Royal Sundaram

Royal Sundaram Alliance Insurance Company Limited
Corp. Office : Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR) Karapakkam, Chennai - 600097. Regd office : 21, Patullos Road, Chennai - 600 002.

FAMILY HEALTH FLOATER POLICY

IMPORTANT NOTES ABOUT THIS INSURANCE

- Please read and check the details of this Policy carefully to ensure its accuracy and see that it meets your requirements.
- Please inform us immediately of any change in your address, occupation, state of health, or of any other changes affecting any Insured Person.
- The Policy is an evidence of the contract between You and Royal Sundaram Alliance Insurance Company Limited.
- The information given to us in the Proposal form and Declaration signed by you/Proposer and/or over telephone to our teleagent by You/proposer, forms the basis of this Contract.
- The Policy, Schedule and any Endorsement thereon shall be considered as one document and any word or expression to which a specific meaning has been attached in any of them shall bear such meaning throughout.
- Provided that You pay the premium for all the persons intended to be Insured under this Policy and We receive and accept it, We will provide the insurance described in the Policy.
- Insurance under this Policy is given subject to the Endorsements if any, exclusions, terms and conditions shown below and failure in compliance may result in the claim being denied.

A.PERSONS WHO CAN BE INSURED

This insurance is available to persons who are family members of proposer who are between the age of 91 days and 65 years at the Commencement Date of the Policy. Family means comprising of:

- Self.
- Spouse,

Dependent children (including unmarried children,step children or legally adopted children, who are financially dependent and aged between 91 days and 21 years).

Dependent Parents upto age of 65 years.

B. DEFINITIONS & INTERPRETATIONS

In this Policy the singular will be deemed to include the plural, the male gender includes the female where the context permits, and the following words or phrases shall have the meanings attributed to them wherever they appear in this Policy.

Accident / Accidental

An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Alternative treatments

Alternative treatments are forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

Cashless facility

"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 approved.

Company/We/Our/Insurer/Us

Royal Sundaram Alliance Insurance Company Limited.

Commencement Date

Commencement date of this Policy shall be the inception date of first health Insurance policy under this Family Health Floater Policy for that Insured Person, insured with Us, with out any break in period of cover.

Condition Precedent

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

Congenital Anomaly

Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a. Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body.

b. External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body.

Contribution

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a rateable proportion of sum insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

Cumulative Bonus

Cumulative Bonus shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Day care centre

A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

- has qualified nursing staff under its employment;
- has qualified medical practitioner/s in charge;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Day Care Treatment

Day care treatment refers to medical treatment, and/or surgical procedure which is:

I. undertaken under General or Local Anaesthesia in a hospital/ day care centre in less than 24 hrs because of technological adva ncement, and

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

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

Dental Treatment

Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns,

extractions and surgery excluding any form of cosmetic surgery/ implants.

Emergency Care

Emergency care means management for a severe 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.

Endorsement

Endorsement means written evidence of change to Your Policy including but not limited to increase or decrease in the period, extent and nature of the cover agreed by Us in writing.

Floater Sum Insured

Floater Sum Insured means the Sum Insured as specified in the schedule of the policy is available for any one or all members of his family who have been mentioned as Insured Persons in the schedule, for one or more claims during the period of certificate of insurance

Grace Period

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

Hospital

A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- 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;
- has qualified medical practitioner(s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out;
- maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Hospitalization

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

Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

a. **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

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

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms.
- it requires your rehabilitation or for you to be specially trained to cope with it.
- it continues indefinitely.
- it comes back or is likely to come back.

Injury

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

Inpatient Care

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

Insured Person/ You/Your/Insured

Anybody shown on the Schedule as Insured in this Policy.

Intensive Care Unit

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.

Medical Advise

Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

Medical expenses

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.

Medically Necessary

Medically necessary treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

- is required for the medical management of the illness or injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a medical practitioner,
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Medical Practitioner

A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence. The registered practitioner should not be the insured or close family members

Network Provider

"Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

Non- Network

Any hospital, day care centre or other provider that is not part of the network.

