FAMILY SHIELD

PART II OF THE POLICY SCHEDULE

1. PREAMBLE

This Policy is a contract of insurance issued by ICICI Lombard General Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. DEFINITIONS

Certain words are used in the policy and this Policy Schedule, which have a specific meaning and are shown below. They have this meaning wherever they appear in the Policy. Where the context so permits, references to the singular shall also include references to the plural and references to the male gender shall also include references to the female gender, and vice versa in both cases.

i. STANDARD DEFINITIONS -

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **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.
3. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
4. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies, which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
   Deductible shall be applicable per year, per life or per event as stated in the policy certificate and specific benefit based deductible shall be applied if specified in the policy certificate.
5. **Disclosure to Information Norm** means that the policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

6. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner t*o prevent death or serious long term impairment of the insured person's health
7. **Grace Period m**eans 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.

8. **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 Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:
    a. Has qualified nursing staff under its employment round the clock;
    b. Has at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
    c. Has qualified medical practitioner(s) in charge round the clock;
    d. Has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e. Maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.
9. **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.
10. **Illness** means a sickness or disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. **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, checkups, and / or tests
    - It needs ongoing or long-term control or relief of symptoms
    - It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
    - It continues indefinitely
    - It recurs or is likely to recur
11. **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.
12. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow up prescription
13. **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.
14. **Medical Practitioner** is a person who holds a valid registration from 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 his license. The term Medical Practitioner would include physician, specialist, anesthetist and surgeon but would exclude the Insured Person and his/her Family Members.
15. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer
16. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:
    a. is required for the medical management of the illness or injury suffered by the insured
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c. must have been prescribed by a medical practitioner;

d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

17. **Network Provider** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a Cashless Facility.
18. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
19. **Pre Existing Disease** means any condition, ailment, 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 or its reinstatement.
20. **Portability** means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.
21.
22. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
    a. Such Medical Expenses are incurred for the same condition for which the insured person's Hospitalization was required, and
    b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company
23. **Pre-hospitalization Medical Expenses** means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
24. **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 .
25. **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.
26. **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.
27. **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

ii. SPECIFIC DEFINITIONS -

1. **Adventure Sport** means sports/activities including but not limited to Sky Diving, Bungee Jumping, Bungee swoop, Bungee slingshot, Dune sliding, Hot air ballooning, Bridge Swinging, Zip Lining, Zip Trekking, Rock Climbing, Bicycle Polo, Bamboo rafting, Rock Scrambling, Rappelling, Via Ferrata, Fell Running, Fell Walking, Gorge Walking, Indoor Rock Climbing, Mountain Biking, Mountaineering, Body Boarding, Sailing, Ski boarding, Scuba Diving, Snorkeling, Shark Diving, Sky Diving, Swimming with Dolphins, Banana boating/donuts/inflatable's behind power boat Diving with Whales, Wakeboarding, Surfing, Auto (car) racing, Motor rallying, Motorcycle racing, Air racing, Kart racing, Boat racing, Hovercraft racing, Lawn mower racing, Snowmobile racing, Zorbing, and Truck racing Bodies or

organizations conducting any such adventure sports must be recognized and licensed by Government authorities.

2. **Age** means the completed years on last birthday as per the English calendar calculated on the day of inception of cover under the Policy.

3. **Air Ambulance** means a specially equipped aircraft, typically a helicopter, which is equipped with life saving medications, CPR equipments, cardiac monitoring unit and qualified EMS personnel, used to transport injured people to Hospital in an emergency.

4. **Ambulance Charges** means transportation costs incurred by the insured person towards availing ambulance services from the site of Accident to the nearest Hospital or from the site of first treatment to the nearest higher center of care in case of life threatening emergency conditions.

5. **Assault** means any unlawful use of force inflicted by an individual(s) upon an Insured Person that is a criminal offence in the jurisdiction in which it occurs and which results in Injury to the Insured Person.

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

7. **Child** means dependent child/children including adopted and step child/children of the Insured Person up to the age of twenty five (25) years and dependent on the insured person for maintenance and financial support.

8. **Coma** means 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:
    a. No response to external stimuli continuously for at least 96 hours;
    b. Life support measures are necessary to sustain life; and
    c. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma
    d. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

9. **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), taxi services or any other mode of transport operating under license issued by the appropriate authority for transportation of passengers and / or cargo and / or any other vehicle licensed to carry fare paying passengers.

10. **EMI or EMI Amount** means and includes the amount of monthly payment required to repay the principal amount of Loan and interest by the Insured Person as set forth in the amortization chart. For the purpose of claim settlement against any coverage under this Policy the amortization schedule prepared by the financier as on the loan disbursal date or risk inception date (whichever is later) shall be considered wherever applicable.

11. **Family Member** means an Insured Person's legally wedded spouse, children, ward, step or adopted children, parents, stepparents , mother in law, father in law, children in law, legal guardian, siblings, and siblings in law

12. **Franchise** means a per Insured event provision in the policy whereby the insurer will not pay unless damage (or loss) exceeds the specified number of days/hours/months as defined in the Policy Certificate. Once a franchise is met, the Sum Insured subject to the Benefit is payable as per terms and conditions. **Illustration:** If the customer opts for a Franchise of two days and he is admitted in a hospital for one day the benefit shall not be triggered. However, if the Insured is hospitalized for more than two days the Insured shall be entitled for a benefit for all days of hospitalization (up to the sum insured).

13. **Healthcare Service Provider Agreement** means an agreement prescribing the terms and conditions of services which may be rendered to the holders of health insurance policies of Insurance company and may be entered into between:
    a. Service provider and an insurer; or
    b. Service provider, a TPA and the insurer

14. **Immediate Family Member** means spouse, children, step or adopted children, brother(s), sister(s) and parent(s) or stepparents of the Insured Person.

15. **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.

16. **Insured Event** means any event specifically mentioned in the Policy Certificate as covered under this Policy for which premium is received by the Company.

17. **Insured Person(s)** means the persons named as insured persons in the Policy Schedule who are insured for the applicable Benefits under this Policy.

18. **Loan** means the sum of money lent at an interest or otherwise to the Insured Person by any bank/financial institution as identified by the Loan Account Number specified in the Policy Certificate or certified in writing by the bank/financial institution.

19. **Nominee** means the person(s) nominated by the Insured Person to receive the Benefits payable under this Policy on death.

20. **Permanent Total Disablement** means any of the following:
    a. Total and irrevocable loss of sight in both eyes, or
    b. Total and irrevocable physical separation of two entire hands or two entire feet, or
    c. Total and irrevocable loss of one entire hand and one entire foot, or
    d. Total and irrevocable loss of sight of one eye and physical separation of one entire hand or physical separation of one entire foot, or Total and irrevocable loss of use of two hands or two feet, or
    e. Total and irrevocable loss of use of one hand and one foot, or
    f. Total and irrevocable of loss of sight of one eye and loss of use of one hand or one foot.

    For the purpose of this definition:
    a. Physical separation of a hand or foot means separation of the hand at or above the wrist, and of the foot at or above the ankle.
    b. Loss of use or Loss of sight means total paralysis of one or more limb, or loss of vision respectively, which is certified in writing by a Medical Practitioner to be permanent, complete and irreversible and substantiated by physical examination and investigation to be permanent, complete and irreversible.

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

22. **Policy Period** means the period commencing from the Policy Start Date, Time and ending at the Policy End Date, Time of the Policy and as specifically appearing in the Policy Schedule during which the policy is valid and Insured Person is liable to get a claim subject to waiting periods and policy terms and conditions

23. **Period of Cover** means the period specified in the Policy Certificate during which the insured Person is covered under the Policy.

24. **Policy Schedule** means the Policy Schedule attached to and forming part of the Policy.

25. **Professional Sports** means a sport which would remunerate a player in excess of 50% of his or her annual income as a means of their livelihood.

26. **Proposal and Declaration Form** means any initial or subsequent declaration made by the policyholder and is deemed to be attached and which forms a part of this Policy.
    While filling the proposal form, you are expected to provide all information pertaining to your health and to the cover you would be opting/buying in this policy. Any non-declaration of information which insurance Company should have known for underwriting this policy can lead to cancellation of policy and Company will have a right to forfeit the premium.

27. **Service Provider** means any person, organization, institution, company providing services in individual capacity or through aggregation that has been empanelled with the Insurance Company to provide services specified under the benefits (including add-ons) to the Insured Person on cashless or reimbursement basis. These shall also include providers empanelled to form a part of network other than hospitals
28. **Sum Insured** means the amount specified in the Policy Certificate against a Benefit **or set of Benefits** that represents Our maximum, total and cumulative liability for any and all claims made in respect of that Insured Person during the Period of Cover under that Benefit/set of Benefits.

29. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Certificate which shall be served before a claim related to such condition becomes admissible.

30. **We/ Our / Us** means the ICICI Lombard General Insurance Company Limited.

31. **You / Your** means person or the entity named as the policyholder in the Policy Schedule and who is responsible for payment of premium.

II. BENEFITS COVERED UNDER THE POLICY

This Policy is a contract of insurance between the Policyholder and Us which is subject to the receipt of premium against each Benefit in full (first installment in case the customer has opted for Periodic Premium Payment option) in respect of the Insured Persons and the terms, conditions and exclusions of this Policy.

The customer may opt for any one or more base benefits under one or more sections Extensions may be opted only if a base benefit under the respective section has been opted. Customer shall be eligible for the

base benefits and/or extensions only if premium for the same is paid by the customer and accepted by Us. The Policy Certificate will specify which of the following Basic Benefits and Extensions are applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Benefit applicable to the Insured Person shall be subject to the availability of the Sum Insured, applicable sub-limits for the Benefit claimed as specified in the Policy Certificate and the terms, conditions and exclusions of this Policy.

