

**THE ORIENTAL INSURANCE COMPANY LIMITED,**  
 Regd. Office: Oriental House, P.B. No. 7037, A\_25/27, Asaf Ali Road, New Delhi 110002

**PROSPECTUS**

**MEDICLAIM INSURANCE POLICY (GROUP)**

**1. Salient Features of the policy.**

1.1 a) The Group Mediclaim Policy will be available to any Group/Association/ Institution/ Corporate Body of more than **50 persons/families** provided it has a central administration point. Each insured should cover all eligible members (insured Persons) under one group policy only. In other words different categories of eligible members shall not be allowed to be covered under different group policies. It is not permissible to issue any un-named group policies.

b) The group policy will be issued in accordance with IRDA guidelines, in the name of the Group/ Association / Institution / Corporate Body (called insured) with a schedule of names of the members including his/her eligible family members as per the following definition.

**DEFINITION OF FAMILY :**

- a) Self (Primary Insured).
- b) Legal Spouse.
- c) Dependent Children (i.e. legitimate or legally adopted children) upto the age of 21 years. If the child above 18 years is employed or if the girl child is married, he or she shall cease to be covered under the policy and no claim shall be admissible .However male child can be covered upto the age of 26 years if he is a bonafide regular student and fully dependent on primary insured. Female child can be covered until she is unmarried.
- d) Dependent parents /parents-in-law.

1.2 The policy reimburses reasonable, customary and necessary expenses of Hospitalisation and / or Domiciliary Hospitalisation expenses as detailed below only for illness / diseases contracted or injury sustained by the Insured Persons during the policy period upto the limit of Sum Insured.

- a. Room, Boarding and Nursing Expenses as provided by the Hospital /Nursing Home not exceeding 1 % of the Sum Insured or Rs. 5000 /- per day whichever is less.
- b. I.C. Unit expenses not exceeding 2% of the Sum Insured or Rs. 10,000 /- per day whichever is less.  
(Room stay including I.C.U. stay should not exceed total number of admission days).
- c. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.
- d. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of Prosthetic devices implanted during surgical procedure like pacemaker, Relevant Laboratory / Diagnostic test, X-Ray etc.
- e. Ambulance services - 1% of the sum insured or Rs 2000/- whichever is less.

1.3 **Cash Less Facility:** This facility is available in the Network Hospitals through the appointed TPAs of the company. A discount of 5% will be given on the scheduled premium if the proposer opts out of the facility.

## 2. DEFINITIONS

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

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

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.

Note: In case of Ayurvedic / Homeopathic / Unani treatment, Hospitalisation expenses are admissible only when the treatment is taken as in-patient, in a Government Hospital / Medical College Hospital.

2.2 **HOSPITALISATION PERIOD**: Expenses on Hospitalisation are admissible only if hospitalisation is for a minimum period of 24 hours, except in cases of specialized treatment as detailed here below

- i. Haemo Dialysis,
- ii. Parentral Chemotherapy,
- iii. Radiotherapy,
- iv. Eye Surgery,
- v. Lithotripsy (kidney stone removal),
- vi. Tonsillectomy,
- vii. D&C,
- viii. Dental surgery following an accident
- ix. Hysterectomy
- x. Coronary Angioplasty
- xi. Coronary Angiography
- xii. Surgery of Gall bladder, Pancreas and bile duct
- xiii. Surgery of Hernia
- xiv. Surgery of Hydrocele.
- xv. Surgery of Prostrate.
- xvi. Gastrointestinal Surgery.
- xvii. Genital Surgery.
- xviii. Surgery of Nose.
- xix. Surgery of throat.
- xx. Surgery of Appendix.
- xxi. Surgery of Urinary System.
- xxii. Treatment of fractures / dislocation excluding hair line fracture, Contracture releases and minor reconstructive procedures of limbs which otherwise require hospitalisation.
- xxiii. Arthroscopic Knee surgery.
- xxiv. Laproscopic therapeutic surgeries.
- xxv. Any surgery under General Anaesthesia.
- xxvi. Or any such disease / procedure agreed by TPA/Company before treatment.

**NOTE: PROCEDURES / TREATMENTS USUALLY DONE IN OUT PATIENT DEPARTMENT ARE NOT PAYABLE UNDER THE POLICY EVEN IF CONVERTED TO DAY CARE SURGERY / PROCEDURE OR AS IN PATIENT IN THE HOSPITAL FOR MORE THAN 24 HOURS.**

**2.3 DOMICILIARY HOSPITALISATION BENEFIT:** Domiciliary hospitalization means medical treatment for a period exceeding three days for such an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- the patient takes treatment at home on account of non availability of room in a hospital.

