THE ORIENTAL INSURANCE COMPANY LIMITED
Regd. Office : Oriental House, P.B. No. 7037,
A-25/27, Asaf Ali Road, New Delhi - 110 002

BANK GRAHAK SURAKSHA POLICY

WHEREAS the Insured named in the Schedule hereto has made to THE ORIENTAL INSURANCE CO. LTD. (hereinafter called "the Company") a proposal and declaration which shall be the basis of this contract and is deemed to be incorporated herein for the insurance hereinafter contained and has paid or agreed to pay the premium stated herein.

The Company hereby agrees subject to terms and conditions contained herein or endorsed or otherwise expressed hereon that if the Insured shall sustain LOSS or DAMAGE or the Insured or any member of the Insured's family named in the schedule shall sustain BODILY INJURY by accident at any time during the period of insurance stated herein or any subsequent period in respect of which the Insured shall have paid or agreed to pay and the Company shall have accepted or agreed to accept the premium required for the renewal thereof, the Company shall pay to the Insured the value, at the time of happening of such LOSS of the property so lost or the amount of such damage or the benefits specified herein but not exceeding in any one period of insurance in respect of each of the several items specified herein the sum set opposite thereto respectively.

GENERAL CONDITIONS

General Conditions pertaining to the Policy are placed below. However, if any of these conditions appear as Special Conditions in particular Sections of the Policy the same shall prevail.

1 **NOTICE:** Every notice and communication to the Company required by this policy shall be in writing to the office of the Company through which this insurance is effected.

2 **MISDESCRIPTION**: This Policy shall be void and all premium paid hereon to the Company shall be forfeited in the event of misrepresentation, misdescription or non disclosure *of* any material particulars.

3 **REASONABLE CARE**: The Insured shall take all reasonable steps to safeguard the property insured against any loss or damage. The Insured shall exercise reasonable care and shall take all reasonable precautions to prevent all accidents and shall comply with all statutory or other regulations.

4 Cancellation

Company may at any time cancel this section of the Policy (on grounds of fraud, moral hazard, misrepresentation or non-co-operation), by sending the Insured 15(fifteen) days' notice by registered post at the Insured's last known address. No refund of premium shall be made in such cases, except in case of cancellation on ground of non-co-operation, where refund shall be made on prorate basis.

The Insured may at any time cancel this policy and in such event the Company shall charge premium at Company's short period rate as per the table below and make refund, provided no claim has been reported during the policy period up to date of cancellation.

	Period on Risk	Premium to be charged
1	Up to 1 Month	¼ th of the annual premium
2	Up to 3 Months	½ of the annual premium
3	Up to 6 Months	¾ th of the annual premium
4	Exceeding 6 Months	Full annual premium

5. CLAIMS PROCEDURE:

i The Insured shall upon the occurrence of any event giving rise or likely to give rise to a claim under this Policy:

a) In the event of theft, lodge forthwith a complaint in writing with the Police and take all practicable steps to apprehend the guilty person or persons and to recover the property lost.

b) Give immediate written notice thereof to the Company and shall within Fourteen (14) days thereafter furnish to the Company at his own expense detailed particulars of the amount of the loss or damage together with such explanations and evidence to substantiate the claim as the Company may reasonably require.

ii If the Insured or their spouse named in the schedule sustains any bodily injury in respect of which claim is or may be made hereunder, prompt written notice thereof shall be given to the company immediately but in any event within Fourteen days of the date of injury. If the insured or their spouse covered under this Policy shall die, immediate notice of death shall be given by the Insured or the members of the Insured family or Assignee forthwith. In the event of loss of sight or amputation of limbs, written immediate notice thereof must be given after such loss of sight or amputation. All certificates, information and evidence whether from a Medical Attendant or otherwise required by the company shall be furnished at the expense of the Insured or the members of the Insured family or Assignee and shall be in such form and of such nature as the Company may prescribe. The Insured Person must immediately after the occurrence of an accident, which may be the subject of a claim hereunder, obtain medical treatment, failing which the Company shall not be liable for any consequences thereof.

iii Any medical or other agent/ investigator of the Company shall be allowed to examine the Insured Person on the occasion of any alleged injury or disablement when and so often as the same may reasonably be required on behalf of the Company and in the event of death, to make a post mortem examination of the Body of the Insured Person. Such evidences as may be from time to time required by the Company shall be furnished and a postmortem examination be furnished within 14 (fourteen) days after demand in writing and in the event of a claim in respect of loss of sight, the Insured or the Insured Person shall undergo at the Insured's expense such operation or treatment as the Company may reasonably deem fit.

iv The Insured shall upon the occurrence of any event giving rise or likely to give rise to a claim under the Policy give immediate written notice thereof to the Company.

v Claim Procedure clause appearing as a special condition in any of the sections of the policy shall hold good for that section.

6. CONTRIBUTION: At the time of any loss or damage happening to any property hereby insured, if there be any other subsisting insurance or insurances, whether effected by the Insured or by any other person or persons covering the same property, this Company shall not be liable to pay or contribute more than its rateable proportion of such loss or damage.

7. SUBROGATION : The Insured and any claimant under this policy shall at the expense of the Company do and concur in doing and permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing any rights and remedies for obtaining relief or indemnity from other parties to which the Company shall be or would become entitled or subrogated upon the Company paying for or making good any loss or damage under this policy whether such acts or things shall be or become necessary or required before or after the Insured's indemnification by the Company.

8. FRAUD: If any claim under the Policy shall be in any respect fraudulent or if any fraudulent means or devices are used by the Insured or anyone acting on the Insured's behalf to obtain any benefit under the Policy, all benefits under the policy shall be forfeited.

9. INDEMNITY: The Company may at its option reinstate, replace or repair the property or premises lost or damaged or any part thereof instead of paying the amount of loss or damage or may join with any other insurer in so doing but the Company shall not be bound to reinstate exactly or completely but only as circumstances permit, and in a reasonable and sufficient manner and in no case the Company shall be bound to expend more in reinstatement than it would have cost to reinstate such property as it was at the time of occurrence of such loss or damage nor more than the Sum Insured by the Company thereon.

10. AVERAGE: If the property hereby insured shall at the time of any loss or damage be collectively of greater value than Sum Insured thereon then the Insured shall be insurer considered as being his own insurer for the difference and shall bear a rateable proportion of the loss or damage accordingly. Every item, if more than one, of the Policy shall be separately subject to this condition.

11. ARBITRATION: If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator, to be appointed by the parties in difference or if they cannot agree upon a sole arbitrator within 30 (thirty) days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

It is hereby clearly agreed and understood that no difference or dispute shall be referable to arbitration as hereinbefore provided if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit under this policy that the award by such arbitrator, arbitrators or presiding arbitrator of the amount of the loss or damage shall be first obtained.

The parties to such arbitration shall pay the arbitrators respectively appointed by them and bear equally the expenses of the arbitration and charges of the presiding arbitrator.

12. DISCLAIMER: It is also hereby further expressly agreed and declared that if the Company shall disclaim liability to the insured for any claim hereunder and such claim shall not within 12 (Twelve) calendar months from the date of such disclaimer have been made the subject matter of a suit in a court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.
No sums payable under this Policy shall carry interest under any circumstances.

13. GEOGRAPHICAL SCOPE: Geographical scope of this policy shall be India except Section 3 (Personal Accident) and Section 7 (Laptop/Tablet) for which the cover is Worldwide.

14. STATUTORY AND OTHER SAFETY REQUIREMENTS: The insured shall always comply with all statutory and other regulations.

15. OBSERVATION OF TERMS AND CONDITIONS: The due observance and fulfilment of the terms, conditions and endorsements of this Policy in so far as they relate to anything to be done or complied with by the Insured shall be condition precedent to any liability of the Company to make any payment under the Policy.

16. Applicable law and jurisdiction

This Policy will be subject to the laws of India and the jurisdiction of Courts in India.

GENERAL EXCEPTIONS

The Company shall not be liable in respect of:

1 Loss, damage, injury, liability *or* expenses, whether direct *or* indirect occasioned by, happening through or arising from any consequences *of* war, invasion, act *of* foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, military *or* usurped power, civil commotion or loot or pillage in connection herewith.

2 Loss, injury *or* damage caused by depreciation *or* wear and tear.

3 Consequential loss *of* any kind *or desc*ription unless specifically covered.

4 Loss, injury or damage directly *or* indirectly caused by *or* arising from or in consequence of *or* contributed *to* by nuclear weapons material.

5 This insurance does not cover loss, injury *or* damage directly or indirectly caused by or arising from or in consequence *of or* contributed to by ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste *from* the combustion *of* nuclear fuel. For the purpose of this Condition only, *'Combustion'* shall include any self-sustaining process of nuclear fission.

6 Loss, damage or destruction to any electrical/electronic machine, apparatus, fixture, or fitting by over-running, excessive pressure, short circuiting, arcing, self-heating or leakage of electricity from whatever cause (lightning included). This exclusion applies only to the particular machine so lost, damaged or destroyed.

7 Loss or damage to bullion or unset precious stones, manuscripts, plans, drawings, securities, obligations or documents of any kind, coins or paper money, cheques, vehicles, and explosive substances unless otherwise expressly stated in the policy.

8 Loss of any Insured Property which is missing or has been mislaid, or its disappearance cannot be linked to any single identifiable event.

9 Loss or damage to any Insured Property removed from the House Building insured to any other place.

10 Any reduction in market value of any Insured Property after its repair or reinstatement.

11 Any addition, extension, or alteration to any structure of the Home Building that increases its Carpet Area by more than 10% of the Carpet Area existing at the Commencement Date or on the date of renewal of this Policy, unless the Insured has paid additional premium and such addition, extension or alteration is added by Endorsement.

12 Costs, fees or expenses for preparing any claim.

13 Loss, injury or damage occasioned by permanent or temporary dispossession resulting from confiscation, commandeering or requisition by any lawfully constituted authority.

14 Loss, injury or damage caused by or arising out of willful act or wilful gross negligence on the part of the insured.

SECTION I
BUILDING AND CONTENTS
(Excluding Jewellery and Valuables)

The Company shall indemnify the Insured in respect of physical loss or damage, or destruction caused to the Insured property i.e. Building and Contents whilst contained in the insured premises occurring during the policy period by the unforeseen events mentioned hereunder:

The events covered are given in Column A and those not covered in respect of these events are given in Column B.

	Column A	**Column B**
	The Company covers physical loss or damage, or destruction caused to the Insured Property by	**The Company does not cover** any loss or damage, or destruction caused to the Insured Property
1.	Fire	caused by burning of Insured Property by order of any Public Authority.
2.	Explosion or Implosion	-
3.	Lightning	-
4.	Earthquake, volcanic eruption, or other convulsions of nature	-
5.	Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado,	

	Tsunami, Flood and Inundation	
6.	Subsidence of the land on which the Insured's Home Building stands, Landslide, Rockslide	caused by a. normal cracking, settlement or bedding down of new structures, b. the settlement or movement of made up ground, c. coastal or river erosion, d. defective design or workmanship or use of defective materials, or e. Demolition, construction, structural alterations or repair of any property, or ground works or excavations.
7.	Bush fire, Forest fire, Jungle fire	-
8.	Impact damage of any kind, i.e., damage caused by impact of, or collision caused by any external physical object (e.g. vehicle, falling trees, aircraft, wall etc.)	Caused by pressure waves caused by aircraft or other aerial or space devices travelling at sonic or supersonic speeds.
9.	Missile testing operations	-
10.	Riot, Strikes, Malicious Damages	caused by a. temporary or permanent dispossession, confiscation, commandeering, requisition or destruction by order of the government or any lawful authority, or b. temporary or permanent dispossession of the Home by unlawful occupation by any person.
	The Company covers physical loss or damage, or destruction caused to the Insured Property by	**The Company does not cover** any loss or damage, or destruction caused to the Insured Property
11	Acts of terrorism (Coverage as per Terrorism Clause attached)	Exclusions and Excess as per Terrorism Clause attached.
12.	Bursting or overflowing of water tanks, apparatus and pipes.	-
13.	Leakage from automatic sprinkler installations.	a. repairs or alterations in the Home or the building in which the Home is located, b. repairs, removal or extension of any sprinkler installation, or c. Defects in the construction known to the Insured.

14.	Theft within 7 (seven) days from the occurrence of and proximately caused by any of the above Insured Events.	if it is a. of any article or thing outside the Home, or b. of any article or thing attached from the outside of the outer walls or the roof of the Home, unless securely mounted.

1. **Special meaning of certain words:** Words stated in the table above have a special meaning throughout this Policy, the Policy Schedule and Endorsements.

Word /s	***Specific meaning***
Bank	A bank or any financial institution
Carpet Area	1. for the main building unit of the Home, it is the net usable floor area, excluding the area covered by the external walls, areas under services shafts, exclusive balcony or verandah area and exclusive open terrace area, but including the area covered by the internal partition walls of the residential unit; 2. for any enclosed structure on the same site, it is the net usable floor area of such structure; and 3. for any balcony, verandah area, terrace area, parking area, or any enclosed structure that is part of the Home, it is 25% of its net usable floor area.
Home Contents	Those articles or things in the Home that are not permanently attached or fixed to the structure of the Home. Home Contents may consist of General Contents and/or Valuable Contents.
General Contents	**General Contents** are all the contents of household use in the Home, e.g., furniture, electronic items and goods, antennae, solar panels, water storage equipment, kitchen equipment, electrical equipment (including those fitted on walls), clothing and apparel and items of similar nature.
Valuable Contents	**Valuable Contents** of the Home consist of items such as jewellery, silverware, paintings, works of art, antique items, curios and items of similar nature.
Kutcha Construction	Building(s) having walls and/or roofs of wooden planks/thatched leaves and/or grass/hay of any kind/bamboo/plastic cloth/asphalt/canvas/tarpaulin and the like.
Pucca Construction	Construction other than Kutcha Construction.
Spouse	Insured's wife or husband.
Sum Insured	It represents Insurer's maximum liability for each cover or part of cover and for each loss. The Sum Insured for the Home Building Cover is the prevailing Cost of Construction of the insured Home Building at the Commencement Date as declared by the Insured and accepted by Insurer and will be the maximum amount payable in the event the Home Building is a Total Loss.

Total Loss	A situation where the Insured Property or item is completely destroyed, lost or damaged beyond retrieval or repair or the cost of repairing it is more than the Sum Insured for that item or in total.
Home Building	**Home Building** is a building consisting of a residential unit, having an enclosed structure and a roof, basement (if any) and used as a dwelling place. **Home Building includes** i. Fixtures and fittings permanently attached to the floor, walls or roof, like fixed sanitary fittings, electrical wiring and other permanent fittings. ii. the following 'additional structures' if they are on the same site, and are used as part of the Home Building: a) garage, domestic out-houses used for residence, parking spaces or areas, if any b) compound walls, fences, gates, retaining walls and internal roads, c) verandah or porch and the like, d) septic tanks, bio-gas plants, fixed water storage units or tanks, e) solar panels, wind turbines and air conditioning systems, central heating systems and the like, if not included in Home Contents Cover, iii. any other structure shown in the Policy Schedule. iv. This insurance policy pays only if the Home Building is used for the purpose of residence of the Insured and their family, or of their tenant or licensee. Note : This insurance will not pay if a) the Home Building is used as a holiday home, or for lodging and boarding, or b) the Home Building or any part of the Home Building is used for purposes other than residential except where it is used both for the Insured's residence and for the purposes of earning his livelihood if they are self-employed or they have shifted their office to their Home Building for a temporary period due to lockdown or closure of their office ordered by a Public Authority.