All claims shall be made in accordance with the procedures set out in this Policy. Admitted claims will be payable to the Insured Person or the Nominee (as applicable).

SECTION A: SPECIFIC INFECTIOUS DISEASES BENEFIT

SECTION A.1: SPECIFIC VECTOR BORNE DISEASE BENEFIT

For the purpose of benefit under Section A.1 under this policy, Specific Vector-Borne Disease means Malaria, Dengue, Chickungunya, Kala Azar, Japanese encephalitis, Zika Fever and Filariasis

Benefit A.1.1: Base Benefit: Specific Vector Borne Disease related Hospitalization 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.

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 2 successive days.
iii. We shall not be liable to make any payment under this Benefit, if the Insured 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 waiting 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.
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.

Claims Documents for Section A.1.1:

- Duly filled claim form
- Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital
- Laboratory Reports confirming the diagnosis of Specific Vector Borne Disease, as follows:
    - Dengue - NS1 antigen test or Ig M- Elisa test
    - Malaria – Peripheral Smear Test confirming the presence of Malarial parasites

- Chickungunya - Presence of IgM and IgG anti chikungunya antibodies
- Kala-Azar - Direct Agglutination Test or Rapid dipstick test or ELISA for detecting IgG, Anemia, Leucopenia, thrombocytopenia and Hypergammaglobulinemia
- Japanese encephalitis - Ig M antibody detection in serum or cerebrospinal fluid
- Zika Fever – PCR report confirming the diagnosis
- Filariasis - Antigen detection in blood sample or IgG4 antibody detection using routine assays

SECTION A.2: RABIES AND TETANUS BENEFIT

Benefit A.2.1: Basic Benefit: Rabies and Tetanus related Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Rabies or Tetanus occurring on account of an Injury from an Accident that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Rabies or Tetanus and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in Hospital should continue for a minimum period of 2 successive days
iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to Rabies or Tetanus is prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Rabies or Tetanus is within a waiting 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.
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.

Claims Documents for Section A.2.1:

- Duly filled claim form
- Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital

Benefit A.2.2: Basic Benefit: Rabies and Tetanus 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 Rabies or Tetanus occurring on account of an Injury from an Accident 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 Rabies or Tetanus.

This Benefit shall be payable subject to the following:

i. We shall not be liable to make any payment under this Benefit, if Rabies or Tetanus 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 Rabies or Tetanus is first diagnosed within a waiting 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 Rabies or Tetanus 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 Rabies or Tetanus.
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.

Claims Documents for Section A.2.2:

- Duly filled claim form
- Duly attested death certificate issued by municipal authorities
- Cause of Death certificate from the treating physician
- Out- patient consultation paper wherever applicable
- Indoor case papers of treating hospital, if available
- Certificate from treating doctor confirming the diagnosis

SECTION A.3: SPECIFIC GASTRO INTESTINAL INFECTIONS BENEFIT

For the purpose of benefit under Section A.3 under this policy, Specific Gastro Intestinal Infections mean the following:

Acute Inflammatory Diarrhoea – Acute onset, caused by invasive or noninvasive pathogens and their enterotoxins characterized by the following:

- Watery Stools containing blood and pus cells,
- Clinical signs of dehydration
- High grade fever

Typhoid Fever - An infection from Salmonella Typhi characterized by the following:

- Fever for more than 5 days,
- Presence of Salmonella Typhi bacteria in the blood and
- Multi organ involvement

Benefit A.3.1: Base Benefit: Specific Gastro Intestinal Infections Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Specific Gastro Intestinal Infections that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Specific Gastro Intestinal Infections and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in Hospital should continue for a minimum period of 2 successive days

iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to Specific Gastro Intestinal Infection is prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Specific Gastro Intestinal Infection is within a waiting 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.
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.

Claims Documents for Section A.3.1:

- Duly filled claim form
- Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital
- Laboratory Reports confirming the diagnosis of Specific Gastro Intestinal Infections, as follows:
    - Acute Inflammatory Diarrhoea – Routine Stool Examination confirming the presence of RBCs and Pus Cells in stools
    - Typhoid Fever - Presence of Salmonella Typhi in Blood / Urine / Stool sample

SECTION A.4: SPECIFIC VIRAL INFECTIONS BENEFIT

For the purpose of benefit under Section A.4 under this policy, Specific Viral Infections means Viral Hepatitis (Hepatitis A, B C and E), Measles, Mumps, Poliomyelitis, Avian Influenza and Swine Influenza

Benefit A.4.1: Base Benefit: Specific Viral Infections Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Specific Viral Infection that solely and directly requires the Insured Person to be hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Specific Viral Infection and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in Hospital should continue for a minimum period of 2 successive days
iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to Specific Viral Infection is prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Specific Viral Infection is within a waiting 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.
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.

Claims Documents for Section A.4.1:

- Duly filled claim form
- Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital
- Laboratory Reports confirming the diagnosis of Specific Viral Infections, as follows:
    - Viral Hepatitis:
        - Hepatitis A - Positive HAV IgM antibody test
        - Hepatitis B – Positive HBsAg Test
        - Hepatitis C – Positive HCV RNA test
        - Hepatitis E - IgG / IgM Antibody Test confirming diagnosis
    - Measles – IgG / IgM Antibody Test
    - Mumps – IgG / IgM Antibody Test
    - Poliomyelitis – Throat swab / Stool / CSF culture for Poliovirus
    - Avian Influenza: Laboratory test of a Throat Swab confirming the diagnosis
    - Swine Influenza: Laboratory test of a Throat Swab confirming the diagnosis

SECTION A.5: SPECIFIC NERVOUS SYSTEM INFECTIONS BENEFIT

For the purpose of benefit under Section A.5 under this policy, Specific Nervous System Infections means Meningitis, Encephalitis, Creutzfeldt–Jakob disease, Guillain–Barré syndrome

Benefit A.5.1: Basic Benefit: Specific Nervous System Infections Hospitalization Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person is diagnosed with Specific Nervous System Infection that solely and directly requires the Insured Person to be Hospitalized during the Period of Cover.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment of Specific Nervous System Infection and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person's stay in Hospital should continue for a minimum period of 2 successive days
iii. We shall not be liable to make any payment under this Benefit, if Hospitalization due to Specific Nervous System Infection is prior to the commencement of the Period of Cover.
iv. We shall not be liable to make any payment under this Benefit, if hospitalization due to Specific Nervous System Infection is within a waiting 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.

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.

Claims Documents for Section A.5.1:

- Duly filled claim form
- Hospital Discharge summary duly signed and attested by treating doctor confirming the diagnosis and period of Hospitalization
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital
- Laboratory Reports confirming the diagnosis of Specific Nervous System Infection, as follows:
  - Meningitis: CSF Examination confirming the diagnosis of Meningitis
  - Encephalitis: EEG / MRI / CSF / Examination confirming the diagnosis of Meningitis
  - Creutzfeldt–Jakob disease: MRI / CSF Examination / Electroencephalography confirming the diagnosis
  - Guillain–Barré syndrome: EMG / CSF Examination confirming the diagnosis

SECTION B – HOSPITAL DAILY CASH - ILLNESS

B.1 Basic Benefit: Hospital Daily Cash Benefit

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate for each continuous and completed day of Hospitalization.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner and is fora minimum of continuous 24 Hours duration

ii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each period of Hospitalization within the Period of Cover.

iii. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.

iv. We shall not be liable to make any payment under this Benefit, if Hospitalization commenced prior to the commencement of the Period of Cover or within the waiting period specified in the Policy Certificate.

v. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

B.2 Extension: Intensive Care Unit (ICU) Cash Benefit

If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Period of Cover and which solely and directly requires the Insured Person to be Hospitalized in an Intensive Care Unit,

then We will pay the daily amount specified in the Policy Certificate for each continuous and completed day of confinement in the Intensive Care Unit.

This Benefit shall be payable subject to the following:

i. The Hospitalization in the Intensive Care Unit is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner and is for a minimum of continuous 24 Hours duration
ii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each period of Hospitalization within the Period of Cover.
iii. Our liability to make any payment under this Benefit shall be in excess of the Deductible stated in the Policy Certificate. However, the Deductible shall not apply to the extent of days in respect of which the Insured Person has already been admitted in the Hospital in a non- ICU room.
iv. We shall not be liable to make any payment under this Benefit, if Hospitalization commenced prior to the commencement of the Period of Cover or within the waiting period specified in the Policy Certificate.
v. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION B

We shall not be liable to make any payment for any claim under Section B of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

i. STANDARD EXCLUSIONS -

1. **30-day waiting period(Code – Excl 03)** Any hospitalization falling within the initial waiting period as specified in the policy certificate subject to a maximum of 30 days-

    1. Expenses related to the treatment of any illness within the initial waiting period shall be excluded except claims arising due to an accident, provided the same are covered.

    2. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

    3. The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

2. **Pre-existing Diseases (Code – Excl 01)** (Unless specifically covered and mentioned in the policy certificate)

    1. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.

