years on the date of commencement of the Certificate of Insurance and/or
iv. Insured Person's dependent parents or dependent parents-in-law; and/or
v. Insured Person's 2 dependent siblings, upto a maximum of 25 years.

31. Felonious Assault means any wilful or unlawful use of force upon the Insured that is a felony or a misdemeanour in the jurisdiction in which occurs and which results in bodily harm to the Insured.

32. 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.

33. Group means any association of persons who assemble together with a commonality of purpose or for engaging in a common economic activity, like employees of a company. Non-employer-employee groups, like employee welfare associations, holders of credit cards issued by a specific company, customers of a particular business where insurance is offered as an add-on benefit, borrowers of a bank, professional associations or societies. However, an association of persons coming together with the main purpose of availing an insurance cover will not qualify to be a group for the purpose of this Policy.

34. Hazardous Activities means Persons whilst working in underground mines, explosives, magazines, workers whilst involved in electrical installation with high tension supply, jockeys, circus personnel, Miner and other occupations underground , nuclear installations, Off-shore oil or gas rig worker , Policeman, ,Roofing contractors and all construction, maintenance and repair workers, Saw miller, Scaffolder, Scrap metal merchant, Security guard (armed), Ship crew, Steeplejack ,Stevedore ,Structural steelworker, Tower crane operator ,Tree feller.

35. 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;

36. 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.

37. Health Service Provider means any person or entity providing healthcare and medical services in individual capacity, or through aggregation under "Health Service Provider Agreement", and shall include but not be limited to any clinic, diagnostic centre, pharmacy, associated facility for diagnosis, treatment or wellness services, and health care providers empanelled with us/our authorized TPA(s) to provide services specified under the benefits (including extensions) to the Insured Persons on cashless/reimbursement basis for Out-patient treatment or otherwise. The list of the Health Service Providers is available on our website (https://www.edelweissinsurance.com).

38. Healthcare Professional means a qualified/certified individual/counsellor/medical practitioner who provides/creates awareness for preventive, curative and rehabilitative healthcare services.

39. Health Service Provider Agreement means an agreement, prescribing the terms and conditions of the services which may be rendered to the Insured Persons under this Policy, entered into between a Health Service Provider and us; or a Health Service Provider, a TPA and us.

40. 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

41. Indemnity/Indemnify means compensating the Policy holder/Insured Person, upto the extent of expenses incurred, upon occurrence of an event, which results in a financial loss and is covered as the subject matter of the insurance cover.

42. 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.

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

44. Insured Person (also referred to as Insured) means a person named as an insured in the Policy Schedule/Certificate of Insurance.

45. 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.

46. 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.

47. 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.

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

49. 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.

50. 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.

51. 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.

52. Network Provider means hospitals or health care providers enlisted by an EGIC, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

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

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

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

56. Nominee means the person named in the proposal and appearing in the Policy Schedule or Certificate of Insurance or who is included as a nominee through an endorsement to the Policy Schedule or Certificate of Insurance and to whom the benefit under the Policy has been nominated to by the Insured Person.

57. Out-patient means the Insured Person, who is not Hospitalized but visits a clinic/Hospital/any associated facility, like a consultation room for Diagnosis or treatment (encompassing but not limited to consultation, diagnostic tests & services, medicines/drugs, vaccination, medical procedure, and external medical aid). However, any Insured Person undergoing any specified Day care treatment will not be considered as an Out-patient.

58. 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.

59. 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

60. 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.

61. Policy means these terms and conditions contained herein and Appendices thereto, the Proposal Form, Policy Schedule, Certificate of Insurance, any applicable endorsements or extensions thereto and optional cover(s) (if applicable) attaching to or forming part thereof, which, together, constitute the Policy, and shall be read together. This Policy contains details of the extent of cover available to the Insured Person, what is excluded from the cover and the terms and conditions on which this Policy is issued to the Policyholder/Insured Person.

62. Policyholder (also referred to as You) means the person or entity named as such in the Policy Schedule.

63. 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.

64. Policy Period Start Date means the date on which the cover under the Policy/Certificate of Insurance (as applicable) commences, as specified in the Policy Schedule.

65. Policy Period End Date means the date on which the cover under the Policy/Certificate of Insurance (as applicable) expires, as specified in the Policy Schedule.

66. Policy Schedule means the schedule attached to and forming part of this Policy, mentioning the details of the Insured/Insured Persons, the Sum Insured in respect of each Insured Person, the period of cover, available coverage and the limits to which benefits under this Policy are subject to.

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

68. 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.

69. Proposal and Declaration Form means any initial or subsequent declaration made by the Insured Person(s) and is deemed to be attached and forming part of this Policy.

70. 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.

71. 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.

72. Reimbursement means settlement of Claims paid directly by the Company to the Policyholder/Insured Person/Claimant.

73. 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.

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

75. Sum Insured means the amount stated as such in the Policy Schedule or Certificate of Insurance and as available to the insured during each Policy Year through the Policy Period. The Sum Insured shall be subject, at all times, to the terms and conditions of the Policy, including but not limited to the exclusions and any additional limitations contained in the respective sections.

76. 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.

77. Third Party Administrator or TPA means any person or entity licensed under the IRDAI (Third Party Administrators-Health Services) Regulations, 2016 and is engaged, for a fee or remuneration by the Company, for the purposes of providing health services.

78. Total Sum Insured is the sum total of the Sum Insured amount and the Sum Insured amounts accrued under the optional cover(s) chosen by the Policyholder. It represents the Company's maximum, total and cumulative liability in respect of the Insured Person(s) for any and all Claims incurred during the Policy Year. If the Policy Period is for more than 12 months, then this Total Sum Insured shall be applicable separately to each such Policy Year through the Policy Period.

79. 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.

80. Valuables shall mean and include photographic, audio, video, painting, computer and any other electronic equipment, telecommunications and electrical equipment, telescopes, binoculars, antiques, watches, jewelry and gems, furs and articles made of precious stones and metals.

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 arising out of/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 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 (including optional benefits) shall be limited to the Sum Insured against Accidental Death, unless expressly stated to the contrary.

- The Policyholder will have selected any, all or atleast one cover from the below mentioned options (from 3.1.1 to 3.1.4).

3.1 Basic covers

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/Certificate of Insurance 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.

	Table of Benefits	Percentage of Capital Sum Insured Payable
1.	Loss of sight of both eyes	100%
2.	Loss of, by physical separation of two entire hands or two entire feet	100%
3.	Loss of one entire hand and one entire foot	100%
4.	Loss of sight of one eye and such loss of one entire hand or one entire foot	100%
5.	Complete loss of hearing of both ears and complete loss of speech	100%
6.	Complete loss of hearing of both ears and loss of one limb/loss of sight of one eye	100%
7.	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, where such cases would be accepted, basis of certification from Independent medical advisor from Govt hospital/ civil surgeon.
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.
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, where such cases would be accepted, basis of certification from Independent medical advisor from Govt hospital/ civil surgeon.

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

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, only one amount, the largest, will be paid

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 treating Doctor.

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 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 week, 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 treating 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.

3.2 Optional benefits available on payment of additional premium

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.

1. Enhanced Temporary Total Disability

If there is an admissible Claim under the Policy and all the criteria are fulfilled as per clause 3.1.4, then We will pay the lesser of the ones mentioned below or as shall be mentioned in the Policy Schedule:

a. In case of salaried persons: A lump sum amount equal to gross salary, as specified in the Policy Schedule, based on the average of the last 3 months' salary slip of the employer.

b. In case of self-employed persons or where income information is not available: Based on the certified documents proving his/her annual income, average amount equal to 1/12th of his/her provided annual income, subject to the maximum amount specified in the Policy Schedule.

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

Definition-
Salary shall mean and include Basic Salary along with the Daily Allowance and any other allowance being paid by the Employer.

It shall not include Overtime, Seasonal allowance, Bonus, variable pay, performance bonus etc., tips, commissions or any other special compensation or anything available in kind or in lieu of such items in whatever form. Further, salary shall exclude income from any other sources. In case of the Insured earning from more than one source, only the higher of the two shall be considered for the purpose of calculation of payout under this benefit.

Certified Income Documents shall refer to Income Tax returns, Income Tax assessment, Audited profit and loss A/C statement, CA (Chartered Accountant) certificate, certified balance sheet or any other valid/ legal statement proving his/her annual income.

2. Loss owed to terrorism
If an Insured Person suffers Accidental Death, Permanent Total Disability, Permanent Partial Disability, in patient hospitalization arising due to an act of terrorism, then we will pay the amount as specified under Section 3.1.1, 3.1.2, 3.1.3 or 3.2.7 or 3.2.8 in the Policy Schedule or Certificate of Insurance in respect of the Insured Person provided that the insured person has opted any of the respective covers as mentioned above.
For the purpose of this cover, and act of terrorism shall mean and include an act or series of acts, including but not limited to the use of force or violence and/or threat thereof, committed by any person or group(s) of person(s), whether acting alone or on behalf of or in connection with any organization(s) or government(s) or unlawful association(s) recognized under Unlawful Activities (Prevention) Amendment Act, 2008, Government of India or any other related and applicable national or state legislation formulated to combat unlawful and terrorist activities in the nation for the time being in force, for political, religious, ideological or similar purposes, with the intention to influence or affect the conduct of any government and/or to put the public at large or any section of the public in fear, by use of force or violence or threat to human life and/or property.

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 the policy.

3. Burns Benefit
If the Insured Person suffers from second or third degree Burns due to an Injury arising out of an Accident during the Policy Period, We will pay the amount specified in the table below to the Insured Person, subject to the following:

- The Burns are not self-inflicted by the Insured Person in any way; and
- A Medical Practitioner has confirmed the diagnosis of the burn and the percentage of surface area in writing.

For the purposes of this benefit, Burns mean any burns suffered by the Insured Person, as specifically defined in the table below.

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

Body Surface	Nature of Burns	% of Sum Insured
Head	Third degree burns of 8% or more of the total head surface area	100%
	Second degree burns of 8% or more of the total head surface area	50%
	Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
	Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
	Third degree burns of 2% or more, but less than 5% of the total head surface area	60%
	Second degree burns of 2% or more, but less than 5% of the total head surface area	30%
Rest of the body	Third degree burns of 20% or more of the total body surface area	100%
	Second degree burns of 20% or more of the total body surface area	50%
	Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
	Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
	Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
	Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
	Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
	Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

4. Last rite costs/Funeral Expenses

If there is an admissible claim under the policy and all the criteria are fulfilled as per clause 3.1.1, then We will pay the amount specified in policy schedule towards the costs of the cremation or burial of the Insured Person. Once a claim has been accepted and paid under this Benefit, this Policy will automatically terminate in respect of that Insured Person.