Notification of Claim

Notification of claim is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

OPD treatment

OPD treatment is 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.

Period of Insurance

Period of Insurance means the period shown in the Schedule, for which You have paid and We have received and accepted Your premium.

Portability

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

Post-hospitalization Medical Expenses

Medical Expenses incurred immediately after the insured person is discharged from the hospital provided that:

I. Such Medical Expenses are incurred 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.

Pre-Existing Disease

Any condition, ailment or injury or related condition(s) for which you had signs or symptoms and/or were diagnosed and/or received medical advice/treatment, within 48 months prior to your first Policy issued by the insurer.

Pre-hospitalization Medical Expenses

Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

I. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

II. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

Proposer

Insured Person or the person who signs the Proposal form or gives telephonic consent on behalf of the Insured person/s.

Qualified Nurse

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

Reasonable and Customary Charges

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.

Renewal

Renewal defines 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 all waiting periods.

Room Rent

Room rent means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

Subrogation

Subrogation shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

Surgery

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 of suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Unproven/Experimental treatment

Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

C. BENEFITS

The Policy covers Reasonable and Customary charges incurred towards hospitalization for the disease, illness, medical condition or injury contracted or sustained by the Insured Person during the Period of Insurance stated in the Schedule subject to terms, conditions, limitations and exclusions mentioned in the Policy.

For a claim to be admitted under this Policy, the Insured Person should be hospitalised as an In-Patient during the Period of Insurance for a minimum period of 24 hours. However this time limit is not applicable to the following specific treatments:

Dialysis, Chemotherapy, Radiotherapy, Eye surgery, Cataract, Lithotripsy (kidney stone removal) Tonsillectomy, D&C, Cardiac Catheterization, Hydrocele Surgery, Hernia repair surgery and such other Surgical Operation that necessitate hospitalisation less than 24 hours due to medical/ technological advancement / infrastructure facilities.

In the event of any claim becoming admissible under the Policy, the Company will pay to the Proposer, the Reasonable and Customary charges, subject to the various limits mentioned hereunder, but not exceeding the Sum Insured and the Cumulative Bonus, if any, mentioned in the Schedule for all claims admitted during the Period of Insurance.

Expenses covered under the Policy

1. Room, Boarding Expenses as provided by the Hospital/ Nursing Home subject to a limit of 2% of the Sum Insured per day and for Intensive Care Unit 4% of the Sum Insured per day.
2. Nursing Expenses incurred during In-Patient hospitalization.
3. Surgeon, Anaesthetist, Medical Practitioner, Consultants & Specialist Fees are subject to a limit of 40% of the Sum Insured.
4. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Medicines and Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Donors medical expenses towards Organ transplant, Cost of Pacemaker, Artificial Limbs, Cost of Organs.
5. Pre - Hospitalisation Medical Expenses incurred for a period of 30 days prior to hospitalization.
6. Post - Hospitalisation Medical Expenses incurred for the period of 60 days after discharge from hospital.
7. Ambulance charges in an emergency, subject to a limit of Rs.1000/-per claim.
8. Reimbursement of expenses, subject to a maximum of Rs.1500/- per Insured Person, towards Master Health Check up for the Insured Person, after each 4 consecutive claim free years. This benefit shall not be available even if any one individual insured person makes a claim during the 4 consecutive period of insurance.

   Benefits under Sl. No. 5, 6 and 7 are strictly under reimbursement mode and no cashless facility will be offered for these benefits.