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

3. 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

4. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3. Maternity (Code – Excl 18)

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

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

4. **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

5. Investigation & Evaluation (Code – Excl 04) -

1. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded

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

6. **Obesity/Weight Control (Code – Excl 06)** - 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);

    1. greater than or equal to 40 or

    2. 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:

        1. Obesity-related cardiomyopathy

2. Coronary heart disease
3. Severe Sleep Apnea
4. Uncontrolled Type2 Diabetes

7. **Rest Cure, rehabilitation and respite care (Code – Excl 05)** - Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

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

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

8. **Hazardous or Adventure Sport (Code – Excl 09)** (unless specifically covered and mentioned in Policy certificate): 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.
9. **Change of Gender Treatments (Code – Excl 07)** - Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex
10. **Breach of Law (Code – Excl 10)**: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent
11. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code – Excl 12)**
12. **Refractive Error (Code – Excl 15)**: Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres
13. **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.
14. Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons **(Code – Excl 13)**
15. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure **(Code – Excl 14)**
16. **Excluded Providers (Code – Excl 11) -**

    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policy holders are not

admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

31. . Specified disease/procedure waiting period (Code – Excl 02) -Two Years Exclusions- (Unless the waiting period is specifically waived off and mentioned in the policy certificate)-

a. Expenses related to the treatment of the below listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c. If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
d. The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
e. If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
f. List of specific disease/procedures -
    i. Deviated Nasal Septum, CSOM-Chronic Suppurative Otitis Media
    ii. Stapedectomy, Mastoidectomy, any treatment for conditions related to tonsils, adenoids, sinuses, turbinates/ concha
    iii. Fibroids (fibromyoma), Endometriosis, Uterine Prolapse, Polycysyic Ovarian Syndrome(PCOS)
    iv. Dilatation and curettage (D&C), Myomectomy, Hysterectomy
    v. Arthritis, Gout and Rheumatism
    vi. Stones in gall bladder & Biliary System; Cholecystitis, Fissure/fistula in anus, hemorrhoids, pilonidal sinus, piles, Esophageal Varices & Gastric Varices, Gastritis, Duodenitis & Pancreatitis
    vii. Gastric & Duodenal ulcers, Gastro Esophageal Reflux Disorder (GERD)/Acid Peptic Disease, Ulcerative colitis, Crohn's disease, Irritable Bowel Syndrome, Inflammatory Bowel disease
    viii. All forms of cirrhosis, Rectal prolapse, Perineal Abscesses, Perianal Abscesses
    ix. Cholecystectomy, Endoscopy
    x. Stones in Urinary system, all prostate diseases, chronic renal failure or end stage renal failure or chronic kidney disease, dialysis
    xi. Dysfunctional uterine bleeding, pelvic inflammatory diseases, stress incontinence, Hydrocele, varicocele/ rectocele/ spermatocele
    xii. Cataract, Glaucoma, Diseases of the vitreous and retina
    xiii. Unless malignant, All Internal/ External tumors, cysts, nodules, polyps, sinus, fistula, adenoma, lumps including teratoma, breast lumps, dermoid cyst, ovarian cyst, desmoid tumour, umblical granuloma, mucous cyst of lip/cheek
    xiv. Diseases related to thyroid
    xv. All skin ailments
    xvi. Ulcers of any kind (whether internal or external) including decubitus ulcers
    xvii. Varicose veins & Varicose ulcers
    xviii. Intervertebral disc disorders , Arthroscopy, Spinal and Vertebral Disorders including diagnosis as low back ache, Surgeries for joint replacements (except if hospitalization is required due to an accidental injury)
    xix. All Hernias (except if Hospitalization is required due to an Injury)

ii. SPECIFIC EXCLUSIONS -

1. Any physical, or medical condition or treatment or service which is specifically excluded in the Policy Certificate under Special Conditions.

2. All dental treatment or dental surgery of any kind unless necessitated due to an Accident Any alternative treatments except treatment taken under Ayurveda, Unani, Sidha and Homoeopathy in a Government Hospital or any institute recognized by the Government and/or accredited by Quality Council of India / National Accreditation Board for Hospitals and Healthcare Providers.

3. Circumcision unless necessary for treatment of an underlying diseases

4. Any treatment received outside India.

5. Hormone replacement therapy.

6. Routine medical, dental, eye and ear examinations is not covered unless specifically covered and specified in the Policy Certificate.

7. Any medical examination for the purpose of employment or travel.

8. Intentional self Injury, suicide or attempt to suicide.

9. Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought. Any Illness, complication or ailment arising out of or connected to such Injury.

10. Any external congenital anomalies.

11. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world

12. Treatment by a Family Member and self-medication or any treatment that is not scientifically recognized.

13. War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, police, military, naval or air service, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.

14. Death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

Claim Documents for Section B (Applicable for Benefit B.1 and B.2)

- On the occurrence of an Insured Event which may give rise to a claim under Section B of the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Benefit being claimed within 30 days of the occurrence of the Insured Event: Duly filled claim form
- Hospital Discharge summary filled and attested by Hospital
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital
- First Information Report (F.I.R.) copy / Medico-legal case papers - Notarized/ Attested by a gazetted officer in case of an Injury

SECTION C – ACCIDENTAL INJURY BENEFITS

Our maximum, total and cumulative liability for claims arising in respect of the Insured Person during the Period of Cover under Benefits C.1.1, C.1.2, and C.1.3 shall be the Sum Insured as specified against this set of Benefits in the Policy Certificate.

C.1.1 Base Benefit: 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 suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person's death within 365 days from the date of the Accident.

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

Claims Documents for Section C.1.1:

- Claim Form
- MLC or FIR
- Cause of Death Certificate and Death Certificate by municipal corporation
- Post Mortem Report
- Viscera / Chemical Analysis / Forensic Report
- Police Final Charge Sheet / Court Final Order
- Spot / Inquest Panchnama
- Indoor case papers, if available

C.1.2 Base Benefit: Permanent Total Disablement (PTD) 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 suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Benefit C.1.1 (Death Benefit), if in force for the Insured Person.
ii. If the Insured Person suffers Injuries resulting in more than one of the Permanent Total Disablements, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured.
iii. If We have admitted a claim for Permanent Total Disablement in accordance with this Benefit, then We shall not be liable to make any payment under Benefit C.1.1 (Death Benefit), if the Insured Person subsequently dies (unless the sum insured against death benefit is greater, during which the balance amount shall be paid to the nominee). However, any other applicable Benefits which may get triggered will be considered in accordance with the terms and conditions of the respective Benefits.
iv. We will only accept one claim under this Benefit in the lifetime of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Benefit and Benefit C.1.1 (Death Benefit) & C.1.3 (Permanent Total Disablement (PTD) Benefit) in respect of the Insured Person shall immediately and automatically cease.
v. On the acceptance of a claim under this Benefit, insurance cover under any other applicable Benefits under this Policy whether in the present Period of Cover or any subsequent Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

Claims Documents for Section C.1.2:

- Claim Form
- MLC or FIR
- Police Final Charge Sheet / Court Final Order
- Spot / Inquest Panchnama
- Disability Certificate issued by civil or government Hospital mentioning the details of the disability
- Indoor case papers, if available
- Medical Certificate

C.1.3 Base Benefit: Permanent Partial Disablement (PPD) Benefit

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Certificate) in the manner which is specified in the table below if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person (which is of the nature specified in the table below) within 365 days from the date of the Accident.

For the purpose of this Benefit, Permanent Partial Disablement means total and/or partial irrecoverable loss of use or the actual loss by physical separation of the body parts as specified in the table below:

SR No.	LOSSES COVERED	% OF SUM INSURED payable
1	Loss of one entire hand	70
2	Loss of one entire foot	70
3	Loss of use of one eye	50
4	Loss of all toes	20
5	Loss of great toe - both phalanges	5

6	Loss of great toe - one phalanx	2
7	Other than great toe if more than one toe lost each	5
8	Loss of use of both ears	75
9	Loss of use of one ear	30
10	Loss of four fingers and thumb of one hand	40
11	Loss of four fingers	35
12	Loss of thumb - both phalanges	25
13	Loss of thumb - one phalanx	10
14	Loss of index finger - three phalanges	10
15	Loss of index finger - two phalanges	8
16	Loss of index finger - one phalanx	4
17	Loss of middle finger - three phalanges	6
18	Loss of middle finger - two phalanges	4
19	Loss of middle finger - one phalanx	2
20	Loss of ring finger - three phalanges	5
21	Loss of ring finger - two phalanges	4
22	Loss of ring finger - one phalanx	2
23	Loss of little finger - three phalanges	4
24	Loss of little finger - two phalanges	3
25	Loss of little finger - one phalanx	2
26	Loss of metacarpus - first or second (additional)	3
27	Loss of metacarpus - third, fourth or fifth (additional)	2

This Benefit shall be payable subject to the following:

i. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit, but a claim will be considered under Benefit C.1.1 (Death Benefit, if opted).
ii. If the insured person dies or develops Permanent Total Disability after a claim is paid under this benefit, then the remaining Sum Insured shall be paid under the respective Benefit (If Benefit C.1.1 and/or C.1.2 are opted)
iii. If a claim is accepted under this Benefit and the amount due under this claim and claims already admitted in respect of the Insured Person cumulatively leads to the Sum Insured being exceeded, then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this Benefit and the Policy shall continue, subject to the availability of the Sum Insured and the terms, conditions and exclusions of this Policy.

Claims Documents for Section C.1.3:

- Claim Form
- MLC or FIR
- Police Final Charge Sheet / Court Final Order

- Spot / Inquest Panchnama
- Disability Certificate issued by civil or government Hospital
- Indoor case papers, if available
- Medical Certificate

C.1.4 Base Benefit: Temporary Total Disablement (TTD) Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the total incapacitation of the Insured Person which prevents the Insured Person from engaging in any employment or occupation on a temporary basis, then We will pay upto the weekly amount specified against this Benefit in the Policy Certificate for the duration that the Temporary Total Disablement continues.