Section 1 A. Home Building Cover:

1. Who can buy

This insurance cover can be bought by the owner of the Home building, i.e. house, apartment, flat, duplex apartment, bungalow or any dwelling place or by a tenant of the Home Building under a written Agreement if he is liable for insurance. The building has to be used for residence.

2. What is covered

Physical loss or damage, or destruction of the insured Home Building because of any insured event listed in Column A mentioned above.

3. Sum Insured

The Sum Insured for the Home Building is the prevailing cost of construction of the Home Building at the commencement date of this insurance as declared by the Insured and accepted by the company after payment of requisite premium by the Insured**.** The Sum Insured for the Home Building Cover shall be equal to the Cost of Construction of the Home Building including fittings and fixtures at the Policy Commencement date. The cost of construction is calculated as follows-
[Carpet area of the home structure in sq.m. X rate of cost of construction at the commencement date declared by the Insured and accepted by the Company] + cost of construction for additional structures at the Policy Commencement date as declared and accepted.

If the actual carpet area is less than the carpet area declared, the claim amount shall be calculated on the basis of the actual carpet area.

The insurance cover will at all times be maintained during the Policy Period to the full extent of the respective Sum Insured. This means that after payment for any loss, the policy shall be restored to the full original amount of Sum Insured upon payment of the proportionate premium for the unexpired Policy Period from the date of loss. This premium can also be deducted from the net claim that that the Company pays to the Insured.

4. What is payable:

a. If the Insured makes a claim under the policy for damage to their Home Building due to any of the insured perils, the Company shall reimburse the cost to repair it to a condition substantially the same as its condition at the time of damage. The Insured should spend for repairs, and claim that amount from the Company.
b. The amount of claim on the basis of the actual Carpet Area subject to the Carpet Area not exceeding that declared by the Insured in the Proposal Form and stated in the Policy Schedule.
c. The maximum payable for all items together is the Sum Insured shown in the Policy Schedule for Home Building Cover. If the Policy Schedule shows any limit for any item, such limit is the maximum the Company will pay for that item.
d. If the Home Building is a Total Loss, the maximum the Company will pay is the Sum Insured of the Home Building.
e. If only an additional structure is destroyed, the Company will pay the Insured an amount equal to the Cost of Construction of the additional structure.
f. The Company shall, in addition pay the following expenses:
   i. up to 5% of the claim amount for reasonable fees of architect, surveyor, consulting engineer;
   ii. up to 2 % of the claim amount for reasonable costs of removing debris from the site.

Special Condition applicable to Section 1 : Building and Contents : The condition of average as mentioned in General condition No. 10 of the policy shall be of no effect if the Sum Insured on the property insured, be it Building or Contents, at the breaking out of such fire or any allied peril or such destruction or damage is not less than 85% of the collective value of the property insured.

Section 1B. Home Contents Cover

The Contents: Articles or things of personal, non-commercial use which are located inside the home building . Contents denote general contents that are usual in any home i.e., furniture and fittings, television sets, telephones, electronic items, antennae, water storage equipment, air conditioners, kitchen equipment and other household items.

Valuable Contents, like jewellery, silverware, paintings, works of art, valuable carpets, antique items, curios, paintings **are not covered**. Also, contents like bullion or unset precious stones, manuscripts, vehicles, explosive substances **are not covered**.

1. **Who can Buy**

The Owner Insured who has purchased the articles, even if purchased under instalment or hire purchase or on lease.

2. **What is covered :**

Physical loss or damage to or destruction of the **General Contents** of the Home caused by an Insured Event as listed in **Column A** of this Policy. **Valuable Contents** of the Home are not covered under this Policy unless specifically mentioned in the policy Schedule and premium paid therefor.

3. **Sum Insured**:

a. The Sum Insured for the Home Contents Cover is shown in the Policy Schedule and will be the maximum amount payable in the event the Home Contents are destroyed/lost completely.
b. The Insured has to choose a Sum Insured for Home Contents and declare the Sum Insured in the Proposal Form and pay premium therefor.
c. The Sum Insured chosen for General Contents must be enough to cover the cost of replacement of the General Contents.
d. Restoration of Sum Insured: The insurance cover will at all times be maintained during the Policy Period to the full extent of the respective Sum Insured. This means that after payment for any loss, the policy shall be restored to the full original amount of Sum Insured. By payment of proportionate premium for the unexpired Policy Period from the date of loss. This premium may also be deducted from the net claim that the Company pays to the Insured.

4. **What is payable**

a. If the General Home Contents insured are physically damaged by any Insured Event, the Company will at its option,
    i. reimburse the cost of repairs to a condition substantially the same as its condition at the time of damage, or
    ii. pay the cost of replacing that item with a same or similar item, or
    iii. repair the damaged item to a condition substantially the same as its condition at the time of damage.

b. The maximum payable for Home Contents is the Sum Insured shown in the Policy Schedule for Home Contents Cover. If the Policy Schedule shows any limit for any item, or category or groups of items, such limit is the maximum amount payable for that item. *+

Important : If the Home Building and/or Home Contents have been mortgaged, pledged or hypothecated with a Bank, the Policy Schedule will show an 'Agreed Bank Clause' and the name of such Bank. The terms and conditions of this arrangement will be added to this Policy as an additional clause.

Claims Procedure for any Loss under Section 1 - Building and Contents

In case of a loss because of an Insured Event, the Insured must make a claim for the financial loss at their own cost. The procedure for making a claim is given below. These include things that the Insured **must do**, and that they **must not do**. It is important to comply with these to ensure that the claim is not prejudiced in any manner.

1. Immediate notice to the Company

a. As soon as there is any physical loss or damage to the Home Building or Home Contents due to an Insured Event, the Insured must immediately give notice to the Company of the loss or damage so that the loss or damage can be surveyed/ investigated, as may be required.
b. Notice can be given to any of the Offices of the company or at the Comapany's call-centers.
c. This notice should specify :
    i. the Policy Number,
    ii. Name of the Insured,
    iii. Details of report to the police by the Insured,
    iv. Details of report to any Authority
    v. Details of the Insured Event,
    vi. A brief statement of the loss,
    vii. particulars of any other insurance of the Home Building or any of Home Contents insured
    viii. photographs of loss or physical damage, wherever possible.

2. Steps to prevent loss and damage

a. The Insured must take all reasonable steps to prevent further loss or damage to the Home Building and Home Contents.
b. Until the representatives of the Company have inspected the Home Building and Home Contents, and have given their consent,
    i. The Insured must not sell, give away or dispose of any damaged items of any property for which a claim has been made on the Company;
    ii. The damaged item or debris must not be washed or cleaned, or removed, except for any urgent necessity;
    iii. Repairs, unless urgent and the Company cannot be contacted.

3. Immediate notice to Authorities

a. As soon as any loss or damage occurs to the Insured Property, the Insured must give immediate report to appropriate legal authorities. For example, he/she must report to the fire brigade of the local authority and the police if there is damage by fire/ explosion / implosion or lightning. In case of subsidence /landslide/rockslide, the Insured must inform the District Administration. In the event of impact damage of any kind or Riot Strikes, Malicious damages and acts of terrorism, he/she must inform the police. If there is a theft within 7 (seven) days following an Insured Event he/she must inform the police.

b. The Company may, but not necessarily, waive this condition if it is satisfied that by reason of extreme hardship it was not possible for the Insured or any other person on their behalf to give such report.

4. Submit claim

a. Claim form:

i. The Insured must submit the claim in the Company's claim form at the earliest opportunity, but within 30 days of the loss coming to the notice of the Insured. The claim form is available in any of our Company's offices and on Our Web-site.

ii. Details of any other insurance policy that covers the damage or loss for which the claim has been filed, should be given, whether purchased by the Insured or someone else on his behalf.

5. Establish loss

a. The occurrence of the loss and the extent of physical loss or damage suffered with full details must be proved by the Insured.

b. At the Company requires :

i. The claim for Home Building and/or Home Contents must be supported with plans, specification books, vouchers, invoices pertaining to costs incurred by the Insured for reconstruction/replacement/repairs.

ii. The Insured must allow The Company's officers, surveyors or representatives to inspect the loss or damage to the Home Building and/or Home Contents, and to take measurements, samples, damaged items or parts, and photographs that are relevant.

iii. The Company and its authorized representatives must be given the authority to see the relevant records and get information about the Event and the loss from the police or any other authority.

6. Fraudulent claim

If the Insured or anyone on their behalf, makes a false or fraudulent claim, or support a claim with any false or fraudulent statement or documents:

i. The company will not pay,

ii. The policy can be cancelled by the Company forfeiting all benefits under the policy and the premium paid, and

iii. The Company can also inform the police, and start legal proceedings against the Insured.

7. Other insurance

a. If there is any other policy in existence whether from our Company or any other Insurance Company (taken by the Insured or by anyone else on their behalf) covering in whole or in part any claim that the

Insured have made under this Policy, the Insured have a right to ask for settlement of their claim under any of these policies.

b. If the Insured chooses to claim under this Policy from our Company, the Company will settle the claim within the limits and the terms and conditions of this Policy.

c. After the payment of the claim amount, the Company has the right to ask for contribution from the Insurers that have given the other policies.

d. The Company will ensure that its actions do not impose any liability on the Insured.

8. Recovery action by the Company

a. When a claim is paid by the Company under the Policy, it can start legal proceedings to recover the amount or property from the third party who has caused the loss or damage to the insured Home Building or Home Contents. The Insured must, on request from the Company give authority to the Company to take such action and exercise this right effectively, whether before or after making payment of the claim. The Insured must give all information, cooperation, assistance and help for this purpose and must not do anything which will prejudice the right of the Company. The Company can do this

i. without seeking the consent of the Insured,

ii. in Insured's name, and

iii. whether or not the Insured's loss has been fully compensated.

b. Any amount that the Company recovers from such person will be applied first to the costs of the legal proceedings and recovery, then to the claim amount it has paid or must pay to the Insured. The balance, if any, shall be payable to the Insured.

c. The Insured can start legal proceedings against any person who has caused the loss or damage only with the company's prior consent, and on conditions that the Company will impose. The Insured must not compromise or settle any claim against such person without the Company's consent. If the Insured recovers any amount from such person, the claim amount paid by the Company shall be returned. The Company can take over the conduct of legal proceedings that the Insured has started and continue the proceedings in his name.

Section 2 HOUSE BREAKING (Excluding Money and Valuables)

The Company shall indemnify the Insured in respect of loss or damage to the contents whilst contained in the Insured premises by housebreaking.

SPECIAL EXCEPTIONS: The Company shall not be liable in respect of

b) loss or damage by Housebreaking where any member of the Insured's family is concerned as principal or accessory.

c) Loss of or damage to livestock, motor vehicles and pedal cycles.

d) Loss of or damage to money, securities, stamps, bullion, deeds, bonds, bills of exchange, promissory notes, stock and share certificates, business books, manuscripts, documents of any kind, unset precious stones and Jewellery and valuables, unless specifically declared.

d) Liability assumed by the insured by agreement unless such liability would have attached to the insured notwithstanding such agreement.

e) Loss of or damage to any insured item by perils which are insurable under any other Section of the Policy.

SECTION - 3
PERSONAL ACCIDENT

Scope of Cover

If the Insured and/or their spouse as named in the schedule shall during the currency of the policy sustain anywhere in the world, bodily injury solely and directly caused by accidental, violent external and visible means resulting in death or disablement within 12 (Twelve) calendar months of occurrence of such injury as stated hereinafter, the Company shall pay to the Insured or insured person or his/her Assignee or his/her legal representative the sum or sums hereinafter set forth:

	TABLE OF BENEFITS	**PERCENTAGE OF INDIVIDUAL CAPITAL SUM INSURED (C.S.I.)**
1.	Death	100%
2.	Permanent Total and Absolute Disablement disabling the insured person from engaging in any employment or occupation of any description whatsoever.	100%
3.	Total and irrecoverable loss of	
i)	Sight of both eyes or of the actual loss by physical separation of the two entire hands or two entire feet or of such loss of sight of one eye and loss of one entire hand/ one entire foot.	100%
ii)	Use of two hands or two feet, or of one hand and one foot or of such loss of sight of one eye and such loss of use of one hand/ one foot, without physical separation.	100%
4.	Total and irrecoverable loss of	
i)	The sight of one eye or of the actual loss by physical separation of one entire hand or one entire foot.	50%
ii)	Use of a hand or a foot without physical separation.	50%
iii)	Hearing (both ears).	50%

5. iv)	Loss of toes – all Both Great phalanges One Great phalanx Other than great, if more than one toe lost each	20% 5% 2% 1%
iv)	Loss of hearing both ears	50%
v)	Loss of hearing one ear	15%
vi)	Loss of four fingers and thumb of one hand	40%
vii)	Loss of four fingers	35%
viii)	Loss of thumb both phalanges -one phalanx	25% 10%
ix)	Loss of index finger -three phalanges -two phalanges -one phalanx	 10% 8% 4%
x)	Loss of middle finger -three phalanges -two phalanges -one phalanx	 6% 4% 2%
xi)	Loss of ring finger -three phalanges -two phalanges -one phalanx	 5% 4% 2%
xii)	Loss of little finger -three phalanges -two phalanges -one phalanx	 4% 3% 2%
xiii)	Loss of metacarpals -first or second(additional) -third, fourth or fifth(additional)	 3% 2%
xiv)	Any other permanent Partial disablement	As assessed by the doctor

NOTE : For the purpose of Item 3 and 4 of table of benefits, Physical Separation means separation at or above wrist and at or above ankle of the hand and foot respectively.

SPECIAL EXCEPTIONS: The Company shall not be liable under this section or policy for:

1. Compensation under more than one of the foregoing benefits 1 to 4 in respect of the same period of disablement.
2. Any other payment after a claim under one of the foregoing benefits (1, 2, 3, 4) has been admitted and becomes payable.
3. Any payment in case of more than one claim under the policy during any one period of insurance by which the maximum liability of the Company in that period would exceed the sum payable under Benefit (1) of the Section.
4. Payment of compensation in respect of death, injury or disablement from intentional self injury, suicide or attempted suicide whilst under the influence of intoxicating liquor or drugs, whilst

engaging in ballooning or Aviation, whilst mounting into, dismounting from or traveling in any Balloon or Aircraft other than as passenger (fare paying or otherwise) in any duly licensed standard type of Aircraft anywhere in the world.

5. Directly or indirectly caused by insanity.
6. Death or disablement resulting directly or indirectly caused by or contributed to or aggravated or prolonged by childbirth or pregnancy or in consequence thereof.
7. Arising or resulting from the insured person committing any breach of law with criminal intent.

SECTION 4 Critical Illness

Scope of Cover : if during the policy period stated in the schedule or during the continuance of the Policy by renewal, the insured person is first diagnosed as suffering from an illness or undergoes a surgery, mentioned in the Table of Benefits, under the Plan opted (hereinafter called Critical Illness) and satisfies the respective definition mentioned below, symptoms (and/or the treatment) of which were not present in such insured person at any time prior to inception of the Policy, the Company shall pay to the insured the benefit as defined below.