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

5. Medical Evacuation Benefit (Domestic)

Insured can choose this benefit on sum insured basis or Assistance service basis

• For Sum Insured basis

We will pay the Reasonable and Customary Charges up to the maximum shown in the Policy Schedule or the Schedule of Benefits for covered expenses incurred if Injury or Sickness results in Your necessary Emergency Evacuation. An Emergency Evacuation must be ordered by the Assistance Company and Physician who certifies that the severity or the nature of Your Injury or Sickness warrants Your Emergency Evacuation.

The cover will be applicable for the medical evacuation within India.

Covered expenses are those for Transportation and medical treatment, including medical services and medical supplies necessarily incurred in connection with Your Emergency Evacuation. All Transportation arrangements made for evacuating You must be by the most direct and economical route possible. Expenses for Transportation must be:

(a) recommended by the attending Physician;

(b) In accordance with the laws of the land, if any, applicable to the mode of conveyance to be used; and

(c) arranged and authorized in advance by the Assistance Company.

Definitions:

Emergency Evacuation means:

(a) Your medical condition warrants immediate Transportation from the place where You 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 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. Transportation includes, but is not limited to, air ambulances, land ambulances and private motor vehicles.

• For Assistance Services

Eligible Participant: Eligible participant shall mean a Participant who is traveling 150 Kilometres or more from his/her primary legal residence and within India, and has not been away from such residence for more than 90 days.

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 over and above the basic Sum Insured

When an adequate facility is not available proximate to the eligible participant, as determined by service providers consulting physician and eligible participants 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 in India. – Only possible through assistance services

• Exclusion from services:

Service provider will not provide any of these services to an eligible participant 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 v)the eligible participant is transferred or is to be transferred from one medical facility to another of similar capabilities which provides a similar level of care. Service provider will not repatriate or evacuate an eligible participant if the eligible participant 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 eligible participant from continuing the trip and returning home iii)if the eligible participant 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 eligible participant was traveling beyond 28th week or iv) a mental or nervous disorder, unless hospitalized. Service provider will not provide services for trips exceeding 90 days from legal residence.

The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company, no claims for reimbursement are accepted.

6. Medical Evacuation Benefit (Worldwide)

Insured can choose this benefit on sum insured basis or Assistance service basis.

For Sum Insured basis

We will pay the Reasonable and Customary Charges up to the maximum shown in the Policy Schedule or the Schedule of Benefits for covered expenses incurred if Injury or Sickness results in Your necessary Emergency Evacuation. An Emergency Evacuation must be

ordered by the Assistance Company and Physician who certifies that the severity or the nature of Your Injury or Sickness warrants Your Emergency Evacuation.

Covered expenses are those for Transportation and medical treatment, including medical services and medical supplies necessarily incurred in connection with Your Emergency Evacuation. All Transportation arrangements made for evacuating You must be by the most direct and economical route possible. Expenses for Transportation must be:
(a) recommended by the attending Physician;
(b) in accordance with the laws of the land, if any, applicable to the mode of conveyance to be used; and
(c) arranged and authorized in advance by the Assistance Company.

Definitions:
Emergency Evacuation means:
(a) Your medical condition warrants immediate Transportation from the place where You 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 medical condition warrants Transportation to the country 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. Transportation includes, but is not limited to, air ambulances, land ambulances and private motor vehicles.

For Assistance Services" "Eligible Participant" shall mean a Participant (as defined below) who is traveling 150 kilometres or more from his/her primary legal residence within India or in another country and has not been away from such residence for more than 90 days."

When an adequate facility is not available proximate to the eligible participant, as determined by service providers consulting physician and eligible participants 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.

Exclusion from services:
Service provider will not provide any of these services to an eligible participant 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 v)the eligible participant is transferred or is to be transferred from one medical facility to another of similar capabilities which provides a similar level of care. Service provider will not repatriate or evacuate an eligible participant if the eligible participant 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 eligible participant from continuing the trip and returning home iii)if the eligible participant 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 eligible participant was traveling beyond 28th week or iv) a mental or nervous disorder, unless hospitalized. Service provider will not provide services for trips exceeding 90 days from legal residence.

The services would be provided by Us /through our appointed Service provider, with prior intimation and acceptance by the Company, no claims for reimbursement are accepted.

For clients who opt to have this benefit under SI whether additional SI or Over and Above SI:
Service Provider will arrange for the provision of air and/or surface transportation, medical care during transportation, communications and all usual ancillary services required to move the User to the nearest hospital where appropriate medical care is available. **Service provider** will arrange for the provision of appropriate communication and linguistic capabilities, mobile medical equipment and medical escort crew.

General exclusions as per policy definition will apply.

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

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 over and above the basic Sum Insured.

7. In- Patient Hospitalization (Domestic) – Accident only
If any Insured Person suffers an Accident during the Policy Period that requires such Insured Person's Hospitalisation for a minimum period of 24 hrs as an in-patient, then We will cover in patient hospitalization medical expenses for

- Room rent, boarding expenses,
- Nursing,
- Intensive care unit,
- A Medical Practitioner,
- Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
- Medicines, drugs and consumables,
- Diagnostic procedures,
- The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.

Our maximum liability will be limited to the **In - Patient Hospitalization** sum Insured mentioned for this cover in the Policy Schedule which is over and above the basic Sum Insured

Condition-

a) The Insured Person is hospitalized in India;
b) The Hospitalization is for Medically Necessary Treatment and is on the written advice of a Medical Practitioner;
c) The Insured Person is admitted in the Hospital within 14 days of the occurrence of the Accident.

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

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

8. In- Patient Hospitalization (Worldwide) - Accident only

If any Insured Person suffers an Accident during the Policy Period that requires such Insured Person's Hospitalisation for a minimum period of 24 hrs as an in-patient, then We will cover Medical Expenses for

- Room rent, boarding expenses,
- Nursing,
- Intensive care unit,
- A Medical Practitioner,
- Anaesthesia, blood, oxygen, operation theatre charges, surgical appliances,
- Medicines, drugs and consumables,
- Diagnostic procedures,
- The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.

Further, the Insured Person's medical condition during and after hospitalization shall be monitored and be subject to obligations in respect of confidentiality and authorization.

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

Condition-

a) The Hospitalization is for Medically Necessary treatment and is on the written advice of a Medical Practitioner.
b) The Insured Person is admitted in the Hospital within 14 days of the occurrence of the Accident.

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 over and above the basic Sum Insured.

Service Provider will, when authorised by EGIC, assist the User by guaranteeing on behalf of the User medical expenses incurred during a User's hospitalisation.

9. Broken Bones

If an Accident causes an Insured Person to suffer a fracture (a break in the continuity of a bone) and this is certified by a Medical Practitioner and also confirmed by imaging investigations such as by X-ray, then We will pay the percentage of the benefit Sum Insured (mentioned in schedule of benefits) specified in the table below.
Broken Bones resulting in an Injury to Percentage of the Sum Insured payable.

Vertebral body resulting in spinal cord damage	100%
Pelvis	100%
Skull (excluding nose and teeth)	30%
Chest (all ribs and breast bone)	50%
Shoulder (collar bone and shoulder blade)	30%
Arm	25%
Leg	25%
Vertebra – vertebral arch (excluding coccyx)	30%
Wrist (collies or similar fractures)	10%
Ankle (Potts or similar fracture)	10%
Coccyx	5%
Hand	3%
Finger	3%
Foot	3%
Toe	3%
Nasal Bone	3%

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

a. Our maximum liability is limited to the Sum Insured, irrespective of the number of fractures that the Insured Person suffers owing to the same Accident.

b. If a claim in respect of any fracture of a whole bone also encompasses some or all of its parts, Our liability to make payment will be limited to the whole bone only and not any of its parts.

c. Any Fracture which results due to any Illness or disease (including malignancy) or due to osteoporosis shall not be payable under this Benefit unless the fracture occurs to such insured due to accidental injury.

d. If We have admitted a claim in accordance with this Benefit, which results in 100% of the Sum Insured under this Benefit being paid, the cover under this benefit shall immediately and automatically cease in respect of that Insured Person.

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.

Note: In this Benefit:
a. Pelvis means all pelvic bones, which shall be treated as one bone. The sacrum is part of the vertebral column.
b. Skull means all skull and facial bones, (excluding nasal bones and teeth) which shall be treated as one bone.

10. Hospital Daily Cash

If, during the Policy Period, an Insured Person sustains bodily Injury or illness which, directly and independently of all other causes, 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 through which the Insured Person is Hospitalised.

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

The cover shall be provided to against any of the below conditions, as mentioned in the Policy Schedule:

- Hospital Daily Cash due to Accident only
- Hospital Daily Cash due to Accident and illness only

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

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 over and above the basic Sum Insured.

11. Family Transport Benefit/ Compassionate Visit

Insured can choose this benefit on sum insured basis or Assistance service basis

For Sum insured basis

The Company shall reimburse the cost of the economy carrier transportation incurred by the person rendering such special assistance from and to the place of origin of such person or the place of residence of the person. Company will also agree to pay the amount as specified in policy schedule for each continuous and completed period of 24 hours that the Insured Person is Hospitalised for Per day expenses of family member or personal friend during hospital stay. The family member or personal friend is responsible to meet all visa and travel document requirements, if applicable.
The insured person's stay in hospital should continue for more than 2 days to avail this benefit.
This Benefit shall not be payable for more than 10 days per Policy Year.
This cover is applicable if it is shown on your schedule and If there is an admissible claim under the policy and all the criteria's are being fulfilled as per benefit clause 3.1.1, 3.1.2, 3.2.7, 3.2.8.
Our maximum liability will be limited to the Sum Insured mentioned for this cover in the Policy Schedule which is over and above the basic Sum Insured.

For Assistance Services:

"Eligible Participant" shall mean a Participant (as defined below) who is traveling 150 kilometres or more from his/her primary legal residence within India or in another country and has not been away from such residence for more than 90 days."
When an eligible participant will be hospitalized for more than seven consecutive days and is travelling in India/abroad without a companion, service provider will arrange for a family member or person friend to travel to visit the Eligible participant in India/abroad by providing an appropriate means of transportation via economy carrier transportation as determined by service provider. The family member or personal friend is responsible to meet all visa and travel document requirements, if applicable.