This Benefit shall be payable subject to the following:

i. We shall not be liable to make any payment under this Benefit in respect of the Insured Person for more than the total number of weeks specified in the Policy Certificate for any and all claims arising within the Period of Cover under this Benefit.
ii. Such disability is within 30 days after the date of Accident causing such Injury
iii. If the Injury is sustained to or suffered in relation to the spine and its muscular girdle, ligamentous system, cartilage, nervous system and blood supply to the spine which is not detectable by means of radiological scanning, imaging, or neurological fallout testing, then Our liability under this Benefit shall extend for a maximum period of five (5) weeks.
iv. We shall not be liable to make any payment which is more than the Insured Person's Gross Weekly Income
v. In the event of any dispute as to the date when the Temporary Total Disablement ceased, such date shall be finally determined by an external Medical Practitioner approved by Us who certifies either:
   a) the date upon which the Insured Person recovered; or
   b) the date upon which the Insured Person recovered as far as he/she will ever recover.
vi. If the Insured Person is disabled for a part of a week, then only a proportionate part of the weekly amount will be payable in respect of that week.

Gross Weekly Income 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 coverage, but not including, overtime, bonuses, tips, commissions, and special compensation.

Claims Documents for Section C.1.4:

- Claim Form
- MLC
- FIR
- Medical Certificate
- Fitness Certificate
- Income Documents (ITR/Form 16, as applicable)

C.1.5 Base Benefit: Adventure Sports 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 suffers an Injury due to an Accident while engaging in Adventure Sports during the Period of Cover and that Injury solely and directly results in the Insured's Person's death or Permanent Total Disablement within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. The Insured Person was engaging in the Adventure Sport under the supervision of a trained professional.
ii. If the Insured Person received or was eligible to receive any kind of remuneration for performing the Adventure Sport, no amount shall be payable under this Benefit. However, we would cover running marathon events provided that the distance of such event does not exceed 42 kilometers
iii. Section C Exclusion (8) shall not apply to the extent of the cover under this Benefit.
iv. We will only accept one claim under this Benefit 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 in the present Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

Claims Documents for Section C.1.5:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of Injury)
- Proof of participation in adventure sports such as tickets and details of the company carrying out such activities

C.1.6 Base Benefit: Children's Education Grant Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death or Permanent Total Disablement within 365 days from the date of the Accident, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate in respect of the expenses towards education of the surviving Dependent Children of the Insured Person, irrespective of whether the child is an Insured Person under this Policy.

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.

If the Insured Person's Dependent Children also die in the same Accident or due to any event occurring after the death of the Insured Person and before the claim amount payable under this Benefit can be paid in full, the amount payable shall be paid to the Dependent Child's legal heirs in the manner specified in the Policy Certificate.

For the purpose of this Benefit, Dependent Child means a child of the Insured Person who is less than 25 years of Age on the date of Accident and is financially dependent on the Insured Person.

This Benefit shall be payable subject to the following:

i. Our maximum, total and cumulative liability under this Benefit is the Sum Insured specified against this Benefit, irrespective of the number of surviving Dependent Children of the Insured Person.

Claims Documents for Section C.1.6:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of Injury)
- Bonafide Certificate from the educational institute certifying the enrolment of the Insured Person's child in his/her educational course
- Proof of relationship of children with Insured Person such as passport/Aadhar card with full DOB /election card / PAN card
- Age proof of children such as passport,/Aadhar card with full DOB /election card / PAN card

C.1.7 Base Benefit: Orphan Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death within 365 days from the date of the Accident, We will pay the Sum Insured in the manner specified in the Policy Certificate in respect of the surviving Dependent Children of the Insured Person, irrespective of whether the child is an Insured Person under this Policy.

For the purpose of this Benefit, Dependent Child means a child of the Insured Person who is less than Age 25 on the date of the Accident and does not have any independent source of income.

This Benefit shall be payable subject to the following:

i. The Dependent Child's other parent also dies as a result of the same Accident or has pre-deceased the Insured Person. In case the Insured is a single parent, this clause shall not be applicable.
ii. Our maximum, total and cumulative liability under this Benefit is the Sum Insured, irrespective of the number of surviving Dependent Children of the Insured Person.
iii. If the claim payment under this Benefit is being made as per Periodic Claim Payment Clause as specified in the Policy Certificate and the Dependent Child dies before the entire payment has been under this Benefit, then the remaining instalments shall be paid in one lump sum to the Dependent Child's legal heirs.
iv. We will only accept one claim under this Benefit in respect of the Insured Person. On the acceptance of a claim under this Benefit, all cover under this Policy in respect of the Insured Person shall immediately and automatically cease.

Claims Documents for Section C.1.7:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit)
- Death Certificate of the Insured's spouse
- Proof of relationship of children with insured such as passport/Aadhar card with full DOB/election card/PAN card
- Age proof of children such as passport/Aadhar card with full DOB/election card/PAN card

C.1.8 Base Benefit: Parental Care Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death or Permanent Total Disablement within 365 days from the date of the Accident, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate in respect of the surviving parents of the Insured Person, irrespective of whether the parent(s) is an Insured Person under this Policy.

This Benefit shall be payable subject to the following:

i. Our maximum, total and cumulative liability under this Benefit is the Sum Insured, irrespective of

whether one or both parents of the Insured Person are alive.

ii. In case the parent/s pre-decease the Insured Person after the Policy Start Date but before the Insured event, the Benefit shall be payable to the Legal heir/s of the parent/s.

iii. If the claim payment under this Benefit is being made as per Periodical Claim Payment Clause as specified in the Policy Certificate and the surviving parents die before the entire payment has been under this Benefit, then the remaining instalments shall be paid in one lump sum to the parent's legal heirs.

iv. We will only accept one claim under this Benefit 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.

Claims Documents for Section C.1.8:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of injury)
- Proof of relation such as passport, birth certificate school/college leaving certificate of Insured Person

C.1.9 Base Benefit: Accidental Hospitalization Expenses Reimbursement Benefit

We will reimburse the Medical Expenses incurred in respect of the Insured Person for treatment of Injury sustained by the Insured Person in an Accident which occurs within the Period of Cover and solely and directly requires the Insured Person to be Hospitalized.

This Benefit shall be payable subject to the following:

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

ii. The Insured Person is admitted to the Hospital within 7 days of the occurrence of the Accident.

iii. We will reimburse only those Medical Expenses that are Reasonable and Customary Charges.

iv. We shall not be liable to make any payment in respect of any non-payable items, the list of which is attached to this Policy and is available on Our website www.icicilombard.com

v. We shall not be liable to pay any claim arising out of Hospitalization in any Hospitals that have been blacklisted by Us, the updated details of which will be available on Our website www.icicilombard.com. However, following an accident, expenses up to the stage of stabilization are payable but not the complete claim

vi. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable

vii. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

viii. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

Claims Documents for Section C.1.9:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary

C.1.10 Base Benefit: Accidental Hospitalization Daily Cash Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Certificate for each continuous and completed day of Hospitalization.

This Benefit shall be payable subject to the following:

i. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
ii. The Insured Person is admitted to the Hospital within 7 days of the occurrence of the Accident.
iii. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Certificate for each period of Hospitalization within the Period of Cover.
iv. Our liability to make any payment under this Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Certificate, if applicable.
v. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured and the maximum number of days as mentioned against this Benefit in the Policy Certificate.
vi. If We have admitted a claim under this Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Benefit directly to the Hospital where the Insured Person was treated provided that We are able to offer Cashless Facility at that Hospital.

Claims Documents for Section C.1.10:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary
- Certificate from Medical Practitioner

C.1.11 Base Benefit: Common Carrier Accident 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 suffers an Injury due to an Accident to the Common Carrier on which the Insured Person is travelling during the Period of Cover and that Injury solely and directly results in the Insured Person's death or Permanent Total Disablement. We will only accept one claim under this Benefit in respect of the Insured Person.

On the acceptance of a death claim under this Benefit, all cover under this Policy in respect of the Insured Person shall immediately and automatically cease.

On the acceptance of a Permanent Total Disablement claim under this Benefit, all subsequent coverages under this Benefit and Benefit C.1.1 (Death Benefit), C.1.2 (Permanent Total Disablement (PTD) Benefit) & C.1.3 (Permanent Partial Disablement (PPD) Benefit) in respect of the Insured Person shall immediately and automatically cease.

However, insurance cover under any other applicable Benefits under this Policy in the present Period of Cover shall continue subject to the availability of the Sum Insured and the terms, conditions and exclusions of the Policy.

Claims Documents for Section C.1.11:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of injury)
- Proof of Travel (Ticket or boarding pass)

C.1.12 Base Benefit: Loan Protection Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the death or the Permanent Total Disablement of the Insured Person, then We will pay an amount equal to the principal outstanding amount as on the date of Accident in respect of the Insured Person's outstanding Loan specified in the Policy Certificate.

This Benefit shall be payable subject to the following:

i. We will make payment under this Benefit in accordance with the amortization schedule (as on Loan disbursement or the actual amount outstanding on the date of the Accident, whichever is less).
ii. If the Sum Insured under this Benefit is less than the Insured Person's outstanding Loan amount on the date of the Accident, then Our liability under this Benefit shall be reduced proportionately and shall in any event not exceed the Sum Insured.
iii. Any payments that are overdue and unpaid by the Insured Person prior to the occurrence of the Accident will not be considered for the purpose of this Benefit and shall be deemed as paid by the Insured Person and our liability shall be restricted to the principal outstanding amount on the date of loss as per the details mentioned on the original amortization schedule issued at the time of loan disbursal by the financer.
iv. 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.