**Subject however to the condition that Domiciliary Hospitalisation benefit shall not cover**

- a) Expenses incurred for pre and post hospital treatment and
- b) Expenses incurred for treatment for any of the following diseases :
  - i. Asthma
  - ii. Bronchitis,
  - iii. Chronic Nephritis and Nephritic Syndrome,
  - iv. Diarrhoea and all types of Dysenteries including Gastro-enteritis,
  - v. Diabetes Mellitus and Insipidus,
  - vi. Epilepsy,
  - vii. Hypertension,
  - viii. Influenza, Cough and Cold,
  - ix. All Psychiatric or Psychosomatic Disorders,
  - x. Pyrexia of unknown origin for less than 10 days,
  - xi. Tonsillitis and Upper Respiratory Tract infection including Laryngitis and Pharyngitis,
  - xii. Arthritis, Gout and Rheumatism.

**Note:** Liability of the Company under this clause is restricted as stated in the schedule attached hereto.

**2.4 INSURED PERSON:** Means Person(s) named on the schedule of the policy.

**2.5 ENTIRE CONTRACT:** This policy / proposal and declaration given by the insured constitute the complete contract of this policy. Only Insurer may alter the terms and conditions of this policy. Any alteration that may be made by the insurer shall only be evidenced by a duly signed and sealed endorsement on the policy.

**2.6 NETWORK PROVIDER:** means hospitals or healthcare providers enlisted by an insurer, or by a TPA and insurer together, to provide medical services to an insured on payment, by a cashless facility.

**2.7 PRE-HOSPITALISATION EXPENSES:** Medical Expenses incurred during the period upto 30 days prior to the date of admission, provided that:

- i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
- ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

**2.8 POST-HOSPITALISATION: EXPENSES:** Medical Expenses incurred for a period upto 60 days from the date of discharge from the hospital, provided that:

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

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

**2.9 MEDICAL PRACTITIONER:** A Medical practitioner is a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

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

**2.11 PRE EXISTING DISEASE:** Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer. Further any complications arising from pre-existing ailment / disease / injuries will be considered as a part of that pre existing health condition.

**2.12 IN-PATIENT:** 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.

**2.13 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.

**2.14 CASHLESS FACILITY:** It means a facility extended by the insurer to the insured where the payments of 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 approved.

**2.15 I .D. CARD:** means the card issued to the Insured Person by the TPA to avail Cashless facility in the Network Hospital.

**2.16 LIMIT OF INDEMNITY:** means the amount stated in the schedule against the name of each insured person which represents maximum liability for any and all claims made during the policy period in respect of that insured person for hospitalization taking place during the currency of the policy.

**2.17 ANY ONE ILLNESS:** Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation OR 105 days from the date of discharge , whichever is earlier, from the Hospital/Nursing Home where treatment may have been taken.

**2.18 PERIOD OF POLICY:** This insurance policy is issued for a period of one year as shown in the schedule.

### **3. MATERNITY EXPENSES AND NEWBORN CHILD COVER BENEFIT EXTENSION:**

This is an optional cover, which can be obtained on payment of 10% of the total basic premium for all the insured persons under the policy. Total basic premium means the total premium computed before applying group discount and /or High Claims Ratio Loading, Low Claim Discount.

Option for Maternity Expenses and Newborn Child Cover Benefit Extension has to be exercised at the time of inception of the policy period and no refund is allowable in case of cancellation of this option during the currency of the policy.

Those insured persons who are already having two or more living children will not be eligible for this benefit

Claim in respect of only first two children and/or operations associated therewith will be considered in respect of any one insured person covered under the policy or any valid and effective renewal thereof. The maximum benefit allowable under this clause will be Rs. 50,000/-and would fall under different heads mentioned under item 1.2. The sum insured under above benefit shall be a part of basic sum insured.

#### **Special conditions applicable to Maternity Expenses & Newborn Child Cover Benefit Extension**

These benefits are admissible only if the expenses are incurred in hospital/nursing home as in-patient in India.

A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarean section or abdominal operation for extra uterine Pregnancy. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency.

Expenses incurred in connection with voluntary medical termination of pregnancy during the first twelve weeks from the date of conception are not covered.

Pre-natal and post-natal expenses are not covered unless admitted in Hospital/nursing home and treatment is taken there.

Pre Hospitalisation and post Hospitalisation benefits are not available under this section.

New born child shall be covered from day one upto the age of 3 months and expenses incurred for treatment taken in hospital as in patient shall only be payable within the specified sum insured of Rs 50,000/- under Maternity benefit extension. Congenital diseases of new born child shall be excluded.

#### **4 EXCLUSIONS:**

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

**4.1 Pre-existing health condition or disease or ailment / injuries :** Any ailment / disease / injuries / health condition which are pre-existing (treated / untreated, declared / not declared in the proposal form), when the cover incepts for the first time are excluded upto 4 years of this policy being in force continuously.

This exclusion will also apply to any complications arising from pre existing ailments / diseases / injuries.