   The Claim amount payable per person towards the treatment of following disease, illness, medical condition or injury during the period of insurance is subject to a limit of:

Treatment	Limit per claim
Cataract	8% of the Sum Insured
Piles, Fistula, Fissure, Tonsilitis, Sinusitis	10% of the Sum Insured
Benign Prostatic Hypertrophy, Hernia	20% of the Sum Insured
Knee/Hip Joint Replacement (other than caused by accident)	50% of the Sum Insured
Appendicitis, Gall bladder stones and Gynaec disorders	20% of the Sum Insured
Dialysis, Chemotherapy and Radiotherapy	10% of the Sum insured per month

Additional Features:

1. **Cashless Facility: (Through Third Party Administrators - TPA)**
   Cashless facility is offered through Third Party Administrators (TPA) who will be guided by TPA regulations formed by IRDA.

   In network hospitals, provided pre-admission authorisation in writing is taken from TPA appointed by Us, Insured need not pay for the eligible expenses at the hospital. The TPA will pay it directly. The cashless facility can be availed subject to compliance of the procedure laid down in the information handbook issued along with this Policy.

   In non-network hospitals, all admissible hospitalisation expenses will only be reimbursed.

2. **Ambulance Referral facility:**
   TPA will be providing a referral facility for availing ambulance in case of emergency

3. **Income Tax Relief**
   This insurance scheme is approved by IRDA and the premium is eligible to get exemption from income tax under section 80D subject to the relevant provisions of the Income Tax Act 1961.

4. **Cumulative Bonus**
   The Limits under this Policy shall be progressively increased by slabs of 5% of the Sum Insured in respect of each claim-free year of insurance with Us, subject to a maximum accumulation of 10 slabs of cumulative bonus.

   Sum Insured for the purpose of calculation of Cumulative Bonus shall be the expiring Sum Insured or the revised Sum Insured whichever is lower.

   Where a claim has arisen under the expiring policy, the earned cumulative bonus, if any, in respect of such insured person shall be reduced by 1 slab of cumulative bonus. However under no circumstances shall the Sum insured under the policy be reduced on account of reduction of cumulative bonus.

   Cumulative bonus will not be considered for settling claims for pre existing disease.

D. EXCLUSIONS

The Company shall not be liable under this Policy for any claim in connection with or in respect of:

1 Any Pre-Existing Disease which shall however be covered after 4 years of continuous insurance from the commencement date of the first policy issued by Us or any Indian Insurer subject to Portability guidelines.

2. **30 Days Waiting Period**: Any disease contracted by the Insured Person during the first 30 days from the Commencement Date of the cover.

3. **(a) First Year Exclusions:**
   Treatment of Congenital Internal Anomaly, any type of Migraine /Vascular head ache, Stones in the Urinary and Biliary systems, Surgery on Tonsils /Adenoids, Gastric and Duodenal Ulcer, any type of Cyst/ Nodules / Polyps, any type of Breast Lumps for all Insured Persons for one year from the Commencement Date of the cover with Us under this Family Health Floater policy. These exclusions will not be applicable if caused directly due to an accident during period of insurance. However if these diseases are Pre Existing as defined, at the time of proposal then they will be considered as falling under Exclusion 1.

   (b) Two Year Exclusions:
   Treatment of Spondylosis / Spondilitis – any type, Inter vertebral Disc Prolapse and such other Degenerative Disorders, Cataract, Benign Prostatic Hypertrophy, Hysterectomy, Fistula, Fissure in Anus, Piles, Hernia, Hydrocele, Sinusitis, Knee / Hip Joint replacement, Chronic Renal Failure or end stage Renal Failure, Heart diseases, any type of Carcinoma / Sarcoma /Blood Cancer, Osteoarthritis of any joint for all Insured Persons for two years from the Commencement Date of the cover with Us under this Family Health Floater policy. These exclusions will not be applicable if caused

   directly due to an accident during period of insurance. However if these diseases are Pre Existing as defined, at the time of proposal then they will be considered as falling under Exclusion 1.