Claims Documents for Section C.1.12:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of injury)
- Loan Sanction Letter & Loan Disbursement Letter
- Original amortization schedule on disbursal letter, statement of account as on date of loss

C.1.13 Base Benefit: Assault Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if the Insured Person suffers an Injury due to an Accident which is a violent crime or Assault that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized for more than 2 days.

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.

Claims Documents for Section C.1.13:

- Claim Form
- MLC
- FIR
- Police Final Charge Sheet
- Spot / Inquest Panchnama
- Hospital Discharge Summary
- Indoor case papers, if available

C.1.14 Base Benefit: Mysterious Disappearance Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in the manner specified in the Policy Certificate if the Insured Person has, due to an accident to the common carrier in which he was travelling during the period of the cover, disappeared and is not heard of for more than 365 days from the date of the accident.

This Benefit shall be payable subject to the following:

i. The Insured Person's disappearance is certified in writing by the police authorities.
ii. We shall not be liable to make any payment under this Benefit if the Common Carrier on which the Insured Person was travelling was a private taxi, yacht, charter airline or a rented car.
iii. On the acceptance of a claim under this Benefit, all cover under this Policy shall immediately and automatically cease in respect of that Insured Person.
iv. If after payment of claim under this Benefit, the Insured Person is found to be alive, We reserve the right to recover in full from the Nominee/legal heir of the Insured Person the amount paid under this Benefit as well as stop any future payments due in respect of this Benefit.

Claims Documents for Section C.1.14:

- Claim Form
- FIR (Police certificate confirming disappearance)
- Police Final Charge Sheet
- Spot / Inquest Panchnama

C.1.15 Base Benefit: Reconstructive Surgery Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in respect of the Insured Person, for treatment of Injury sustained in an Accident which occurs within the Period of Cover and solely and directly requires the Insured Person to be Hospitalized and undergo Reconstructive Surgery.

Reconstructive Surgery would mean surgery to reconstruct cutaneous or underlying tissue, prescribed as necessary, by a physician.

This Benefit shall be payable subject to any reconstructive surgery:

i. Prescribed as necessary, by a physician.
ii. Arising solely and directly out of a sustained bodily injury, in an accident
iii. Performed by a registered and licensed cosmetic / reconstructive surgeon
iv. Taking place within six months from the date of the Accident

The Insured Person's stay in a hospital should continue for a minimum period of 2 successive days.

Claims Documents for Section C.1.15:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary

C.1. 16 Base Benefit: Catastrophic Evacuation Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in the manner specified in the Policy Certificate if the Insured Person suffers an accidental injury, requiring Hospitalization during a catastrophic evacuation.

Catastrophic evacuation means an emergency exit due to natural calamities

Claims Documents for Section C.1.16:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary

C.1.17 Base Benefit: Physical Rehabilitation Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in respect of the Insured Person, for treatment of Injury sustained in an Accident which occurs within the Period of Cover and solely and directly requires the Insured Person to undergo Physical Rehabilitation within 8 weeks from the date of the accident.

Physical Rehabilitation means a treatment/therapy by a licensed physical therapist who remediates impairments and promotes mobility and function by using mechanical force & movements, manual therapy, exercise therapy and electrotherapy.

This Benefit shall be payable subject to the following:

i. Any such therapy or treatment must be approved by the treating medical practitioner/surgeon
ii. Any physical or mechanical therapy that is arising solely and directly out of a sustained bodily injury, in an accident

Claims Documents for Section C.1.17:

- Claim Form
- Complete Medical bills containing the expenses incurred on Physical Rehabilitation
- Certificate from treating doctor stating the need for Physical Rehabilitation

Certificate from the Physical Therapist certifying the course of treatment

C.1.18 Base Benefit: Loss of Job Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in the manner specified in the Policy Certificate if the insured person loses his job on account of an Injury due to an Accident resulting in Permanent Total Disablement or Permanent Partial Disablement during the Policy Period

This Benefit shall be payable subject to the following:

i. The Insured Person is employed on the direct payroll of an organization or entity having a registered office in India or of an Indian branch of such organization or entity, for a minimum of six continuous months before the Risk Inception Date
ii. The onus of establishing that the loss of Job was due an injury to the Insured during the Policy Period, solely and directly resulting in the Insured Person's suffering Permanent Total Disablement or Permanent Partial Disablement and providing proof of such reason where required by Us, shall lie on the Insured Person/claimant. Any form of self resignation shall not be admissible.
iii. Once a claim has been considered admissible and payable by Us under this Section, any subsequent Renewal of the cover under this Section will be solely as per Our discretion, on a case to case basis.

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Claims Documents for Section C.1.18:

- Documentation requirement mentioned against Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) or C.1.3 (Permanent Partial Disablement (PPD) Benefit) (As per the nature of injury)
- Certificate from the employer of the Insured confirming the termination / dismissal, with the reasons for the same. Appointment letter
- Last 3 Months Salary Slip
- Form 16
- Contact details of employer-phone no. mobile no., email ID, contact person in HR/Admin/Personnel dept. Appointment letter Employer if Re employed

C.1.19 Base Benefit: Recovery Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in respect of the Insured Person if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that solely and directly results in hospitalization of the insured person requiring the insured person to be hospitalised for at least 5 continuous days.

For the purpose of this Benefit, the payout is, as specified in the table below:

Continuous Hospitalization for atleast	% of Sum Insured Payable
5 Days	25
10 Days	Additional 25
15 Days	Additional 50

For the purpose of an example, let us consider an Insured Person, having a Sum Insured of Rs. 100,000 under this benefit, suffers an Injury due to an Accident that occurs during the Period of Cover and that solely and directly results in 4 days of hospitalization of the insured person. No benefit shall be payable.

However, in case he is Hospitalized for 7 days, we shall be liable to pay him 25%, Rs. 25,000 for the first continuous 5 days of Hospitalization,

If in case he is Hospitalized for 12 continuous days, We shall be liable to pay him 50%, Rs. 50,000 for the first 10 continuous days of Hospitalization.

This Benefit shall be payable subject to the following:

i. We will accept multiple claims under this Benefit during the Period of Cover in respect of the Insured Person. However Our maximum, total and cumulative liability for claims arising in respect of the Insured Person under this Benefit during the Period of Cover shall be the Sum Insured as specified against this Benefit in the Policy Certificate.
ii. Our maximum liability under this cover shall be the sum insured mentioned against this benefit in the policy certificate

Claims Documents for Section C.1.19:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary

C.1.20 Base Benefit: Diagnostic Test Benefit

We will reimburse the expenses incurred upto the Sum Insured, as specified against this Benefit in the Policy Certificate, in the manner specified in the Policy Certificate if the Insured Person suffers an injury due to an Accident during the Policy Period and needs to undergo an imaging diagnostic test which includes X-Rays, CT Scan, MRI or Ultrasonography tests, Within 7 days from the date of accident. This Benefit shall be payable subject to the following:

Any such tests must be done to diagnose an injury due to an accident and should be prescribed by a registered medical practitioner/surgeon

Claims Documents for Section C.1.20:

- Claim Form
- Prescription from the treating doctor indicating the diagnostic tests to be undertaken
- Complete Medical bills containing the expenses incurred on Diagnosis

Reports of the diagnostic tests

C. 2. 1 Extension Benefit: Lifestyle Support Benefit

We will pay a lump sum amount which is equal to the claim amount that would be payable under Benefit C.1.2 or C.1.3 (if a claim is accepted under that Benefit) to the Insured Person towards modification of home, office and / or vehicle or towards purchase of an Artificial Limb or any prosthesis or any other expenses because of Permanent Total Disablement or Permanent Partial Disablement caused due to an accident. However, Our liability for payment of all claims under this Benefit in aggregate for Period of Cover shall in no case exceed the Sum Insured for this Benefit as specified in the Policy Certificate.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) or C.1.3 (Permanent Partial Disablement (PPD) Benefit) in respect of that Insured Person.
ii. We will accept only one claim under this Benefit in the lifetime 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.

Claims Documents for Section C.2.1:

- Documentation requirement mentioned against Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) or against Benefit C.1.3 (Permanent Partial Disablement (PPD) Benefit)

C.2.2 Extension Benefit: Last Rites Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death, We will pay the Sum Insured specified against this Benefit in the Policy Certificate towards the cost of the last rites of the Insured Person and/or transporting the mortal remains (including ash) from the place of death to the residence of the Insured Person.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit C.1.1 (Death Benefit) in respect of that Insured Person.

Claims Documents for Section C.2.2:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit)
- All original bills associated with the repatriation expenses

C.2.3 Extension Benefit: Counseling Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's death or Permanent Total Disablement, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of the expenses incurred on professional counselling in respect of the Insured Person or the Nominee/legal heir (as the case may be) provided that We have accepted a claim under Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit).

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.

Claims Documents for Section C.2.3:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of Injury)
- Proof of counselling sessions along with councillor's prescription or certificate

C.2.4 Extension Benefit: Repatriation in case of Permanent Disability Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Permanent Total Disablement of the Insured Person, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of transporting the Insured Person from the place of Accident or Hospitalization to the residence of the Insured Person.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) in respect of that Insured Person.
ii. The Accident occurred in a location that is not the city/place of residence of the Insured Person.
iii. 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.

