Super No Claim Bonus Rider - Policy Terms and Conditions

I. Preamble

The Super No Claim Bonus Rider can only be bought along with the Group Health Indemnity Policy, herein after referred as "Base Plan" and cannot be bought as standalone or as a separate Policy.

This is a legal contract between the Policyholder and Us subject to the receipt of full premium, Disclosure to information norm including the information provided by the Policyholder in the Proposal Form and the terms, conditions and exclusions stated below for this Rider and also the Policy terms, conditions, exclusions and applicable endorsements of the Base Plan. This Rider shall be available only if the same is specifically mentioned in the Policy Schedule.

If any claim arising as a result of an Injury or Illness that occurs during the Policy Period becomes payable, then We shall pay the Benefits specified below in accordance with the terms, conditions and exclusions of the Policy and Base Plan.

II. Definitions

A. Standard Definitions

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

2. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

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

4. **Day Care Centre** means any institution established for day care treatment of illness and / or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under-
   i) Has qualified nursing staff under its employment;
   ii) Has qualified medical practitioner/s in charge;
   iii) Has fully equipped operation theatre of its own where surgical procedures are carried out;
   iv) Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

5. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
   i) Undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
   ii) Which would have otherwise required hospitalization of more than 24 hours.
   Treatment normally taken on an out-patient basis is not included in the scope of this definition.

6. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.

7. **Domiciliary Hospitalization** means medical treatment for an illness/disease/ injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
   i) The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
   ii) The patient takes treatment at home on account of non-availability of room in a hospital.

8. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

9. **Hospital** means any institution established for in- patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said act Or complies with all minimum criteria as under:
   i) Has qualified nursing staff under its employment round the clock;
   ii) Has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
   iii) Has qualified medical practitioner (s) in charge round the clock;
   iv) Has a fully equipped operation theatre of its own where surgical procedures are carried out;
   v) Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

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

11. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
   (a) Acute condition- Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery

   (b) Chronic condition- A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
   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 rehabilitation for the patient or for the patient to be specially trained to cope with it;
   iv) It continues indefinitely;
   v) It recurs or is likely to recur;

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

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

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

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

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

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

18. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

19. **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.

20. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time- bound exclusions and for all waiting periods.

B. Specific Definitions

21. **Age** or **Aged** is the age as on last birthday, and which means completed years as at the Start Date.

22. **Ambulance** means a motor vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.

23. **Annexure** means a document attached and marked as Annexure to this Policy.

24. **Benefit** means any benefit shown in the Policy.

25. **Base Plan** means Group Health policy issued by Us including its terms and conditions, any annexure thereto and the Policy Schedule / Certificate of Insurance (as amended from time to time), the information statements in the proposal form and the Policy wording (including endorsements, if any) and to which this Rider is attached

26. **Certificate of Insurance** means the certificate We issue to the Insured Person confirming the Insured Person's cover under the Policy.

27. **Employee** means any member of the Policyholder's staff under full time employment who is nominated and sponsored by the Policyholder and who becomes an Insured Person under the Policy.

28. **Expiry Date** means the date on which this Policy expires as specified in the Policy Schedule or Certificate of Insurance.

29. **Family Floater Policy** means a policy named as a Family Floater Policy in the Policy Schedule or Certificate of Insurance under which the family members named as Insured Persons in the Policy Schedule are covered.

30. **In-patient** means an Insured Person who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving treatment.

31. **Individual Policy** means a policy named as an Individual Policy in the Policy Schedule or Certificate of Insurance under which one or more persons are covered as Insured Persons.

32. **Insured Person** means the person(s) named in the Policy Schedule to whom a Certificate of Insurance has been issued, who is/are covered under this Policy, and in respect of whom the appropriate premium has been received.

33. **IRDAI** means the Insurance Regulatory and Development Authority of India.

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

35. **Policy** means this Policy document containing the Terms and Conditions, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form a part of the Policy including endorsements, as amended from time to time which form a part of the Policy and shall be read together.

36. **Policy Period** means the period between the Start Date and the Expiry Date as specified in the Policy Schedule or the Certificate of Insurance or the date of cancellation of this Policy, whichever is earlier.

37. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the group, the period and the limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

38. **Policy Year** means a period of 12 consecutive months commencing from the Start Date.

39. **Start Date** of the Policy means the inception date of this Policy as specified in the Policy Schedule or Certificate of Insurance.

40. **Sum Insured** means:
    For an Individual Policy, the amount specified in the Policy Schedule or Certificate of Insurance against an Insured Person which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of that Insured Person.
    For a Family Floater Policy, the amount specified in the Policy Schedule or Certificate of Insurance which is Our maximum, total and cumulative liability for any and all claims arising during a Policy Year in respect of any and all Insured Persons.

