Registered Office: Religare Health Insurance Company Limited, D-3, District Centre, Saket, New Delhi - 110017

PRODUCT NAME: GRAMEEN CARE-MICRO INSURANCE PRODUCT

Policy Terms & Conditions

For the purposes of interpretation and understanding of this Policy the Company has defined, below some of the important words used in this Policy. Words not defined below are to be construed in the usual English language meaning as contained in Standard English language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority of India ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, insurance coverage and exclusions, other benefits, various procedures and conditions which have been built in to the Policy are to be construed in accordance with the applicable provisions contained in the Policy.

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

1. Definitions

1.1. **Accidental / Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means

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

1.3. **Age** means the completed age of the Insured Member as on his last birthday

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

1.5. **Annexure** means the document attached and marked as Annexure to this Policy

1.6. **Any One Illness** means a continuous period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where the treatment may have been taken

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

1.8. **Cashless Facility** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the insurer to the extent pre-authorization approved

1.9. **Certificate of Insurance** means the certificate the Company issues to an Insured Member evidencing cover under the Policy

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

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

ii. It needs ongoing or long-term control or relief of symptoms

iii. It requires your rehabilitation or for you to be specially trained to cope with it

iv. It continues indefinitely

v. It comes back or is likely to come back

1.11. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment of Hospitalization Expenses or any benefit in respect of the Insured Member as covered under the Policy

1.12. **Company** (also referred as We/Us) means the Religare Health Insurance Company Limited

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

1.14. **Congenital Anomaly**

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

i. **Internal Congenital Anomaly**

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

ii. External Congenital Anomaly

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

1.15. **Contribution** is essentially the right of an insurer to call upon other insurers liable to the same Insured Member to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.

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

1.17. **Cover End Date** means the date specified in Annexure 'A' (Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy expires

1.18. **Cover Period** means the period commencing from the Cover Start Date and ending on the Cover End Date for each Insured Member as specified in Annexure 'A' (Certificate of Insurance)

1.19. **Cover Start Date:** means the date specified in Annexure 'A' (Certificate of Insurance) for the respective Insured Member on which the Insured Member's cover under the Policy commences

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

1.21. **Day Care Centre** means any institution established for day care treatment of Illness and/or injuries or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under—

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

1.22. **Day Care Treatment** means medical treatment, and/ or Surgical Procedure which is:

i. undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 hours because of technological advancement, and
ii. which would have otherwise required a Hospitalization of more than 24 hours.

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

1.23. **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.

1.24. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants

1.25. **Disclosure to information norm** means the Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact

1.26. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care or treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

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

1.27. **Emergency care (Emergency)** means management for a severe Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a Medical Practitioner to prevent death or serious long term impairment of the Insured Member's health

1.28. **Family** means a unit comprising of husband, wife, dependent parents, dependent parents-in-law and maximum of three children and who is named in the Certificate of Insurance as an Insured Member

1.29. **Grace Period** means the specified period of time immediately following the premium due date during which 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

1.30. **Hazardous Activities** mean any sport or activity, which is potentially dangerous to the Insured Member whether he is trained or not. Such sport/activity includes racing and competition or stunt activity of any kind, adventure racing, base jumping, biathlon, big game hunting, rafting of any kind, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, vave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling of any kind and activities of similar nature

1.31. **Hospital** means any institution established for In-patient Care and Day Care Treatment of Illness and/or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

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

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

iii. has qualified Medical Practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
v. maintains daily records of patients and makes these accessible to the Our authorized personnel.

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

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

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

1.35. **In-patient Care** means treatment for which the Insured Member has to stay in a Hospital for more than 24 hours for a covered event

1.36. **Insured Member (Insured)** means a member whose name specifically appears under Insured in the Certificate of Insurance and is a covered group member.

1.37. **Intensive Care Unit (ICU)** 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

1.38. **Maternity Expense / Treatment** shall include—
i. medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
ii. expenses towards lawful medical termination of pregnancy during the Policy Period.

1.39. **Medical Advice** means any consultation or advice from a Medical Practitioner including issue of any prescription or repeat prescription

1.40. **Medical Expenses** means those expenses that an Insured Member 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 Member had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment

1.41. **Medically necessary** means a treatment is defined as any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
i. Is required for the medical management of the Illness or Injury suffered by the Insured Member;
ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. Must have been prescribed by a Medical Practitioner;
iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India

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

1.43. **Network Provider** means the Hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an Insured Member on payment by a Cashless Facility

1.44. **New Born Baby** means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive

1.45. **Non-Network means** any Hospital, Day Care Centre or other provider that is not part of the network

1.46. **Notification of Claim (Intimation)** is the process of notifying a Claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified

1.47. **Out-Patient Treatment (OPD Treatment)** is one in which the Insured Member visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured Member is not admitted as a day care or in-patient

1.48. **Policy** means these Policy Terms & Conditions, the Proposal Form / data sheet, Policy Certificate and Annexures which form part of the policy contract and shall be read together

1.49. **Policy Certificate** is a certificate attached to and forming part of this Policy

1.50. **Policy Year** means a period of one year commencing on the Policy Period Start Date or any anniversary thereof

1.51. **Policyholder** also referred as You) means the member or entity, who is the Group Administrator and named in the Policy Certificate as the Policyholder

1.52. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date of the Policy as specifically appearing in the Policy Certificate

1.53. **Policy Period End Date** means the date on which the Policy expires, as specifically appearing in the Policy Certificate

1.54. **Policy Period Start Date** means the date on which the Policy commences, as specifically appearing in the Policy Certificate

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

1.56. **Post-hospitalization Medical Expenses** means Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required and

ii. The inpatient Hospitalization claim for such Hospitalization is admissible by the Company

1.57. **Pre-existing Diseases** means any condition, ailment or Injury or related condition(s) for which the Insured Member had signs or symptoms, and / or were diagnosed, and / or received Medical Advice / treatment within 48 months prior to the first Policy issued by the insurer

1.58. **Pre-hospitalization Medical Expenses** means Medical Expenses incurred immediately before the Insured Person is Hospitalized, provided that :

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

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

1.59. **Primary Insured Member** means a member of the group who satisfies and continues to satisfy the eligibility criteria as specified in Policy Certificate and who is named in Annexure 'A' (Certificate of Insurance) to the Policy as an Insured Member

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

1.61. **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

1.62. **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 all waiting periods

1.63. **Room Rent** shall mean the amount charged by a Hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated Medical Expenses

1.64. **Senior Citizen** means any person who has completed sixty or more years of age as on the date of commencement or renewal of a health insurance policy

1.65. **Subrogation** shall mean right of the insurer to assume the rights of the Insured Member to recover expenses paid out under the Policy that may be recovered from any other source

1.66. **Sum Insured** means the amount specified in the Policy Certificate which represents the company's maximum, total and cumulative liability for that Insured Member for any and all Claims incurred in respect of that Insured Member during the Cover Period

Whereas in case of Floater, **Sum Insured** means the amount specified in the Policy Certificate which represents the company's maximum, total and cumulative liability for all Insured Members for any and all Claims incurred during the Cover Period

1.67. **Surgery/Surgical Procedure** means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner

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

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

2. Scope of Cover

General Conditions applicable to all Benefits:

a) All Claims shall be payable subject to the terms, conditions, exclusions and wait periods of the Policy and subject to availability of the Sum Insured.
b) Claim under Benefit 1 (Hospitalization Expenses) can be admissible if treatment is taken in any of the Network Provider empanelled specifically for this Product (As per Annexure – III to Policy Terms & Conditions) and can be made on Cashless basis only as per Clause 4.2 (a).
c) Any Claim paid or payable for Benefit 1 (Hospitalization Expenses) shall reduce the Sum Insured of Benefit 1 (Hospitalization Expenses) for the Cover Period and only the balance shall be available for all the future claims for the unexpired Cover Period.
d) Admissibility of a Claim under Benefit 2.1.1 (In-patient Care) is a pre-condition to the admission of a Claim for Benefit 2.1.3 (Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses). The event giving rise to a Claim under Benefit 2.1.1 (In-patient Care) should occur within the Cover Period for the Claim to be accepted under Benefit 2.1.3 (Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses).
e) Claim documents as specified in Clause 4.3 is applicable to each and every claim. Additional Claim documents related to specific Benefit are mentioned against respective Benefit.
f) Any Claim made under Benefit 1 (Hospitalization Expenses) shall always be subject to Clause 4.5 (Claim Assessment).
g) Scope of cover under the Benefit 2 – Personal Accident is available only to Primary Insured Member.
h) Option of Mid-term inclusion of a Member in the Policy will be only upon marriage or childbirth.