Service provider will arrange for one return airfare for a relative or a friend of the User wishing to join the User who, when travelling alone, is hospitalised outside the Home Country or Usual Country of Residence.

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 over and above the basic Sum Insured.

12. Double Indemnity

If the insured person is involved in an accident whilst travelling as a fare paying passenger in any of the listed Common Carrier during the policy period, then We will pay an amount equivalent to the Sum Insured as stated in the Policy Schedule. In order to avail this benefit, the insured should have taken the cover under section 3.1.1 or 3.1.2 and the valid claim, under these clauses, having been admitted.

Definition

Common Carrier shall mean any commercial public airline, railway, bus transport, or water borne vessel (which shall include ocean going and/ or coastal vessels and/ or vessels engaged for official or personal purposes), operating under license issued by the appropriate authority for transportation of passengers and/ or cargo.

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 over and above the basic Sum Insured.

13. Child Enhancement Benefit

If there is an admissible claim under the policy and all the criteria are fulfilled as per benefit clause 3.1.2, and if the insured has opted for this cover (3.1.2), then the benefit payable under this cover shall be doubled for any eligible Dependent children covered, and if payable under this Policy.
This cover is applicable if it is shown on your schedule and will be paid for any one child.

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

14. Escalation Benefit

The principal sum insured for any Insured Person will increase by percentage on each anniversary date of the policy provided there is no interruption in coverage. The total of all increases is limited to the percentage mentioned 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 over and above the basic Sum Insured.

This cover can be opted only for policies issued on named basis.

15. Loss of Employment Benefit

If there is an admissible claim under the policy and all the criteria's are being fulfilled as per benefit clause 3.1.2 or benefit 3.1.3, then We will pay the amount as specified in the Policy Schedule or Certificate of Insurance provided that the Insured Person is disabled from engaging in his/her primary occupation and loses his/her source of income generation.

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

16. Reconstructive Surgery Benefit

If, during the Policy Period, the Insured Person sustains bodily injury, which requires reconstructive surgery 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 for this cover in the Policy Schedule, which is over and above the basic Sum Insured.

17. Parental Care Benefit

If, during the Policy Period, an Insured Person sustains bodily Injury, which, directly and independently of all other causes, results in death within 12 months from the date of loss, the Company agrees to pay the compensation shown in the Policy Schedule, which shall be an equal share to each dependent parent of the Insured Person.

This cover shall be available only if the cover under 3.1.1 has been opted for and the Claim, under section 3.1.1 of the Policy, has been accepted.

Dependent parents means parents and grand parent of the insured's person or the insured's person spouse
Dependent parent should be eligible for benefit if he or she, at the time of bodily injury, is receiving support and care provided by the insured person or spouse.

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 over and above the basic Sum Insured.

18. Rehabilitation Benefit

If, during the Policy Period, an Insured Person sustains bodily Injury, which requires rehabilitation within 3 weeks from the date of loss, the Company agrees to pay the actual cost of treatment upto the Sum Insured specified in the Policy Schedule.

Definition -

In this Benefit, **Rehabilitation** means healthcare services that intend to prepare the Insured Person to get back to work in the Insured Person's regular occupation that have been lost or impaired because that person is disabled following an Accident. These services may include physical and occupational therapy, speech-language therapy and psychiatric rehabilitation services, in a variety of In-patient and/or Out-patient settings.

Specific Exclusion -

The Company shall not be liable to pay any benefit, in respect of an Insured Person, for any treatment not performed by a duly registered and licensed physiotherapist, occupational therapist, speech therapist or psychiatrist.

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 over and above the basic Sum Insured.

19. Purchase of Blood

If there is an admissible claim under the policy and all the criteria are fulfilled as per the benefits under clauses 3.1.1, 3.1.2, 3.1.3, 3.2.7 and 3.2.8, We will reimburse the actual expenses incurred in purchasing blood through a Hospital or lawful blood bank for the purpose of the Insured Person's medical or surgical treatment, provided that such treatment is necessitated by the Accident.

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 over and above the basic Sum Insured.

20. Transportation of Imported Medicine :

If an Insured Person suffers an Injury due to an Accident and such

Injury requires the Insured Person to be Hospitalized as an In-patient, We will reimburse the costs incurred towards freight charges for importing medicines to India, provided that:
a. An In-patient Claim under clause 3.2.7 or 3.2.8 has been admitted and payable under the Policy;
b. Such medicines, formulations or their alternatives are not available in India;
c. Such medicines are necessary for the medical or surgical treatment of the Insured Person in a Hospital following the Accident;
d. Such medicines shall not include any drugs under clinical trial or medicines, formulations or molecules of unproven efficacy.

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 over and above the basic Sum Insured.

21. Comatose Benefit Accident
If an Insured Person is rendered comatose due to an Accident during the Policy Period, We will pay a weekly benefit for as long as the Insured Person remains comatose, provided that:

a. The Insured Person is certified to be comatose by a specialised Medical Practitioner, and

b. The Insured Person is rendered comatose within 3 days of occurrence of the Accident and continues to be in such state for a period of at least 7 days thereafter, and

c. Our liability to make payment shall be limited to a percentage of the Sum Insured for each week that the Insured Person is comatose, for a period not exceeding the number of weeks mentioned in the Policy Schedule, from the date of the Accident, and`

d. If the Insured Person is comatose for a part of a week, then only a proportionate part of the weekly benefit will be payable.

In this Benefit, **Comatose** means a profound state of unconsciousness, where the patient cannot be awakened, fails to respond normally to external stimuli, internal needs or pain, does not have sleep-awake cycles and cannot take voluntary actions and also includes a state of coma.

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 over and above the basic Sum Insured.

22. Out-patient Expenses / Emergency Room/Casualty Expenses - Domestic
If, during the Policy Period, an Insured Person sustains bodily Injury and/or Illness, which has been opted for by the Policyholder at the time of purchasing the Policy and that requires Out-patient treatment, We will reimburse the Medical Expenses incurred by the Insured Person, provided that such expenses are incurred within the same Policy Period. Our liability to meet the Medical Expenses caused by such Accident and/or illness will be limited to the Sum Insured of that Policy Period.

Out-patient expenses shall include:
- Diagnostic Tests
- Vaccinations
- Pharmacy
- Consultations with a Medical Practitioner, physiotherapist and speech therapist
- Plaster cast, crutches
- Minor OT charges

Conditions
a. Applicable for treatment taken in India.
b. Applicable for Medically Necessary Treatment and is on the written advice of a Medical Practitioner.
c. Applicable for treatment taken within first 2 days followed by the Accident.

Company shall not be liable to pay for the Deductible amount as mentioned against this Benefit 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 over and above the basic Sum Insured.

23. Out-patient Expenses / Emergency Room/Casualty Expenses - Worldwide
If, during the Policy Period, the Insured Person sustains bodily Injury and/or illness, which has been opted for by the Policyholder at the time of purchasing the Policy and that requires Out-patient treatment, We will reimburse the Medical Expenses incurred for the Insured Person, provided that such expenses are incurred within the same Policy Period. Our liability to meet the Medical Expenses owing to such Accident and/or illness will be limited to the Sum Insured of that Policy Period.

The Insured Persons shall be assisted with arrangements for appointments with local Doctors for purposes of treatment.

Out-patient expenses include:
- Diagnostic tests
- Vaccinations
- Pharmacy
- Consultations with a Medical Practitioner, physiotherapist and speech therapist
- Plaster cast and crutches
- Minor OT charges

Conditions
a. Applicable for Medically Necessary Treatment and is on the written

advice of a Medical Practitioner.
b. Applicable for treatment taken within the first 2 days followed by the Accident.

Company shall not be liable to pay for the Deductible amount as mentioned against this Benefit 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 over and above the basic Sum Insured.

Service Provider will assist the User by arranging for appointments with local doctors for treatment.

24. Sports Activity Cover Only
If an Insured Person suffers from Accidental Death, Permanent Total Disability, Permanent Partial Disability, accidental In-patient hospitalization or accidental Out-patient treatment in accordance with clauses 3.1.1, 3.1.2 or 3.1.3, 3.2.7, 3.2.8, 3.2.22 and 3.2.23, having specifically opted for this benefit, whilst engagement in sporting activities carried out in accordance with the guidelines, codes of good practice and recommendations as laid down by a governing body or authority in respect of that sport, We will pay the amount as specified under these clauses in the Policy Schedule or Certificate of Insurance in respect of the Insured Person.

The Sum Insured amounts under these clauses will be payable only once under the Policy and payment under this cover is applicable only if the Insured Person has engaged in adventure sports, in a non-professional capacity and under the supervision of trained professionals.

The exclusion under clause 4.II.V of General Exclusions will not be applicable in respect of 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.

25. Emergency Road Ambulance Charges
If We have accepted a Claim under this Policy and following the Accident, it is necessary to immediately transfer the Insured Person to the nearest Hospital by ambulance offered by a healthcare or an ambulance service provider, We will reimburse the actual expenses incurred towards such transfer to the Hospital, upto the amount as mentioned in the Schedule.

Conditions
- Treating Medical Practitioner certifies, in writing, that the transportation of the Insured Person by Ambulance was medically necessary, and
- Such transportation was availed of immediately following the Accident.

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

The territorial limit for this cover will be as specified in the Policy Schedule, whether within India or worldwide.

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

26. Emergency Air Ambulance Charges
In case of emergency life threatening health conditions due to an accident within India, which requires immediate and rapid ambulance transportation from the site of first occurrence to the hospital/medical centre that ground transportation cannot provide, in such case, We will pay for ambulance transportation in an airplane or helicopter, subject to the maximum limit specified under the policy, provided that:

- Necessary medical treatment not being available at the location where the Insured Person is situated at the time of Emergency;
- The Medical Evacuation has been prescribed by a Medical Practitioner and is Medically Necessary;

This cover is applicable if it is shown on your schedule.
Territorial Limit for this cover will be as specified in policy schedule (Within India / Worldwide).