4. Treatment arising from or traceable to pregnancy/ childbirth.
5. Circumcision unless necessary for treatment of a disease, not excluded hereunder or necessitated due to an accident.
6. The cost of spectacles, contact lenses and hearing aids.
7. Dental treatment or surgery of any kind unless requiring Hospitalisation.
8. Convalescence, general debility, `Run-down' condition or rest cure, Congenital External Disease or defects or anomalies, Tubectomy, Vasectomy, Venereal disease, intentional self injury or attempted suicide.
9. All expenses arising out of any condition directly or indirectly caused by or associated with Human T-Cell Lymphotropic Virus Type III(HTLB-III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS.
10. Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home.
11. Expenses on vitamins and tonics unless forming part of treatment for injury or disease.
12. Directly or indirectly caused by or contributed to by Nuclear weapons/materials or Radioactive Contamination.
13. Directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, Warlike Operations (whether war be declared or not).
14. Directly or indirectly caused by or arising from or attributable to:

14. 1. Ionising radiation or contamination by any Nuclear fuel or from any Nuclear waste from burning Nuclear fuel or

14. 2 Radioactive, toxic, explosive or other dangerous properties of any explosive nuclear machinery or part of it.

15. Any routine or preventative examinations, vaccinations, inoculation or screening.
16. Outpatient treatment charges.
17. Sex change or treatment, which results from, or is in any way related to, sex change.

18. Hormone replacement therapy, Cytotron Therapy.
19. Cost incurred towards non-allopathic treatment even if the treatment is administered and/or recommended by an allopathic medical practitioner.
20. Cost of allopathic treatment if administered and /or recommended by non allopathic medical practitioner.
21. Treatment of obesity (including morbid obesity) and any other weight control programs, services or supplies.
22. The treatment of psychiatric and psychosomatic disorders, mental or nervous conditions, insanity.
23. Any cosmetic, plastic surgery, aesthetic or related treatment of any description , corrective surgery for refractive error , including any complication arising from these treatments, whether or not for psychological reasons, unless medically necessary as a result of an accident.
24. Use of intoxicating drugs alcohol and the treatment of alcoholism, solvent abuse, drug abuse or any addiction and medical conditions resulting from, or related to, such abuse or addiction. Diseases due to tobacco abuse such as Atherosclerosis, Ischemic Heart Disease, Coronary Artery Disease, hemorrhagic stroke, ischemic stroke, Chronic Obstructive Pulmonary Disease, Chronic Obstructive Airway Disease, Emphysema, Chronic Bronchitis, Buerger's Disease (Thromboangitis Obliterans). All types of pre malignant conditions/cancer in situ, oral cancer, Leukoplakia, Larynx cancer, Cancer of Oesophagus, Stomach, Kidney, Pancreas and Cervical Cancers due to tobacco abuse only.
25. Any treatment received in convalescent homes, convalescent hospitals, health hydros, nature cure clinics or similar establishments.
26. Any stay in Hospital for any domestic reason or where there is no active regular treatment by a specialist.
27. Any treatment received outside India.
28. Any other alternative medicine except Allopathy (Modern Medicine).
29. Taking of drug unless it is taken on proper medical advice and is not for the treatment of drug addiction.
30. Any fertility, sub-fertility or assisted conception operation.
31. Any person whilst engaging in speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports and activities of similar hazard.
32. Any claim in respect of stem cell implantation/surgery and storage except Bone Marrow Transplantation which is otherwise covered by policy.
33. Any claim respect of Unproven / Experimental treatment.
34. Excluded Expenses as per Annexure 1.

E. CONDITIONS

1. Claims Procedure

Provided that the due observance and fulfillment of the terms and conditions of this Policy (conditions and all Endorsements hereon are to be read as part of this Policy) shall, so far as they relate to anything to be done or not to be done by the Insured and / or Insured person, be a condition precedent to any liability of the Company under this Policy.

The Claims Procedure is as follows:

- **For admission in network Hospital** - The Insured must call the helpline and furnish membership no and Policy Number and take an eligibility number to confirm communication. The same has to be quoted in the claim form. The call must be made 72 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 48 hours of admission.

  For admission in non-network Hospital - Preliminary notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us within seven days from the date of hospitalization /injury/ death, failing which admission of claim is at insurer's discretion.