2.1 Benefit 1: Hospitalization Expenses

If an Insured Member is diagnosed with an Illness or suffers an Injury (including pre-existing diseases covered from the inception of the Policy subject to exclusions as per Clause-3) which requires the Insured Member to be admitted in a Network Provider in India, which should be Medically Necessary, during the Cover Period and while the Policy is in force for:

2.1.1 In-patient Care

The Company will indemnify the Insured member for Medical Expenses incurred on Hospitalization up to the Sum Insured specified in the Policy Certificate provided that the Hospitalization is for a minimum period of 24 consecutive hours and was on the advice of a Medical Practitioner, and the Medical Expenses incurred are Reasonable and Customary Charges that were necessarily incurred.

2.1.2 Day Care Treatment

The Company will indemnify the Insured member for Medical Expenses incurred on Day Care Treatment up to the Sum Insured specified in the Policy Certificate provided that:

a) the Day Care Treatment is listed as per the Annexure-I to Policy Terms & Conditions; and
b) the period of treatment of the Insured Member in a Network Provider does not exceed 24 hours; and
c) the Day Care Treatment was taken on the advice of a Medical Practitioner; and
d) the Medical Expenses incurred are Reasonable and Customary Charges that were necessarily incurred.

2.1.3 Pre-hospitalization Medical Expenses and Post-hospitalization Medical Expenses

a) The Company will indemnify the Medical Expenses up to the Sum Insured specified in the Policy Certificate provided that is incurred for the Insured Member:

   i. As Pre-hospitalization Medical Expenses, for a period of 1 day immediately prior to the Insured Member's date of admission to the Network Provider.
   ii. As Post-hospitalization Medical Expenses, for a maximum period of 5 days immediately following the date of the Insured Member's discharge from Network Provider.

Provided that the Medical Expenses relate to the Illness/Injury for which the Company has accepted the Insured Member's Claim and which falls within the Cover Period.

b) If the provisions of Clause 4.6(d) is applicable to a Claim, then:
   i. The date of admission to Network Provider for the purpose of this Benefit shall be the date of the first admission to the Network Provider for the Illness deemed to be Any One Illness; and
   ii. The date of discharge from Network Provider for the purpose of this Benefit shall be the last date of discharge from the Network Provider in relation to the Illness deemed to be Any One Illness.
   iii. The date of admission to Network Provider for the purpose of this Benefit shall be the date of the first admission to the Network Provider for the Injury.
   iv. The date of discharge from Network Provider for the purpose of this Benefit shall be the last date of discharge from the Network Provider in relation to the Injury.

2.1.4 Maternity Expenses:

a) The Company will indemnify for the Medical Expenses incurred in respect of the Hospitalization of the Insured Member up to the Sum Insured for treatment taken in a Network Provider arising from pregnancy including Normal Delivery / Caesarean/ Miscarriage and / or abortion induced by accident or other medical emergency.

   Specific Conditions applicable to this Benefit:
   i. Claims under this benefit are admissible only if the expenses are incurred in Network Provider for Normal Delivery / Caesarean/ Miscarriage and or abortion induced by accident or other medical emergency as an in-patient.
   ii. Claims under this benefit are admissible only after the completion of waiting period of 9 months as specified in clause 3.1 (b) (Maternity wait period).
   iii. The Company shall cover pre-natal and post-natal expenses under this benefit, provided that the condition necessitates treatment in a Network Provider and the Insured Member is hospitalized.
   iv. Claim in respect of only first two living children will be considered in respect of any one insured member covered under the policy or any renewal thereof.
   v. Congenital Diseases (internal & external) of new born child is covered under this Benefit.

b) **Exclusions applicable to Benefit-2.1.4 –Maternity Expenses:**

i. Expenses incurred in connection with the voluntary medical termination of pregnancy during the first 12 weeks from the date of conception shall not be admissible under this Benefit except induced by accident or other medical emergency to save the life of mother.

2.1.5 Reinstatement of Sum Insured:

a) If a Claim is payable under the Policy, then the Company agrees to make the re-instatement of the Sum Insured for all Insured Members once for that Cover Period, only upon the request of the insured member on payment of additional pro-rata premium for the remaining Cover Period provided that:

i. The Reinstated amount shall be utilized only after the Sum Insured has been completely exhausted in that Cover Period.
ii. Reinstatement of Sum Insured is applicable only for Benefit 2.1.1, Benefit 2.1.2, Benefit 2.1.3 and Benefit 2.1.4
iii. The Reinstated amount shall be available only for all future Claims and not in relation to any Illness or Injury for which a Claim has already been admitted for that Insured Member during that Cover Period.
iv. The total amount of Reinstatement shall not exceed the Sum Insured for that Cover Period.
v. Any unutilized Reinstated amount cannot be carried forward to any subsequent Cover Period.
vi. If the Policy is issued on a Floater basis, then the Reinstatement will also be available only on Floater basis.
vii. For any single Claim during a Policy Year the maximum Claim amount payable shall be the Sum Insured.
viii. During the Cover Period, the aggregate Claim amount payable under Benefit 1 (Hospitalization Expenses) subject to admissibility of the Claim, shall not exceed the sum of:
    I The Sum Insured under Hospitalization Expenses
    II Reinstatement of Sum Insured
ix. The balance of the Reinstated amount shall be available during the Cover Period till it is exhausted completely.

Note:

i. This additional premium should be received by the company within 15 days of exhaustion of Sum Insured under Benefit 1 (Hospitalization Expenses) for any future claim to be payable.

2.2 Benefit 2: Personal Accident

i. A claim is payable only once under this benefit during the Cover Period.
ii. If the Primary Insured Member suffers an Injury during the Cover Period solely and directly due to an Accident that occurs during the Cover Period which results in an Insured Event within twelve calendar months from the Injury, the company will pay to the Primary Insured Member (or Nominee or Legal Heir), the amount specified against

the benefits in the Policy certificate subject always to the terms and conditions of the Policy and the availability of the Sum Insured and while the policy is in force for:

2.2.1 Accidental Death

a) If the Primary Insured Member suffers an Injury during the Cover Period, which directly results in the Primary Insured Member's death within 12 months from the date of Accident (including date of Accident), the Company will pay the Sum Insured as specified in the Policy Certificate against this Benefit.

b) **Documents to be submitted for any Claim under this Benefit-2.2.1:**
It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

i. Documents as specified in Clause 4.3(a).
ii. Medical reports giving the details of the Accident, nature of Injury and the details of treatment provided, Admission and Death Summary, Accident Report
iii. Original Death Certificate
iv. Post Mortem Report, Inquest Panchnama Report issued by the Police, F.I.R (First Information Report)
v. Legal Heir Certificate or Succession Certificate (if no nomination has been made)
vi. Investigation Reports (Lab tests, X-Ray, MRI, etc.), Medical Bills and Cash receipts
vii. Chemical Analysis Report (if available), Newspaper cutting (if available)
viii. Bank details of the claimant seeking compensation

2.2.2 Permanent Total Disablement

a) If the Primary Insured Member suffers an Injury during the Cover Period, which directly results in any of the following Insured Events within twelve calendar months of the occurrence of the Injury, the company will pay the amount specified against this Benefit in the Policy Certificate:

i. Total and irrecoverable loss of sight of both eyes, or speech or hearing of both ears or
ii. Actual loss by physical separation of two entire hands or two entire feet or
iii. One entire hand and one entire foot or
iv. Total and irrecoverable loss of sight of one eye and loss by physical separation of one entire hand or one entire foot

Note: For the purpose of the above Insured Events, physical separation of a hand or foot shall mean separation of the hand at or above the wrist and of the foot at or above the ankle.