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

For Assistance Services:
An Insured Person, who is traveling 150 kilometres or more from his/her primary legal residence within India or in another country and has not been away from such residence for more than 90 days, shall be eligible for this benefit.
When an adequate facility is not available proximate to the eligible participant, as determined by service provider's consulting physician and eligible Insured Person's attending physician, arrangement for transportation under appropriate medical supervision shall be made, by an appropriate mode of transport, to the nearest medical facility capable of providing the required care in India.

For clients who opt to have this benefit under SI whether additional SI or Over and Above SI:
Service Provider will arrange for the provision of air and/or surface transportation, medical care during transportation, communications and all usual ancillary services required to move the User to the nearest hospital where appropriate medical care is available. **Service provider** will arrange for the provision of appropriate communication and linguistic capabilities, mobile medical equipment and medical escort crew.
General exclusions as per policy definition will apply.

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

27. Cost Support Items

If there is an admissible claim under the policy and all the criteria's are being fulfilled as per benefit clause 3.1.2, 3.1.3 or 3.1.4, then We will reimburse expenses for support items including but limited to crutches, artificial limbs, wheelchairs, tri-cycles, intra-ocular lenses or any other item which in the opinion of a Medical Practitioner is necessary for the Insured Person for normal living due to the Injury sustained in the Accident, up to a limit specified in the Policy Schedule or Certificate of Insurance.

Expenses incurred on spectacles, contact lenses, hearing aids, blood pressure and blood sugar monitoring devices are not covered under this benefit.

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 over and above the basic Sum Insured.

28. Disappearance Benefit

If an Insured Person disappears during the Policy Period due to an Accident followed by a forced landing, stranding, sinking or wrecking of a conveyance, earthquake or flood during the Policy Period and is legally declared dead (declared death in absentia or legal presumption of death) provided that such disappearance is certified in writing by the local police authorities, We will pay the amount specified under Section 3.1.1 in the Policy Schedule or Certificate of insurance to the Nominee.

This cover is applicable and will be payable provided the insured has opted for cover 3.1.1.
Sum insured under section 3.1.1 will be payable only once under the policy.

On payment of claim under this benefit, the policy shall terminate for that Insured Person for whom the claim has been paid.
This cover is applicable if it is shown on your policy schedule.

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

29. Multiple Member Disability

In an event of Accident of two or more Insured Persons, insured under the same policy which results in permanent disablement then, We will pay additional percentage of the benefit payable under Benefit 3.1.2, provided that

- The insured has opted for the cover 3.1.2
- We have accepted a claim under Benefit 3.1.2 and,
- Injuries leading to disability are sustained in a single Accident.

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

Our maximum liability will be limited to the additional percentage of Sum Insured mentioned in the Policy which is over and above the basic Sum Insured.

30. Nursing Assistance

If there is an admissible claim under Permanent Total Disablement in accordance with Sections 3.1.2, then We will pay the Reasonable and Customary Charges for the cost of a Qualified Nurse arranged by the Hospital to visit the Insured Person's home to give expert nursing services when it is medically necessary and relates directly to an injury. Cover for nursing at home is restricted to the number of weeks and opted sum insured as specified in the policy schedule.

Our maximum liability will be limited to the number of weeks mentioned in the Policy Schedule per policy year and the Sum insured mentioned for this cover in the Policy Schedule, which is over and above the basic Sum Insured.

This cover is applicable, provided the insured has opted cover 3.1.2

The Company shall not be liable to make any payment in respect of below:

- Home Nursing applicable immediately after the Insured Person's Hospitalization/Treatment unless it is required by medical necessity; and
- Nursing Visits from hospital, unless it is required by medical necessity for Treatment which would normally be provided in a Hospital;
- In either case, the specialist Medical Practitioner who treated the Insured Person must have recommended these services in writing. This cover is not related to any Domiciliary Hospitalisation.

31. Felonious Assault/Kidnapping /Hijack /Riots

If an Insured Person suffers Accidental Death, Permanent Total Disability, Permanent Partial Disability, in patient hospitalization due to accidental injury in accordance with Section 3.1.1, 3.1.2 or 3.1.3, 3.2.7 or 3.2.8 arising due to Felonious Assault / Kidnapping / Hijack/ Riots then we will pay the amount as specified under the respective covers provided the insured has opted for any of the applicable covers in the Policy Schedule or Certificate of Insurance.

The cover is applicable only if the Death, Permanent Total Disability or Permanent Partial Disability, sustained by an Insured Person(s), caused due to Felonious Assault / Kidnapping / Hijack /Riots, which were beyond his / her control. This cover will also be applicable if the Insured person was met with **Felonious Assault / Kidnapping / Hijack /Riots** while being involved in the handling or negotiation of the Kidnapping, Wrongful Detention, Extortion, or Hijacking incident.

The Company at its own expense, will have the right to examine the person without prior notice of any individual, when and as often as it may reasonably required for assessment of a claim hereunder and to

make an autopsy in case of death, where it is not forbidden by law.

All claims under this section will be payable to the Insured or Insured Person's legal heirs/representatives, upon receipt and acceptance by the Company of Proof of Loss. Proof of Loss may include a death certificate, coroner's report, police report, or other evidence of the Death or Dismemberment of the Insured Person(s), deemed sufficient by the Company.

In Patient hospitalization costs incurred by any person(s) and paid by the Insured as a direct result of an Insured event either following the release of the victim(s) or the last credible Extortion threat occurring during the Policy Period. Such medical services and hospitalization costs shall include but not be limited to any costs for treatment by a neurologist or psychiatrist, costs for cosmetic surgery, and expense of confinement for such treatment. In Patient Hospitalization cover (3.2.7/3.2.8) is applicable under this benefit if it is specifically opted in the policy.

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.

32. Education Benefit
If there is an admissible claim under the policy and all the criteria's are being fulfilled as per benefit clause 3.1.1, Benefit 3.1.2 or benefit 3.1.3, then We will, in addition, pay the benefit Sum Insured for Dependent Children upto the maximum limit specified in the policy schedule provided that:
a. Such Dependent Child/ Children(s) is/are pursuing an educational course as a full time student in an educational institution.
b. Age of the child or children as the case may be should not be more than 25 completed years.
c. The Sum Insured mentioned in the schedule of benefits is the total amount payable for all Dependent Children collectively and not per insured child basis.

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

33. Transportation of Mortal Remains
Insured can choose this benefit on sum insured basis or Assistance service basis:

Sum Insured basis
The Company shall reimburse the cost associated with transportation of mortal remains from the place of death to the residence of the Insured Person.

This cover is applicable if it is shown on your schedule and If there is an admissible claim under the policy and all the criteria's are being fulfilled as per benefit clause 3.1.1.
Our maximum liability will be limited to the Sum Insured mentioned for this cover in the Policy Schedule which is over and above the basic Sum Insured.

For Assistance Services:
" Eligible Participant" shall mean a Participant (as defined below) who is traveling 150 kilometres or more from his/her primary legal residence within India or in another country and has not been away from such residence for more than 90 days."
In case of an eligible participant in India/abroad, service provider will arrange and pay for return of mortal remains to an authorized funeral home proximate to the eligible participant's legal residence.

Service provider will arrange for the transportation of the User's mortal remains to the Home Country or Usual Country of Residence or arrange, if requested by the User's family, arrange for local burial at the place of death, subject to any governmental regulations.

34. 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 or the Certificate of Insurance. Payment of the Benefit will be subject to the availability of 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, occurs or manifest itself 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.
To avail this benefit, Insured person should survive for atleast number of days as specified in policy schedule.

1. Waiting Period
We shall not be liable to make any payment in respect of any Critical Illness whose signs or symptoms first occur within the first 90 days from the Inception Date.

There is also an option for waiver/reduce of waiting period under the Policy if specified in the Policy Schedule or Certificate of Insurance.

2. Survival Period:
The payment under this Section shall be subject to survival of the Insured Person for a number of days as specified in the Policy Schedule or Certificate of Insurance following the first diagnosis of the Critical Illness/undergoing the Surgical Procedure for the first time.

There is also an option for waiver of survival period under the Policy if specified in the Policy Schedule or Certificate of Insurance.

Benefit Structure

Sr. No.	Particulars	Value (09 CI)	Bonus (12 CI)	Superior (15 CI)	Supreme (18 CI)	Ultimate (25 CI)
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

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. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

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

The following are excluded:
- Other stem-cell transplants;
- Where only Islets of Langerhans are transplanted.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. 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.

23. 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.

24. 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.

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.

Exclusions applicable to Major Medical Illness and Procedures.

We shall not be liable to make any payment under this policy towards a covered critical illness, directly or indirectly caused by, based on,

arising out of or howsoever attributable to any of the following:
1. Any illness, sickness or disease other than those specified as critical illnesses under this policy;
2. Any claim with respect to any critical illness diagnosed or which manifested prior to policy inception date;
3. Pre-Existing Diseases(Code- ExclOl)
a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.
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 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us
4. Any condition directly caused by or associated with any sexually transmitted disease, venereal diseases including genital warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic lice and Trichomoniasis;
5. Unproven Treatments: Code- Excl-16
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
6. 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.
7. Change of Gender treatment code -Excl-07
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
8 Cosmetic or Plastic Surgery -Code-Excl-08
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
9. 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
10. Sterility and Infertility: Code- Excl-17
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

35. Specific Vector Borne Disease Benefit
In this benefit Specific Vector-Borne Disease means Dengue, Malaria, Chikungunya, Kala azar, Zika virus, Plague Japanese encephalitis and Filariasis.

I. Specific Vector Borne Disease related In patient Benefit
We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with a Specific Vector Borne Disease that solely and directly requires the Insured Person to be hospitalized during the Period of Cover.

Benefit will be applicable to the diseases opted by the insured and mentioned in the policy schedule. We will not make payment for the deductible period per event as mentioned in the policy schedule.

This Benefit shall be payable subject to the following:
i. The Hospitalization is for Medically Necessary Treatment of the Specific Vector Borne Disease and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in the Hospital should continue for a minimum period of days as mentioned in the policy schedule.
iii. We shall not be liable to make any payment under this Benefit, if the Specific Vector Borne Disease is first Hospitalized prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if the Insured Person is hospitalized due to Specific Vector Borne Disease within a period of 30 days from the commencement of the Period of Cover.
This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with us or receipt of additional premium and specifically mentioned in policy schedule.
v. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.
vi. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

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

II. Specific Vector Borne Disease related Death Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if an Insured Person is diagnosed with a Specific Vector Borne Disease during the Period of Cover that solely and directly results in the Insured Person's death within 15 days from the first laboratory diagnosis of the Insured Person contracting the Specific Vector Borne Disease.