2. Coverage:

The Company shall pay the full sum insured as mentioned in the schedule, provided the insured person survives for the survival period applicable to the Critical Illness and if,

i. The insured person is diagnosed with a critical illness specifically listed and defined in this policy; and

ii. such critical illness occurs or manifest itself as a first incident; and

iii. such critical illness manifest after number of days specified in the policy schedule as waiting period from Inception of first policy/ certificate of insurance with us; and

iv. the insured person survives such critical illness by number of days specified in the policy schedule as survival period or more, from the date of diagnosis/ date of undergoing the surgical procedure.

***NOTES:**

a. for this benefit critical illness shall mean the illness/ surgical procedures specified under clause 2.B.1 to 2.B.22.

b. the company shall compensate the insured person, only once in respect of anyone or more of the covered diseases under the policy.

c. should a benefit paid in terms of this policy on behalf of an insured person the coverage for that person terminates under this policy and such person shall not be entitled to be covered by this policy or its renewal thereof.

d. Survival Period : A claim shall be admissible under the Policy, provided the insured person survives the specified survival period (30 days), after diagnosis of a Critical Illness or undergoing the procedure.

2.A. Table of Benefits:

The Cover shall be available under two plans as under:-

	PLAN A	PLAN B
A. Covers 11 critical Illnesses named as under:-		**A. Covers 22 critical Illnesses named as under:-**
1. Cancer of specified severity 2. myocardial infarction (first heart attack) 3. open chest CABG 4. open heart replacement or repair of heart valves 5. coma of specified severity 6. kidney failure requiring regular dialysis 7. stroke resulting in permanent symptoms 8. major organs/ bone marrow transplant 9. permanent paralysis of limbs 10. motor neuron disease with permanent symptoms 11. multiple sclerosis with persisting symptoms. (Detailed definitions are as per clause 2.B.1 to 2.B.11)		1. Cancer of specified severity 2. myocardial infarction (first heart attack) 3. open chest CABG 4. open heart replacement or repair of heart valves 5. coma of specified severity 6. kidney failure requiring regular dialysis 7. stroke resulting in permanent symptoms 8. major organs/ bone marrow transplant 9. permanent paralysis of limbs 10. motor neuron disease with permanent symptoms 11. multiple sclerosis with persisting symptoms. 12. Angioplasty 13. benign brain tumour 14. Blindness 15. Deafness 16. end stage lung failure 17. end stage liver failure 18. loss of speech 19. loss of limbs 20. major head trauma 21. Primary (ideopalhic) pulmonary hypertension 22. third degree burns (Detailed definitions are as per clause 2.B.1 to 2.B.22)
B. **Medical second opinion** - if the insured person is diagnosed with any of the 11 specified critical illness listed above, and takes medical second opinion (including open and obtained from overseas) whether before starting the treatment or during the course of treatment, the policy covers medical expert's fees up to 1% of the sum insured in a policy period subject to maximum of Rs.10000 for Sum Insured upto Rs. 20 lacs and Rs.20000 for Sum Insured upto Rs.50 lacs. Claim under this clause would be admissible subject to the critical illness claim being admissible. This expense is payable only once per illness per insured person during the lifetime of the insured person. the second opinion benefit is valid only if critical illness policy is in force.		B. **Medical second opinion** - if the insured person is diagnosed with any of the 22 specified critical illness listed above, and takes medical second opinion (including open and obtained from overseas) whether before starting the treatment or during the course of treatment, the policy covers medical expert's fees maximum up to 1% of the sum insured in a policy period subject to maximum of Rs.10000 for Sum Insured upto Rs.20 lacs and Rs.20000 for Sum Insured upto Rs.50 lacs. Claim under this clause would be admissible subject to the critical illness claim being admissible. This expense is payable only once per illness per insured person during the lifetime of the insured person. the second

	opinion benefit is valid only if critical illness policy is in force.

DEFINITION OF CRITICAL ILLNESSES COVERED ;

CANCER OF SPECIFIED SEVERITY

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
II. The following are excluded–

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non- invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 andCIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classificationT2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) orbelow;
vi. Chronic lymphocytic leukaemia less than RAI stage3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50HPFs;
ix. All tumors in the presence of HIV infection.

2.B.2. MYOCARDIAL INFARCTION
(First Heart Attack of specific severity)
The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

III. The following are excluded:
i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

2.B.3 OPEN CHESTCABG
I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

II. The following are excluded:

iv. Angioplasty and/or any other intra-arterial procedures

2.B.4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

2.B.5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
i. no response to external stimuli continuously for at least 96 hours;
ii. life support measures are necessary to sustain life; and
iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

2.B.6. KIDNEY FAILURE REQUIRING REGULARDIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

2.B.7. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage and embolisation from an extra cranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:
v. Transient ischemic attacks (TIA)
vi. Traumatic injury of the brain
vii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

2.B.8. MAJOR ORGAN /BONE MARROWTRANSPLANT

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

ii. Human bone marrow using hematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:
viii. Other stem-cell transplants
ix. Where only islets of langerhans are transplanted

2.B.9. PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

2.B.10. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

2.B.11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

II. Other causes of neurological damage such as SLE and HIV are excluded.

2.B.12. ANGIOPLASTY

I. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stunting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

II. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

III. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

2.B.13 BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

2.B.14. BLINDNESS

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or;

ii. the field of vision being less than 10 degrees in both eyes.

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

2.B.15. DEAFNESS

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

2.B.16. END STAGE LUNG FAILURE

I. End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$);and

iv. Dyspnea at rest.

2.B.17. END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

2.B.18. LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

II. All psychiatric related causes are excluded.

2.B.19. LOSS OF LIMBS

I. The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

2.B.20. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

III. The Activities of Daily Living are:

i. **Washing**: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

ii. **Dressing**: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. **Transferring:** the ability to move from a bed to an upright chair or wheelchair and viceversa;

iv. **Mobility:** the ability to move indoors from room to room on level surfaces;

v. **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

vi. **Feeding**: the ability to feed oneself once food has been prepared and made available.

2.B.21. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

i. **Class III:** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. **Class IV:** Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thrombo embolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

2.B.22. THIRD DEGREE BURNS

I. There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

2. GENERAL DEFINITIONS :As specified in Section V

4. POLICY EXCLUSIONS:

The Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

A. Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.

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

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. **Critical illness** contracted or evident through Sign and symptoms within 3 months of the inception date of this policy. This exclusion does not apply for subsequent renewal with the Company without a break.

C. Any diseases causing the death of the Insured within the stipulated **Survival Period**, measured from the date of incidence of the illness.

D. Certification/diagnosis by a family member or any diagnosis that is not scientifically recognized.

E. Certification / diagnosis from a person not registered as Medical Practitioners under respective medical councils.

F. **Hazardous or Adventure sports:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

G. Breach of law:

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

H. Excluded Providers:

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

4. Special Exclusions: The Company shall not be liable to make any payment for any claim caused by, based on, arising out of or howsoever attributable to any of the following:

A. Pre-Existing Diseases

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

B. Critical illness diagnosed within 3 months of the inception date of this policy. This exclusion does not apply for subsequent renewal with the Company without a break.

C. Any diseases causing the death of the Insured within the stipulated **Survival Period**, measured from the date of first diagnosis.

D. Certification/diagnosis by a family member or any diagnosis that is not scientifically recognized.

E. Certification / diagnosis from a person not registered as Medical Practitioners under respective medical councils.

F. Hazardous or Adventure sports: Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

G. Breach of law:
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

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

I. Unproven Treatments:
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

J. Maternity and Pregnancy:
i. Medical treatment expenses traceable to childbirth (including complicated deliveries and cesarean sections incurred during hospitalization);
ii. Expenses towards miscarriage and lawful medical termination of pregnancy during the policy period.

K. Non Payable Conditions: Any Critical Illness resulting out of the following:-

i. Congenital external diseases, defects or anomalies, genetic disorders not resulting into specified critical illnesses.

ii. Sterility, infertility/sub fertility, assisted conception procedures.
iii. The ingestion of drugs other than those prescribed by a medical practitioner.
iv. Treatment arising out of disease/ injury/ directly attributable to abuse of drugs/alcohol and intoxicating substances, and treatment thereof.
v. Intentional self-inflicted injury, attempted suicide.
vi. Self exposure to needless perils except in an attempt to save human life.
vii. AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus). AIDS and HIV will be interpreted as broadly as possible so as to include all or any mutants, derivatives or variations thereof. The onus will always be on the insured person to show that any event was not caused by or did not arise through AIDS or HIV.
viii. Cosmetic treatment or aesthetic treatment of any description, change of life or sex change operation.

L. War Group Perils:
Directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition of or damage by or under the order of any government or public local authority.

M. Radioactivity :

Caused by or contributed by nuclear weapons/materials or arising from ionizing radiation or contamination by any nuclear fuel or from any nuclear waste or combustion of nuclear fuel.

6. CLAIM PROCEDURE:

6.1. Notification of Claim

i. The insured person or an authorized representative of insured person shall notify the Policy issuing office in writing regarding the occurrence of a Critical Illness that may give rise to a claim under the Policy, within 15 days of diagnosis or undergoing the procedure.
ii. The notification should contain full particulars like policy number, policy period, name of the insured person suffering Critical Illness, date of diagnosis or undergoing procedure, name of the Critical Illness suffered for the Policy issuing office to verify the records and register the claim.
iii. The underwriting office after registration of the claim shall supply a claim form, if required, which shall be filled in all respects, signed and submitted to the underwriting office along with the required documents.

6.2. Claim Documents:-

I. Policy number.

II. Duly filled Claim form

III. Photo ID and Age proof.

IV. Medical practitioner's certificate confirming diagnosis of the Critical Illness or undergoing the procedure along with the date of diagnosis or undergoing procedure.

V. Original/Attested copy of Discharge summary

VI. Original/ Attested copies of all diagnostic/ radiological/ Histopathological/ investigation reports

VII. Original/Attested copies of Indoor case papers(If needed)

VIII. Original/Attested copies of all the medical bills(If needed)

IX. Any other document (e.g. Disability Certificate, Dialysis records etc.) deemed necessary at the time of claim assessment for a specific Critical Illness condition

X. Copy of PAN Card and NEFT Details (to enable direct credit of claim amount in bank account) and a cancelled cheque.

XI. KYC (Identity proof with Address) of the proposer, where claim liability is above
Rs. One lakh as per AML Guidelines.
XII. Legal heir/ succession certificate, where ever applicable.

6.3. Waiver

Waiver of delay in submission of claim documents may be considered in genuine cases of hardship, but only if it is proved to Company's satisfaction that it was not possible for insured or any other person to comply with the prescribed time-limit.

The Insured person shall give the Company/TPA any additional information and assistance as the TPA / Insurer may require.

6.4 Claim Settlement (provision for Penal Interest):

I. Any claim arising under the Policy will be processed and settled by the Company/TPA.

II. 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.

III. 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.

IV. However, where the circumstance 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.

V. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

6.5. Payment of Claim

All claims under the Policy shall be payable in Indian currency and through NEFT/ RTGS only.

6.6. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

6.7. Cessation of Cover

i. Upon occurrence of a Critical Illness and payment of the benefit amount to the insured person, the cover shall cease.

ii. In case a claim has been paid to any insured person for a Critical Illness, in subsequent renewals no claim shall be paid to that insured person.

6.8. 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, 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 policy 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 mis- statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

7. OTHER TERMS AND CONDITIONS:

7.1. Eligibility: Any person aged between 18 years and 65 years, residing in India can take this insurance. Beyond 65 years, only renewals accepted. No cap on exit age.

7.2. Family:

i. Self

ii. Legally wedded Spouse

***Proof of age must be submitted at the time of proposal, which could be one of the following:**

1) Passport
2) Birth Certificate
3) Driving License
4) PAN Card
5) Class 10th/12thCertificate
6) School leaving Certificate
7) Domicile Certificate (issued by Government of India)
8) Adhaar Card

8. Sum Insured:

8.1. The Sum Insured slabs available under both the plans of the policy are:-

i. **For Insured age up to 50 years** - Minimum Rs. 2.0 lacs and maximum Rs. 50.0 lacs.

In multiples of Rs.2.0 lacs up to Rs.20.0 lacs, and thereafter, in multiples of Rs.5.0 lacs up to Rs.50.0 lacs.
ii. **For Insured age above 50 years**- Minimum Sum Insured is Rs.2.0 lacs, and maximum Rs.20.0 lacs, in multiples of Rs.2.0 lacs.
8.2. Sum Insured is available on **Individual Basis only** (i.e., Sum Insured shall apply separately on each Insured Person).
8.3.I. Change of Sum Insured
i. Sum Insured can be changed (increased/ decreased) only at the time of Renewal, subject to discretion of the Company.
ii. Increase in SI shall be allowed by one slab at a time.
iii. Increase in Sum Insured is allowed in policies where there are no claims reported in two successive policy years.

*** Midterm increase/decrease in SI is not allowed.**

8.3.II. Change of Plan

i. Change of Plan from Plan A to Plan B is allowed only at the time of renewal, subject to four years of continuous coverage with the Company and no claim reported under the Policy.
ii. For change of plan, medical reports are required to be submitted with respect to each insured person aged forty five years and above.

8.4 All persons of age 45 years and above must complete the medical examination report. The proposer whose medical test is conducted and for whom the company grants an insurance cover under this policy and whose name specifically appears as Insured person in the schedule, the company shall reimburse 50% of the cost of such medical tests.

Medical tests would be as follows:
1. Complete Blood count
2. Fasting Blood Sugar
3. ESR
4. Serum Creatinine
5. SGPT
6. Urine Routine
7. ECG
8. Medical Examination Report with BP recordings – By a medical practitioner.

In addition, from case to case, as per individual medical history, one might have to go for any other test as may be suggested by the Company.

8.5. Midterm Inclusion:
Midterm inclusion of Newly wed spouse within 90 days of marriage is permitted under the Policy, on payment of pro-rata premium only or at the time of renewal of the Policy.

8.6 Single policy:
Proposer/Insured is not allowed to take multiple policies of Oriental Critical Illness Policy. This condition shall be applicable to all the Insured persons covered under Oriental Critical Illness Policy.

8.7. Portability:

The Insured Person will have the option to port the Policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.
For Detailed Guidelines on Portability, kindly refer the link:
https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

8.8. Migration: Migration will be not be allowed from any of our other products to this product.

8.9. Change of Address:
Insured must inform the Company immediately in writing of any change in the address.

8.10. 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. For Claim settlement under reimbursement, the Company will pay the policyholder. Ill 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.

8.11. IRDA REGULATION: This section of the policy is subject to IRDAI Health Insurance Regulations2016 and Guidelines on Standardization in health insurance, as amended from time to time.