Insured Event means an event that is covered under the Policy and which is in accordance with the Policy Terms & Conditions.

b) **Documents to be submitted for any Claim under this Benefit-2.2.2:**

It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

i. Documents as specified in Clause 4.3(a)
ii. Disability Certificate issued by CMO (Chief Medical Officer) as appointed by the Hospital Authorities
iii. Accident Report, Copy of F.I.R (First Information Report)
iv. Details of treatment taken by the patient/injured after accident, Medical Bills and Cash receipts, Investigation Reports (Lab tests, X-Ray, MRI, etc.)
v. Admission/Discharge summary
vi. A newspaper cutting about accident (if available)
vii. Bank details of the claimant seeking compensation.

3. Exclusions

3.1. Waiting Periods:

(a) **30-Day waiting period(applicable only for Benefit 1 (Hospitalization Expenses))**
Claim for any Medical Expenses incurred for treatment of any Illness during the first 30 days from the Cover Start Date shall not be admissible, except those Medical Expenses incurred directly as a result of an Injury taking place within the Cover Period.

(b) **Maternity wait period (applicable only for Benefit 2.1.4- Maternity Expenses of Benefit 1 (Hospitalization Expenses))**
Claims will not be admissible for any expenses incurred for diagnosis / treatment related to any Maternity Expenses until 9 months since the inception of the first Policy with the company.

(c) The above Waiting Periods shall not apply for subsequent renewals provided that there is no Break in Policy for that Insured Member and that the Policy has been renewed with the Company for that Insured Member within the Grace Period.

(d) The Waiting Periods as defined in Clauses 3.1 (a) and 3.1 (b) shall be applicable individually for each Insured Member and Claims shall be assessed accordingly.

3.2. General Exclusions:

Any Claim in respect of any Insured Member for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

i. Any condition or treatment as specified in List of Non-Medical Items (Annexure – II to Policy Terms & Conditions).
ii. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
iii. Treatment of mental illness, stress or psychological disorders.
iv. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
v. Any Illness or Injury directly or indirectly resulting or arising from or occurring during commission of any breach of any law by the Insured Member with any criminal intent.
vi. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of intoxicating drugs and alcohol or hallucinogens.
vii. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.
viii. Any claim related to Hazardous Activities.
ix. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
    I Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal,

release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

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

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

In addition to the foregoing, any loss, claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above shall also be excluded.

3.3. Additional Exclusions applicable to Benefit-1 –Hospitalization Expenses

Any Claim in respect of any Insured Member for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

i. Any treatment arising from or traceable to any fertility, sterilization, birth control procedures, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.
ii. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.
iii. Any condition that do not require hospitalization such as Outpatient Diagnostic, Medical and Surgical procedures or treatments unless necessary for treatment of a disease covered under Day Care procedures or Inpatient hospitalization.
iv. The Company shall not admit any Claim in relation to the Alternative Treatment.
v. Charges incurred in connection with cost of routine eye and ear examinations, spectacles and contact lens, hearing aids, laser surgery for correction of refractory errors, dentures, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment.
vi. Any diagnosis or treatment of an Illness or Injury which does not require Hospitalization.
vii. Unproven/Experimental or investigational treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment.
viii. Expenses incurred on High Intensity Focused Ultra Sound, Balloon Sinuplasty, Enhanced External Counter Pulsation Therapy and related therapies. Deep Brain Simulation, Hyperbaric Oxygen Therapy, Robotic Surgery, Holmium Laser Enucleation of Prostate, KTP Laser surgeries, Femto laser surgeries and such other similar therapies.
ix. Any expenses incurred on prosthesis, corrective devices, external durable medical / Non-medical equipment of any kind, like wheelchairs, walkers, belts, collars, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer/thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P)

or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition, cost of cochlear implants and related surgery.

x. Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence, cure, rest cure, Run-down condition, health hydros, nature cure clinics, sanatorium treatment, Rehabilitation measures, private duty nursing, respite care, long-term nursing care, custodial care or any treatment in an establishment that is not a Hospital.

xi. Treatment of any genetic disorder or external Congenital Anomalies or Illness or defects or anomalies or treatment relating to external birth defects. However, Congenital Diseases (internal & external) of new born child shall be covered during the currency of the policy only.

xii. Any Dental treatment, Aesthetic treatment, cosmetic surgery or plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury or disease which requires hospitalization for treatment or mentioned in Annexure-I (List of Day Care Procedures).

xiii. Any treatment/surgery for change of sex or gender reassignments including any complication arising from these treatments.

xiv. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

xv. All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment).

xvi. Expenses on vitamins and tonics etc. unless forming part of treatment for injury or disease as certified by the attending Physician.

xvii. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

xviii. All expenses related to donor treatment, including surgery to remove organs from the donor, in case of transplant surgery.

xix. Non-allopathic treatment.

xx. Any OPD Treatment.

xxi. Treatment received outside India.

xxii. Charges incurred at Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, for which In-patient Care/ Day Care Treatment is required.

xxiii. Stem cell implantation, harvesting, storage or any kind of treatment using stem cells.

xxiv. Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to telephone and telephone calls (wherever specifically charged separately), foodstuffs (except patient's diet), cosmetics, hygiene articles, body or baby care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies.

xxv. Expenses related to any kind of RMO charges, service charge, surcharge, night charges levied by the Hospital under whatever head.

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

3.4. Additional Exclusions applicable to Benefit-2 –Personal Accident

Any Claim in respect of Primary Insured Member for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

i. Any pre-existing injury or physical condition;

ii. An Insured Member operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft or Scheduled Airline or any airline personal;

iii. An Insured Member flying in an aircraft other than as a fare paying passenger in a Scheduled Airline;

iv. Sexually transmitted conditions, mental or nervous conditions, insanity, disorder, anxiety, stress or depression

v. Participation in actual or attempted felony, riot, civil commotion or criminal misdemeanor;

vi. A complication of infection with Human Immune Deficiency Virus (HIV) or any variance including Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC) or venereal disease;

vii. Training for or participating in professional sport of any kind;

viii. The Primary Insured Member serving in any branch of the military, navy, air force or any branch of armed forces or any paramilitary forces;

ix. Primary Insured Member working in or with mines, tunneling or explosives or involving electrical installation with high tension supply or conveyance testing or oil rigs or ship crew services or as jockeys or circus personnel or aerial photography or engaged in any Hazardous Activities as specified under Clause 1.30

x. Impairment of the Primary Insured Member's intellectual faculties by abuse of stimulants or depressants or by the illegal use of any solid, liquid or gaseous substance;

xi. Resulting due to any disease or infection except where such condition arises directly as a consequence of an accident during the Cover period.

xii. Resulting from pregnancy or childbirth

xiii. Persons whilst working with in activities like racing on wheels or horseback, winter sports, canoeing involving white water rapids, any bodily contact sport.

xiv. Bacterial infections (except pyogenic infection which occurs through an Accidental cut or wound).

xv. Treatments rendered by a Doctor who shares the same residence as an Insured Member or who is a member of an Insured Member's family.

xvi. Any change of profession after inception of the Policy which results in the enhancement of the Company's risk, if not accepted and endorsed by the Company on the schedule of Policy Certificate.

xvii. As a result of any curative treatments or interventions that the Insured Member has carried out or have carried out on the Insured Member's body.