Benefit will be applicable to the diseases opted by the insured and mentioned in the policy schedule.

This Benefit shall be payable subject to the following:

i. We shall not be liable to make any payment under this Benefit, if the Specific Vector Borne Disease is first diagnosed prior to the commencement of the Period of Cover;

ii. We shall not be liable to make any payment under this Benefit, if the Specific Vector Borne Disease is first diagnosed within a period of 30 days from the commencement of the Period of Cover. This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with Us;

iii. The first laboratory diagnosis of the Specific Vector Borne Disease is certified and attested by a registered pathologist, unless the death has occurred post admission in a Hospital and cause of death is certified by the Hospital as death due to the Specific Vector Borne Disease;

iv. On the acceptance of a claim under this Benefit and any other applicable Benefit pertaining to the same event, all cover under this Policy in respect of the Insured Person shall immediately and automatically cease.

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

III. Specific Vector Borne Disease related Hospitalization Indemnity-

We will indemnify the expenses of the insured person upto the Sum Insured specified against this Benefit for the in patient hospitalization treatment if an Insured Person is diagnosed with a Specific Vector Borne Disease that solely and directly requires the Insured Person to be hospitalized during the Period of Cover.

Benefit will be applicable to the diseases opted by the insured and mentioned in the policy schedule.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of the Specific Vector Borne Disease and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. We shall not be liable to make any payment under this Benefit, if the Specific Vector Borne Disease is first Hospitalized prior to the commencement of the Period of Cover.

iii. We shall not be liable to make any payment under this Benefit, if the Insured Person is hospitalized due to Specific Vector Borne Disease within a period of 30 days from the commencement of the Period of Cover.

This exclusion shall cease to apply from the first Renewal of the Insured Person's cover under the Policy with us or receipt of additional premium and specifically mentioned in policy schedule.

iv. We shall not be liable to make any payment under this Benefit in respect of Pre-hospitalization Medical Expenses or Post-hospitalization Medical Expenses.

v. We will only accept one claim under this Benefit during the Period of Cover in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit in respect of the Insured Person shall immediately and automatically cease but insurance cover under any other applicable Benefits under this Policy during the Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

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

36. Medical Monitoring

This benefit is available only on Assistance service basis.

This cover is applicable if it is shown in your policy schedule.

Medical Monitoring means Medical Personnel will monitor Eligible Participant's condition and will

i. Stay in regular communication with attending physician and / or hospital and

ii. Relay necessary and legally permissible information to family members.

4. Discount Covers

I. On Duty Cover Only-

Coverage will be effective whilst the insured is on duty. On Duty cover discount will be given only on the Basic premium and not on the Add-on covers. The cover is applicable only for Employer-Employee relationships. Our Maximum liability would be only during the working hours of the employee.

II. Cover in India Only - Territorial limits of this policy is within India only. If this cover is opted for, coverages mentioned in clauses 3.2.8 or 3.2.31 cannot be opted. Discount will be given only on the Basic premium and not on the Add-on covers.

III. Group Discount - Discount on the base premium

A group discount will be given only on the Basic premium and not on the Add-on covers. The discount is not cumulative. The applicable scale of the discount is to be reckoned in accordance with the group size at the inception of the policy.

No. of members	Group Discounts (% upto)
Up to 25 persons	0%
26 Persons – 1000 Persons	20%
1001 Persons - 5000 Persons	25%
Above 5000	30%

IV. Any One Accident / Event:
The maximum liability under the Policy, in case of multiple Claims arising out of any one Accident/ event, inclusive of all benefits (including optional benefits), will be limited, per individual, to the Sum Insured specified in the Policy Schedule, further subject to the maximum liability per event, in case of multiple Claims arising out of the same event.

V. Any one year / aggregate:
The maximum liability, during the Policy Period, for any one year and/or in the aggregate, arising out of multiple Claims and or events, shall be limited to as specified in the Policy.

5. Exclusions
We will not make any payment for any claim in respect of any Insured Person, directly or indirectly, for, caused by, arising from or, in any way, attributable to any of the following, unless expressly stated to the contrary in this Policy:

I. Special Exclusion-
a. Special Exclusions to Benefits 3.1, 3.2.1, 3.2.7, 3.2.8 and 3.2.9.
Medical or surgical treatment, except as necessary solely and directly as a result of an Accident.

b. Special Exclusions to Benefit 3.2.3
(a) Self Inflicted Burns;
(b) Any modifications or alterations not compliant with the applicable law.
c. Special Exclusion for Benefits 3.2.7 and 3.2.8
Treatment at a healthcare facility which is NOT a Hospital.

d. Special Exclusion for Benefits 3.2.7 and 3.2.22
Treatment availed outside of India.

e. Special Exclusion for Benefit 3.2.9
(a) Illness or disease.
(b) Any pathological fracture.
(c) Any hair line fracture.

f. Special Exclusion for Benefit 3.2.16
Any Reconstructive surgery that an Insured Person elects to have and is not recommended by the Medical Practitioner.

g. Special Exclusion for Benefit 3.2.21
Coma resulting directly from alcohol consumption or drug abuse.

h. Special Exclusions to Benefits 3.2.10, 3.2.22, 3.2.23, 3.2.7 and 3.2.8
Any expenses due to declared / not declared Pre-Existing Diseases.

This exclusion shall cease to apply from the fourth continuous Renewal of the Insured Person's cover under the Policy with us.

II. General Exclusion -
(I) Any Pre-Existing Disease or Injury or disability arising out of a Pre-Existing Diseases or any complication arising therefrom.
(II) Any payment in case of more than one claim under the Policy during any one Policy Period by which Our maximum liability in that period would exceed the Sum Insured. This would not apply to payments made under the Additional Covers.
(III) Suicide or attempted suicide, intentional self-inflicted Injury, acts of self-destruction, whether the Insured Person is medically sane or insane.
(IV) Breach of law- Code- Excl-I0
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent
(V) Hazardous or Adventure sports - Code- Excl-09
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 not applicable unless specifically opted for
(VI) Voluntary participation in actual or attempted felony, riots or civil commotion.
(VII) Felonious assault , riots, terrorism/terror attack, hijacking, kidnapping unless specifically opted
(VIII) Cosmetic or Plastic Surgery -Code-Excl-08
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
This exclusion not applicable unless specifically opted for
(IX) Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl-12
(X) Treatment, directly, arising from or consequent upon war or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.
(XI) Maternity Expenses : Code – Excl-18
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
(XII) Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed.
(XIII) 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.
(XIV) Congenital external diseases, defects or anomalies or in

consequence thereof.
(XV) Treatment other than AYUSH and Allopathic systems of medicines.
(XVI) 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 or Certificate of Insurance.
(XVII) Death or disablement caused by participation of the Insured Person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable.
(XVIII) Insured Persons involved in naval, military or air force operations.
(XIX) Working in underground mines, tunnelling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities.
(XX) Accidental death or Injury occurring after twelve calendar months from the date of the Accident.
(XXI) 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.
(XXII) 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.
(XXIII) 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.
(XXIV) Diseases spread/ caused through an insect bite by transfer of organisms for which the insect is a known carrier or host, unless specified.
(XXV) Automatic passenger covers (Airlines).
Air travel except as a fare paying 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.

6. Terms and Conditions

1. Material Change

Material information to be disclosed includes every matter that the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk of insurance. The Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement of the contract. The Policy terms and conditions will not be altered.

2. Arbitration clause

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted), such difference shall, independently of all other questions, be referred to the decision of a sole arbitrator, to be appointed, in writing, by the parties thereto, or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996 (as amended).
It is clearly agreed and understood that no dispute or difference shall be referable to arbitration as herein before provided, if We have disputed or not accepted liability under or in respect of this Policy.
It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/ arbitrators of the amount of the loss or damage shall be first obtained.

The venue of the arbitration proceedings shall be Mumbai and it is shall be conducted and the award passed in the English language.

3. Alterations to the Policy

This policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by us, which approval shall be evidenced by a written endorsement signed and stamped by us. However upon the inception of the policy, the option to modify plan and/ or sum insured shall be available to policyholder only at the time of policy renewal with us.

4. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder/ Insured Person which is in Our possession and not specifically informed by the Policyholder / Insured Person shall not be held to bind or prejudicially affect Us, notwithstanding subsequent acceptance of any premium.

5. Eligibility

Policy Type	Individual	Floater
Relationship covered	Self	Self
	Spouse	Spouse
	Dependent Children	Dependent Children
	Parent/s Parent(s)-in-law	Parent/s
	Siblings	Parent(s)-in-law
Minimum Age	0 days (Proposer 18 years)	0 days
Maximum Age	No upper Limit	No upper Limit
Cover ceasing age	No	No

6. Currency for Payment
All claims shall be payable in India and in Indian Rupees only.

7. Short Period Cover
The Policy can be issued for a period from one hour upto 365 days.

8. Unnamed Policy Cover
Policies can be issued on named as well as un-named basis.

9. Geography
This Policy applies to events or occurrences taking place anywhere in the world unless limited under this Policy in a particular Benefit or definition or by Us, through an endorsement.

10. Premium
The premium for each Policy will be determined based on the available data of each group and applicable discounts and loadings. Payment of premiums will be available in single mode or instalment options of monthly/ quarterly/ half yearly, as agreed with the Policyholder.

11. Grace Period
The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any claim arising out of an Illness/Injury/ Accident that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act 1938 shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

12. Renewal Terms
(1) This Policy will automatically end on the Policy Period End Date, so please send us your renewal application before such date.
(2) The renewal premium should be paid to us on or before the Policy Period End Date or before the last date of the Grace Period.
(3) The Grace Period means a period of 30 days immediately after the Policy Period End Date, during which you can pay to renew the policy, without losing the continuity benefits. However:

- Insured persons are not covered for the period during which we did not get the premium, and no claims can be made during such period till appropriate premium towards renewal of the expiring year policy is received by us. The Policy will lapse after the last date of the Grace Period.