- Please ensure that You send the claim form duly completed in all respects along with all the following documents within 30 days from the date of discharge from Hospital.

- **Mandatory documents**
  1. Test reports and prescriptions relating to First / Previous consultations for the same or related illness.
  2. Case history/Admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital
  3. Death summary in case of death of the insured person at the hospital
  4. Hospital Receipts/bills/cash memos in Original (including advance and final hospital settlement receipts)
  5. All test reports for X-rays, ECG, Scan, MRI, Pathology etc., including doctor's prescription advising such tests/investigations (CDs of angiogram, surgery etc need not be sent unless specifically sought)
  6. Doctor's prescriptions with cash bills for medicines purchased from outside the hospital
  7. FIR/MLC. in the case of accidental injury and English translation of the same, if in any other language
  8. Detailed self-description stating the date, time, circumstances and nature of injury/accident in case of claims arising out of injury
  9. Legal heir certificate in the absence of nomination under the policy, in case of death of the proposer. In the absence of legal heir certificate, evidence establishing legal heirship may be provided as required by Us
  10. For a) Cataract claims - IOL sticker b) PTCA claims - Stent sticker
  11. Copies of health insurance policies held with any other insurer covering the insured persons
  12. If a claim is partially settled by any other insurer, a certificate from the other insurer confirming the final claim amount settled by them and that Original claim documents are retained at their end.

- **Documents to be submitted if specifically sought**
  1. Copy of indoor case records (including nurse's notes, OT notes and anesthetists' notes, vitals chart)
  2. Copy of extract of Inpatient Register.
  3. Attendance records of employer/educational institution.
  4. Complete medical records (including indoor case records and OP records) of past hospitalization/ treatment if any.
  5. Attending Physician's certificate clarifying
     - reason for hospitalization and duration of hospitalization

- history of any self-inflicted injury
- history of alcoholism, smoking
- history of associated medical conditions, if any

6. Previous master health check-up records/pre-employment medical records if any
7. Any other document necessary in support of the claim on case to case basis.

- Insured /Insured Person must give Us at his expense, all the information We ask for about the claim and he must help Us to take legal action against anyone if required.
- If required, the Insured / Insured Person must give consent to obtain Medical opinion from any Medical Practitioner at Our expense.
- If required the Insured or Insured Person must agree to be examined by a Medical Practitioner of Our choice at Our expense.

The documents should be sent to:

Health Claims Department

M/s.Royal Sundaram Alliance Insurance Co.Ltd.,

Corporate office: Vishranthi Melaram Towers, No. 2 / 319

Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

Claim documents may also be submitted to local Royal Sundaram Offices address of which can be obtained by calling Customer Service Helpline Number 1860 425 0000.

2. Payment of Claim

- All claims under this Policy shall be payable in Indian Currency. All medical treatments for the purpose of this insurance will have to be taken in India only.
- Benefits payable under this policy will be paid within 30 days of the receipt of last necessary document
- The Company shall be liable to pay any interest at 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed, for sums paid or payable under this Policy, upon acceptance of an offer of settlement by the insured but there is delay in payment beyond 7 days from the date of acceptance
- Any claim intimated after 90 days from the date of discharge from the Hospital/Nursing Home, shall not be entertained
- No Claim is admissible beyond 180 days from date of expiry of the policy in respect of hospitalization commencing within the Period of Insurance.
- The claim if admissible shall be paid to the nominee of the proposer incase if the proposer is not surviving at the time of payment of claim
- At the time of claim settlement, Company may insist on KYC documents of the Proposer as per the relevant AML guidelines in force.
- In the event of the hospitalization falling within two policy periods, the sum insured considered for such claim shall be the available sum insured under both policy periods.

3. Transfer

Transferring of interest in this Policy to anyone else is not allowed.