4. CLAIM INTIMATION, ASSESSMENT AND MANAGEMENT

Upon the occurrence of any event that may give rise to a Claim under this Policy, then as a condition precedent to Company's liability under the Policy, the Policyholder or Insured Member (or the Nominee or legal heir if the Insured Member is deceased) shall undertake in addition to any specific requirements specified within the Benefit under which the Claim is made:

4.1. Claims Intimation

a. If any Illness is diagnosed or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Policyholder or Insured Member (or the Nominee or legal heir if the Insured Member is deceased), shall notify the Company either at the Company's call center or in writing immediately and in any event within the timeframe (if any) specified in the Benefit under which the Claim is made.
b. If the Insured Member is to undergo planned Hospitalization, the Insured Member shall give written intimation to the company of the proposed Hospitalization at least 24 hours prior to the planned date of admission to Network Provider.
c. In case of an Emergency Hospitalization, the Company shall be notified either at the Company's call center or in writing immediately and in any event within 24 hours of admission to Network Provider. Health card will need to be produced and authenticated within 24 hours of admission and no pre-authorization is required in case of emergency hospitalization.
d. It is agreed and understood that the following details are to be provided to the Company at the time of intimation of the Claim:
    i. Policy Number;
    ii. Name of Primary Insured Member;
    iii. Name of the Insured Member in whose relation the Claims is being made;
    iv. Nature of Illness or Injury or contingency for which Claim has been made and the Benefit under which the Claim is being made;
    v. Date and place of Injury or Death and/or Date of admission to Network Provider or proposed date of admission to Network Provider for planned Hospitalization;
    vi. Name and address of the attending Medical Practitioner and Hospital;
    vii. Any other information, documentation or details requested by the Company.

4.2. Claim Procedure

a. Cashless: Cashless treatment facilities are available only at Network Provider. The Insured Member can avail of this cashless facility at the time of admission into a Network Provider by completing the following procedure.
    i. Pre-authorization: The Policyholder/ Insured Member must call the Company's call centre number as specified in the Policy Certificate and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least within 24 hours of admission to the Network Provider.
    ii. Present the health card provided by the Company under this Policy along with a valid photo identification document (Voter ID card / Driving License / Aadhar card / Passport / PAN Card or any other identification documentation as approved by the Company).
    iii. The Company will process the request for authorization after having obtained accurate and complete information for the Illness or Injury for which cashless facility for is

sought to be availed. The Company will confirm in writing authorization or rejection of authorization to avail cashless facility for the Insured Member's Hospitalization.

iv. If the request for availing cashless facility is authorized by the Company, then payment for the Medical Expenses incurred in respect of the Insured Member shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing cashless facility.

v. If the Company does not authorize the cashless facility due to insufficient Sum Insured or insufficient information provided to the Company to determine the admissibility of the Claim, payment for the treatment will have to be made by the Policyholder or Insured Member to the Network Hospital, following which a Claim for reimbursement may be made to the Company which will be considered by the Company subject to the Policy terms and conditions.

b. It is agreed and understood that:

i. When authorizing the availing of cashless facility under this Policy, the Company may authorize the Policyholder's or Insured Member's request for direct settlement of admissible Claims resulting from the Hospitalization in accordance with the agreed charges and the terms and conditions between the Network Provider and the Company. If this authorization is provided then, the Company will directly pay all amounts payable in accordance with the terms and conditions of the Policy to the Network Provider to the extent the Claim is admissible under the Policy.

ii. The Company may modify or add to the list of Network Provider or modify or restrict the extent of cashless facilities that may be availed at any particular Network Provider. The updated list would be available at the Company's website or call centre.

iii. Before availing the cashless facility, the Policyholder or the Insured Member is required to check the applicable list of Network Provider for the area where he intends to avail the cashless facility through the call centre number as provided in the Policy Certificate.

c. Reimbursement :

i. It is agreed and understood that in all cases where intimation of a Claim has been provided under this provision, all the information and documentation specified against the Benefit and Clause 4.3 below shall be submitted (at the Insured Member's expense) to the Company immediately and in any event within 30 days of Insured Member's discharge from Network Provider or completion of treatment or date of loss, whichever is later.

ii. No claim can be made under this Policy, if the treatment is taken in Non-Network Provider.

4.3. Claim Documentation

The Policyholder or Insured Member (or Nominee or legal heir if the Primary Insured Member is deceased) shall (at his expense) give the documentation specified below and any additional information or documentation specified in the Benefit provision under which the Claim is being made to the Company immediately and in any event within 30 days of the occurrence of the Injury.

a) The following information and documentation shall be submitted to the company in accordance with the procedures and within the timeframes specified in Clause 4 of the Policy in respect of all Claims:

i. Duly completed and signed Claim form, in original;

ii. Copy of Health Card;
iii. Medical Practitioner's referral letter advising Hospitalization;
iv. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation;
v. Original bills, receipts and discharge card from the Hospital / Medical Practitioner;
vi. Original bills from pharmacy / chemists;
vii. Original pathological / diagnostic test reports and payment receipts;
viii. Indoor case papers

Note:

i. Additional documents as specified against any benefit shall be submitted to the company.
ii. The company may seek any other document as required to assess the Claim.
iii. The company will only accept bills/invoices which are made in the Insured Member's name.
iv. Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company, the company will accept properly verified photocopies of such documents attested by such other insurance company along with an original certificate of the extent of payment received from such insurance company.

However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay.

4.4. POLICYHOLDER'S OR INSURED MEMBER'S OR CLAIMAINT'S DUTY AT THE TIME OF CLAIM

It is agreed and understood that as a condition precedent for a Claim to be considered under this Policy:

a. The Insured Member shall check the updated list of Network Provider before availing Cashless Facility
b. All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.
c. The Insured Member shall follow the directions, advice or guidance provided by a Medical Practitioner and the Company shall not be obliged to make payment that is brought about or contributed to by the Insured Member failing to follow such directions, advice or guidance.
d. Intimation of the claim, notification of the claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 4 of the Policy and the specific procedures and timeframes specified under the Benefit under which the Claim is being made.
e. The Insured Member will, at the request of the Company, submit himself / herself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.
f. The Company's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Member's medical and hospitalization records and to investigate the facts and examine the Insured Member.
g. The Company shall be provided with complete documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

4.5. CLAIM ASSESSMENT

a. All admissible Claims under this Policy shall be assessed by the company.
b. The Claim amount assessed would be deducted from the following amounts in the following progressive order:

   i. Sum Insured;
   ii. Reinstatement of Sum Insured (if applicable).