(4) We will be happy to renew the policy, except in cases of fraud, mis-description, misrepresentation or non-co-operation by the Policyholder.
(5) Any request for a change in the sum insured or deductible at the time of renewal shall be subject to underwriting as per our Board-approved underwriting policy.
(6) We may decide to withdraw this product under which this policy is issued to policy holder, in such case we will provide with an option to migrate to a policy of similar nature with us subject to portability conditions.
We will give the notice to policyholder in the event we may decide to withdraw the product. Such notice will be given to the policyholder at least 3 months prior to the date when such withdrawal comes into effect. The product will be withdrawn only after due approval from insurance regulatory and development authority. However, if the policyholder do not respond to our intimation in case of such withdrawal, the policy will be withdrawn on the renewal date.
(7) We may change the renewal premium, but only in accordance with the applicable rules and regulations issued by IRDAI from time to time. Change in rates will be effective from the date of approval by IRDAI, and will be applied only for new policies and on the date of renewal.
(8) Policyholder may keep renewing this policy, although we are under no obligation to give notice in this regard. The Policyholder will be given an option to move from this policy to any of our other health insurance products, and credit will be given for the number of years of continuous coverage, for the standard waiting periods.
(9) The policy is subject to changes in terms and conditions, including change in premium rates.

The policy can be renewed as a separate contract under the then prevailing other health insurance Product or its nearest substitute (in case the product Edelweiss Group Total Protect Policy is withdrawn by the company) approved by IRDAI.

13. Portability
Insured Persons and their family members, who are covered under this policy, have the option of moving on to any other similar products, as per our guidelines and the terms and conditions of the new policy.
The Insured Person, desirous of porting his/her policy, has to apply for porting 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 premium renewal date of his/her existing policy.
a. Portability benefit is available upto the existing SI under the current group policy.
b. Individual members shall be given waiting period credit based on the number of years of continuous insurance cover availed by them in accordance with the guidelines of IRDAI.
c. Portability benefit is available subject to fulfilment of the pre-policy medical examination requirements and subsequent acceptance of the risk by the Company.

Upon completion of the Policy Period or Policy Years, the Policyholder or Insured Persons can move on to another insurer, in accordance with the IRDAI (Health Insurance) Regulations, 2016 and other regulations/guidelines/circulars issued by IRDAI, as applicable from time to time.

14. Communication & Notices
Any communication meant for us must be sent to address shown in the policy schedule or as an electronic mail communication. Any communication meant for the Policyholder will be sent by us to his last known address or the address as shown in the Policy Schedule. All notifications, Endorsements and Declarations for us must be in

writing and sent to the address specified in the Policy Schedule. Agents, brokers or any other persons or entity are not authorized to receive notices and declarations on our behalf unless expressly stated to the contrary, in writing.

15. Duty of Disclosure

The Policy shall be null and void and no Benefit shall be payable hereunder in the event of an untrue or incorrect statement, misrepresentation, mis-description or non-disclosure of any material particular in the Proposal Form, personal statements, declarations, medical history and connected documents, or any material information having been withheld by the Policyholder or any one acting on their behalf, under this Policy. Under such circumstances, We may, at Our sole discretion, cancel the Policy and the premium paid shall be forfeited to Us.

16. Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by You or the Insured Person or anyone acting on their behalf to obtain any benefit under this Policy then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons. All sums paid under this Policy shall be repaid to Us by You on behalf of all Insured Persons, who shall be jointly liable for such repayment.

17. Policy Dispute

Any dispute arising out of this Policy shall be tried under Indian laws and in the Indian courts.

18. Complete Discharge

We will not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy. The payment made by Us to the Insured Person or to the Claimant or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall, in all cases, be complete, valid and construe as an effectual discharge in favour of Us.

19. Cancellation/Termination

(1) We may cancel the Policy after giving you a 15 days' advance written notice by Registered Post or electronically, through official e-mail, in the following scenarios:

i. Any insured person or any person on his/her behalf has been dishonest or fraudulent;

ii. Any Insured Person has not disclosed the material facts or misrepresented in relation to the Policy

iii. The insured person /Policyholder fails to or refuses to pay or refund any amount owed to us;

iv. To avoid any doubt, no claims will be paid by us unless the insured is able to justify a valid reason for non-cancellation of policy.

(2) The insured person can also cancel by giving us 15 days' advance written notice, in writing, in which case we will cancel from the date of the notice, and refund the premium for the unexpired period on the basis of the below grid unless anything else was mutually agreed between us, only if no claim has been made.

Length of time Policy in force	Refund of Premium (% of Annual Premium)
Up to 1 Month	75%
Up to 3 Months	50%
Up to 6 Months	25%
Up to 9 Months	NIL

The table is applicable only when free-look period is not applicable.

(3) What about the worst case: death of the Policyholder?

i. Where the policy covers only insured , it will come to an end from the time of his/her passing away. The premium will be refunded for the unexpired period of this at pro-rata basis if there is no claim.

ii. Where the policy covers other insured persons, it will continue till the end of the policy period for the other insured persons. If the other Insured Person(s) wish to continue with us after the policy period, and we hope they do, we will renew the policy if an insured member is added as below:

a) We get a written notice about this before the Policy Period End Date; and

b) The new insured member should be at least 18 years old, and should be eligible under the various clauses.

20. Assignment

The Policy and the benefits under this Policy cannot be assigned in whole or in part.

21. Other conditions

At any time during the policy period the company shall be entitled to inspect any or all records of the insured that may be relevant to this policy. The company shall also have the right of interaction with any and/or all advisors of the insured as may be relevant for examination/verification of the data/documents in connection with the process and disposal of any claims under this policy. The insured shall provide reasonable support to the company in this regard.

If so required by the company, the insured will have to submit to a medical examination by the company's nominated person / authority or undergo diagnostic or other medical tests as often as the company considers necessary, in its sole discretion.

In case of any claim being admissible and payable up to the full sum insured, the policy will seize to exist. In case where only partial sum insured is paid under any of the sections, then the policy will still exist on the balance sum insured.

22. Multiple Policies

If two or more policies are taken by an insured during a period from one or more insurers to indemnify treatment costs, the policyholder shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

a. In all such cases the insurer who has issued the chosen policy 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.
b. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies.
c. If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.
d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified for the hospitalization costs in accordance with the terms and conditions of the chosen policy.

Caption clause will be applicable to the indemnity sections/ coverages of the policy.

23. Special Provisions
Any special provisions subject to which this Policy has been entered into and endorsed in the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

24. Electronic Transactions
The Policyholder agrees to comply with all the terms and conditions of electronic transactions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as 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, in respect of this Policy and claim related details, shall constitute legally binding when done in compliance with Our terms for such facilities.
Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by the Policyholder.

25. Withdrawal of product
This sounds painful to even think about, but it's always good to be prepared – even for us! In case this policy doesn't get the kind of response we expect, we may stop it, as per approval under the Insurance Regulatory & Development Authority of India (Health Insurance) Regulations 2016. Of course we will inform you well in advance, and give you the option of moving to one of our similar policies. We shall allow the benefit of Portability in all such cases

26. Sum Insured Enhancement:
The provision for increase in Sum insured is available at the time of renewal of the policy and also during the policy period subject to specific approval and acceptance by the company.

27. Fraudulent claims
If any claim is fraudulent, or if any false statement/declaration is made or used or if any fraudulent means are used by the insured person or any one acting on his/her behalf to get any benefit under this Policy, or if a claim is made and rejected and no legal action is taken within 12 months of the rejection, all the benefits under the policy will stop.

28. Free Look Period
1. The Policyholder can, within 15 days of getting the policy document, return it and let us know why he/she would like to part ways with us.
2. If no Claim has been made under the Policy, we will refund the premium received after deducting the needed risk premium for the period on cover, costs for medical examination and stamp duty charges. If only part of the risk has started, we will consider only this amount while deducting the premium. All rights under the policy will immediately end in case of free look cancellation.
3. Refunds will be carried out within 15 days from the date of receiving the request for free look cancellation.
4. The free look period is not available at the time of renewal of the policy.

29. Complete discharge
A payment made by us to you, the Policyholder or to the Insured Person or the nominee/legal representative of the Policyholder, or to the Hospital, for any medical cost or compensation or benefit, will be considered a complete discharge by us.

30. Disclosure to Information Norm
If we are given any false information while issuing the policy, or if any relevant information is kept back from us, the policy will stand cancelled at once, and no premiums paid will be refunded.

31. Claims Intimation
For planned In-patient hospitalization, please let us know at least 48 hours prior to hospitalization. In case of an emergency, do let us know within 24 hours of the insured person being admitted, or before discharge, whichever is earlier.

For Reimbursement of Claim: The Insured Person/s should give the complete claim file at his/her own cost to the TPA/ASP/OSP/EGIC within 15 days of discharge from the hospital.

32. Customer Services and Grievances Redressal:
The Company has developed proper procedures and effective mechanism to address of complaints by the customers. The Company is committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued by the Authority (IRDAI) from time to time in this regard.

In case of any grievance the insured person may contact the company through
Website: "http://www.edelweissinsurance.com"

www.edelweissinsurance.com,
Link:https://www.edelweissinsurance.com/documents/20143/1081704/Service+Parameters+and+Grievance+Mechanism20-03-2020.pdf/6492436c-5e64-c837-b9de-8de5e135ec28
Toll free: 1800120216216 / 180012000
E-mail: "grievance@edelweissinsurance.com"
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" grievance@edelweissinsurance.com.
For updated details of grievance officer, kindly refer the link…….
https://www.edelweissinsurance.com/documents/20143/1081704/GRO+DETAILS+05-06-2020.pdf/d1c5e1b6-0acc-2e05-f14b-3c5cca0c0797?t=1591374023226

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/

GRIEVANCE MECHANISM

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.

Escalation Matrix:

Step 1
Call: 1800 12000
Email: support@edelweissinsurance.com

Step 2
If the response is not as per Complainant's expectations he/she may contact the Grievance Cell at the below touch-points:
- Email: grievance@edelweissinsurance.com
- Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

Step 3
If the response is not as per Complainant's expectations he/she may contact the Company's Grievance Redressal Officer at:
- Email: grievanceofficer@edelweissinsurance.com
- Address: Edelweiss General Insurance Company Limited, Kohinoor City Mall, Tower 3, Kirol Road, Kurla West, Mumbai 400070

Step 4
If the Complainant is not still not satisfied with the response or does not receive a response from the Company within 14 days, the Complainant may approach the Grievance Cell of the 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

Step 5
If the complaint/grievance has still not been resolved, 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.