Claims Documents for Section C.2.4:

- Documentation requirement mentioned against Benefit C.1.2 Permanent Total Disablement (PTD) Benefit)
- All original bills associated with the repatriation expenses

C.2.5 Extension Benefit: Accidental Pre & Post Hospitalization Expenses Benefit

We will reimburse the Pre-hospitalization Medical Expenses (due to an injury arising out of an accident) incurred for up-to 7 days immediately preceding the Hospitalization of the Insured Person and the Post-hospitalization Medical Expenses incurred for up-to 60 days immediately following the Insured Person's discharge from Hospital.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit C.1.9 (Accidental Hospitalization Expenses Benefit) in respect of the Insured Person.
ii. We will reimburse only those Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses that are Reasonable and Customary Charges.
iii. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due

under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.

Claims Documents for Section C.2.5:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Discharge Summary
- All receipts & bills related to pre and post Hospitalization
- Certificate from Medical Practitioner

C.2.6 Extension Benefit: Air Ambulance Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of Air Ambulance services for transportation of the Insured Person from the site of the Accident to the nearest Hospital or from the site of first treatment to a higher center of care where the Insured Person is being treated to the nearest Hospital.

This Benefit shall be payable subject to the following:

i. The transportation is required to stabilise the condition of the Insured Person and the Insured Person is alive while boarding the Air Ambulance.
ii. The Air Ambulance services are availed within 7 days from the date of the Accident.

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.

Claims Documents for Section C.2.6:

- Claim Form
- MLC or FIR
- Discharge Summary
- All receipts related to availment of any Ambulance services
- Certificate from Medical Practitioner mentioning the requirement of Air Ambulance services

C.2.7 Extension Benefit: Comatose Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in the Insured Person being in a Coma within 30 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. We will only accept one claim under this Benefit during in the lifetime 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.

Claims Documents for Section C.2.7:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary
- Certificate from Medical Practitioner mentioning the neurological condition of the insured

C.2.8 Extension Benefit: Broken Bones Benefit

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Certificate) in the manner which is specified in the table below if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely, directly and immediately results in a fracture (of the nature specified in the table below).

Sr No.	Region	Fracture	% of the Sum Insured payable
1	Skull	Compound fractures of skull with damage to the brain tissue	100%
		All other fractures	75%
2	Lower jaw	Multiple fractures (at least one compound fracture)	75%
		Compound fracture	50%
		All other fractures	25%
3	Shoulder blade, kneecap, sternum, hand (excluding fingers and wrist), foot (excluding toes and heel)	Multiple fractures (at least one compound fracture)	75%
		Compound fracture	50%
		All other fractures	25%
4	Upper arm (including elbow and wrist)	Multiple fractures (at least one compound fracture)	75%
		Colles type fracture (compound)	50%
		All other fractures	25%
5	Spinal cord	All compression fractures	30%
		All spinous, transverse process or pedicle fractures	25%
		All other vertebral fractures	20%
6		Multiple fractures (at least one compound)	50%

	Rib or ribs, cheekbone, coccyx, upper jaw, nose, toe and toes, finger or fingers	Compound fracture	25%
		All other fractures	20%
7	Thigh or heel:	Multiple fractures (at least one compound)	50%
		Compound fracture	25%
		All other fractures	20%
8	Hip or pelvis (excluding thigh or coccyx):	Multiple fractures (at least one compound)	50%
		Compound fracture	25%
		All other fractures	20%
9	Lower leg, clavicle, ankle,	Multiple fractures (at least one compound)	50%
		Compound fracture	25%
		All other fractures	20%

This Benefit shall be payable subject to the following:

i. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.
ii. On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this Benefit and the Policy shall continue, subject to the availability of the Sum Insured and the terms, conditions and exclusions of this Policy.
iii. We will be liable to pay a claim under this Benefit only if the Insured Person is taken to a medical care facility where he/she is diagnosed for the above mentioned fractures by a Medical Practitioner.

Claims Documents for Section C.2.8:

- Claim Form
- Indoor Case Papers (In case of Hospitalization), if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital
- Certificate from Medical Practitioner

C.2.9 Extension Benefit: Compassionate Visit Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of the expenses incurred on tickets on a Common Carrier for an Immediate Family Member of the Insured Person to travel to the place of death or Hospitalization of the Insured Person

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit C.1.1 (Death Benefit), Benefit C.1.2 (Permanent Total Disablement (PTD) Benefit) or Benefit C.2.8 (Broken Bones Benefit) (where the percentage of the Sum Insured payable is at least 50%) in respect of the Insured Person.
ii. The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence.
iii. The Medical Practitioner treating the Insured person recommends in writing the personal attendance of an Immediate Family Member.
iv. 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.

Claims Documents for Section C.2.9:

- Claim Form
- MLC or FIR
- All receipts related to availment of any Travel Service through a licensed Common Carrier

C.2.10 Extension Benefit: Burns Benefit

We will pay the percentage of the Sum Insured (specified against this Benefit in the Policy Certificate) which is specified in the table below if an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly results in a Second Degree Burns or Third Degree Burns (of the nature specified in the table below).

	Losses Covered	**% of the Sum Insured payable**
1)Head, Face and Neck	a) Third degree burns	100%
	b) Second degree burns of 10% or more of the total head surface area	75%
	c) Second degree burns of 3% or more, but less than 10% of the total head surface area	25%
2) Rest of Body	a) Third degree burns of 25% or more of the total body surface area	100%
	b) Second degree burns of 25% or more of the total body surface area	75%
	c) Second degree burns of 10% or more, but less than 25% of the total body surface area	50%
	d) Second degree burns of 5% or more, but less than 10% of the total body surface area	25%

For the purpose of this Benefit, **Burns** mean an injury caused by exposure to heat or flame including chemical and electric burns. **Second Degree Burns** involve the epidermis and part of the dermis layer of skin and are also known as partial burns. **Third Degree Burns** mean 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. **First Degree Burns** are not covered under this Policy.

This Benefit shall be payable subject to the following:

i. If a claim is accepted under this Benefit in respect of an Insured Person and the amount due under this claim and claims already admitted under the Benefit in respect of the Insured Person will cumulatively lead to the Sum Insured being exceeded then Our maximum, total and cumulative liability under any and all such claims will be limited to the Sum Insured.
ii. On the acceptance of a claim under this Benefit, the Insured Person's insurance cover under this Benefit and the Policy shall continue, subject to the availability of the Sum Insured and the terms, conditions and exclusions of this Policy.

Claims Documents for Section C.2.10:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital
- Certificate from Medical Practitioner mentioning the details of the burns injury suffered by the insured

C.2.11 Extension Benefit: Ambulance Charges Benefit

If an Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and that Injury solely and directly requires the Insured Person to be Hospitalized, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of road Ambulance Services for transportation of the Insured Person from the site of the Accident to the nearest Hospital or from the site of first treatment to a higher center of care.

This Benefit shall be payable subject to the following:

i. The transportation is recommended in writing by a Medical Practitioner.
ii. 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.

Claims Documents for Section C.2.11:

- Claim Form
- Discharge Summary
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of

Admission and Discharge from the Hospital
- All receipts related to availment of any Ambulance services
- Certificate from Medical Practitioner

C.2.12 Extension Benefit: Chauffeur Cash Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in the manner specified in the Policy Certificate for the hire of a taxi or chauffeur driven car, if the Insured Person suffers an Accidental injury during the Policy Period such that he suffers from Temporary Total Disablement and unable to attend his/her business commitments (as a result of the accidental bodily injury)

This Benefit shall be payable subject to the following:

i. The Insured Person need to follow proper medical advice from a physician after sustaining the bodily injury
ii. The hire of a taxi or chauffeur driven car should be necessitated out of a sustained bodily injury, in an accident
iii. Presentation of bill(s) proving the usage of such services by the insured

Claims Documents for Section C.2.12:
- Documentation requirement mentioned against Benefit C.1.4 (Temporary Total Disablement (TTD) Benefit)
- Bills certifying use of Taxi or Chauffeur services

C.2.13 Extension Benefit: Skill Development Benefit

If the Insured Person suffers an Injury due to an Accident that occurs during the Period of Cover and solely and directly results in the Insured Person's Death or Permanent Total Disablement or Permanent Partial Disablement, We will pay the Sum Insured specified against this Benefit in the Policy Certificate in respect of the expenses incurred towards enrolment in any skill development course.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) or C.1.3 (Permanent Partial Disablement (PPD) Benefit) in respect of that Insured Person.
ii. The coverage is applicable to either the Insured Person in case of Permanent Total Disablement or Permanent Partial Disablement of the Insured Person or to the immediate family member in case of Death of the Insured Person

Claims Documents for Section C.2.13:
- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of injury)
- Relevant bills to confirm enrolment in a skill development course

C.2.14 Extension Benefit: On Duty Enhanced Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in the manner specified in the Policy Certificate towards additional coverage while being on duty, if the Insured suffers an Injury due to an Accident On Duty during the Period of Cover and that Injury solely and directly results in the Insured's Person's death or Permanent Total Disablement within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) in respect of that Insured Person.
ii. The Employer shall certify that such Accidental Injury has occurred while the Insured Person was On Duty
iii. We will accept only one claim under this Benefit 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.

Claims Documents for Section C.2.14:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of injury)
- Certificate from the employer establishing that the insured person was Employed and On-Duty at the time of accident

C.2.15 Extension Benefit: Home Tuition Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in the manner specified in the Policy Certificate towards the Home Tuition Fees if the Insured's Dependant Child (if covered under this policy) suffers an injury during the Policy Period which solely and directly results in his Temporarily Total Disablement**.**

Home Tuition Fees means the costs for a fully registered and licensed teacher to continue the education of the Insured Dependant Child at home, during his Temporary Total Disablement.