4.6. Payment terms

a. This Policy covers treatment taken entirely within India. All payments under this Policy shall be made in Indian Rupees and within India.
b. For Cashless Claims, the payment shall be made to the Network Provider whose discharge would be complete and final.
c. If the Insured Member suffers a relapse within 45 days of the date of discharge from the Network Provider for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim.
d. For Reimbursement Claims, the Company will make payment to the Insured Member unless specified otherwise in the Certificate of Insurance. In the event of Primary Insured Member's death, the Company will make payment to the Nominee (as named in Certificate of Insurance) and in case of no Nominee to the legal heir of the Primary Insured Member whose discharge shall be treated as full and final discharge of the Company's liability under the Policy.
e. If any Claim under Benefit – 1 (Hospitalization Expenses) is made which extends in to two Cover Periods then such Claim shall be paid taking into consideration the available Sum Insured in these Cover Periods. Such eligible Claim amount will be paid to the Insured Member after deducting the extent of premium to be received for the renewal/due date of premium of the Certificate of Insurance, if not received earlier.
f. On payment of renewal premium, the Primary Insured Member shall give written notice to the company of any disease, physical defect or infirmity or change in occupation or profession.
g. The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Member during the Cover Period, once Sum of Sum Insured and Reinstatement of Sum Insured (if applicable) for that Insured Member is exhausted.
h. The Company shall settle any Claim within 30 days of receipt of all the necessary documents/ information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder an offer of settlement of Claim and upon acceptance of such offer by the Policyholder the Company shall make payment within 7 days from the date of receipt of such acceptance. In case there is delay in the payment beyond the stipulated timelines, the Company shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

5. General Terms and Conditions

5.1 Disclosure to Information Norm

If any untrue or incorrect statements are made or there has been a misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld, or if a Claim is fraudulently made or any fraudulent means or devices are used by the Policyholder, the Insured Member or any one acting on his or their behalf, the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited to the Company on cancellation of the Policy.

5.2 Observance of Terms and Conditions

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

5.3 Reasonable Care

Insured Members shall take all reasonable steps to safeguard the interests against any Illness or Injury that may give rise to a Claim.

5.4 Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder/ Insured Member shall immediately notify the Company in writing of any material change in the risk on account of change in occupation or business of any Insured Member at his own expense. The Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

5.5 Records to be maintained

The Policyholder and Insured Member shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Member shall furnish such information as the Company may require under this Policy at any time during the Policy Period or Cover Period or until final adjustment (if any) and resolution of all Claims under this Policy.

5.6 No constructive Notice

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

5.7 Complete Discharge

Payment made by the Company to the Policyholder or Insured Member or the Nominee or the legal heir of the Insured Member , as the case may be, under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

5.8 Contribution

a. In case any Insured Member is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder/Insured Member shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to the sum insured of such Policy.

b. In case the Claim amount under a single policy exceeds the Sum Insured, then Policyholder shall have the right to choose the companies with whom the Claim is to be settled. In such cases, the settlement shall be done as under:

   i. If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company may not be liable to pay or contribute more than its ratable proportion of any Claim.

   ii. This clause shall not apply to any Benefit offered on a fixed benefit basis.

5.9 Free Look Period

a. The Policyholder may, within 15 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions.

b. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.

c. Provision for Free look period is not applicable and available at the time of renewal of the Policy.

5.10 Policy Disputes

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

5.11 Renewal Notice

a. The Coverage will automatically terminate on the Cover End Date. All renewal applications and requisite premium shall be given to the company on or before the Cover End Date provided the policy is in force and in any event before the expiry of the Grace Period. The Policyholder shall give the company written notice along with the renewal application of any material changes to the risk insured under the Policy. If no such written notice is received by the company along with the renewal application, it shall be deemed that there is no material change to the risk.

For the purpose of this provision, Grace Period means a period of 30 days immediately following the Cover End Date during which a payment can be made to renew this Policy without loss of continuity benefits. Coverage is not available for the period for which premium is not received by the Company and the Company shall not be liable for any Claims incurred during such period. This Clause is applicable at member level.

b. The company will ordinarily not refuse to renew the Policy except on grounds of fraud, moral hazard or misrepresentation or non-co-operation by the Insured.

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

d. Renewal shall be offered lifelong. The Insured Member shall be given an option to port this Policy into any other health insurance product of the Company and credit shall be given for number of years of continuous coverage under this Policy for the standard waiting periods.

e. This product may be withdrawn / modified by the company after due approval from the IRDAI. In case this product is withdrawn / modified by the company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDAI. The company shall duly intimate Policyholder atleast three months prior to the date of such withdrawal / modification of this product and the options available to Insured Member at the time of renewal of this policy.

f. No loading based on individual claim experience shall be applicable on renewal premium payable

5.12 Cancellation / Termination

a. The Company may at any time, cancel this Policy on grounds as specified in Clause 5.1 and the Company shall have no liability to make payment of any claims and the premium paid shall be forfeited to the Company and no refund of premium shall be effected by the company, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder or Insured Member at his last known address.

b. The Policyholder may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice, cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided no Claim has been made under the Policy.

Refund % to be applied on premium received

Cancellation date from Cover Start Date	Policy Tenure – 1 Year
Up to 1 month	75.0%
1 month to 3 months	50.0%
3 months to 6 months	25.0%
6 months to 12 months	0.0%

c. In case of demise of the Primary Insured Member,
   i. Where the Policy covers only the Primary Insured Member, this Policy shall stand null and void from the date and time of demise of the Primary Insured Member.
   ii. Where the Policy covers other Insured Members, this Policy shall continue till the end of Cover Period for the other Insured Members. If the other Insured Members wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a Primary Insured Member provided that:

I. Written notice in this regard is given to the Company before the Cover End Date; and

II. A Person who satisfies the Company's criteria to become a Primary Insured Member. The criteria being:

(a) He / She should become a member of the Group against whom the Master policy is issued.

(b) He / She should satisfy the age limit criteria as mentioned in the product.

(c) In case of all the surviving members being aged above 70 years, criteria as per Clause 5.13 (c) (ii) (II) (b) need not be required to be met.

d. The Primary Insured Member may also give 15 days' notice in writing, to the Company, for the cancellation of the Certificate of Insurance, in which case the Company shall from the date of receipt of the notice, cancel the Certificate of Insurance and refund the premium for the unexpired Cover Period on pro-rata basis.

5.13 Limitation of liability

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

5.14 Communication

a. Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Certificate/ Certificate of Insurance. Any communication meant for the Policyholder or Insured Member will be sent by the Company to his last known address or the address as shown in the Policy Certificate/ Certificate of Insurance.

b. All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Certificate/ Certificate of Insurance. Agents are not authorized to receive notices and declarations on the Company's behalf.

c. Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

5.15 Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company.

5.16 Overriding effect of Policy Certificate/ Certificate of Insurance

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

5.17 Electronic Transactions

The Policyholder and Insured Member agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the

Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

5.18 Portability and Continuity Benefits

The company will grant continuity of benefits which were available to the Insured Members under a group insurance policy with any other Indian Non-life insurance company or Health Insurance Company in the immediately preceding Cover period provided that:

i. The company shall be liable to provide continuity of only those benefits (for e.g: Initial wait period, wait period for Maternity Expenses payable)which are applicable under the Policy;
ii. The Insured Members to whom continuity benefits will be provided under this Policy were covered under that group insurance policy;
iii. There is no Break in Policy between the previous group insurance policy and this Policy, provided further that the application for this Policy is made within 45 days before the expiry of that group insurance policy;
iv. Insured Members covered under this Policy shall have the right to migrate from this Policy to an individual health insurance policy or a family floater policy offered by the company and the credit for wait periods would be given in the opted individual health insurance policy or a family floater policy offered by the company.
v. Insured Member can apply only at the time of renewal of the group Policy.

5.19 Nominee

The Primary Insured Member can at the inception or at any time before the expiry of the Policy make the nomination for the purpose of payment of Claims.

Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement to the Policy is made by the company.

In case of any Insured Member other than the Primary Insured Member under the Policy, for the purpose of payment of Claims in the event of death, the default nominee would be the Primary Insured Member.