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Ombudsman and Addresses

Mentioned below are contact details of Ombudsman:

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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.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@ecoi.co.in**	State of Maharashtra, Area of Navi Mumbai and Thane, excluding Mumbai Metropolitan Region

The updated details of Insurance Ombudsman are available on website of IRDAI: www.irda.gov.in, on the website of General Insurance Council: www.gicouncil.org.in, on the Company's website www.edelweissinsurance.com or from any of the Company's offices. Address and contact number of Governing Body of Insurance Council-

Office of the 'Governing Body of Insurance Council' Secretary General/Secretary,
3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz (W), Mumbai - 400 054.
Tel: 022-26106245/889/671 Fax: 022-26106949
Email - inscoun@gbic.co.in

Addendum to the Policy Wording (to be attached as applicable)

1. Additions/Deletion of Members

It is hereby declared and agreed that the Insured Person/s is/are covered under this Policy only till such time they are on rolls of the Insured (Policy Holder). It is further agreed that any addition/deletion of members shall be communicated to the Insurer in writing within a reasonable time from the date of joining/ leaving but not later than last day of the succeeding month of joining / leaving the employment. The cover will commence from the joining date for such Insured Person/s (as requested by the Insured and agreed to by the Insurance Company) subject to adequate premium balance maintained with the Insurer for such additions. In case of inadequate premium balance with the Insurer on the day of inclusion of the additional members, the balance premium available as on that date would be reckoned for such members as per the serial number of the list received from the Insured. Where no such premium balance is maintained, the cover for such additions will commence from the date of receipt of premium by the Insurer. Provided however that the Group Policyholder has intimated the joining of the said Insured person to the group.
Refund on deletion of members will be effected only for such members who have not preferred any claims under the Policy.
Dependents of Primary members shall be declared at the inception of the Policy. Any mid-term inclusion of dependents will not be allowed except for spouse by marriage, child by birth and for insured persons joining the group during the Policy Period.
In case of intimation received beyond the stipulated time period, the risk commencement date for additional members would be from the date of intimation to the Insurer or as otherwise specifically agreed to by the Insurer subject to adequate premium balance.
All other terms, conditions, warranties & exclusions of the Policy remain unaltered.
The Company may issue multiple group insurance policies in tranches to the Group Organizer, subject to minimum group size and maximum policy term, for providing insurance coverage to the new members on an ongoing basis.

2. Payment of premium on Installment basis

a. Notwithstanding anything to the contrary in the Policy, the Company as a matter of facility to the Insured, agrees to accept payment of premium by installments. Premium can be paid in either monthly, quarterly or half yearly installments subject to approval and acceptance by the Company.

b. Notwithstanding the provisions of the preceding clause, upon non-payment of any instalment on its due date as specified in the Schedule to this Policy, the Policy shall cease to operate from the time and date of the default in payment of the instalment and no liability shall attach under this Policy for any claim occurring thereafter, nor shall any refund of premium become due under the Policy.

c. The Policy can be revived within the relaxation period (which is grace period for annual instalment frequency & 15 days for other instalment frequencies) by payment of the Installment due subject however to the condition that no liability shall attach under this Policy for any claim occurring during the period when the Policy is deemed to have ceased to operate following default in payment of Installment premium due under the Policy.

d. Additionally, in the event of claim during the currency of this Policy from any cause whatsoever, all the subsequent installments applicable to the respective Insured member/s shall immediately become due and payable notwithstanding anything to the contrary hereinabove contained.

NOTE: IT IS NOT OBLIGATORY ON THE PART OF THE INSURERS TO GIVE ANY NOTICE TO THE INSURED FOR PAYMENT OF PREMIUM INSTALMENT.

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

Sr.No.	Item	Sr.No.	Item
1	BABY FOOD	48	NIMBUS BED OR WATER OR AIR BED CHARGES
2	BABY UTILITIES CHARGES	49	AMBULANCE COLLAR
3	BEAUTY SERVICES	50	AMBULANCE EQUIPMENT
4	BELTS/BRACES	51	ABDOMINAL BINDER
5	BUDS	52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
6	COLD PACK/HOT PACK		
7	CARRY BAGS	53	SUGAR FREE Tablets
8	EMAIL/ INTERNET CHARGES	54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)		
		55	ECG ELECTRODES
10	LEGGINGS	56	GLOVES
11	LAUNDRY CHARGES	57	NEBULISATION KIT
12	MINERAL WATER	58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETCI
13	SANITARY PAD		
14	TELEPHONE CHARGES	59	KIDNEY TRAY
15	GUEST SERVICES	60	MASK
16	CREPE BANDAGE	61	OUNCE GLASS
17	DIAPER OF ANY TYPE	62	OXYGEN MASK
18	EYELET COLLAR	63	PELVIC TRACTION BELT
19	SLINGS	64	PAN CAN
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	65	TROLLY COVER
		66	UROMETER, URINE JUG
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	67	AMBULANCE
		68	VASOFIX SAFETY
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		
44	DIABETIC FOOT WEAR		
45	KNEE BRACES (LONG/ SHORT/ HINGED)		
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER		
47	LUMBO SACRAL BELT		

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

Sr.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
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

Sr.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
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

Sr.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.

Appendix II –

Annexure regarding Claims: Indicative List of Documents required

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
- Letter from HR stating the attendance closure to the incident
- 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
- Duly filled and signed claim form
- Policy Copy and Annexure
- Photographs of the insured
- Disability certificate duly attested by the treating doctor with details of disability
- l) Letter from HR stating the attendance closure to the incident
- 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
- Leave certificate from HR department
- Salary certificate / income proof
- 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
- 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
- Leave certificate from HR department
- Salary certificate / income proof
- Photographs of the insured showing affected area
- Any other document that may be required for assessment of the claim

Enhanced Temporary Total Disability
- FIR / police report 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
- Leave certificate from HR department
- Salary certificate / income proof/ certified income documents
- Photographs of the insured showing affected area
- Any other document that may be required for assessment of the claim

Loss owed to Terrorism
- Duly filled Claim Form
- Police Panchnama / First Information Report / Final Investigation Report
- Fire Brigade Report
- Newspaper cutting / web news wherein the incidence of terrorist attack has been reported
- Photographs of area showing extent of damage &/or video film of loss area where terrorist attack occurred

Burns Benefit
- Duly filled Claim Form
- Self-declaration of details of the accident leading to injury
- Police Report
- Fire Brigade Report, if available
- Newspaper cutting / web news wherein the incidence of accident leading to burn injury has been reported, if available.
- Photographs of area showing extent of damage &/or video film of loss area where the accident has occurred

Last rite costs/Funeral Expenses
- Duly filled Claim Form
- Police Panchnama / First Information Report / Final Investigation

Report
- Fire Brigade Report, if available
- Newspaper cutting / web news wherein the accident has been reported
- Photographs of area showing extent of damage &/or video film of loss area where accident occurred
- Complete details of Funeral services availed including but not l imited to embalming, caskets, burial vault, wooden pyre, grave-liners, tombstone, service fees of funeral staff and director / priest, graveside service, transportation with hearse etc.

Medical Evacuation (Domestic)
- Caller's name and contact details (i.e. telephone number and email address)
- Insurance Policy Number
- Valid Photo identification document
- Description of the incident from the caller mentioning circumstances of necessity of evacuation
- First attending physician's/ medical emergency services' assessment report of the condition of insured necessitating evacuation to the nearest medical centre
- Required/estimated date and time for evacuation
- Details of the type of evacuation required as per medical condition of the patient and availability (i.e. commercial flight, air ambulance or ground transport)
- A 'Fit to Travel' certificate confirming that the member is medically stable and fit to make the journey.
- Contact details of clinic / place of accident and contact details of the nearest medical centre where the patient is likely to be evacuated
- Any other document that may be required for assessment of the claim

Medical Evacuation (Worldwide)
- Caller's name and contact details (i.e. telephone number and email address)
- Insurance Policy Number
- Valid Photo identification document
- Valid Passport and residency status of the insured at place of accident or whether in transit
- Description of the incident from the caller mentioning circumstances of necessity of evacuation
- First attending physician's/ medical emergency services' assessment report of the condition of insured necessitating evacuation to the nearest medical centre along with treatment papers if available.
- Required/estimated date and time for evacuation
- Details of the type of evacuation required as per medical condition of the patient and availability (i.e. commercial flight, air ambulance or ground transport)
- A 'Fit to Travel' certificate confirming that the member is medically stable and fit to make the journey.
- Contact details of clinic / place of accident and contact details of the nearest medical centre where the patient is likely to be evacuated
- Any other document that may be required for assessment of the claim

In- Patient Hospitalization (limited to India) – Accident only
- Details of Claim intimation given to Company / TPA / OSP/ ASP together with photocopy of policy & premium receipt
- Duly filled Claim Form
- Hospital Discharge Report/Medical Treatment Report
- Medical recovery report
- Original Test Reports (X-Rays/Sonography/ECG etc.)
- Details of medical expenses original bills/cash memos receipts along with prescriptions
- Leave certificate from employer
- 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
- Photographs of the insured showing affected area
- 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, no claims for cashless are accepted

In- Patient Hospitalization (worldwide) – Accident only
- Details of Claim intimation given to Company / TPA / OSP/ ASP together with photocopy of policy & premium receipt
- Duly filled Claim Form
- Hospital Discharge Report/Medical Treatment Report
- Medical recovery report
- Original Test Reports (X-Rays/Sonography/ECG etc.)
- Details of medical expenses original bills/cash memos receipts along with prescriptions
- Leave certificate from employer
- 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
- Photographs of the insured showing affected area
- 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.

Broken Bones
- Details of accident
- Duly filled Claim Form
- Medical Treatment Reports

- Original Test Reports (X-Rays/CT etc.)
- Details of medical expenses original bills/cash memos receipts along with prescriptions
- Leave certificate from employer
- Police report / first information report about accident
- Photographs of the insured showing affected area
- 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 and immediate intimation of the incident, post occurrence of the accident and acceptance of the same by EGIC.