Section 5 Super Health Top Up

The Company undertakes that if during the period of insurance stated in the Schedule, any Insured Person(s) contracts or suffers from any illness / ailment /disease (hereinafter called '**DISEASE**') or sustains any bodily injury through accident (hereinafter called '**INJURY**') and if such disease or injury shall require any such Insured Person(s), upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called **MEDICAL PRACTITIONER**) or of a duly qualified Surgeon (hereinafter called '**SURGEON**') to incur expenses on hospitalisation (as defined hereinafter) for medical/surgical treatment at any Nursing Home/Hospital (hereinafter called '**HOSPITAL**') as an inpatient in India (or in SAARC countries), the Company will pay to the Hospital(s) (only if treatment is taken at Network Hospital(s) with prior written approval of Company / TPA) or reimburse to the Insured Person, as the case may be, the amount of such admissible expenses, as specified hereunder. It is a **condition precedent** that the expenses incurred in respect of **medically necessary treatment are reasonable and customary**; and in any case the liability of the Company, in respect of one or all the **Insured Persons** stated in the schedule, shall be in excess of the Deductible and upto the Sum Insured specified in the policy and/or schedule of the policy for all claims arising during the policy period mentioned in the schedule.

1.2. BASIS OF PAYMENT: The Company shall indemnify the insured, subject to
a. aggregate of all admissible expenses incurred exceeding the Deductible but not exceeding the Sum Insured, under this policy and
b. dates of admission in the hospital falling within the policy period.

I	Insured Expenses	Limits of Insured Expenses
i	Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home	1 % of the Deductible Amount (mentioned in the Policy Schedule) per day. *
ii	Intensive Care Unit (**ICU**) expenses as provided by the Hospital /Nursing Home.	2 % of the Deductible Amount (mentioned in the Policy Schedule) per day.*
	a. Number of days of stay under 'i' and 'ii' above should not exceed total number of days of stay in the Hospital. Expenses as specified in iii and iv below shall also be payable as per the entitled room rent limit as mentioned above. However, medicines / pharmaceuticals and body implants would be payable on actual basis. b. Any expense in excess of reasonable and customary charges as defined under 3.40, or in excess of negotiated prices (in case of network hospitals) shall be borne by the insured.	
iii	Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees	within the limits of Sum Insured, subject to 'a' & 'b' above
iv	Expenses in respect of Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial limbs and similar expenses.	within the limits of Sum Insured, subject to 'a' & 'b' above
v.	Organ Donor Benefit when Insured Person is Donor.	Lumpsum payment of 10% of the Sum Insured
vi.	Donor Expenses when Insured Person is Recipient	within the limits of Sum Insured
vii	Pre and Post hospitalisation expenses	Medical expenses incurred 30days prior to hospitalisation and upto 60 days post hospitalisation.

***Deletion of Room Rent Limit:** These limits are not applicable if the insured has paid the requisite additional premium for removal of Room Rent limits. In such a case, room rents and expenses in respect of iii & iv above, become payable on actuals basis, subject to other terms & conditions of the policy.

B. Relaxation to 24 hours minimum duration of hospitalisation is allowed in

a. specified Day Care procedures / Surgeries (as per appendix-I) where such treatment is taken by an Insured Person in a Hospital / Day Care Centre (but not the Out-Patient department of a hospital), Or

b. any other Day Care Treatment as mentioned in clause 3.11 and for which prior approval from Company / TPA is obtained in writing.

C. In case of Ayurvedic, Yoga and Naturopathy, Unani, Siddha and Homeopathic treatment, Hospitalisation expenses are admissible only when the treatment is taken as an inpatient.

NOTE: Maximum liability of the Company under the policy is the Sum Insured stated in the schedule.

2 A. INSURED EXPENSES

1. ORGAN DONOR EXPENSES- WHEN INSURED PERSON IS THE RECIPIENT: The section of the policy covers inpatient hospitalisation expenses in respect of the person donating the organ to the insured person, provided that the donation conforms to the Transplantation of Human Organs Act 1994 (or as amended from time to time) and/or any other extant Act, Central / State Rules /regulations, as applicable, in respect of transplantation of human organs.
Further provided that:

i. the organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant
ii. The claim of the Insured Person is admissible under the hospitalisation section of the policy.

The policy does not cover:
a) costs directly or indirectly associated with the acquisition of the organ and/or cost of organ.
b) costs towards donor screening
c) Pre & post hospitalisation medical expenses of the donor.

2. ORGAN DONOR BENEFIT- WHEN INSURED PERSON IS THE DONOR: A lumpsum payment of 10% of Sum Insured, to take care of medical and other incidental expenses is payable to the Insured Person donating an organ, provided that the donation conforms to the Transplantation of Human Organs Act 1994(as amended from time to time) and any other extant Act, Central / State Rules / regulations, as applicable, in respect of transplantation of human organs. This benefit is available only to the Insured person provided that this policy has been in force for a continuous period of minimum 24 months in respect of such an insured person.

This lumpsum payment will be made even if the Deductible has not been exceeded, and will be in addition to any amount payable under this head in any other Policy / or any other source. However, payment made under this section shall be within the Sum Insured limit of the Policy.

3. MATERNITY EXPENSES: The policy provides automatic maternity cover upto 10% of the Sum Insured. The Company shall pay the Medical Expenses incurred as an inpatient for a delivery (including caesarean section) or lawful medical termination of pregnancy during the policy period limited to two deliveries or terminations or either, during the lifetime of the Insured Person. Cover under this section is not available to those insureds who already have two living children. This benefit is available only to the Insured or his spouse provided that this policy has been in force for a continuous period of minimum 12 months in respect of both the Insured and his/her spouse. However, miscarriage due to accident or abdominal operation for extra uterine pregnancy (ectopic pregnancy) which is proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner, if left untreated, is not part of maternity coverage and hence no waiting period would apply in such cases.

4. NEW BORN BABY COVER: This benefit is available only if both the insured and his/her

spouse are covered under the family floater plan/Individual plan in this section of the policy. The section provides automatic cover upto 5% of the Sum Insured to the new born baby upto 90 days from the date of birth. Cover beyond 90 days is available for full Sum Insured only on payment of requisite additional premium.

In case the 90 days period for the New Born Baby is spread over two policy periods, the aggregate liability of the Company, for all claims in respect of the New Born Baby, shall be limited to 5% of the Sum Insured of this section of the policy under which the claim had triggered.

Claim under this section is independent of the claim status in respect of Maternity expenses, i.e admissibility or otherwise of claim under 2A3 will not affect the claim in respect of **New Born Baby.**

Special conditions applicable to Maternity Expenses and New Born Baby Cover

i. These benefits are admissible only if the expenses are incurred in a Hospital as an inpatient.
ii. Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.
iii. Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there. Prenatal is the medical care given to a pregnant woman and for the purpose of this policy it starts from the date of conception upto the childbirth. Post natal is the medical care given to a woman after her baby is born and coverage is for a period of six weeks from the date of childbirth.
iv. Pre Hospitalisation and Post Hospitalisation benefits are not available under these two clauses.
v. Subject to the terms & conditions, the policy covers New Born Baby beyond 90 days only on payment of requisite premium.

Note: **Coverage under 3 & 4 above**: In case of the Family floater plan, the Sum Insured of the section (would be considered for arriving at the sublimit of 10% & 5% for coverage under 3& 4 respectively. The Company's overall Liability in respect of all claims admitted under clause **1.2** (I), **2A (1, 2, 3 and 4)** during the policy period shall not exceed the Sum Insured mentioned in the Schedule.

5. COVERAGE TO SAARC COUNTRIES: The section automatically covers Insured Persons visiting other SAARC (South Asian Association for Regional Cooperation) countries viz- Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan, and Sri Lanka. However Cashless service will not be available for treatment taken in countries outside India and such claims shall be considered only on reimbursement basis on the return of the insured person to India. All other conditions in respect of claim shall apply as such.

2B. TRIGGER: This cover would trigger when the aggregate of actual admissible expenses incurred in respect of any one or more claims (either for an Individual in case of an individual plan, or for one or more than one insured person, in case of Family Floater plan) in a policy period exceed the Deductible under the Policy.

If there are other sources (other than Insurance policies) from where the Insured Person can receive an amount which is greater than the Deductible, the Insured Person has the option either to exhaust other options first and subsequently claim under this section. If the Insured person chooses to first claim under this section of the Policy, and if subsequently he receives reimbursement from other sources for any amount which has also been paid under this Policy, the Insured Person shall refund to the Company such excess payment.

In no case shall the liability of the Company exceed the Sum Insured for one or all claims in aggregate under this section during the policy period.

2C. WORKING OF ADMISSIBLE CLAIM AMOUNT: The cover under this section of the policy would trigger when the aggregate of admissible expenses incurred exceed the Deductible in this section of the policy. This means that all the claims, including those falling within the Deductible, will be assessed based on the terms and conditions of this section of the policy for working out the admissible expenses. Expenses related to pre hospitalisation & post hospitalisation in respect of all previous claims would also be taken into consideration. If the insured's policy has Room rent capping, then expenses as stated in 1.2 IA would be linked to the
entitled room rent limit. So, if the room availed by the insured person has a higher rent than the room rent limit as per his policy, the Insured would have to bear the difference between what he has actually incurred and what he is entitled for (in terms of room rent and associated expenses), as per his policy's room rent limit.

Claim admissibility will be decided based on the terms and conditions of this Policy. Admissibility of claim would be worked out only if the insured expenses, in aggregate, have exceeded or are likely to exceed the Deductible. If the claim is admissible as per the terms and conditions, the maximum amount payable (admissible claim amount) under this section of the policy would be that amount which is in excess of the Deductible, subject to Company's liability not exceeding the Sum Insured under this section.

Illustration:

- Deductible chosen – Rs.3 lakhs
- Sum Insured chosen – Rs. 5lakhs

		How the Claim payment will be considered
Case 1:	There is one single hospitalisation in the policy period. Hospitalisation expenses incurred is Rs.3lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.4lakhs	Scenario 1: Admissible expenses is Rs.2.50lakhs, which is within the Deductible so nothing is payable under this section of the policy. Scenario 2: Admissible expenses is Rs.3.50lakhs, which has exceeded the Deductible by Rs.50,000, so the amount payable under the policy is Rs.50,000
Case 2:	There are multiple claims under the policy. Claim no.1: Hospitalisation expenses incurred is Rs.2lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.3lakhs Claim no.2: Hospitalisation expenses incurred is Rs.1.75 lakhs Pre & post hospitalisation expenses incurred is Rs.0.5 lakh. Total incurred expenses – Rs.2.25 lakhs	Scenario 1: There are two claims under the policy, Claim Nos.1&2: Admissible expenses under Claim no.1 is Rs.2.lakhs and under Claim no.2, it is Rs.1.40 lakhs. So the total admissible expenses under the policy considering both the claims is 3.40lakhs, which has exceeded the Deductible by Rs.40,000, so the amount payable under the policy is Rs.40,000 in respect of Claim no.2. Scenario 2: The above is an example where Room rent is 1% of the Deductible. Now suppose, the insured's policy does not have room rent capping, then Admissible expenses under Claim no.1 is Rs.2.75lakhs and under Claim no.2 it is Rs.2lakhs. Thus the total admissible expenses under the policy considering both the claims, is 4.75lakhs, which has exceeded the Deductible by Rs.1.75 lakhs, so the amount payable under the policy is Rs.1.75 lakhs in respect of Claim no.2.

Case 3:	Claim no.1: This is the first hospitalisation in the policy period. Hospitalisation expenses incurred in respect of a pre-existing disease, is Rs.4.50lakhs Pre & post hospitalisation expenses incurred is Rs.1 lakh. Total incurred expenses – Rs.5.50lakhs Claim no.2: Hospitalisation expenses incurred is Rs.1.75lakhs. Pre & post hospitalisation expenses incurred is Rs.0.65lakhs. Total incurred expenses – Rs.2.40lakhs Claim no.3: Hospitalisation expenses incurred is Rs.1.75lakhs. Pre & post hospitalisation expenses incurred is Rs.0.75lakhs. Total incurred expenses – Rs.2.50lakhs	Scenario 1: Claim No.1 relates to pre-existing disease and is not admissible since it relates to Pre-existing disease. Claim No.2 has not exceeded the Deductible, hence nothing is payable, though the disease does not fall under any exclusion. In working out the payable amount for claim No.2, the Company will not consider Claim no.1 at all, since it falls under exclusion of pre-existing disease and is not admissible under the policy. It is of no concern whether or not the insured's claim (no.1) has been paid under the Base policy. Aggregate of Claim Nos. 2&3 has exceeded the Deductible Admissible expenses under Claim no.2, Rs.2.10lakhs and under Claim no.3 it is Rs.2.20lakhs. Now the aggregate is Rs.4.30lakhs, which has exceeded the Deductible by Rs.1.30lakhs. So the amount payable under the policy is Rs.1.30lakhs in respect of Claim no.3. Scenario 2: The above is an example where Room rent is 1% of the Deductible. Now suppose, the insured's policy does not have room rent capping, then Admissible expenses under Claim no.2 is Rs.2.20lakhs and under Claim no.3 it is Rs.2.30lakhs. Thus the total admissible expenses under the policy considering both the claims, is 4.50lakhs, which has exceeded the Deductible by Rs.1.50lakhs, so the amount payable under the policy is Rs.1.50lakhs in respect of Claim no.3.
Case 4	There is one single hospitalisation in the policy period. Hospitalisation expenses incurred is Rs.8.50 lakhs Pre & post hospitalisation expenses incurred is Rs.1lakh. Total incurred expenses – Rs.9.50lakhs	Admissible expenses is Rs.8.30 lakhs, which has exceeded the Deductible by Rs.5.30lakhs. Sum Insured is Rs.5lakhs. So, the admissible expenses after considering the Deductible, is Rs.5.30lakhs, which is greater than the Sum Insured (Rs.5lakhs). However, the maximum admissible claim amount payable cannot exceed the Sum Insured under the policy. Hence amount payable in this case under the policy is Rs.5lakhs only and not Rs.5.30lakhs.
Case 5:	There is one single hospitalisation in the third policy (i.e in the second renewal) in respect of **donation of one kidney** by the insured to his father. Hospitalisation expenses incurred is Rs.0.45 lakhs. Pre & post hospitalisation Rs.1lakh. Total incurred expenses – Rs.1.45 lakhs	Since this relates to Organ Donor by the Insured Person, hospitalisation in respect of him, does not get paid. However, the policy would still pay him a lumpsum of 10% of the Sum Insured, as per clause 2A2 which would be Rs.50,000 in this case.

3. DEFINITIONS:

3.1 Accident: is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 Admissible Expenses: are those expenses, which conform to the insured expenses as per the terms and conditions of the policy.

3.3 Admissible Claim Amount: means the amount payable under the policy, upto the Sum Insured, after applying the deductible and sub-limits, wherever applicable.

3.4 AYUSH: AYUSH treatment refers to the Medical and/or hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy systems.

3.5 Cashless Facility: means a facility extended by the insurer or TPA on behalf of the Insurer to the insured, where the payments for the costs of the 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 of pre authorization is approved.

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

a. Internal Congenital Anomaly: which is not in the visible and accessible parts of the body
b. External Congenital Anomaly**:** which is in the visible and accessible parts of the body

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

3.8 Deductible: is a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies, and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

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

3.10 Day Care Centre: means any institution established for day care treatment of illness and /or injuries OR a medical set -up 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:

a. has qualified nursing staff under its employment,
b. has qualified medical practitioner (s) in charge,
c. has a fully equipped operation theatre of its own, where surgical procedures are carried out
d. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

3.11 Day Care Treatment: means medical treatment, and/or surgical procedure which is:

a. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and
b. which would have otherwise required a hospitalization of more than 24 hours.
Treatments normally taken on an outpatient basis is not included in the scope of this definition.