5.20 Grievances

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

(a) If the Policyholder / Insured Member has a grievance that the Policyholder / Insured Member wishes the Company to redress, the Policyholder / Insured Member may contact the Company with the details of the grievance through:

Website: www.religarehealthinsurance.com
Email: customerfirst@religarehealthinsurance.com
Contact No.:1800-200-4488
Fax: 1800-200-6677
Courier: Any of Our Branch Office or corporate office

The Policyholder/Insured Member may also approach the grievance cell at any of the Company's branches with the details of his/her grievance during the Company's working hours from Monday to Friday.

(b) If the Policyholder / Insured Member is not satisfied with the Company's redressal of the Policyholder's / Insured Member's grievance through one of the above methods, the Policyholder / Insured Member may contact the Company's Head of Customer Service at:

Head – Customer Services,
Religare Health Insurance Company Limited,
GYS Global,
Plot No. A3, A4, A5, Sector - 125,
Noida, U.P. – 201301.

(c) If the Policyholder / Insured Member is not satisfied with the Company's redressal of the Policyholder's / Insured Member's grievance through one of the above methods, the Policyholder / Insured Member may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsmen offices are mentioned below:

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD		Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, 5, Navyug Colony, Nr. C.U. Shah College, Ashram Road, AHMEDABAD-380 014. Tel : 079-27545441/27546139 , Fax : 079-27546142 E-mail : bimalokpal.ahmedabad@gbic.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Shri. M. Parshad	Insurance Ombudsman, Office of the Insurance Ombudsman, 24th Main Road, Jeevan Soudha Bldg., JP Nagar, 1st Phase, BENGALURU - 560 025. Tel No: 080-22222049/22222048 Email: bimalokpal.bengaluru @gbic.co.in	Karnataka
BHOPAL	Shri Raj Kumar Srivastava	Insurance Ombudsman,	Madhya Pradesh & Chhattisgarh

		Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL (M.P.)-462 023. Tel : 0755-2769201/9202 , Fax : 0755-2769203 E-mail : bimalokpal.bhopal@gbic.co.in	
BHUBANESHWAR	Shri B.N. Mishra	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel : 0674-2596455/2596003 , Fax : 0674-2596429 E-mail: bimalokpal.bhubaneswar@gbic.co.in	Orissa
CHANDIGARH	Shri Manik B. Sonawane	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel : 0172-2706468/2705861, Fax : 0172-2708274 E-mail: bimalokpal.chandigarh@gbic.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh
CHENNAI	Shri Virander Kumar	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453,	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)

		Anna Salai, Teynampet, CHENNAI-600 018. Tel : 044-24333668 /24335284, Fax : 044-24333664 E-mail : bimalokpal.chennai@gbic.co.in	
DELHI	Smt. Sandhya Baliga	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel : 011-23237539/23232481 , Fax : 011-23230858 E-mail : bimalokpal.delhi@gbic.co.in	Delhi
GUWAHATI		Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel : 0361-2132204/5, Fax : 0361-2732937 E-mail : bimalokpal.guwahati@gbic.co.in	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri G.Rajeswara Rao	Insurance Ombudsman, 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 : 040-65504123/23312122 , Fax : 040-23376599	Andhra Pradesh, Telangana and Yanam – a part of Territory of Pondicherry

		E-mail : bimalokpal.hyderabad@gbic.co.in	
JAIPUR	Shri. Ashok K. Jain	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel : 0141-2740363 Email : bimalokpal.jaipur@gbic.co.in	Rajasthan
ERNAKULAM	Shri P.K. Vijay Kumar	Insurance Ombudsman, 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 E-mail : bimalokpal.ernakulam@gbic.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
KOLKATA	Shri K.B. Saha	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindustan Bldg. Annexe, 4, C.R.Avenue, Kolkata – 700 072. Tel : 033-22124339/22124340, Fax : 033-22124341 E-mail : bimalokpal.kolkata@gbic.co.in	West Bengal, Bihar, Jharkhand, Andaman & Nicobar Islands, Sikkim
LUCKNOW	Shri N.P. Bhagat	Insurance Ombudsman, Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road,	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh,

		Hazaratganj, LUCKNOW-226 001. Tel : 0522 -2231331/2231330, Fax : 0522-2231310 E-mail : bimalokpal.lucknow@gbic.co.in	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.
MUMBAI	Shri A.K. Dasgupta	Insurance Ombudsman, 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@gbic.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA		Office of the Insurance Ombudsman, Email: bimalokpal.noida@gbic.co.in	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, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras,

			Kanshiramnagar, Saharanpur
PUNE	Shri. A. K. Sahoo	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel: 020-32341320 Email: bimalokpal.pune@gbic.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

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

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

Annexure –I: List of Day Care Procedures / Surgeries

Category	Procedure / Surgery Name
Dental	Apisectomy including LA
Dental	Complicated Ext. per Tooth including LA
Dental	Cyst under LA (Large)
Dental	Cyst under LA (Small)
Dental	Extraction of tooth including LA
Dental	Flap operation per Tooth
Dental	Fracture wiring including LA
Dental	Gingivectomy per Tooth
Dental	Impacted Molar including LA
Dental	Intra oral X-ray
Dental	Extraction of 2 teeth in same quadrant
Dental	Extraction of 3 teeth in same quadrant
Dental	Extraction of 4 teeth in same quadrant
Dental	Extraction of 2 teeth in more than one quadrant
Dental	Extraction of 3 teeth in more than one quadrant
Dental	Extraction of 4 teeth in more than one quadrant
Dental	Extraction of more than 5 teeth in more than one quadrant
Dental	Flap operation involving 1-3 teeth
Dental	Flap operation involving 4-6 teeth
Dental	Flap operation involving 7-11 teeth
Dental	Gingivectomy involving 1-3 teeth
Dental	Gingivectomy involving 4-6 teeth
Dental	Gingivectomy involving 7-11 teeth
Ear	Ear lobe repair – single
Ear	Excision of Pinna for Growth (Squamous/Basal/ Injuries) Skin and Cartilage
Ear	Excision of Pinna for Growth (Squamous/Basal/ Injuries) Skin Only
Throat	Retro pharyngeal abscess - Drainage
General Surgery	Corn - Large - Excision
General Surgery	Dermoid Cyst - Large - Excision
General Surgery	Dermoid Cyst - Small - Excision
General Surgery	Dorsal Slit and Reduction of Paraphimosis
General Surgery	Drainage of large Abscess
General Surgery	Epidymal Cyst
General Surgery	Excision of Small Growth from Tongue
General Surgery	Excision of Large Swelling in Hand

Category	Procedure / Surgery Name
General Surgery	Excision of Small Swelling in Hand
General Surgery	Ganglion - Small - Excision
General Surgery	Growth – Excision
General Surgery	Nodular Cyst
General Surgery	Lipoma
General Surgery	Sebaceous Cyst - Excision
General Surgery	Dressing under GA
General Surgery	Excision of Corns
General Surgery	Excision of Moles
General Surgery	Excision of Molluscumcontagiosum
General Surgery	Excision of Sebaceous Cysts
General Surgery	Excision of Superficial Liipoma
General Surgery	Excision of Superficial Neurofibroma
General Surgery	Phimosis Under LA
General Surgery	Suturing of wounds with local anesthesia
General Surgery	Suturing without local anesthesia
General Surgery	Urtheral Dilatation
General Surgery	Varicose veins - injection
General Surgery	Vasectomy
General Surgery	Heamodialysis
Gynaecology	Bartholin abscess I & D
Gynaecology	Bartholin cyst removal
Gynaecology	Cyst – Labial
Gynaecology	Cyst -Vaginal Enucleation
Gynaecology	D&C (Dilatation & curretage)
Gynaecology	Electro Cauterisation Cryo Surgery
Gynaecology	Fractional Curretage
Gynaecology	Haemato Colpo/Excision - Vaginal Septum
Gynaecology	Perineal Tear Repair
Gynaecology	Vaginal Tear -Repair
Gynaecology	D&C (dilatation & Curretage) upto 12 wks
Gynaecology	D&C (Dilatation & curretage)upto 8 wks
Gynaecology	Insertion of IUD Device
Endoscopic procedures	Ablation of Endometriotic Spot
Endoscopic procedures	Cyst Aspiration
Endoscopic procedures	Esophageal Sclerotheraphy for varies first sitting
Endoscopic procedures	Esophageal Sclerotheraphy for varies subseqent sitting
Endoscopic procedures	Upper GI endoscopy
Endoscopic procedures	Upper GI endoscopy with biopsy