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

42. **We/Our/Us** means Aditya Birla Health Insurance Company Limited.

43. **You/Your/Policyholder** means the person named in the Policy Schedule or Certificate of Insurance as the policyholder and who has concluded this Policy with Us.

III. Benefit Covered under the Policy

The Benefit listed below shall be available to all Insured Persons as specified in the Policy Schedule or Certificate of Insurance.

We will indemnify the Reasonable and Customary Charges incurred towards Necessary Medical Treatment taken by the Insured Person during the Policy Period for an Illness, Injury or the conditions described in the Benefits below if it is contracted or sustained by an Insured Person during the Policy Period.

Benefit under this Section are subject to the terms, conditions and exclusions of this Policy and Base Plan and the availability of the Sum Insured and subject always to any sub-limits for the Benefit as specified in the Policy Schedule or Certificate of Insurance.

All claims must be made in accordance with the procedure set out in Base Plan.

(1) Super Cumulative Bonus:

What is covered

We shall apply a Cumulative Bonus in the form of No Claim Bonus at such rates as specified in the Policy Schedule/ Certificate of Insurance/Product Benefit Table of this Policy on the Sum Insured of the expiring Policy as specified for Section (III.A.1.1) of Base Plan (In-patient Hospitalization) in the Policy Schedule on a cumulative basis, provided that the Insured Person(s) has not made any claim under Section (III.A.1.1) of Base Plan (In-patient Hospitalization) in a Policy Year and has successfully Renewed the Policy with Us continuously and without any break. The accumulated Cumulative Bonus shall not exceed 100% of the Sum Insured on the Renewed Policy as specified in the Policy Schedule/ Product Benefit Table of this Policy.

Conditions

(i) If the Policy is a Family Floater Policy, then Cumulative Bonus will accrue only if no claims have been made in respect of the Insured Person(s) in the expiring Policy Year. Cumulative Bonus which is accrued during the claim free Policy Year will only be available to those Insured Person(s) who were insured in such claim free Policy Year and continue to be Insured Person(s) in the subsequent Policy Year.
(ii) Cumulative Bonus shall not be accumulated in excess of the percentage applicable under the Plan in force for the Insured Person as stated in the Policy Schedule.
(iii) Cumulative Bonus will not be added if the Policy is not Renewed with Us by the end of the Grace Period.
(iv) If the Policy Period is two or three years, any Cumulative Bonus that has accrued for the first/second Policy Year will be credited at the end of the first/second Policy Year as the case may be and will be available for any claims made in the subsequent Policy Year.
(v) The accumulated Cumulative Bonus can be utilised for Benefits covered under Section (III.A.1.1) of Base Plan (In-patient Hospitalization), (III.A.1.4) of Base Plan (Pre-hospitalization Medical Expenses), (III.A.1.5) of Base Plan (Post-hospitalization Medical Expenses), (III.A.1.2) of Base Plan (Day Care Treatment), (III.A.1.3) of Base Plan (Domiciliary Hospitalization), (III.A.1.7) of Base Plan (Road Ambulance Cover)
(vi) The accumulated Cumulative Bonus can be utilised only when Sum Insured have been completely exhausted.
(vii) The Cumulative Bonus shall not enhance or be deemed to enhance any condition of this Policy or limits as prescribed in the Policy Schedule and Product Benefit Table of this Policy.
(viii) If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Cumulative Bonus for each Insured Person under the expiring Policy, and such expiring Policy has been Renewed with Us on a Family Floater Policy basis then the Cumulative Bonus to be carried forward for credit in such Renewed Policy shall be the lowest accrued amongst all the Insured Persons.
(ix) If the Insured Persons in the expiring Policy are covered on a Family Floater Policy basis and such Insured Persons Renew their expiring Policy with Us by splitting the Sum Insured in to two or more Family Floater Policies/Individual Policies then the Cumulative Bonus of the expiring Policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy.
(x) If the Sum Insured has been reduced at the time of Renewal, the applicable Cumulative Bonus shall be reduced in the same proportion to the Sum Insured.
(xi) If the Sum Insured under the Policy has been increased at the time of Renewal the Cumulative Bonus shall be calculated on the Sum Insured of the last completed Policy Year.
(xii) The Cumulative Bonus is provisional and is subject to revision if a claim is made in respect of the expiring Policy Year, which is notified after the acceptance of Renewal premium. Such awarded Cumulative Bonus shall be withdrawn only in respect of the expiring year in which the claim was admitted.
(xiii) In case of Family Floater Policies, Dependent Children attaining Age 25 years at the time of Renewal will be moved out of the Family Floater Policy into an Individual Policy. However, all continuity benefits for such Insured Person on the Policy will remain intact. Cumulative Bonus earned on the Policy will stay with the Insured Person(s) covered under the original Policy.
(xiv) In the event of a claim impacting the eligibility of a Cumulative Bonus, the accumulated Cumulative Bonus shall be reduced by the percentage of Sum Insured as accumulated in the previous Policy Year and as mentioned in Policy Schedule/ Product Benefit Table of this Policy.
(xv) Co-Payment, Deductible and Sublimit, if any, applicable as per Base Plan.