3.12 Family: consists of the Insured, and their legally wedded spouse.

3.13 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.

3.14 Hospital/Nursing Home: means any institution established for inpatient 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:

a. has qualified nursing staff under its employment round the clock;
b. has at least 10 inpatient beds, in towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
c. has qualified medical practitioner (s) in charge round the clock;
d. has a fully equipped operation theatre of its own where surgical procedures are carried out
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

* Following are the enactments specified under the schedule of Section 56 of Clinical Establishment (Registration and Regulation) Act, 2010 as of October 2013. Please refer to the Act for amendments, if any:

1. The Andhra Pradesh Private Medical care Establishments (Registration and Regulations) Act, 2002
2. The Bombay Nursing Homes Registration Act, 1949
3. The Delhi Nursing Home Registration Act, 1953
4. The Madhya Pradesh Upcharya Griha Tatha Rujopchar Sanbadhu Sthapamaue (Ragistrikaran Tatha Anugyapan) Adhiniyam, 1973.
5. The Manipur Homes and Clinics Registration Act, 1992
6. The Nagaland Health Care Establishments Act, 1997
7. The Orissa Clinical Establishments (Control and Regulations) Act, 1990
8. The Punjab State Nursing Home Registration Act, 1991
9. The West Bengal Clinical Establishment Act, 1950

Hospital Definition for "AYUSH TREATMENT"

The Company may provide coverage for one or more systems covered under AYUSH treatment "; provided

the treatment is taken in a Government hospital or in any institute recognised by Govt. and/or accredited by Quality Council of India or National accreditation Board on Health; **OR i**n

i. Teaching hospitals of AYUSH colleges recognised by Central Council of Indian medicine (CCIM) and Central Council of Homeopathy (CCH)
ii. AYUSH hospitals having registration with Government authority under appropriate Act in the State /UT and complies with the following as minimum criteria
a. has at least 15 inpatient beds
b. has minimum 5 qualified and registered AYUSH doctors
c. has qualified paramedical staff under its employment round the clock.
d. has dedicated AYUSH therapy sections
e. maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

3.15 Hospitalisation: means admission in a Hospital for a minimum period of twenty four (24) inpatient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

HOSPITALISATION PERIOD: means the period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained during the period of policy. The minimum period of stay shall be 24hours.

3.16 I.D.Card: means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

3.17 Illness: means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
a. Acute condition - 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 - is 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 or to be specially trained to cope with it
iv. it continues indefinitely
v. it comes back or is likely to come back.

3.18 Inpatient: means an Insured Person who is admitted to Hospital and stays for at least 24 hours for the sole purpose of receiving the treatment for suffered ailment / illness / disease / injury / accident during the currency of the policy.

3.19 Inpatient Care: means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

3.20 (a) 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.

(b) ICU Charges: means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

3.21 IRDAI: is Insurance Regulatory and Development Authority of India, and regulates the insurance business in India.

3.22 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.

3.23 Insured Person: means Person(s) named as Insured Person(s) on the schedule of the Policy.

3.24 Maternity Expenses: shall include (a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections) incurred during hospitalisation (b) expenses towards lawful medical termination of pregnancy during the policy period.

3.25 Medical Advice: means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

3.26 Medical Expenses: means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

3.27 Medically Necessary Treatment: Medically necessary treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

a. is required for the medical management of the illness or injury suffered by the insured;

b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. must have been prescribed by a medical practitioner;

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

3.28 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.

3.29 New Born Baby: means a baby born during the policy period and is aged between 1 day and 90 days, both days inclusive.

3.30 Network Provider: means hospital enlisted by an insurer, TPA, or jointly by a hospital and TPA to provide medical services to an insured by a cashless facility.

3.31 Non-Network: Any Hospital, day care centre or other provider that is not part of the Network

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

3.33 Out-Patient Treatment: is one in which the Insured visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or inpatient.

3.34 Pre Hospitalisation Expenses Medical Expenses: means medical expenses incurred during predefined number of days preceding the hospitalisation of the Insured Person, provided that:
a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.35 Post Hospitalisation Medical Expenses: means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital, provided that:
i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.36 Pre Existing Disease: means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and/or were diagnosed, and/or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.

3.37 Policy Period: means the period of coverage as mentioned in the schedule

3.38 Portability: means the right accorded to an individual health insurance Policy holder (including family cover), to transfer the credit gained for preexisting conditions and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer.

3.39 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.

3.40 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.

3.41 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.

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

3.43 Sum Insured - The maximum cover for a policy year, above the chosen Deductible as opted by the Insured Person at the time of taking the Policy.

3.44 Surgery or Surgical Procedure: means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a hospital or a day care centre by a Medical Practitioner.

3.45 Third Party Administrator (TPA): means any person who is registered under the IRDAI (Third Party Administrators – Health Service) Regulations, 2016, notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those regulations.

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

3.47 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, misdescription or non-disclosure of any material fact.

4. EXCLUSIONS:

The Company shall not be liable to make any payment under this section of the policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 All Preexisting Diseases (whether treated / untreated, declared or not declared in the Proposal Form), which are excluded up to 48 months of the Policy being in force and shall be covered only after the Policy has been continuously in force for 48 months. This exclusion shall also apply to any complication(s) arising from preexisting diseases.

4.2 Any disease other than those stated in clause 4.3 below, contracted by the Insured Person during the first 30 days from the inception date of fresh policy. This shall, however, not apply in case the Insured Person is hospitalised for injuries suffered in an accident, which occurred after inception of the policy.

4.3 The expenses on treatment of following ailments / diseases / surgeries, if contracted and / or manifested after inception of first policy (subject to continuity being maintained), are not payable during the waiting period specified below.

	Ailment / Disease / Surgery	Waiting Period
i	Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc.	12 months
ii	Polycystic ovarian diseases	12 months
iii	Surgery of Hernia	24 months
iv	Surgery of Hydrocele	24 months
v	Non infective Arthritis	24 months
vi	Undescendant Testes	24 months
vii	Cataract	24 months
viii	Surgery of benign prostatic hypertrophy	24 months
ix	Hysterectomy for menorrhagia or fibromyoma or myomectomy or prolapse of uterus	24 months
x	Fissure / Fistula in anus.	24 months

xi	Piles.	24 months
xii	Sinusitis and related disorders	24 months
xiii	Surgery of gallbladder and bile duct excluding malignancy	24 months
xiv	Surgery of genito urinary system excluding malignancy	24 months
xv	Pilonidal Sinus.	24 months
xvi	Gout and Rheumatism.	24 months
xvii	Hypertension	24 months
xviii	Diabetes.	24 months
xix	Calculus diseases	24 months
xx	Surgery for prolapsed inter vertebral disk unless arising from accident.	24 months
xxi	Surgery of varicose veins and varicose ulcers.	24 months
xxii	Congenital internal diseases	24 months
xxiii	Joint Replacement due to Degenerative condition	24 months
xxiv	Age related osteoarthritis and Osteoporosis.	24 months

If the above diseases are preexisting at the time of inception, Exclusion no.4.1 for pre-existing disease shall be applicable, which means the above diseases will be covered only after the policy has been continuously in force for 48 months.

i **Note**: If the continuity of renewal is not maintained then subsequent cover will be treated as fresh policy and clauses 4.1, 4.2 & 4.3 shall apply afresh (whether or not a Proposal is submitted afresh), unless agreed by the Company and suitable endorsement passed on the policy by the duly authorised official of the Company. Similarly, if the Sum Insured is enhanced subsequent to the inception of the first policy, the exclusions 4.1, 4.2 and 4.3 will apply afresh on the enhanced portion of the Sum Insured.
ii Ported policy shall also be considered as continuous policy for the purpose of clauses 4.1, 4.2 &4.3.

4.4 Injury or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War like operations (whether war be declared or not) or by nuclear weapons /materials.

4.5 Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident), vaccination (including animal bite unless resulting in hospitalisation), inoculation or cosmetic or aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

4.6 Surgery for correction of eye sight cost of spectacles, contact lenses, cochlear implant, hearing aids and other external aids / implants used for the correction of eyesight or of hearing prowess.

4.7 Any dental treatment or surgery which is corrective, cosmetic or aesthetic procedure, filling of cavity, crowns, root canal treatment including treatment for wear and tear unless arising from disease or injury and which requires hospitalisation for treatment.

4.8 Convalescence, general debility, “run down” condition or rest cure, congenital external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders; diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction.

4.9 All expenses arising out of any condition directly or indirectly caused by, or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the

Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.

4.10 Expenses incurred at Hospital primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period.

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

4.12 Any treatment (except as covered under 2A3) arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy. However, miscarriage due to accident or abdominal operation for extra uterine pregnancy (ectopic pregnancy) which is proved by diagnostic means and certified to be life threatening by the attending Medical Practitioner, if left untreated, do not fall under this exclusion clause.

4.13 Unproven and /or experimental procedure or treatment, acupressure, acupuncture, magnetic therapies.

4.14 Expenses for investigation/treatment irrelevant to the disease for which the insured person has been admitted or diagnosed. Private nursing charges, Referral fee to family doctors.

4.15 Stem cell implantation / surgery.

4.16 Cost of external and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, APDS, Infusion pump, Ambulatory devices i.e. walker, Crutches, Belts, Collars, Caps, splints, slings, braces, Stockings, of any kind, Diabetic foot wear, Glucometer / Thermometer, Blood Pressure monitoring machine and also any medical equipment which is subsequently used at home. Exhaustive list available in Appendix II.

4.17 All non-medical expenses, Personal comfort and convenience items or services, wi-fi/internet charges telephone, television, Ayah / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items, guest services. Exhaustive list available in Appendix II.

4.18 Change of treatment from one system of medicine to another unless agreed / allowed and recommended by the Medical Practitioner / Consultant under whom the treatment is being taken.

4.19 Treatment for Age Related Macular Degeneration (ARMD), treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

4.20 Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme.

4.21 Treatment in respect sleep apnoea and immune modulator drugs for cancer treatment.

4.22 Any treatment required because of Insured Person's participation in any hazardous activity including but not limited to aviation or ballooning, speed contests or racing on any kind(other than on foot), bungee jumping, parasailing, parachuting, ski-diving, BASE jumping, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, solo climbing, ice climbing, ice canoeing, scuba diving, Caving, cave diving, potholing, abseiling, snowboarding, wave-ski surfing, deep

sea diving using hard helmet and breathing apparatus, polo, snow and ice sports and other hazardous activities or involving military, air force or naval operations, or whilst mounting into, dismounting from or travelling in any aircraft other than as a passenger (fare paying or otherwise), in any duly licensed standard type of aircraft, anywhere in the world.

4.23 Treatment taken in an Establishment which is a place for rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel, convalescent home, convalescent hospital, health hydro, nature care clinic.

4.24 Any stay in the hospital for any reason where no active regular treatment is given by the Medical Practitioner.

4.25 All Out-patient treatments including diagnostic, Medical or Surgical procedures, non-prescribed drugs and medical supplies, Hormone replacement therapy, Sex change or treatment which results from or is in any way related to sex change.

4.26 Massages, Steam bathing, Shirodhara under Ayurvedic treatment and all other external therapies which are not essential to the treatment of any disease.

4.27 Any kind of Service charges, Surcharges, Admission fees / Registration charges, RMO charges, levied by the hospital.

4.28 Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalization period.

4.29 Pre and post hospitalisation expenses unrelated with disease / injury for which hospitalization claim has been admitted under the policy.

4.30 Hospital stay which is beyond regular, usual and customary limits for the treatment undertaken for the given disease / condition.

4.31 Any illness or injury arising or resulting from insured committing breach of Law with criminal intent.

5. CONDITIONS:

1. DUE OBSERVANCE AND FULFILMENT of the terms, provisions, conditions and endorsements of this section of the policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this section of the policy shall be valid, unless made in writing and signed by an authorized official of the Company.

2. MATERIAL FACTS: The proposer is required to declare all material facts in the Proposal Form /any other document. Any misrepresentation or concealment of material facts shall render the policy void ab initio. A material fact is one which can influence the insurer's judgement to accept or reject the Proposal or the terms of acceptance.

3. ENTRY AGE: Maximum entry age under the policy is 65 years for all members. Persons above the age of 65 years and upto 70 years can also be covered. However, in such cases, a 10% loading will be

charged on premium applicable to the age of such proposed insured. This 10% loading will also apply on each subsequent renewal thereof.

4 .FAMILY SIZE: Minimum two persons i.e. Insured and his/her spouse to be covered under Family Floater plan. (One person can only be covered under Individual Plan).

5. PLANS : The section has Two Plans – Individual and Family Floater with the following Sums Insured and corresponding Deductibles.

Option is also available to remove the Room rent limits by paying an additional premium:

Sl. No.	Deductible (INR)	Sum Insured (INR)
1	300000	300000
2	300000	500000
3	500000	500000
4	500000	700000
5	600000	600000
6	600000	800000
7	800000	800000
8	800000	1000000
9	1000000	1000000
10	1000000	1500000
11	1500000	1000000
12	1500000	1500000
13	1800000	1000000
14	1800000	1200000
15	2000000	1000000
16	2000000	2000000
17	2000000	3000000

6. PREMIUM LOADINGS/DISCOUNTS

a Family Discount : of 10% is available if more than one person is covered under the section with individual Sums Insured per person (i.e. in respect of an individual plan).

b Loyalty Discount : of 10% in premium is available for the persons who at the inception of this policy are also covered under a base health insurance policy from Oriental (retail or bancassurance only). To be eligible for this discount at renewals, such base health policy from Oriental has to be in force at the time of such renewal also. Even in case of Family Floater Plan, Loyalty discount would only be in respect of the person(s) who already has such a policy fromOriental and not on the whole policy premium .

c ENTRY AGE LOADING FOR PERSONS ABOVE THE AGE OF 65 YEARS : Maximum entry

age for cover under this section is 65 years. However, persons above the age of 65 years and upto the age of 70 years can also take this cover, subject to a premium loading of 10%. So, in all such cases, a 10% loading will be charged on the premium applicable to the age of such proposed insured. This 10% loading will also apply on every subsequent renewal of the policy. No such loadings on renewal shall however, apply in respect of insured persons who had entered the policy at the age of 65years or earlier.

d. DELETION OF ROOM RENT LIMIT: Room Rent limits are linked to the Deductible under this section of the policy. However, on payment of an additional premium these limits can be removed. Additional premium shall be as per the loadings below:

Deductible (INR)	Additional premium to be charged
Upto Rs. 500,000	20% of the applicable premium
6,00,000 – 10,00,000	10% of the applicable premium
15,00,000 and above	5 % of the applicable premium

7. PRE-INSURANCE MEDICAL CHECK-UP: In following cases, pre-insurance Medical Checkup is required:

Age	Pre insurance Medical Tests
Persons with adverse Medical History	Required irrespective of age
Persons above 55 years	Required in all cases

Following tests are required. The list of Diagnostic centres is available with the underwriting office from where the Policy is intended to be taken.