Hysteroscopic	Ablation of Endometrium
Hysteroscopic	Polypectomy
Ophthalmology	Abscess Drainage of Lid
Ophthalmology	Cataract – Unilateral
Ophthalmology	Cataract + Pterygium
Ophthalmology	Corneal Grafting
Ophthalmology	Cyclocryotherapy
Ophthalmology	Cyst
Ophthalmology	Pterigium + Conjunctival Autograft
Ophthalmology	Exentration
Ophthalmology	Ectropion Correction
Ophthalmology	Intraocular Foreign Body Removal
Ophthalmology	Limbal Dermoid Removal
Ophthalmology	Pterygium (Day care)
Ophthalmology	Ptosis
Ophthalmology	Small Tumour of Lid - Excision
Ophthalmology	Iridectomy
Ophthalmology	Acid and alkali burns
Ophthalmology	Cataract with IOL by Phoco emulsification tech. unilateral
Ophthalmology	Cataract with IOL with Phoco emulsification Bilateral
Ophthalmology	Cauterisation of ulcer/subconjuctival injection - both eye
Ophthalmology	Cauterisation of ulcer/subconjuctival injection - One eye
Ophthalmology	Chalazion - both eye
Ophthalmology	Chalazion - one eye
Ophthalmology	Conjuntival Melanoma
Ophthalmology	Dacryocystectomy (to be removed duplicated)
Ophthalmology	Dacryocystectomy (DCY)
Ophthalmology	DCR (Dacryocystorhinostomy)
Ophthalmology	EKG/EOG
Ophthalmology	Entropion correction
Ophthalmology	Epicantuhus correction
Ophthalmology	Epiliation
Ophthalmology	ERG
Ophthalmology	Laser for retinopathy
Ophthalmology	Laser inter ferometry
Ophthalmology	Lid tear
Orthopaedic	Dislocation - Elbow
Orthopaedic	Dislocation - Shoulder
Orthopaedic	Drainage of Abscess Cold
Orthopaedic	Hip Spica
Orthopaedic	Shoulder Jacket
Orthopaedic	Trigger Thumb
Orthopaedic	Wound Debridiment
Orthopaedic	Application of Functional Cast Brace

Orthopaedic	Application of P.O.P. casts for Upper & Lower Limbs
Orthopaedic	Application of P.O.P. Spicas & Jackets
Orthopaedic	Application of Skeletal Tractions
Orthopaedic	Application of Skin Traction
Orthopaedic	Aspiration & Intra Articular Injections
Orthopaedic	Bandage & Stapping for Fractures
Orthopaedic	Close Reduction of Fractures of Limb & P.O.P.
Urology	Reduction of Paraphimosis
Oncology	Chemotherapy - Per sitting
Oncology	Radiotherapy - Per sitting
Oncology	Chemotherapy - per siting plus cost of injections subject to approval for Insurance administrator
Other commonly used procedures	Upto 30% burns first dressing
Other commonly used procedures	Upto 30% burns subsequent dressing

Sr. No.	Annexure – II (List of Expenses Generally Excluded ("Non-medical")in Hospital Indemnity Policy)
	TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS
1	HAIR REMOVAL CREAM
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
3	BABY FOOD
4	BABY UTILITES CHARGES
5	BABY SET
6	BABY BOTTLES
7	BRUSH
8	COSY TOWEL
9	HAND WASH
10	MOISTURISER PASTE BRUSH
11	POWDER
12	SHOE COVER
13	BEAUTY SERVICES
14	BELTS/ BRACES
15	BUDS
16	BARBER CHARGES
17	CAPS
18	COLD PACK/HOT PACK
19	CARRY BAGS
20	CRADLE CHARGES
21	COMB
22	EAU-DE-COLOGNE / ROOM FRESHNERS
23	EYE PAD
24	EYE SHEILD
25	EMAIL / INTERNET CHARGES
26	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
27	FOOT COVER
28	GOWN
29	LEGGINGS
30	LAUNDRY CHARGES
31	MINERAL WATER
32	OIL CHARGES
33	SANITARY PAD
34	SLIPPERS
35	TELEPHONE CHARGES
36	TISSUE PAPER

Sr. No.	Annexure – II (List of Expenses Generally Excluded ("Non-medical")in Hospital Indemnity Policy)
37	TOOTH PASTE
38	TOOTH BRUSH
39	GUEST SERVICES
40	BED PAN
41	BED UNDER PAD CHARGES
42	CAMERA COVER
43	CLINIPLAST
44	CREPE BANDAGE
45	CURAPORE
46	DIAPER OF ANY TYPE
47	DVD, CD CHARGES
48	EYELET COLLAR
49	FACE MASK
50	FLEXI MASK
51	GAUSE SOFT
52	GAUZE
53	HAND HOLDER
54	HANSAPLAST/ ADHESIVE BANDAGES
55	LACTOGEN/ INFANT FOOD
56	SLINGS
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
57	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES
58	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS, ETC.,
59	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
60	HORMONE REPLACEMENT THERAPY
61	HOME VISIT CHARGES
62	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE
63	OBESITY (INCLUDING MORBID OBESITY) TREATMENT
64	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS
65	CORRECTIVE SURGERY FOR REFRACTIVE ERROR
66	TREATMENT OF SEXUALLY TRANSMITTED DISEASES
67	DONOR SCREENING CHARGES
68	ADMISSION/REGISTRATION CHARGES
69	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
70	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED
71	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY
72	STEM CELL IMPLANTATION/ SURGERY and storage

Sr. No.	Annexure – II (List of Expenses Generally Excluded ("Non-medical")in Hospital Indemnity Policy)
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
73	WARD AND THEATRE BOOKING CHARGES
74	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS
75	MICROSCOPE COVER
76	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER
77	SURGICAL DRILL
78	EYE KIT
79	EYE DRAPE
80	X-RAY FILM
81	SPUTUM CUP
82	BOYLES APPARATUS CHARGES
83	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
84	ANTISEPTIC OR DISINFECTANT LOTIONS
85	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES
86	COTTON
87	COTTON BANDAGE
88	MICROPORE/ SURGICAL TAPE
89	BLADE
90	APRON
91	TORNIQUET
92	ORTHOBUNDLE, GYNAEC BUNDLE
93	URINE CONTAINER
ELEMENTS OF ROOM CHARGE	
94	LUXURY TAX
95	HVAC
96	HOUSE KEEPING CHARGES
97	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
98	TELEVISION & AIR CONDITIONER CHARGES
99	SURCHARGES
100	ATTENDANT CHARGES
101	IM IV INJECTION CHARGES
102	CLEAN SHEET
103	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
104	BLANKET/WARMER BLANKET
ADMINISTRATIVE OR NON-MEDICAL CHARGES	
105	ADMISSION KIT
106	BIRTH CERTIFICATE
107	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES

Sr. No.	Annexure – II (List of Expenses Generally Excluded ("Non-medical")in Hospital Indemnity Policy)
108	CERTIFICATE CHARGES
109	COURIER CHARGES
110	CONVENYANCE CHARGES
111	DIABETIC CHART CHARGES
112	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
113	DISCHARGE PROCEDURE CHARGES
114	DAILY CHART CHARGES
115	ENTRANCE PASS / VISITORS PASS CHARGES
116	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
117	FILE OPENING CHARGES
118	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
119	MEDICAL CERTIFICATE
120	MAINTAINANCE CHARGES
121	MEDICAL RECORDS
122	PREPARATION CHARGES
123	PHOTOCOPIES CHARGES
124	PATIENT IDENTIFICATION BAND / NAME TAG
125	WASHING CHARGES
126	MEDICINE BOX
127	MORTUARY CHARGES
128	MEDICO LEGAL CASE CHARGES (MLC CHARGES)
	EXTERNAL DURABLE DEVICES
129	WALKING AIDS CHARGES
130	BIPAP MACHINE
131	COMMODE
132	CPAP/ CAPD EQUIPMENTS
133	INFUSION PUMP – COST
134	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
135	PULSEOXYMETER CHARGES
136	SPACER
137	SPIROMETRE
138	SPO2 PROBE
139	NEBULIZER KIT
140	STEAM INHALER
141	ARMSLING
142	THERMOMETER
143	CERVICAL COLLAR
144	SPLINT
145	DIABETIC FOOT WEAR

Sr. No.	Annexure – II (List of Expenses Generally Excluded ("Non-medical")in Hospital Indemnity Policy)
146	KNEE BRACES (LONG/ SHORT/ HINGED)
147	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
148	LUMBO SACRAL BELT
149	NIMBUS BED OR WATER OR AIR BED CHARGES
150	AMBULANCE COLLAR
151	AMBULANCE EQUIPMENT
152	MICROSHEILD
153	ABDOMINAL BINDER
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
154	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC
155	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
156	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
157	SUGAR FREE Tablets
158	CREAMS POWDERS LOTIONS (Toileteries are not payable, only prescribed medical pharmaceuticals payable)
159	Digestion gels
160	ECG ELECTRODES
161	GLOVES
162	HIV KIT
163	LISTERINE/ ANTISEPTIC MOUTHWASH
164	LOZENGES
165	MOUTH PAINT
166	NEBULISATION KIT
167	NOVARAPID
168	VOLINI GEL/ ANALGESIC GEL
169	ZYTEE GEL
170	VACCINATION CHARGES
PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
171	AHD
172	ALCOHOL SWABES
173	SCRUB SOLUTION/STERILLIUM OTHERS
174	VACCINE CHARGES FOR BABY
175	AESTHETIC TREATMENT / SURGERY
176	TPA CHARGES
177	VISCO BELT CHARGES
178	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
179	EXAMINATION GLOVES
180	KIDNEY TRAY
181	MASK

Sr. No.	Annexure – II (List of Expenses Generally Excluded ("Non-medical")in Hospital Indemnity Policy)
182	OUNCE GLASS
183	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
184	OXYGEN MASK
185	PAPER GLOVES
186	PELVIC TRACTION BELT
187	REFERAL DOCTOR'S FEES
188	ACCU CHECK (Glucometery/ Strips)
189	PAN CAN
190	SOFNET
191	TROLLY COVER
192	UROMETER, URINE JUG
193	AMBULANCE
194	TEGADERM / VASOFIX SAFETY
195	URINE BAG
196	SOFTOVAC
197	STOCKINGS

Annexure-III - List of Network Provider

Sr. No.	Hospital Name	Address	City	zone
1	Hi Tech Hospital	4, Krishna colony, Ambedkar circle	Alwar	North
2	Sethi Children Hospital	19, Lajpat Nagar Vijay Mandir Road	Alwar	North
3	Sania Hospital	N.E.B. Subhash Nagar, Alwar	Alwar	North
4	Madhuri Hospital	30, Panchvati Scheme 7, Alwar	Alwar	North
5	Tarini Cancer Hospital Research Institute	EI-2, MIA, Near lohiya Ka Tibara, Alwar Rajashthan	Alwar	North
6	Harish Hospital	State Highway 14, Ram Nagar, Alwar, Rajasthan 301001	Alwar	North
7	Thareja Hospital	1, Ram Kuteer, Company Garden Rd, Sector 7, Alwar, Rajasthan 301001	Alwar	North
8	Shiva Hospital	RIICO Industrial Area, Khuskhera, Alwar – 301707	Alwar	North
9	Bhardwaj Hospital	Link Road, Bagru, JaipurRajasthan	Jaipur	North
10	Jyoti Nursing Home	Road No4, Opp Sbi Bank, V.K.I, Jaipur	Jaipur	North
11	Chetana Hospital	Puttur, Karnataka- 574201	Puttur	South
12	Benaka Health Centre	Dakshina Kannada,Karnataka-574240	Dakshina Kannada	South
13	Athena Hospital	Mangalore,Karnataka-575001	Mangalore	South
14	Father Muller Hospital	Mangalore,Karnataka-574143	Mangalore	South

Sr. No.	Hospital Name	Address	City	zone
15	Father Muller Medical College Hospital	Mangalore,Karnataka-575002	Mangalore	South
16	Pragathi Speciality Hospital	Puttur,Karnataka-574201	Puttur	South
17	Hariram Memorial Medical Centre	Mangalore,Karnataka-575003	Mangalore	South
18	Omega Hospitals Pvt Ltd	Mangalore,Karnataka-575002	Mangalore	South
19	Sri Manjunatha Hospital	Udupi,Karnataka-576201	Udupi	South
20	Mangala Hospital	Mangalore,Karnataka-575003	Mangalore	South
21	Saraswathi Nursing Home	Dakshina Kannada,Karnataka-574211	Dakshina Kannada	South
22	Mitra Hospital	Udupi,Karnataka-576102	Udupi	South
23	Hitech Medicare Hospital	Udupi,Karnataka-576103	Udupi	South
24	Chinmayi Hospital	Udupi,Karnataka-576201	Udupi	South

Notes:

1. For an updated list of Network Provider empanelled specifically for this product, please visit the Company's website.

ANNEXURE-IV

SERVICE REQUEST FORM

For Change in Occupation / Nature of Job

(Refer Clause 5.4 of Policy Terms and Conditions)

PLEASE NOTE :

1. To be filled in by Policyholder in CAPITAL LETTERS only.
2. If there is insufficient space, please provide further details on a separate sheet. All attached documents form part of this service request.
3. This form has to be filled in and submitted to the company whenever the nature of job / occupation of any insured covered under the Policy changes subsequent to the issuance of the Policy.

Policyholder Details

Policy No. : |__|__|__|__|__|__|__|__|__|

Name (Entity) : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Details of the Insured Members for whom details are to be updated

Certificate of Insurance No. : |__|__|__|__|__|__|__|__|__|

Name : Mr. / Ms |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

(First name) (Last name)

Occupation : |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

DECLARATION

I hereby declare, on my behalf and on behalf of all members insured, that the above statement(s), answer(s) and / or particular(s) given by me are true and complete in all respects to the best of my knowledge and that I am authorized to provide / request for updation of the details on behalf of Insured members.

Place : |__|__|__|__|__|__|__|__|

Date : |__|__|/|__|__|/|__|__|__|__| (DD/MM/YYYY)

Signature of the Policyholder : ____

(On behalf of all the persons insured under the Policy)

Note: *The Company shall update its record with respect to the information provided above. Subsequently, the Company may review the risk involved and may alter the coverage and / or premium payable accordingly.*