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IV. Exclusions

All exclusions as mentioned in the Base Plan unless otherwise stated and covered in Section III of Super No Claim Bonus policy wordings.

V. General Terms & Clauses

A. Standard General Terms & Clauses

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

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

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

4. Multiple Policies

1. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.
2. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.
3. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.
4. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

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

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

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

a) The suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
b) The active concealment of a fact by the insured person having knowledge or belief of the fact;
c) Any other act fitted to deceive; and
d) Any such act or omission as the law specially declares to be fraudulent

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

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

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

Cancellation Grid	
Period* for which risk is retained	Refund
Less than 1 Month	75%
1 Month- less than 3 Month	50%
3 Months – less than 6 months	25%
Beyond 6 Months	Nil

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

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7. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

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

8. Withdrawal of Policy

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

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

9. Moratorium Period

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

10. Premium Payment in instalments

Premium payment mode under this rider Policy will be same as that of premium payment mode chosen in Base Plan

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

i. Grace Period of 15 days would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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

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

12. Redressal of Grievance

In case of a grievance, the Insured Person/ Policyholder can contact Us with the details through:
Our website: www.adityabirlacapital.com/healthinsurance
Email: care.healthinsurance@adityabirlacapital.com
Toll Free : 1800 270 7000
Address: Aditya Birla Health insurance Co. Limited
9th Floor, Tower 1, One World Centre, Jupiter Mills Compound, 841, Senapati Bapat Marg, Elphinstone Road, Mumbai 400013.

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

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at
For updated details of grievance officer, refer the link https://www.adityabirlacapital.com/healthinsurance/#!/homepage

For senior citizens, please contact the respective branch office of the Company or call at 1800 270 7000 or may write an e- mail at seniorcitizen.abh@adityabirla.com.

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of the Ombudsman offices are provided on Our website and in this Policy at Annexure VI.

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

13. Nomination:

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

14. Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.
iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

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B. Specific Terms & Clauses

15. Entry Age

Minimum Entry Age	1 day
Maximum Entry Age	No Limit

16. Relationship covered

Self, lawfully wedded spouse (more than one wife)/ Partner (including same sex partners), son (biological/ adopted), daughter (biological/ adopted), mother (biological/ foster), father (biological/ foster), brother (biological/ step) sister (biological/ step, mother in-law, father in-law, son in-law, daughter in-law, brother in-law, sister in-law.

For the purpose of this section, Partner shall be taken as declared at the time of Start Date and no change in the same would be accepted during a Policy Period. However, an Insured Person may request for change at the time of Renewal of the cover.

17. Material Change

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

18. Alterations in the Policy

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

19. No Constructive Notice

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

20. Grace Period

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

21. Renewal Terms

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy (as stated above). Renewals will not be denied except on grounds of misrepresentation, moral hazard, fraud, non-disclosure of material facts or non-co-operation by the Insured Person.

Upon the Insured Person ceasing to be an Employee/member of the Policyholder or Us discontinuing/withdrawing this product, such Insured Person shall have the option to migrate to an approved retail health insurance policy available with us.

22. Communication & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

i. The Policyholder's/Insured Person, at the address as specified in the Policy Schedule or Certificate of Insurance
ii. To Us, at the address specified in the Policy Schedule or Certificate of Insurance.
iii. No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.

23. Premium

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

24. Special Provisions

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

25. Electronic Transactions

The Policyholder agrees to comply with all the terms and conditions of electronic transactions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centres, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, in respect of this Policy and claim related details, shall constitute legally binding when done in compliance with Our terms for such facilities.
Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Policyholder. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated / confirmed by the Policyholder.

26. Policy Dispute

Any dispute concerning the interpretation of the terms, conditions, limitations and/ or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

27. Records to be maintained

You shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

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28. Assignment

An Insured Person may assign the Benefits or any specific Benefit(s) under the Policy by giving written notice of the assignment and the terms and conditions of the assignment to Us. We will record the assignment in accordance with Section 38 of the Insurance Act 1938.

29. Sequence of Sum Insured utilisation

The utilisation of Sum Insured and limits thereof as applicable across various Benefits shall be as follows

1. Sum Insured for Base Policy – Inpatient Hospitalization
2. Super No Claim Bonus
3. Super Reload
4. Additional S.I. for Pandemic and epidemic

VI. Other Terms and Conditions

1. Claims Process

All claims must be made in accordance with the procedure set out in Base Plan.