1.	GENERAL PHYSICAL EXAMINATION
2.	CBC WITH ESR
3.	LIPID PROFILE
4.	HbA1c
5.	S.CREATININE
6.	URINE-ROUTINE & MOLECULAR
7.	ECG
8.	TSH
9.	X-RAY CHEST
10.	USG
11.	EYE EXAMINATION-FUNDUS & GLAUCOMA

1. In case of adverse medical history, the Company may ask for additional tests depending on the medical condition.
2. Medical reports upto 30 days prior to the date of proposal, are only valid.
3. In case of fresh proposals where an insured person has undergone pre-insurance Medical Check up, 50% cost of Medical Check-up shall be reimbursed if the proposal has been accepted by the Company. Where there has been a break in the Policy Period and continuity benefits are not restored (i.e the Policy is treated as fresh and not as renewal), and the insured person has had to undergo such Medical Check up, in such cases also 50% cost of Medical Check-up shall be reimbursed.

8 FREE LOOK PERIOD: This policy provides for a free look period. The free look period shall be applicable at the inception of the fresh policy and the insured is allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

If the Insured has not made any claim during the free look period, and exercises this option, the Insured shall be entitled to
a refund of the premium paid less any expenses incurred by the Insurer on medical examination of the Insured Persons and the stamp duty charges or
b where the risk has already commenced and the option of return of the policy is exercised by the Insured, a deduction towards the proportionate risk premium for period on cover or
c where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

Premium on cancellation shall be refunded within 15days from the date of receipt of request for Free look cancellation.

9. COMMUNICATION: Every notice or communication to be given or made under this section of the policy shall be delivered in writing at the address of the policy issuing office / TPA as shown in the Schedule. Updated list of the TPAs is also available on Company's website www.orientalinsurance.org.in.

10. MIDTERM INCLUSION: Midterm inclusion of members is permitted under the policy, on payment of pro-rata premium only on written request and only in respect of a newlywed spouse within 90days of marriage or at the time of renewal of the policy.

11. RENEWAL OF POLICY: Renewal of this Policy is not automatic; premium due must be paid to the Company on or before the due date. The Company shall not be responsible or liable for nonrenewal of policy due to non-receipt **or** delayed receipt of premium **or** the proposal form **or** of the Medical Practitioner's report wherever required or due to any other reason within the control of the insured. Further, the Company shall not ordinarily deny the renewal of this policy unless on grounds of fraud, moral hazard, misrepresentation or non-cooperation by the insured. No loadings based on claim(s) and / or age (except to the extent as provided for in clause 5 (8) (e) above) under the policy shall apply.

If the policy is renewed for enhanced Sum Insured then clauses (4.1, 4.2, 4.3) as applicable to a fresh policy shall apply to additional Sum Insured as if a separate policy has been issued for the difference. In respect of Pre-existing Diseases or for a disease / ailment / injury for which treatment has been taken in the earlier policy period, the enhanced Sum Insured will be available only after 48 months of continuous coverage with the increased Sum Insured. In case of addition of new members, the policy will be treated as fresh with respect to the newly added members. No loading, on account of claims, will be levied on premium at the time of renewal.

12. REVISION OF SUM INSURED / DEDUCTIBLE: Revision in Sum Insured under this section of the Policy is allowed only at the time of Renewal based on the medical condition of the insured person(s) and claims experience under the policy. However, lowering of Deductible is not allowed in respect of any insured person, though one may increase the Deductible at renewal

13. GRACE PERIOD: In the event of delay in renewal of the policy, a grace period of 30 days is allowed. However, no coverage shall be available during the grace period.

14. NOTIFICATION OF CLAIM: Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of Insured Person in respect of whom claim is made, Nature of disease / injury and Name and Address of the attending Medical Practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home, by fax, e-mail, etc. Such notice should be given within 48 hours of admission but before discharge from Hospital / Nursing Home, in case of both planned and emergency hospitalisation. Condonation of delay may be considered in cases of hardship where it is proved to the satisfaction of the Company TPA that under the

circumstances in which the Insured Person was placed it was not possible for him or any other person to give such notice within the prescribed time limit.

15. MEDICAL RECORDS:

a The Insured Person hereby agrees to and authorises the disclosure, to the Company / TPA or any other person nominated by the Company, of any and all Medical records and information held by any Institution / Hospital or Person from whom the Insured Person has obtained any medical or other treatment to the extent reasonably required by the Company / TPA in connection with any claim made under this policy or the Company's liability there under.

b The Company / TPA agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (a) above and will only use it in connection with any claim made under this policy or the Company's liability there under.

c Any Medical Practitioner authorised by the Company / TPA shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring Hospitalisation when and so often as the same may reasonably be required on behalf of the Company / TPA.

16. PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME:

a Claim in respect of Cashless Services will be through the Company / TPA provided admission is in a network Hospital / Nursing Home and is subject to pre admission authorization. The Company / TPA shall, upon getting the related medical details / relevant information from the Insured Person / Network Hospital / Nursing Home, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorisation letter, within 48 hours of receipt of such a request, to the Hospital / Nursing Home mentioning the payable sum and the ailment for which the person is seeking to be admitted as an in-patient. The Company / TPA reserves the right to deny pre-authorisation in case the Hospital / Insured Person is unable to provide the relevant information / medical details as required by the Company / TPA. In such circumstances denial of Cashless should in no way be construed as denial of liability. The Insured Person may obtain the treatment as per his/her treating doctor's advice and later on submit the full claim papers to the Company / TPA within 15 days of discharge from the Hospital / Nursing Home for consideration of claim by the Company / TPA.

b Should any information be available with the Company / TPA which makes the claim inadmissible or doubtful, and warrants further investigations, the authorisation of cashless facility may be withdrawn. However this shall be done by the Company / TPA before the patient is discharged from the Hospital and notice to this effect shall be given to the treating Hospital and the insured.

c Liability under this section of the policy in respect of all expenses incurred in a Network Provider shall be subject to the pre-agreed rates between the Company/TPA and the Network Provider. This is irrespective of the claim being under cashless or re-imbursement.

d List of network Hospitals is available on our official website-www.orientalinsurance.org.in and will also be provided to the insured by the concerned TPA.

17. REIMBURSEMENT OF EXPENSES IN CASE OF TREATMENT IN NON-NETWORK HOSPITAL: The Insured Person can take treatment in non-network hospitals. In such a case, he should contact the TPA within 7 days from the date of admission with details of ID card number, nature of illness, name and address of the hospital/Nursing home. The Insured Person must fill the Claim Form and submit the documents required, in original for re-imbursement of the claim.

18. QUALITY OF TREATMENT: The insured hereby acknowledges and agrees that pre-authorisation or payment of any claim by or on behalf of the Company shall not constitute on part of the Company, a guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by the

Insured Person. It being agreed and recognized by the Insured Person that the Company is in no way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a Network Hospital).

19. CLAIM DOCUMENTS: Final claim along with original Bills/Cash memos/reports, claim form and documents as listed below should be submitted to the Company / TPA within 15 days of discharge from the Hospital / Nursing Home

a Original bills, all receipts and discharge certificate / card from the hospital.

b All documents pertaining to the illness, starting from the date it was first detected, i.e Doctor's consultations reports / history

c Medical history of the patient recorded by the Hospital.

d Original Cash-memo from the hospital (s) / chemist (s) supported by proper prescription.

e Original receipt, pathological and other test reports from a pathologist / radiologist including film etc supported by a note from attending medical practitioner / surgeon demanding such tests.

f Original attending Consultants / Anaesthetists / Specialist certificates regarding diagnosis and bills / receipts etc.

g Surgeon's original certificate stating diagnosis and nature of operation performed along with bills/ receipts etc.

h MLC/FIR/Post Mortem Report,(if applicable)

i Document in respect of Organ donation by the insured person: a certificate from the concerned hospital that the organ donation is in accordance with the extant Act, Central / State Rules /regulations, as applicable, in respect of transplantation of human organs. However, no proof of expenses incurred is required.

j Original Bills with supporting documents to the TPA for reimbursement of expenses incurred during pre and post hospitalisation.

k Any other information required by Company / TPA.

NOTE:

- This cover under this section would trigger only when the admissible expenses incurred (in respect of a single claim or in aggregate if more than one claim) has exceeded the Deductible. The Company would, therefore, require all previous proofs of hospitalization and expenses incurred to check if the Deductible under the policy has exceeded. So, the Insured is required to safely keep with himself all the treatment papers & bills & receipts in respect of previous Hospitalization(s) during the policy period. The insured may please refer sub-clause 5 (21) above, for the list of Claim documents in this regard.
- All documents must be submitted in original and duly attested by the Insured Person/Claimant. If the original documents have already been submitted elsewhere, photocopies of the same duly attested by the concerned TPA / Insurer / Organisation, as the case may be, and counter signed by the Insured, are required to be submitted.
- In case of post hospitalisation treatment under this Policy (limited to 60 days) all supporting claim papers / documents as listed above should be submitted within 15 days from completion of such treatment (upto 60 days or actual period whichever is less) to the Company / T.P.A. In addition Insured Person should also provide the Company / TPA such additional information and assistance as the Company / TPA may require in dealing with the claim. Waiver of this condition may be considered in cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the Insured Person was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.

a. DOCUMENTS **IN CASE A SINGLE CLAIM HAS EXCEEDED / IS LIKELY TO EXCEED THE DEDUCTIBLE:** All documents as listed above, are required to be submitted in respect of the claim under consideration.

b. **DOCUMENTS IN CASE THERE ARE PREVIOUS CLAIMS IN THE SAME POLICY PERIOD:** If there are previous claims during the policy period, and a subsequent claim (after considering the aggregate of all previous claims) has exceeded / is likely to exceed the Deductible, then documents as listed above, would also be required for the previous claims in addition to those for the one under consideration.

c. DOCUMENTS WHEN AN INDEMNITY HEALTH INSURANCE POLICY EXISTS AS BASE POLICY:

i. **When the TPA under this policy and the Base Policy is same**: If the TPA is same under both the policies and the documents have been submitted to the TPA, irrespective of the Insurer of the Base policy, the Insured may simply mention the Claim number allotted by the TPA, and submit the same alongwith the duly filled in Claim form.

ii. **When the TPA under this policy and the Base Policy is different:** If the TPA under both the policies are different, the Insured must submit the documents in respect of all the treatments taken during the policy period as given in the policy. If the original documents have already been submitted elsewhere, photocopies of the same duly attested by the concerned TPA / Insurer / Organisation, as the case may be, and counter signed by the Insured, are required to be submitted.

20. DISCLOSURE TO INFORMATION NORM: In case of Non-disclosure, concealment or misstatement in the Proposal Form, Claim Form or any other document, or if the claim be in any manner intentionally or fraudulently or otherwise misrepresented or concealed or involves making false statement or submitting false bills / documents whether by the Insured Person or any other person/Institution/ Organisation on his behalf; Company shall be at liberty to deny its liability and / or take suitable legal action against such Insured Person/ Institution/ Organisation as per the laws.

21. MULTIPLE POLICIES: (a) In case of multiple policies which provide fixed benefits, on the occurrence of the insured event in accordance with the terms and conditions of the policies, each insurer shall make the claim payments independent of payments received under other similar policies.

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

i. In all such cases, the insurer who has issued the chosen policy, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. The insured having multiple policies has the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies even if the sum insured is not exhausted

iii. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, the insured shall have the right to choose insurers from whom he wants to claim the balance amount.

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

22. PROTECTION OF POLICYHOLDERS' INTERESTS: Company shall offer a settlement of claim to the insured / claimant (or convey repudiation, if a claim warrants so) within 30days of receipt of all necessary information / documents. Where the circumstances of a claim warrant an investigation in the opinion of the insurer, it shall initiate and complete such investigation at the earliest, in any case not later than 30days from the date of receipt of last necessary document. In such cases, the claim shall be decided within 45days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days the Company shall be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

23. PAYMENT OF CLAIM: All medical treatments (including diagnostic tests) for the purpose of this insurance will have to be taken in India only (or in SAARC countries) and all claims shall be payable in

Indian currency only. For the purpose of claim settlement in respect of treatment taken in SAARC countries, currency conversion rate on the date of admission to Hospital would apply. Claim for any of the Insured Person will be payable in the name of the insured and discharge voucher signed by him/her will be considered valid. However, in the unfortunate event of demise of the insured, the claim shall be payable to the Nominee as declared by the insured in the Proposal form.

24. REVISION IN PREMIUM / TERMS: The premium rates are valid only for the Policy period. The Company may revise the premium rates and / or the terms & conditions of the Policy, upon Renewal thereof, only after due approval from IRDAI. Any revision or modification in the Policy will be notified to the policyholders at least ninety days prior to the date when such revision or modification comes into effect.

25. MIGRATION: At the time of renewal, or in the event of withdrawal of the product, the insured may migrate to another health insurance policy of the Company with all his continuity benefits remaining intact, provided there is no break in the policy.

26. PORTABILITY: In the event of the Insured Person porting to any other insurer, Insured Person must apply with details of the policy and claims to the insurer where the Insured Person wants to port, atleast 45 days before the date of expiry of the policy. If somebody wants to port into this policy, he has to apply within the above period. In case of acceptance of such request, Portability benefit shall be available only upto the existing Sum Insured. If the proposed
Sum Insured is higher than the Sum Insured under the expiring policy, pre-existing clause and waiting periods shall separately apply on the Sum Insured in excess of the expiring Sum Insured.

27. CHANGE OF ADDRESS: Insured must inform the Company immediately in writing of any change in the address.

28. ID CARD: The card is issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital only. Upon the cancellation or non-renewal of this policy, all ID cards shall immediately be returned to the TPA at the insured's expense and each Insured Person agrees to hold and keep harmless, the Company and the TPA against any or all costs, expenses, liabilities and claims arising in respect of use or misuse of such ID cards prior to their return to the TPA.

29. PRODUCT WITHDRAWAL: This product may be withdrawn in future with due approval of IRDAI. However, in the event of withdrawal of the product, the insured shall be informed of the options available.

30. IRDAI REGULATIONS: This policy is subject to IRDAI (Protection of policy holders' interest)
Regulation, 2017 and IRDAI (Health Insurance) Regulations 2016 and Guidelines on Standardisation in health insurance, as amended from time to time.

31. JURISDICTION: All disputes or differences under or in relation to the policy shall be determined by the Indian Courts and in accordance with the Indian laws.

32. IT EXEMPTION: The premium under the Policy is eligible for Income Tax exemption in accordance with the extant IT Act.