4. Cancellation

The Company may at any time cancel this Policy on the grounds of mis-representation, fraud, non-disclosure of material facts on the Proposal Form or non-cooperation by the insured, by giving fourteen (14) days notice in writing by courier/registered post/acknowledgement due post to the Insured at address recorded/updated in the policy. In the event of such cancellation on the grounds of mis representation or fraud or non disclosure of material facts, the policy shall be void, no refund of premium shall be made and no claim shall be payable under the policy. In the event of cancellation on the grounds of non cooperation, the company shall be liable to repay on demand a rateable proportion of the premium for the unexpired term from the date of cancellation.

The Insured may also cancel this Policy by giving fifteen (15) days notice in writing to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice cancel the Policy and retain the premium for the period this Policy has been in force at the Company's short period scale as mentioned below provided that no refund of premium shall be made if any claim has been made under the Policy by or on behalf of the insured.

Short period Scales : one year insurance

For a period not exceeding	15 days	10% of the Annual Premium
-do-	1 month	15% of the Annual Premium
-do-	2 months	30% of the Annual Premium
-do-	3 months	40% of the Annual Premium
-do-	4 months	50% of the Annual Premium
-do-	5 months	60% of the Annual Premium
-do-	6 months	70% of the Annual Premium
-do-	7 months	75% of the Annual Premium
-do-	8 months	80% of the Annual Premium
-do-	9 months	85% of the Annual Premium
For a period exceeding	9 months	Full Annual Premium

Short period Scales : two year insurance:

For a period not exceeding	30 days	10% of the Premium Paid
-do-	2 months	15% of the Premium Paid
-do-	4 months	30% of the Premium Paid
-do-	6 months	40% of the Premium Paid
-do-	8 months	50% of the Premium Paid
-do-	10 months	60% of the Premium Paid
-do-	12 months	70% of the Premium Paid
-do-	14 months	75% of the Premium Paid
-do-	16 months	80% of the Premium Paid
-do-	18 months	85% of the Premium Paid
For a period exceeding	18 months	Full Premium Paid

5. Notice

Every notice and communication to the Company required by this Policy shall be in writing to the office of the Company,

through which this insurance is effected. However Initial notification of claim can be made by telephone.

6. Misdescription

This Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, misdescription or nondisclosure of any material fact.

7. Geographical Area

The cover granted under this insurance is valid for treatments taken in India only.

8. Contribution

If at the time of a claim under this Policy, there is any other insurance covering the same loss, the right of contribution apply.

9. Continuation of Terms and Conditions

The Insured has to renew the policy without any break to ensure continuity of cover from the commencement. A grace period of 30 days is allowed to renew the policy and maintain continuity of coverage.

However during such grace period, the company shall not be liable for hospitalisation, if any, occurring after the expiry of the policy and before the date of actual receipt of premium for renewal.

10. Insurer's rights

We have the right to do the following, in Insured Person's name at Our expense:

- Take over the defense on settlement of any claim
- Start legal action to get compensation from anyone else
- Start legal action to get back from anyone else for payments that have already been made by Us

11. Fraud

If any claim is in any respect fraudulent, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his behalf to obtain any benefit under this Policy, all benefits under this Policy will be forfeited and the Company may choose to void the Policy and reclaim all benefits paid in respect of such Insured Person.

12. Renewals

This Policy may be renewed by mutual consent every year and in such event, the renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof. Policy must be renewed within the Grace Period of thirty days of expiry to maintain the continuity of Coverage. However no coverage shall be available during the period of such break.

A policy that is sought to be renewed after the Grace Period of 30 days will be underwritten as a fresh policy at the discretion of Us. Any condition / diseases contracted during the break-in period shall not be covered and shall be treated as Pre-existing condition and waiting period for such disease will commence afresh.

In the event of mis-description, fraud, non co-operation by the insured or non disclosure of material facts coming to our knowledge, policy shall not be considered for renewal.

At renewal, the coverages, terms & conditions and premium may change, in which case a three months notice by shall be sent to the Proposer at his last known address as recorded in the policy. Any change in premium on account of change of age will not require any prior notice.