This Benefit shall be payable subject to the following:

i. We shall not be liable to make any payment under this Benefit in respect of the Insured Person for more than the total number of weeks specified in the Policy Certificate for any and all claims arising within the Period of Cover under this Benefit.
ii. If the Injury is sustained to or suffered in relation to the spine and its muscular girdle, ligamentous system, cartilage, nervous system and blood supply to the spine which is not detectable by means of radiological scanning, imaging, or neurological fallout testing, then Our liability under this Benefit shall extend for a maximum period of five (5) weeks.
iii. In the event of any dispute as to the date when the Temporary Total Disablement ceased, such date shall be finally determined by an external Medical Practitioner approved by Us who certifies either:
    a. the date upon which the Insured Person recovered; or
    b. the date upon which the Insured Person recovered as far as he/she will ever recover.
iv. If the Insured Person is disabled for a part of a week, then only a proportionate part of the weekly amount will be payable in respect of that week.

Claims Documents for Section C.2.15:

- Documentation requirement mentioned against Benefit C.1.4 (Temporary Total Disablement (TTD) Benefit)
- Relevant bills to confirm engagement of Home Tuition services

C.2.16 Extension Benefit: Outstanding Bills Payment Benefit

We will pay the Sum Insured, specified against this Benefit in the Policy Certificate, in the manner specified in the Policy Certificate towards the actual costs of outstanding medical insurance premium, electricity and telephone bills or any other utility bills that are unpaid at the time of accident, if the Insured suffers an Injury due to an Accident during the Period of Cover and that Injury solely and directly results in the Insured's Person's death or Permanent Total Disablement within 365 days from the date of the Accident.

This Benefit shall be payable subject to the following:

i. We have accepted a claim under Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) in respect of that Insured Person
ii. Our maximum and cumulative liability shall be the Sum Insured as specified against this Benefit in the Policy Certificate
iii. We will only accept only one claim under this Benefit 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.

Claims Documents for Section C.2.16:

- Documentation requirement mentioned against Benefit C.1.1 (Death Benefit) or C.1.2 (Permanent Total Disablement (PTD) Benefit) (As per the nature of injury)
- Copies of outstanding medical insurance premium, electricity and telephone bills

C.2.17 Extension Benefit: Major Surgery Benefit

We will pay the Sum Insured specified against this Benefit in the Policy Certificate, in respect of the Insured Person for treatment of Injury sustained by the Insured Person in an Accident which occurs within the Period of Cover and solely and directly requires the Insured Person to be Hospitalized and undergo a Major Surgery.

This Benefit shall be payable subject to the following:

i. We will be liable to pay only for a Major Surgery
ii. No benefit payable in any respect of any insured person for:
    a. Congenital anomalies and conditions arising therefrom
    b. Pregnancy, child birth, miscarriage or abortion or any female organs disease
    c. Any hospital, surgical treatment or procedure as the result of sickness within 90 days of the policy start date
    d. Cosmetic or plastic surgery
    e. Any infection occurring during in-patient care
    f. Any hospital, surgical treatment or procedure on adenoids or tonsils 180 days of the policy start date

g. Any surgery not arising out of an accident

For the purpose of this benefit, **Major Surgery** shall mean a surgical procedure performed under General Anesthesia and requiring continuous Hospitalization of atleast 2 days.

Claims Documents for Section C.2.17:

- Claim Form
- Indoor Case Papers, if available
- MLC or FIR
- All Diagnostic Reports
- Complete Hospital bills
- Discharge Summary
- In case of incomplete and / or inconclusive Discharge Summary, Certificate from Treating Doctor (under whom the insured was admitted) mentioning the details of Diagnosis, Investigations and Date & Time of Admission and Discharge from the Hospital
- Certificate from Medical Practitioner

SPECIFIC EXCLUSIONS AND LIMITATIONS APPLICABLE TO SECTION C (Except Benefit C.1.9 and C.2.5)

We shall not be liable to make any payment for any claim under Section C (Except Benefit C.1.9 and C.2.5) of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

1. War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.

2. Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution.

3. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world.

4. Breach of law or while being involved in any unlawful activity.

5. Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide.

6. Any Injury / Illness arising whilst under the influence of alcohol or intoxicating drugs or substance abuse of any kind.

7. Any Injury / Illness occurring whilst working in underground mines or explosives magazines, or involving electrical installation with high tension supply, or as jockeys or circus personnel

8. Injury sustained whilst engaging in Adventure Sports (This exclusion shall not apply if Benefit C.1.5 is in force for the Insured Person)

9. Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought.

10. Expenses incurred on eyeglasses, contact lenses, hearing aids and examination for the prescription or fitting thereof.

11. Any Illness, complication or ailment not arising out of or connected to Injury.

12. Payment of compensation in respect of death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization of the Insured Person resulting directly from, or indirectly caused by, or contributed to or aggravated or prolonged by, childbirth or pregnancy or in consequence thereof.

13. Death, disablement (whether of a permanent nature or of a temporary nature), Injury, Illness or Hospitalization arising from or caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.

14. Any Hospitalization consequent to any condition arising from or traceable to any disease of the organs of generation, malignant disease of mammary gland, pregnancy, childbirth, abortion or miscarriage or any complications and/or sequels arising from the foregoing.

15. Circumcision or strictures, vaccination, inoculation, sex change, beauty treatment of any description, intentional self-Injury, (which expression shall cover also general debility, "run down" conditions), venereal disease, use of intoxicating drugs, or any Illness, Injury, death or disablement directly or indirectly due to any one or more of them.

16. Dental treatment, eye treatment and plastic surgery unless medically necessitated as a consequence of an Injury sustained in an Accident during the Period of Cover.

17. Any Hospitalization not arising out of an Injury sustained in an Accident during the Period of Cover.

18. Medical Expenses not incurred as a direct result of the Injury sustained in an Accident during the Period of Cover.

19. Routine medical, dental, eye and ear examinations.

20. All cosmetic/aesthetic surgeries including but not limited to lasik surgery.

21. Any medical examination or diagnostics or Hospitalization for the sole purpose of investigation or employment or travel:

22. Any Injury sustained while working professionally with any animals reptiles or insects.

23. Any Injury or Illness of any kind caused or infected by or transmitted by or in any way attributed to virus, parasite, bacteria or any microorganism including where the virus, parasite, bacteria or any other microorganism is introduced and/ or caused by bites of insects, reptiles, animals and/or other vector.

24. Any Medical Expenses not incurred in a Hospital as defined in the Policy Wordings.

EXCLUSIONS APPLICABLE TO BENEFITS C.1.9 and C.2.5

We shall not be liable to make any payment for any claim under Benefits C.1.9 and C.2.5 of this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

i. STANDARD EXCLUSIONS -

- **Unproven Treatment (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.
- **Maternity (Code - Excl 18):**
    - Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    - Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period;
- **Sterility and Infertility (Code - Excl 17):** Expenses related to , sterility and infertility.

  This includes:
    - Any type of contraception, sterilization
    - Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    - Gestational Surrogacy
    - Reversal of sterilization.
- **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.
- **Investigation & Evaluation (Code - Excl 04):**
    - Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;
    - Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.
- **Hazardous or Adventure Sport (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.

- **Breach of Law (Code – Excl 10):** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

- Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code – Excl 12)**

- **Rest Cure, rehabilitation and respite care (Code – Exc 05):**

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

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

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

- Treatment received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons **(Code – Excl 13)**

- Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as a part of hospitalization claim or day care procedure **(Code – Excl 14)**

- **Excluded Providers (Code – Excl 11)**

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

ii. SPECIFIC EXCLUSIONS –

- All dental treatment or dental surgery of any kind unless necessitated due to an Accident

- Routine medical, dental, eye and ear examinations is not covered unless specifically covered and specified in the Policy Certificate.

- Any Injury that has occurred prior to the commencement of Policy of Cover whether or not the same has been treated, or medical advice, diagnosis, care or treatment has been sought. Any Illness, complication or ailment arising out of or connected to such Injury

- Any external congenital anomalies.

- Any Injury / Illness occurring whilst engaging in any Adventure Sports as an Amateur. Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world

- War, invasion, act of foreign enemy hostilities or warlike operations (whether war be declared or not) or civil commotion or rebellion, revolution, insurrection, mutiny, arrests, detainments of all kinds and political gatherings, engaging in aviation other than as a passenger (fare paying or otherwise) in any licensed standard type of aircraft.

- Any Injury sustained while performing duty in army, navy, air force, paramilitary force, police or any other such institution.

- Any event which occurs whilst the Insured Person is operating or learning to operate any aircraft or common carrier, or performing duties as a member of the crew on any aircraft, or scheduled airlines or is engaging in aviation, or whilst the Insured Person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any scheduled airline anywhere in the world

- Any Injury / Illness arising from intentional self- Injury, suicide or attempted suicide.

- Any Illness, complication or ailment not arising out of or connected to Injury

BASIS OF ASSESSMENT OF CLAIM

The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the procedures and requirements in relation to claims, shall be Conditions Precedent to Our liability under this Policy**.**

We shall not be liable to make any payment for any claim under this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to negligence on part of the Insured person.

The Claim documents required for the assessment of claims have been provided under the respective Sections. All documents mentioned under the respective sections are mandatory and if required and at the discretion of the Company, additional documents may be called for the final claim settlement.

We shall be given notice of any event that may give rise to a claim on toll free number 1800 2666 or on our website www.icicilombard.com or also in writing at Our address specified in the Policy Certificate:

All claims shall be made within the timelines and in accordance with the procedures set out in the relevant Sections of the Policy. All claims documentation specified within the relevant Section of the Policy for the Benefit being claimed must be submitted in full.

If any claim is not made within 30 days of the Insured Event, then We will condone such delay on merits only where the delay has been proved to be for reasons beyond the claimant's control.