Appendix I

Day care procedures / surgeries
A Microsurgical Operations on the Middle Ear
1 Stapedotomy
2 Stapedectomy

3 Revision of a stapedectomy
4 Myringoplasty (Type -I Tympanoplasty)
5 Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
6 Revision of a tympanoplasty
B Other operations on the middle & internal ear
7 Myringotomy
8 Removal of a tympanic drain
9 Incision of the mastoid process and middle ear
10 Mastoidectomy
11 Reconstruction of the middle ear
12 Fenestration of the inner ear
13 Revision of a fenestration of the inner ear
14 Incision (opening) and destruction (elimination) of the inner ear
C Operations on the nose & the nasal sinuses
15 Excision and destruction of diseased tissue of the nose
16 Operations on the turbinates (nasal concha)
17 Nasal sinus aspiration
D Operations on the eyes

18 Incision of tear glands
19 Incision of diseased eyelids
20 Excision and destruction of diseased tissue of the eyelid
21 Operations on the canthus and epicanthusv
22 Corrective surgery for entropion and ectropion
23 Corrective surgery for blepharoptosis
24 Removal of a foreign body from the conjunctiva
25 Removal of a foreign body from the cornea
26 Incision of the cornea
27 Operations for pterygium
28 Removal of a foreign body from the lens of the eye
29 Removal of a foreign body from the posterior chamber of the eye
30 Removal of a foreign body from the orbit and eyeball
31 Operation of cataract
E Operations on the skin & subcutaneous tissues
32 Incision of a pilonidal sinus
33 Free skin transplantation, donor site
34 Free skin transplantation, recipient site
35 Revision of skin plasty
36 Simple restoration of surface continuity of the skin and subcutaneous tissues
37 Destruction of diseased tissue in the skin and subcutaneous tissues
38 Local excision of diseased tissue of the skin and subcutaneous tissues
39
Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
40 Chemosurgery to the skin
F Operations on the tongue
41 Incision, excision and destruction of diseased tissue of the tongue
42 Partial glossectomy
43 Glossectomy
44 Reconstruction of the tongue
G Operations on the salivary glands & salivary ducts

45 Incision and lancing of a salivary gland and a salivary duct
46 Excision of diseased tissue of a salivary gland and a salivary duct
47 Resection of a salivary gland
48 Reconstruction of a salivary gland and a salivary duct
H Other operations on the mouth & face
49 External incision and drainage in the region of the mouth, jaw and face
50 Incision of the hard and soft palate
51 Excision and destruction of diseased hard and soft palate
52 Incision, excision and destruction in the mouth
53 Plastic surgery to the floor of the mouth
54 Palatoplasty
I Operations on the tonsils & adenoids
55 Transoral incision and drainage of a pharyngeal abscess
56 Tonsillectomy without adenoidectomy
57 Tonsillectomy with adenoidectomy
58 Excision and destruction of a lingual tonsil
J Trauma surgery and orthopaedics
59 Incision on bone, septic and aseptic
60 Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
61 Reduction of dislocation under GA
62 Arthroscopic knee aspiration
K Operations on the breast
63 Incision of the breast
64 Operations on the nipple
L Operations on the digestive tract
65 Incision and excision of tissue in the perianal region
66 Surgical treatment of anal fistulas
67 Surgical treatment of haemorrhoids
68 Division of the anal sphincter (sphincterotomy)
69 Ultrasound guided aspirations
70 sclerotherapy
M Operations on the female sexual organs
71 Incision of the ovary
72 Insufflation of the Fallopian tubes
73 Dilatation of the cervical canal
74 Conisation of the uterine cervix
75 Incision of the uterus (hysterectomy)
76 Therapeutic curettage
77 Culdotomy
78 Incision of the vagina
79 Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
80 Incision of the vulva
81 Operations on Bartholin's glands (cyst)
N Operations on the prostate & seminal vesicles
82 Incision of the prostate
83 Transurethral excision and destruction of prostate tissue
84 Transurethral and percutaneous destruction of prostate tissue
85 Open surgical excision and destruction of prostate tissue
86 Radical prostatovesiculectomy
87 Incision and excision of periprostatic tissue
88 Operations on seminal vesicles

O Operations on the scrotum & tunica vaginalis testis
89 Incision of the scrotum and tunica vaginalis testis
90 Operation on a testicular hydrocele
91 Excision and destruction of diseased scrotal tissue
92 Plastic reconstruction of the scrotum and tunica vaginalis testis
P Operations on the testes
93 Incision of the testes
94 Excision and destruction of diseased tissue of the testes
95 Unilateral orchidectomy
96 Bilateral orchidectomy
97 Orchidopexy
98 Abdominal exploration in cryptorchidism
99 Surgical repositioning of an abdominal testis
100 Reconstruction of the testis
101 Implantation, exchange and removal of a testicular prosthesis
Q Operations on the spermatic cord, epididymis und ductus deferens
102 Surgical treatment of a varicocele and a hydrocele of the spermatic Cord
103 Excision in the area of the epididymis
104 Epididymectomy
105 Reconstruction of the spermatic cord
106 Reconstruction of the ductus deferens and epididymis
R Operations on the penis
107 Operations on the foreskin
108 Local excision and destruction of diseased tissue of the penis
109 Amputation of the penis
110 Plastic reconstruction of the penis
S Operations on the urinary system
111 Cystoscopical removal of stones
T Other Operations
112 Lithotripsy
113 Coronary angiography
114 Haemodialysis
115 Radiotherapy for Cancer
116 Cancer Chemotherapy

SECTION - 6 HAPPY CASH

The **Company** undertakes that, if during the period of insurance stated in the Schedule any **insured** Person shall contract any disease or suffer from any illness / ailment / disease (hereinafter called 'DISEASE') or sustain any bodily injury through accident (hereinafter called 'INJURY') and if such disease or injury shall require, upon the advice of a duly qualified Physician / Medical Specialist/Medical Practitioner (hereinafter called MEDICAL PRACTITIONER) or of a duly qualified Surgeon (hereinafter called 'SURGEON') admission in a Hospital / Nursing home (as defined hereafter) for medical/surgical treatment at any Hospital/Nursing Home in India as herein defined (hereinafter called 'HOSPITAL'), the **Company** shall pay benefits as perthe terms & conditions mentioned in this section of the policy. In any case the liability of the **Company** shall be strictly in accordance with the period and amounts stated in the schedule.

1. COVERAGE: Subject to terms, conditions and exclusions herein contained or otherwise expressed herein, the policy pays to the insured, the following benefits:

HOSPITALISATION BENEFIT – In the event of the insured person getting hospitalized, a **Daily Cash Benefit** as mentioned in the schedule shall become payable, limited to the Daily Cash Benefit Period selected by the insured. For the purpose of calculating the number of days for which this benefit becomes payable, each continuous and completed period of 24 hours of hospitalisation shall only be considered. The Policy will pay for any number of hospitalisations, in a policy period, subject to any single hospitalisation not exceeding the Daily Cash Benefit Period selected by the Insured. However, in case of more than one hospitalisation for the same disease / accident, the aggregate number of days of hospitalisation payable in a policy period would be limited to Daily Cash Benefit Period (30/60 days) selected by the Insured.

NOTE: In case of Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy systems of medicines, this policy will pay only if Hospitalization is in any **AYUSH** Hospital.

The term **'Hospital/Nursing Home'** shall not include an establishment which is a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics, a hotel or a similar place.

a. **CONVALESCENCE BENEFIT** – If a single hospitalisation continues for a period exceeding the **Daily Cash Benefit Period** opted for (30/60days), a lump sum amount is payable towards convalescence,

   i. provided that there is an admissible claim under 'a' above.

   ii. this benefit is payable only once per insured person during any one policy period. Our liability shall be as mentioned in the schedule.

   The payment under this benefit will be in addition to the payment under 'a' above.

2. **DEFINITIONS :** For the sake of clarity, please refer to the Definitions mentioned in **bold** in Section 5 - Super Health Top Up . The same shall apply to this section also. However, definitions of some specific terms applicable to this section are mentioned below :

BENEFITS: Daily Cash Benefit, Daily Cash Benefit Period **and** Deductible **all together are referred to as Benefits.**

DAILY CASH BENEFIT: means the per day (continuous and completed period of 24 hours of hospitalisation) benefit amount selected by the insured at the time of commencement of policy.

DAILY CASH BENEFIT PERIOD: means the maximum number of days for which the **Daily Cash Benefit** is payable under the policy in respect of any one hospitalisation in a policy period. The policy provides two options of either 30 days or 60 days period depending on insured's selection.

DEDUCTIBLE: A deductible is a cost-sharing arrangement 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 Daily Cash Benefit Period.

AYUSH Day Care Centre:

AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered

AYUSH Medical Practitioner(s) on day care basis without inpatient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner (s) in charge.

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre wheresurgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

PRE EXISTING DISEASE (PED): Pre existing disease means any condition, ailment, injury or disease:

a. that is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer, or its reinstatement.

b. for which medical advice or treatment was recommended by, or received from, a physician within48 months prior to the effective date of the policy or its reinstatement.

3. Exclusions: Waiting Period

The Company shall not be liable to make any payment under the policy in connection with or in respect offollowing expenses till the expiry of waiting period mentioned below:

A. Pre-existing Diseases - code –Excl 0 1

a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with the insurer.

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

c) If the Insured person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same wouldbe reduced to the extent of the prior coverage.

d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by insurer.

B. 30 day waiting period- code – Excl 03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

Note: If the continuity of the renewal is not maintained then subsequent cover will be treated as fresh policy and clauses 4.A and 4.B shall apply afresh, unless agreed by the Company and suitable endorsement passed on the policy, by the duly authorised official of the Company. Similarly, if the **Daily Cash Benefit** is enhanced subsequent to the inception of the first policy, the exclusion 4.A and 4.B will apply afresh for the enhanced portion of the **Daily Cash Benefit**.

4.1 GENERAL EXCLUSIONS: The Company shall not be liable to make any payment under this Policy in respect of any expense whatsoever incurred by any Insured Person in connection with or in respect of:

C. Investigation & Evaluation – Code – ExcI04

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

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

D. Rest Cure, rehabilitation and respite care – Code –ExcI 05

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

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

c) Any services for people who are terminally ill to address physical, social, emotional and spiritualneeds.

E. Obesity/Weight Control : Code- EscI 06

Expenses related to the surgical treatment of obesity that does not fulfill all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor.
2. The surgery /Procedure conducted should be supported by clinical protocols.
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI):
   a) greater than or equal to 40 or
   b) greater than or equal to 35 in conjunction with any of the following severe co-morbiditiesfollowing failures of less invasive methods of weight loss:
      i. Obesity – related cardiomyopathy
      ii. Coronary heart diseases
      iii. Severe Sleep Apnea.
      iv. Uncontrolled Type 2 Diabetes.

F. Change of Gender Treatments : Code – ExcI 07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite.

G. Cosmetic or Plastic Surgery- Code- ExcI 08

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an accident burns(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical practitioner.

H. Hazardous or Adventure sports- Code- ExcI 09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

I. Breach of law – Code –ExcI 10

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

J. Excluded Providers- Code – ExcI 11

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

K. Treatment for, Alcoholic drug or substance abuse or any addictive condition and consequences thereof. – Code- ExcI12

L. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.- Code- ExcI13

M. Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.- Code- ExcI14

N. Refractive Error- Code- ExcI 15

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

O. Unproven Treatments- Code – ExcI 16

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures

or supplies that lack significant medical documentation to support their effectiveness.

P. Sterility and Infertility- Code- Excl 17

Expenses related to sterility and infertility. This includes:

i) Any type of contraception, sterilization.

ii) Assisted Reproduction services including artificial insemination and advanced reproductivetechnologies such as IVF, ZIFT, GIFT, ICSI.

iii) Gestation Surrogacy.

iv) Reversal of sterilization.

Q. Maternity- Code- Excl 18

i) Medical treatment expenses traceable to childbirth (including complicated deliveries andcesarean sections incurred during hospitalization) except ectopic pregnancy.

ii) Expenses towards miscarriage (unless due to an accident) and lawful medical termination ofpregnancy during the policy period.

R. 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.

S. 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:

a) 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.

b) 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 causingany Illness, incapacitating disablement or death.

c) 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.

T. Any expenses incurred on Domiciliary Hospitalization and OPD treatment

U. Treatment taken outside the geographical limits of India

4.2 If the proposer is suffering or has suffered from any of the following disease, as per serial no 1-16 of the below table at the time of taking the policy, the specific ICD codes, mentioned therein, will be permanently excluded from the policy coverage:

Sr. No.	Disease	ICD Code
1	Sarcoidosis	D86.0-D86.9
2	Malignant Neoplasms	C00-C14 Malignant neoplasms of lip, oral cavity and pharynx, • C15-C26 Malignant neoplasms of digestive organs, • C30-C39 Malignant neoplasms of respiratory and intrathoracic organs• C40-C41 Malignant neoplasms of bone and articular cartilage• C43-C44 Melanoma and other malignant neoplasms of skin • C45-C49 Malignant neoplasms of mesothelial and soft tissue • C50-C50 Malignant neoplasms of breast • C51-C58 Malignant neoplasms of female genital organs • C60-C63 Malignant neoplasms of male genital organs • C64-C68 Malignant neoplasms of urinary tract • C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system • C73-C75 Malignant neoplasms of thyroid and other endocrine glands • C76-C80 Malignant neoplasms of ill-defined, other secondary and unspecified sites • C7A-C7A Malignant neuroendocrine tumours • C7B-C7B Secondary neuroendocrine tumours • C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue• D00-D09 In situ neoplasms • D10-D36 Benign neoplasms, except benign neuroendocrine tumours • D37-D48 Neoplasms of uncertain behaviour, polycythaemia vera and myelodysplastic syndromes • D3A-D3A Benign neuroendocrine tumours • D49-D49 Neoplasms of unspecified behavior
3	Epilepsy	G40 Epilepsy

4	Heart Ailment Congenital heart disease and valvular heart disease	I49 Other cardiac arrhythmias, (I20-I25)Ischemic heart diseases, I50 Heart failure, I42Cardiomyopathy; I05-I09 - Chronic rheumaticheart diseases. • Q20 Congenital malformations of cardiac chambers and connections • Q21 Congenital malformations of cardiac septa • Q22 Congenital malformations of pulmonary and tricuspid valves • Q23 Congenital malformations of aortic and mitral valves • Q24 Other congenital malformations of heart • Q25 Congenital malformations of great arteries • Q26 Congenital malformations of great veins • Q27 Other congenital malformations of peripheral vascular system• Q28 Other congenital malformations of circulatory system • I00-I02Acute rheumatic fever • I05-I09 • Chronic rheumatic heart diseases Nonrheumatic mitral valve disorders mitral (valve): • disease (I05.9) • failure (I05.8) • stenosis (I05.0). When of unspecified cause but with mention of: • diseases of aortic valve (I08.0), • mitral stenosis or obstruction (I05.0) when specified as congenital (Q23.2, Q23.3) when specified as rheumatic (I05), I34.0Mitral (valve) insufficiency • Mitral (valve): incompetence / regurgitation - • NOS or of specified cause, except rheumatic, I 34.1to I34.9 - Valvular heart disease.
5	Cerebrovascular disease (Stroke)	I67 Other cerebrovascular diseases, (I60-I69) Cerebrovascular diseases
6	Inflammatory BowelDiseases	K 50.0 to K 50.9 (including Crohn's and Ulcerative colitis) K50.0 - Crohn's disease of small intestine; K50.1 -Crohn's disease of large intestine; K50.8 - Other Crohn's disease; K50.9 - Crohn's disease, unspecified. K51.0 - Ulcerative (chronic) enterocolitis; K51.8 -Other ulcerative colitis; K51.9 - Ulcerative colitis,unspecified.
7	Chronic Liver diseases	K70.0 To K74.6 Fibrosis and cirrhosis of liver; K71.7 - Toxic liver diseasewith fibrosis and cirrhosis of liver; K70.3 - Alcoholic cirrhosis of liver; I98.2 - K70.-Alcoholic liver disease; Oesophageal varices in diseases classifiedelsewhere. K 70 toK 74.6 (Fibrosis, cirrhosis, alcoholic liver disease, CLD)
8	Pancreatic diseases	K85-Acute pancreatitis; (Q 45.0 to Q 45.1) Congenital conditions of pancreas, K 86.1 to K 86.8 - Chronic pancreatitis
9	Chronic Kidney disease	N17-N19) Renal failure; I12.0 - Hypertensive renal disease with renal failure;I12.9 Hypertensive renal disease without renal failure; I13.1 - Hypertensive heart and renal disease with renal failure; I13.2 - Hypertensive heart and renal disease with both (congestive) heart failure and renal failure; N99.0 - Post procedural renal failure; O08.4 - Renal failure following abortion and ectopic and molar pregnancy; O90.4 - Postpartum acute renal failure; P96.0 - Congenital renal failure. Congenital malformations of the urinary system