Hospital Daily Cash

- Details of Claim intimation given to Company / TPA / OSP/ ASP together with photocopy of policy & premium receipt
- Duly filled Claim Form
- Hospital Discharge Report/Medical Treatment Report
- Medical recovery report
- Original Test Reports (X-Rays/Sonography/ECG etc.)
- Details of medical expenses original bills/cash memos receipts along with prescriptions
- Leave certificate from employer
- 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
- Photographs of the insured showing affected area
- Any other document that may be required for assessment of the claim

Family Transport Benefit/ Compassionate Visit

- Claim Form and declaration form duly filled in and signed.
- First Assessment sheet of the treating doctor at the hospital / clinic
- Investigation reports like laboratory test, radiology and reports essential of confirmation of an injury if any.
- F.I.R / Police report (with translation in English) if applicable.
- Spot photographs of area of injury, if applicable.
- Copy of treatment papers, including all previous statement records from the treating doctor.
- Self-declaration of the incidence by nominee (if in vernacular / foreign language, provide translation in English)
- Any other document required for claim processing

- Exclusions as applicable for benefit of in patient hospitalization and general exclusion of policy

Double Indemnity

- Details of accident
- Duly filled Claim Form
- 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 and immediate intimation of the incident, post occurrence of the accident and acceptance of the same by EGIC.

Child Enhancement Benefit

- In addition to those documents required in main coverage: Birth certificate / Domicile certificate / Adoption Certificate of the child in addition to valid identity proof

Reconstructive surgery Benefit

In addition to those documents mentioned in basic coverage:

- Claim Form and declaration form duly filled in and signed.
- First Assessment sheet of the treating doctor at the hospital / clinic at the time of injury
- Investigation reports like laboratory test, radiology and reports essential of confirmation of an injury.
- F.I.R / Police report (with translation in English) if applicable.
- Spot photographs of area of injury, if applicable.
- Copy of treatment papers, including all previous statement records from the treating doctor.
- Self-declaration of the incidence by nominee (if in vernacular / foreign language, provide translation in English)
- If reconstruction involves transplantation of tissues from donor to recipient, then approval according to applicable by-laws
- Any other document required for claim processing

Parental Care Benefit

- In addition to those documents required for case of Personal Accident Death claims:
- 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
- Letter from HR stating the attendance closure to the incident
- Identity proof of the dependent parents and their income proof documents
- Any other document that may be required for assessment of the claim.

Rehabilitation Benefit

In addition to those documents mentioned in basic coverage:

- Claim Form and declaration form duly filled in and signed.

- First Assessment sheet of the treating doctor at the hospital / clinic at the time of injury
- Investigation reports like laboratory test, radiology and reports essential of confirmation of an injury.
- F.I.R / Police report (with translation in English) if applicable.
- Spot photographs of area of injury, if applicable.
- Copy of treatment papers, including all previous statement records from the treating doctor.
- Self-declaration of the incidence by nominee (if in vernacular / foreign language, provide translation in English)
- If rehabilitation involves regular hospital / OPD visits, then treatment plan from the treating doctor and / or licensed physiotherapist/ occupational therapist/ speech therapist / psychiatrist along with proof of visits in the form of visit card duly signed and stamped by the doctor.
- Any other document required for claim processing

Purchase of Blood

- Indicative list of documents required for claim in addition to those mentioned in basic coverage:
- Whole Blood / Plasma concentrate / Composite blood products sticker as duly received from blood bank.

Transportation of Imported Medicine

In addition to those documents mentioned under in-patient hospitalization:

- Prescription of the drug(s) from the treating doctor which needs to be imported
- Letter from the treating consultant(s) or the doctor(s) describing the special requirement of the drug(s) for the treatment of the insured and unavailability of the drug(s) / equally efficient alternative drug(s) including combination(s) if any, the end-result of treatment, which would have been the same as the drug which is being specifically imported for the treatment of insured.
- Proof of delivery from the transport company / courier / post including customs duty paid if any.
- Drug Invoice / Distributor Invoice issued by a duly registered pharmacist / drug dispensing authority and having a valid licence / holder of such permission to dispense drugs; of the foreign country from whom such drug(s) is/are being dispensed and / or exported to India.

Comatose Benefit Accident

Indicative list of documents required for claim besides those required for basic coverage:

- Claim Form and declaration form duly filled in and signed.
- Complete set of treatment records including GCS scale as recorded by treating doctors.
- Any other document required for claim processing.

Out-patient Expenses / Emergency Room/Casualty Expenses - Domestic

In addition and besides those documents required for basic coverage:

- Claim Form and declaration form duly filled in and signed.
- Complete set of outpatient treatment records and prescriptions from treating doctor
- Any other document required for claim processing.

Out-patient Expenses / Emergency Room/Casualty Expenses – Worldwide

Service Provider will assist the User by arranging for appointments with local doctors for treatment.

- Indicative list of documents required for claim besides those required for basic coverage:
- Claim Form and declaration form duly filled in and signed.
- Complete set of outpatient treatment records and prescriptions from treating doctor
- Any other document required for claim processing.

Sports Activity Cover Only

In addition and besides those documents required for basic coverage:

- Claim Form and declaration form duly filled in and signed.
- Complete set of outpatient / inpatient treatment records and prescriptions from treating doctor, including details of the sport activity which resulted in accident.
- Any other document required for claim processing.

Emergency Road Ambulance Charges

In addition and besides those documents required for basic coverage:

- Claim Form and declaration form duly filled in and signed.
- Complete set of treatment records and ambulance expenses incurred
- Any other document required for claim processing.

Emergency Air Ambulance Charges

As above, in addition to other documents that may be required during claim processing.

Cost Support Items

In addition and besides those documents required for basic coverage:

- Claim Form and declaration form duly filled in and signed.
- Complete expenses details on the support items duly prescribed by treating medical practitioner.
- Any other document required for claim processing.

Disappearance Benefit

- Duly filled Claim Form by the nominee / legal heir
- Police Panchnama / First Information Report / Final Investigation Report
- Fire Brigade Report
- Newspaper cutting / web news wherein the incidence of terrorist attack has been reported
- Photographs of area showing extent of damage &/or video film of loss area where terrorist attack occurred

Multiple Member disability

- In addition and besides those documents required under basic

coverage

- Duly filled Claim Form
- Police Panchnama / First Information Report / Final Investigation Report / Fire brigade report
- Any other document required for processing of the claim

Nursing Assistance

In addition and besides those documents required under basic coverage.

- Duly filled Claim Form
- Details of treatment records along with injury details describing immobility details of the insured.
- Details of nursing requirements as prescribed by the treating doctor
- Expense and nursing provisioning details provided by the provider (Hospital / specialized nursing service providers)
- Any other document required for processing of the claim

Felonious Assault/Kidnapping /Hijack /Riots

In addition to those mentioned under basic coverage.

- Duly filled Claim Form
- Police Panchnama / First Information Report / Final Investigation Report
- Fire Brigade Report if applicable
- Newspaper cutting / web news wherein the incidence of Felonious Assault/Kidnapping/Hijack/Riots has been reported
- Photographs of area showing extent of damage &/or video film of loss area where Felonious Assault/ Kidnapping/Hijack/Riots occurred

Education Benefit

In addition to those documents required under basic coverage.

- Claim Form and declaration form duly complete.
- Death certificate issued by municipal / local administrative authorities
- Death Summary / Discharge Summary / Transfer summary issued by the hospital
- First Assessment sheet of the treating doctor at the hospital / clinic where deceased was brought immediately after the accident.
- Post Mortem report, Forensic science laboratory report if conducted.
- Investigation reports like laboratory test, radiology and reports essential of confirmation of any injury, if any.
- F.I.R, Police Panchnama / Final Investigation report (with translation in English) if applicable.
- Spot photographs, if applicable.
- Copy of treatment papers like doctor's notes, including all previous statement records from the treating doctor.
- Relation proof between Nominee and the Insured.
- Self-declaration of the incidence by nominee (if in vernacular language, provide translation in English)
- Establishing proof of relationship of legal heir / nominee with deceased insured - Birth Certificate, Adoption Papers (if adopted), Passport, Education certificate, and Photo Identity Proof of nominee or legal heir, including age proof, PAN Card copy of Nominee / legal heir
- 2 recent Photograph of Nominee / legal heir
- Any other document that may be required later for claim processing

Loss of Employment Benefit

In addition to those documents as mentioned in basic coverage:

- Claim Form and declaration form duly filled in and signed.
- First Assessment sheet of the treating doctor at the hospital / clinic at the time of injury
- Investigation reports like laboratory test, radiology and reports essential of confirmation of an injury.
- F.I.R / Police report (with translation in English) if applicable.
- Spot photographs of area of injury, if applicable.
- Letter of Cessation / Letter of Termination / Letter of Separation from the HR of the organization clearly mentioning the cause of termination / separation / cessation where the insured is employed for, immediately prior to the accident.
- Copy of treatment papers, including all previous statement records from the treating doctor.
- Self-declaration of the incidence by insured explaining the inability to generate income (if in vernacular / foreign language, provide translation in English)
- Any other document required for claim processing

Transportation of Mortal Remains

- Caller's name and contact details (i.e. telephone number and email address)
- Insurance Policy Number
- Valid Photo identification document
- Description of the incident from the caller mentioning circumstances of death
- First attending physician's/ medical emergency services' assessment report of the condition of insured leading to death
- Death summary issued by hospital & death certificate issued by local authorities
- Required/estimated date and time for repatriation
- Any other document that may be required for assessment

Critical Illness Cover

- Claim Form duly complete
- Discharge Summary / Transfer summary / Death Summary issued by the hospital.
- First Assessment sheet of the treating doctor at the hospital / clinic along with complete set of Indoor Case papers, Nursing Notes and doctor's notes.
- Pathology reports, radiology or other investigation reports if applicable.
- Copy of treatment papers like doctor's notes, including all previous statement records from the treating doctor(s).
- Any other document that may be required later for claim processing.

Specific vector borne disease Benefit

- Claim Form and declaration form duly complete.
- Discharge Summary / Transfer summary issued by the hospital.
- First Assessment sheet of the treating doctor at the hospital / clinic along with complete set of Indoor Case papers, Nursing Notes and doctor's notes.
- Pathology reports, radiology reports and other investigation reports, if applicable for that ailment suffered.
- Copy of treatment papers like doctor's notes, including all previous statement records from the treating doctor(s).
- Any other document that may be required later for claim processing

Medical Monitoring

- Details of Claim intimation given to Company / TPA / OSP/ ASP together with photocopy of policy & premium receipt
- Duly filled Claim Form
- Hospital Discharge Report/Indoor Case Papers/Medical Treatment Report
- Medical recovery /progress report
- Test Reports (X-Rays/Sonography/ECG etc.)
- Any other document that may be required for assessment of the claim