We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such claim. If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's Injury/Illness and treatment and to investigate the facts surrounding the claim.

Our medical or other representative shall be allowed to examine the Insured Person on the occurrence of any alleged Injury or disablement when and as often as the same may reasonably be required on behalf of Us. Such evidence as We may require from time to time shall be furnished and a post-mortem examination report, be furnished within a period of thirty days.

. All claims will be investigated (as required) and settled in accordance with the applicable regulatory guidelines, including the IRDAI (Protection of Policyholders Interests) Regulations, 2017.

NOTE:-

Please inform us immediately of any change in the address, occupation, state of health, or of any other changes affecting the Insured Person (or his Nominee/ legal heir, as the case may be)

Terms of Renewal

- 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 Injury or Accident or Illness or Hospitalization that occurred during the Grace Period.

- You shall on tendering any premium for the Renewal of this Policy give notice in writing to Us of any disease, physical defect or infirmity with which any of the Insured Person(s) have become affected since the expiring Policy start date.

POLICY RELATED TERMS AND CONDITIONS

- Proof satisfactory to Us shall be furnished of all matters upon which a claim is based. Any medical or other agent of Us shall be allowed to examine the Insured Person(s) on the occasion of any alleged Injury or disablement when and as often as the same may reasonably be required on behalf of Us and in the event of death evidence as We may require from time to time shall be furnished including a post-mortem examination report.
- You shall give immediate notice to Us of any change in any of the business or occupation of the Insured Person.
- Any change in the policy terms and conditions including but not limited to sum insured and/or coverage shall will not be permitted within the Period of Cover.
- In case the customer chooses to pay the premium in installments then he/she shall not be able to change the frequency of payments within the Period of Cover.
- In case the customer has opted for auto renewal, the policy shall be Renewed with the same policy terms & conditions including but not limited to the sum insured, coverage, premium paying terms and claim payment terms and policy terms & conditions.

- We shall make payment to assignee/partial assignee/conditional assignee, as the case may be or in the absence of assignee to the Insured Person or the Insured Person's nominee. If there is no assignee or nominee and the Insured Person is incapacitated or deceased, We will pay to the Insured Person's heir, executor or validly appointed legal representative. For Sections A & B the Insured Person shall have the right to migrate from this Policy to a similar individual health insurance policy, if available with Us.

PART III OF THE POLICY SCHEDULE

GENERAL TERMS & CLAUSES –

i. STANDARD GENERAL TERMS AND CLAUSES -

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

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

2. **Condition Precedent to Admission of Liability**
The terms and conditions of the policy must be fulfilled by the Insured person for the Company to make any payment for claim(s) arising under the policy.

3. **Claim Settlement (provision for Penal Interest)**
- The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document
- In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate
- However, when the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document, In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
- In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.
("Bank rate" shall mean the rate fixed by the Reserve Bank of lndia (RBl) at the beginning of the financial year in which claim has fallen due)

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

5. **Fraud**
- lf any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the

insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

- Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
- For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:
    - a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
    - b) the active concealment of a fact by the insured person having knowledge or belief of the fact;
    - c) any other act fitted to deceive; and
    - d) any such act or omission as the law specially declares to be fraudulent
- The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer

6. Multiple Policies

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

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

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

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

8.

7. Free look period

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

The insured person shall be allowed free look period of fifteen days (30 days if the Policy is sold through distance marketing) from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

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

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

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

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

8. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policyatleast3O days before the policy renewal date as per IRDAI guidelines on Migration. lf such person is presently covered and has been continuously covered without any lapses under any health insurance producuplan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

9. Portability

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

For Detailed Guidelines on portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

10. Cancellation

a) The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

Refund Grid Applicable

	% of Premium refund

Day of cancellation	Policy Period		
	1 year	2 years	3 years
From 16 days to 1 month	75.0%	80.0%	80.0%
Above 1 month to 3 months	60.0%	70.0%	75.0%
Above 3 months to 6 months	40.0%	60.0%	70.0%
Above 6 months to 9 months	20.0%	50.0%	60.0%
Above 9 months to 12 months	0.0%	40.0%	55.0%
Above 12 months to 15 months		30.0%	45.0%
Above 15 months to 18 months		20.0%	40.0%
Above 18 months to 21 months		10.0%	35.0%
Above 21 months to 24 months		0.0%	25.0%
Above 24 months to 27 months			20.0%
Above 27 months to 30 months			10.0%
Above 30 months to 33 months			5.0%
Above 33 months to 36 months			0.0%

* Full refund shall be applicable if cancellation is within the Free Look Period

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of the Insured Person where any claim has been admitted by Us or has been lodged with Us or any Benefit has been availed by the Insured Person under the Policy.

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

11. Renewal of Policy

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

- The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

- At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- No loading shall apply on renewals based on individual claims experience

12. Withdrawal of Policy

- In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period. as per IRDAI guidelines, provided the policy has been maintained without a break

13. Moratorium Period

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

14. Premium Payment in installments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 7 days would be given to pay the instalment premium due for the policy.

ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.

iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

iv. No interest will be charged If the instalment premium is not paid on due date

i. In case of instalment premium due not received within the grace period, the policy will get cancelled.
ii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

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

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

16 .Redressal of Grievance

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

Website: www. icicilombard.com (Customer Support section).

Toll Free: 1800 2666 (Senior Citizen Included)

In case you are a senior citizen, your call shall be transferred to the Priority Desk and immediate support shall be provided

E-mail: customersupport@icicilombard.com

Fax:91-40-66789768

Courier: To the Manager – Service Quality, ICICI Lombard General Insurance Company Limited, ICICI Lombard House 414, Veer Savarkar Marg, Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

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

lf lnsured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at-

Manager- Service Quality,
Corporate Manager- Service Quality,
National Manager- Operations & finally

Director-services and Business development at the following address:
ICICI Lombard General Insurance Company Limited,

ICICI Lombard House,

414, Veer Savarkar Marg,

Near Siddhi Vinayak Temple,

Prabhadevi, Mumbai 400025

For updated details of grievance officer, kindly refer the link https://www.icicilombard.com/grievance-redressallf lnsured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of lnsurance Ombudsman of the respective area/region for redressal of grievance as per lnsurance Ombudsman Rules 2017

The details of Insurance Ombudsman are available below:

S no.	Name of office of insurance Ombudsman	Territorial Area of jurisdiction
1	AHMEDABAD	Gujarat, Dadra & Nagar Haveli, Daman and Diu.

	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	
2	BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka
3	BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh.
4	BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
5	CHANDIGARH	Punjab,

	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.
6	CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
7	DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi
8	ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.

9	GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
10	HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 67504123 / 23312122 Fax: 040 – 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
11	JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@cioins.co.in	Rajasthan.
12	KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341	West Bengal, Sikkim, Andaman & Nicobar Islands.

	Email: bimalokpal.kolkata@cioins.co.in	
13	LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
14	MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
15	NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar,	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya,

	U.P-201301. Tel.: 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur
16	PATNA Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
17	PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org, on the website of General Insurance Council: www.general insurance council.org.in, and website of the company www.icicilombard.com or from any of the offices of the Company.

17. Nomination:

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the

nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

ii. SPECIFIC TERMS AND CLAUSES–

1. Change in Policy

Any change in the Policy terms and conditions including but not limited to Sum Insured and/or coverage shall not be permitted within the Policy Period. In case the customer chooses to pay the premium in installments then he/she shall not be able to change the frequency of payments within the Policy Period.

2. Material change

The Insured Person shall immediately notify the Company in writing of any material change in the risk and cause at his own expense such additional precautions to be taken as circumstances may require to ensure safe operation, trade or business practices thereby containing the circumstances that may give rise to the claim and We may, adjust the scope of cover and / or premium, if necessary, accordingly.

3. Records to be maintained

The Insured Person shall keep an accurate record containing all relevant particulars and shall allow Us to inspect such record.

4. Notice of Charge

We shall 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, but the payment by Us to the Insured Person, Nominee, assignee or his legal heirs of any amount under the Policy shall in all cases be an effectual discharge to Us.

5. Overriding effect of Policy Certificate

The terms and conditions contained herein and in the Policy Certificate shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in the Policy Certificate, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in the Policy Certificate and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

6.The Insured Person is not permitted to cancel only a portion of the Benefits available. If opting for cancelation, all Benefits under the Policy will be cancelled.

7. Scope of Cover

The Scope of Cover shall be worldwide unless specified otherwise in the Policy Certificate

8. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be adjudicated or interpreted in accordance with Indian Laws and only competent Indian courts shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

9. 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 to the dispute/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. 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 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.

10. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to: In case of the Insured Person, at the address specified in the Policy Certificate.

In case of Us:

ICICI Lombard General Insurance Company Limited, ICICI Lombard House,
414, Veer Savarkar Marg, Near Siddhi Vinayak Temple,
Prabhadevi, Mumbai 400 025

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

11. Customer Service

If at any time the Insured Person (or his Nominee/ legal heir, as the case may be) requires any clarification or assistance, they may contact Our offices at the address specified below, during normal business hours.

ICICI Lombard General Insurance Company Limited
ICICI Lombard House 414, Veer Savarkar Marg,
Siddhi Vinayak Temple, Prabhadevi, Mumbai 400025

OTHER TERMS AND CONDITIONS –

1. ENDORSEMENTS AVAILABLE UNDER THIS POLICY

Endorsement I: Premium Installment Clause

a. We will accept payment of the premium applicable taxes, charges, cess etc. in monthly/quarterly/semi-annual/annual installments as specified in the Policy Certificate provided that the Policyholder continues to perform and observe all their obligations hereunder.