		(Q60 to Q64), diabetic nephropathy E14.2, N.083
10	Hepatitis B	B16.0 - Acute hepatitis B with delta-agent (coinfection) with hepatic coma; B16.1 – Acute hepatitis B with delta-agent (coinfection) without hepatic coma; B16.2 - Acute hepatitis B without delta-agent with hepatic coma; B16.9 –Acute hepatitis B without delta-agent andwithout hepatic coma; B17.0 –Acute delta-(super)infection of hepatitis B carrier; B18.0 -Chronic viral hepatitis B withdelta-agent; B18.1 -Chronic viral hepatitis B without delta-agent;
11	Alzheimer's Disease, Parkinson's Disease -	G30.9 - Alzheimer's disease, unspecified; F00.9 - G30.9Dementia in Alzheimer's disease, unspecified, G20 - Parkinson's disease.
12	Demyelinatin gdisease	G.35 to G 37
13	HIV & AIDS	B20.0 - HIV disease resulting in mycobacterial infection; B20.1 - HIV disease resulting in other bacterial infections; B20.2 - HIV disease resulting in cytomegaloviral disease; B20.3 - HIV disease resulting in other viral infections; B20.4 - HIV disease resulting in candidiasis; B20.5 - HIV disease resulting in other mycoses; B20.6 - HIV disease resulting in Pneumocystis carinii pneumonia; B20.7 - HIV disease resulting in multiple infections; B20.8 - HIV disease resulting in other infectious and parasitic diseases; B20.9 - HIV disease resulting in unspecified infectious or parasitic disease; B23.0 - Acute HIV infection syndrome; B24 - Unspecified human immunodeficiencyvirus [HIV] disease
14	Loss of Hearing	H90.0 - Conductive hearing loss, bilateral; H90.1 - Conductive hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.2 - Conductive hearing loss, unspecified; H90.3 - Sensorineural hearing loss, bilateral; H90.4 - Sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.6 - Mixed conductive and sensorineural hearing loss, bilateral; H90.7 - Mixed conductive and sensorineural hearing loss, unilateral with unrestricted hearing on the contralateral side; H90.8 - Mixed conductive and sensorineural hearing loss, unspecified; H91.0 - Ototoxic hearing loss; H91.9 - Hearing loss, unspecified

15.	Papulosquamous disorder of the skin	L40 - L45 Papulosquamous disorder of the skin including psoriasis lichen planus
16.	Avascular necrosis (osteonecrosis)	M 87 to M 87.9

5. CONDITIONS

5.1 COMMUNICATION: Every notice or communication to be given or made under this section of the policy shall be delivered in writing at the address of the policy issuing office / Third Party Administrator, as the case may be, as shown in the Schedule.

5.2 NOTICE OF CLAIM: Immediate notice of claim with particulars relating to Policy Number, ID Card No., Name of insured person in respect of whom claim is made, Nature of disease / injury and Name and Address of the attending medical practitioner / Hospital/Nursing Home etc. should be given to the Company / TPA while taking treatment in the Hospital / Nursing Home, by Fax, Email. Such notice should be given within 48 hours of admission but before discharge from **Hospital / Nursing Home**, unless waivedin writing.

5.3 CLAIM DOCUMENTS: Documents as listed below, along with duly filled in claim form, should be submitted to the **Company** / **TPA** within 15 days of discharge from the **Hospital** / **Nursing Home**.

a. Discharge certificate / card from the **Hospital**/ **Nursing Home**.

b. Alldocumentspertainingtotheillness,startingfromthedateitwasfirstdetected,i.e Doctor's consultations reports
/ history

c. Medical history of the patient recorded by the **Hospita**l, if required.

d. Pathological and other test reports from a pathologist /radiologist.

e. Attending Consultants / Anesthetists / Specialist certificates regarding diagnosis.

f. MLC/FIR/Post Mortem Report,(if applicable)

g. Details of previous policies, if the details are already not with **TPA**.

h. Any other information required by Company /**TPA**.

Photocopies of the above documents are accepted in case the hospitalization expenses have been claimed from other sources (e.g. Employer, Insurance Company, etc). However a written confirmation from such source of having received the claim documents is required.

All documents must be duly attested by the insured person/claimant.

NOTE: Waiver of the condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the

insured person was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. Otherwise Company has a right to reject the claim.

Company shall settle claims including its rejection within 30 days of the receipt of the last 'necessary' document, except in cases where a fraud is suspected, ordinarily no document not listed in the policy terms and conditions shall be deemed necessary.

5.4 MEDICAL RECORDS:

i) The insured person hereby agrees to and authorises the disclosure, to the Company / **TPA** or any other person nominated by the Company, of any and all Medical records and information held by any Institution / **Hospital** or Person from which the insured person has obtained any medical or other treatment to the extent reasonably required by the Company / **TPA** in connection with any claim made under this policy or the Company's liability there under.

ii) The Company / **TPA** agree that they will preserve the confidentiality of any documentation and information that comes into their possession pursuant to (i) above and will only use it in connection with any claim made under this policy or the Company's liability there under.

iii) Any medical practitioner authorized by the Company / **TPA** shall be allowed to examine the Insured Person in case of any alleged injury or disease requiring **Hospitalisation** when and so often as the same may reasonably be required on behalf of the Company /**TPA**.

5.5 **PAYMENT OF CLAIM:** All medical treatment for the purpose of this insurance will have to be taken in India only and all claims shall be payable in Indian currency only. Upon acceptance of an offer of settlement by the insured, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured. In the cases of any delay in the payment, the Company shall be liable to pay 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.

5.6 REPUDIATION:

i) The Company shall repudiate the claim if not payable under this section of the policy. The Company / **TPA** shall mention the reasons for repudiation in writing to the insured person. The insured person shall have the right to appeal / approach the Grievance Redressal Cell of the Company at its policy issuing office, concerned Divisional Office, concerned Regional Office or of the Head Office, situated at A-25/27, Asaf Ali Road, New Delhi-110002 or register the complaint on the grievance Portal available at our website www.orientalinsurance.org.in.

ii) If the insured is not satisfied with the reply of the Grievance Cell under 5.8 (i), he may approach the Insurance Ombudsman, established by the Central Government for redressal of grievance. The list of Offices of Ombudsman is available on the Company website (www.orientalinsurance.org.in).The Insurance Ombudsman is empowered to

adjudicate on personal line insurance claims up to Rs.30lacs.

5.7 DISCLAIMER OF CLAIM: If the Company shall disclaim liability and communicate in writing (either through the **TPA** or by itself) to the Insured in respect of any claim hereunder and such claim has not within 12 calendar months from the date of such disclaimer been made the subject matter of a suit in a Court of law, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.8 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, 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 policy 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. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

5.9 BENEFITS AVAILABLE

i. The Policy provides 4 options of **Daily Cash Benefit**- Rs.500 Rs.1000, Rs.2000 and Rs.3000. Different insured persons, under a policy, may opt for different **Daily Cash Benefits**. For females this **Daily Cash Benefit** automatically gets increased by 25% without any extra premium.

ii. The Policy provides 2 options of **Daily Cash Benefit Period**- 30 days and 60 days per **hospitalisation**.

iii. The Policy provides 3 options of **deductible**- no deductible, 1day &2days **deductible**. The deductible isapplicable per event.

iv. It is mandatory for all the insured persons under a policy to have an identical **Daily Cash Benefit Period** and **Deductible** (ii & iii above).

v. Change in Benefit(s): The **Daily Cash Benefit**, the **Daily Cash Benefit period** and **Deductible** under the policy can be changed only at the time of renewal and at the discretion of the Company. For the said enhanced benefits, **pre-existing disease** clause 4.1 and clause 4.2 of the policy, shall apply afresh.

vi. Discounts

a **Family discount** of 5% on premium is available if two members are covered and7.5% if more than 2 members are covered.

b **Loyalty Discount** of 10% in premium is available for the persons who at the inception of this policy arecovered under Oriental's health insurance policy (retail or bank-tie-up). To be eligible for this discount at renewals, such Health policy from Oriental has to be in force at the time of such renewal also.

5.10 FREE LOOK PERIOD: This policy shall have a free look period. The free look period shall be applicable at the inception of the fresh policy and the insured will be allowed a period of 15 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the same if not acceptable.

If the insured has not made any claim during the free look period, the insured shall be entitled to:

(i). A refund of the premium paid less any expenses incurred by the insurer on medical examination of theinsured persons and the stamp duty charges or

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

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

The free look period is not applicable in case of renewal of the policy.

5.11 RENEWAL OF COVER : The section of the policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavor to give notice for renewal. However, the Company is not underobligation to give notice for renewal

- Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
- Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
- At the end of the Policy Period, the policy shall terminate and the cover under this section can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.

- No loading shall apply on renewals based on individual claims experience.

- **5.12 GRACE PERIOD**:

In the event of delay in renewal of the policy, a **grace period** of 30 days is allowed. However, no coverage shall be available during the **grace period** and any disease/injury contracted during the break period shall not be covered and shall be treated as Pre-existing disease.

- **5.13 Complete Discharge**

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home or Assignee, as the case may be, for any benefit under the Policy shall be a valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.14 WITHDRAWAL OF POLICY

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured personabout 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 waiver of waiting period. As per IRDAI guidelines, provided the policy has been maintained without a break.

5.15. POSSIBILITY OF REVISION OF TERMS OF THE COVER INCLUDING THE PREMIUM RATES

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

5.16. PORTABILITY: The Insured Person will have the option to port the cover under this section of the policy to other insurers by applying to such insurer to port the entire coverage under this section along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For Detailed Guidelines on Portability, kindly refer the link: https://www.irdai.gov.in/ADMINCMS/cms/whatsNew_Layout.aspx?page=PageNo3987&flag=1

5.17. CHANGE OF ADDRESS: Insured must inform the Company immediately in writing of any changein the address.

5.18 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. For Claim settlement under reimbursement, the Company will pay the policyholder. Ill 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.

5.19 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, misdescription or non- disclosure of any material fact by the policyholder.

(Explanation: "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).

5.20 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 bank rate from the date of receipt of last necessary document to the date of payment of claim.

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

SECTION - 7
LAPTOP/TABLET

Scope of Cover

The Company shall indemnify the Insured against physical loss by fire and allied perils, theft, robbery and also any accidental damage to the Laptop/Tablet during the currency of this policy for the laptop specified in the Schedule and belonging to insured and in personal custody of Insured, his family members whilst anywhere in the World .

Provided that

i) The liability of the Company shall be limited to Sum Insured against each item in Schedule and not exceeding in aggregate the total Sum Insured stated in the Schedule during any one period of Insurance.

SPECIAL EXCEPTIONS: The Company shall not be liable in respect of :-

1) Loss or damage caused by any faults or defects existing at the time of commencement of the present insurance within the knowledge of the insured or his representatives, whether such faults or defects were known to the company or not.

2) Loss or damage due to or consequent upon wear and tear, gradual deterioration, damage due to atmospheric conditions such as rust, corrosion etc.

3) Any cost incurred in connection with the elimination of functional failures unless such failures were caused by an indemnifiable loss of or damage to the insured items.

4) Any cost incurred in connection with the maintenance of the insured items, such exclusion also applying to parts exchanged in the course of such maintenance operations.

5) Loss or damage due to defects of design material or workmanship or otherwise for which the manufacturer or supplier of the insured items is responsible either by law or under contract.

6) Loss of or damage to rented or hired equipment for which the owner is responsible either by law or under a lease and / or maintenance agreement.

7) Cessation of work, total or partial.

8) Consequential loss or liability of any kind or description.

9) Any laptop/tablet 5 (five) years old or more is not covered.

10) Insured shall bear upon himself the first Rs 2500/- (Rupees One Thousand) only each and every occurrence of damage in respect of which claim is admitted under this policy.

Amount payable

In the event of insured item being damaged the company shall pay the reasonable and necessary expenses in order to restore the damaged item to its former state of serviceability OR pay the actual value of item immediately before the occurrence of the loss, if the cost of repair exceeds or equals the actual value of machine.

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

The insured shall be allowed free look period of fifteen days from the date of receipt of the policy document to review the terms and conditions of the policy and to return the same if not acceptable.

If the insured has not made any claim during the free look period, the insured shall be entitled to

(i) A refund of the premium paid less any expenses incurred by the insurer on medical examination of the insured persons and the stamp duty charges

or

(ii) where the risk has already commenced and the option of return of the policy is exercised by the policyholder, a deduction towards the proportionate risk premium for period on cover

or

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

GRIEVANCE REDRESSAL

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

Website: www.orientalinsurance.org.in ,

Toll free: 1800118485 Or 011- 33208485

E-mail: csd@orientalinsurance.co.in

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, insuredperson may contact the grievance officer at:

Customer Service Department, 1st Floor, Oriental House A25/27 Asaf Ali Road, New Delhi 110002

For updated details of grievance officer, kindly refer the link https://orientalinsurance.org.in/documents/10182/7605007/List+of+Nodal+Officer+.pdf/992a7f9b-aef7- 5cac-c613-ffc05d578a3e

Insurance Ombudsman –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. The contact details of the Insurance Ombudsman offices have been provided as Annexure-III & revised details of insurance ombudsman as and when amended as available in the website http://ecoi.co.in/ombudsman.html.

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

6.1 IRDA REGULATION: This Policy is subject to IRDAI (Protection of Policy holders' interest) Regulation, 2017 and IRDAI (Health Insurance) Regulations 2016 and Guidelines on Standardization in health insurance, as amended from time to time.

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ANNEXURE I: CONTACT DETAILS OF INSURANCE OMBUDSMEN

Office Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU Office of the Insurance Ombudsman, JeevanSoudha Building, PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JPNagar, Ist Phase, Bengaluru – 560 078 Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka
BHOPAL Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003 Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh Chattisgarh
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009 Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103,2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017 Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir,Chandigar

Email: bimalokpal.chandigarh@ecoi.co.in	
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai – 600 018 Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which arepart of Pondicherry)
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002 Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh,Nagaland and Tripura
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004 Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory ofPondicherry
JAIPUR Office of the Insurance Ombudsman, JeevanNidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005 Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015 Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe - a part of Pondicherry
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe,4th Floor, 4, C.R. Avenue, KOLKATA - 700 072 Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi,Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti,

	Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti,
	Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur,Chandauli, Ballia, Sidharathnagar
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, JeevanSeva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054 Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding NaviMumbai & Thane
NOIDA Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301 Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.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
PATNA Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006 Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030 Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Area of Navi Mumbai and Thane excluding MumbaiMetropolitan Region