The product / plan may be withdrawn at any time, by giving a notice of 3 months to the Proposer at the address recorded / updated in the policy. When the policy is withdrawn, the product / plan shall not be available for renewal at the due date. However, the cover under such policy shall continue till the expiry date shown in the Schedule of the policy. In the event of withdrawal of a product, Company shall offer similar alternative product from its currently marketed product suites.

13. Arbitration

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 to difference 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.

It is clearly agreed and understood that no difference or dispute shall be referable to Arbitration as hereinbefore provided, if the Company has 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.

14. Disclaimer

It is also hereby further expressly agreed and declared that if the Company shall disclaim liability to the Insured for any claim hereunder and such claim shall not within 12 calendar months from the date of such disclaimer have been made the subject matter of a suit in a Court of law or pending reference before Ombudsman, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

15. Jurisdiction

The Policy is subject to the laws of India and the jurisdiction of its Courts.

16. Change of address

The Insured must inform in writing of any change in his/her address.

17. Change in Sum Insured

When the Company is admitting liability for disease/illnesses / medical condition/injury contracted by the Insured Person during the previous period of Insurance(s) with Us, then We shall pay either the Sum Insured for that Insured Person during the first occurrence of such disease/ illness/medical condition/ burns or the available Sum Insured under the current Policy, whichever is less.

When the Company is admitting liability for pre existing disease the least sum insured opted in all years of insurance will be considered.

18. Compliance with Policy provisions

Failure to comply with any of the provisions contained in this Policy shall invalidate all claims hereunder.

19. Free Look in:

At the inception of the policy you will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable. If you have not made any claim during the free look period, you will be entitled to the following, provided no claim has been settled or lodged for the period the policy has been in force:

a) A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured person and the stamp duty charges or;

b) where the risk has already commenced and the option of return of the policy is exercised, a deduction towards the proportionate risk premium for period on cover or;

c) Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

20. Portability

This policy is portable. If proposer desires to port to this policy, application in the appropriate form should be made before 45 days from the date of renewal. The company retains the rights to underwrite proposals falling under portability as per the company's underwriting guidelines. In the event of acceptance of proposal under portability the commencement date for the purpose of applying time bound exclusions and Pre-existing Disease(s) shall be deemed from the first inception date of any Indemnity Health Insurance Policy and such rights shall be limited to the extent of the sum insured including CB, in each of the year, provided the Policy has been continuously renewed without any break.

21. Grievances

In case the Insured Person is aggrieved in any way, the Insured Person may contact the Company at the specified address, during normal business hours for the following grievances:

a. Any partial or total repudiation of claims by the Company.
b. Any dispute regard to premium paid or payable in terms of the policy.
c. Any dispute on the legal construction of the policies in so far as such disputes relate to claims.
d. Delay in settlement of claims.
e. Non-issue of any insurance document to customer after receipt of the premium.
f. any other grievances

The Insurance Ombudsman's offices are located at Ahmedabad, Bhubaneshwar, Bhopal, Chandigarh, Chennai, Guwahati, Kochi, Kolkatta, Lucknow, Hyderabad, Mumbai and Delhi. For Contact Details of Insurance Ombudsmen, please visit our website www.royalsundaram.in

WHAT IF I EVER NEED TO COMPLAIN?

We hope, of course, that you will never feel the need to complain. Nevertheless, sometimes things do go wrong. When they do, we want to know straight away, so we can put them right as quickly as possible, and take steps to make sure they don't happen again.

In all instances, call our Customer Services at our Chennai office at 1860 425 0000 or e-mail at customer.services@royalsundaram.in or write us to Royal Sundaram Alliance Insurance Company Limited, Vishranthi Melaram Towers, No. 2 / 319, Rajiv Gandhi Salai (OMR), Karapakkam, Chennai - 600097.

Royal Sundaram Alliance Insurance Company Limited

IRDA Registration No.102