**4.2** Any disease other than those stated in clause 4.3, contracted by the Insured person during the first 30 days from the commencement date of the policy except treatment for accidental external injuries.

**4.3** During the period of insurance cover, the expenses on treatment of following ailment / diseases / surgeries for specified periods are not payable if contracted and / or manifested during the currency of the policy.

|     |   |         |
|-----|---|---------|
| I   | Benign ENT disorders and surgeries i.e. Tonsillectomy, Adenoidectomy, Mastoidectomy, Tympanoplasty etc. | 1 year  |
| ii  | Polycystic ovarian diseases .   | 1 year  |
| iii | Surgery of hernia.  | 2 years |

|       |  |         |
|-------|--|---------|
| Iv    | Surgery of hydrocele.  | 2 years |
| V     | Non infective Arthritis.   | 2 years |
| Vi    | Undescendent Testes.   | 2 Years |
| Vii   | Cataract.  | 2 Years |
| Viii  | Surgery of benign prostatic hypertrophy.   | 2 Years |
| Ix    | Hysterectomy for menorrhagia or fibromyoma.or myomectomy or prolapse of uterus . | 2 Years |
| X     | Fissure / Fistula in anus.   | 2 Years |
| Xi    | Piles.   | 2 Years |
| Xii   | Sinusitis and related disorders.   | 2 Years |
| Xiii  | Surgery of gallbladder and bile duct excluding malignancy.                       | 2 Years |
| Xiv   | Surgery of genito urinary system excluding malignancy.                           | 2 Years |
| Xv    | Pilonidal Sinus.   | 2 Years |
| Xvi   | Gout and Rheumatism.   | 2 Years |
| Xvii  | Hypertension.  | 2 Years |
| Xviii | Diabetes.  | 2 Years |
| Xix   | Calculus diseases.   | 2 Years |
| xx    | Surgery for prolapsed inter vertebral disk unless arising from accident.         | 2 Years |
| xxi   | Surgery of varicose veins and varicose ulcers.                                   | 2 Years |
| xxii  | Congenital internal diseases.  | 2 Years |
| xxiii | Joint Replacement due to Degenerative condition.                                 | 4 Years |
| xxiv  | Age related osteoarthritis and Osteoporosis..                                    | 4 Years |

**If the continuity of the renewal is not maintained, then subsequent cover will be treated as fresh policy and clauses 4.1., 4.2, 4 .3 will apply unless agreed by the Company and suitable endorsement passed on the policy.**

- 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, inoculation or change of life or cosmetic or of 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** Cosmetic surgery for correction of eye sight, cost of spectacles, contact lenses, hearing aids etc.
- 4.7** Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc 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 and diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.
- 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 or Nursing Home 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 etc. unless forming part of treatment for injury or disease as certified by the attending physician.
- 4.12** Any Treatment 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. .
- 4.13** Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupuncture, acupressure, magnetic and such other therapies etc.
- 4.14** Expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalization or primary reasons for admission. Private nursing charges, Referral fee to family doctors, Out station consultants / Surgeons fees etc.
- 4.15** Genetical disorders and stem cell implantation / surgery.
- 4.16** External and or durable Medical / Non medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e. walker, Crutches, Belts, Collars, Caps, splints, slings, braces, Stockings etc of any kind, Diabetic foot wear, Glucometer / Thermometer and similar related items etc and also any medical equipment which is subsequently used at home etc.
- 4.17** All non medical expenses including Personal comfort and convenience items or services such as telephone, television, Aya / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items etc, guest services and similar incidental expenses or services etc.
- 4.18** Change of treatment from one pathy to other pathy unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.
- 4.19** Treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme, services or supplies etc.
- 4.20** Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company.
- 4.21** Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
- 4.22** Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.
- 4.23** Out patient Diagnostic, Medical and Surgical procedures or treatments, 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.
- 4.24** Massages, Steam bathing, Shirodhara and alike treatment under Ayurvedic treatment.
- 4.25** Any kind of Service charges, Surcharges, Admission fees / Registration charges etc levied by the hospital.
- 4.26** Doctor's home visit charges, Attendant / Nursing charges during pre and post hospitalization period.
- 4.27** Treatment which is continued before hospitalization and continued during and after discharge for an ailment / disease / injury different from the one for which hospitalization was necessary.

**5.1 CANCELLATION CLAUSE:** Company may at any time, cancel this Policy by sending the Insured 30 (Thirty) days notice by registered letter at the Insured's last known address and in such an event the Company shall refund to the Insured a pro-rata premium for un-expired Period of Insurance. (Such cancellation by the Company shall be only on grounds of moral hazards such as intentional misrepresentation / malicious suppression of facts intended to misleading the Company about the acceptability of the proposal, lodging a fraudulent claim and such other intentional acts of the insured / beneficiaries under the policy). The Company shall, however, remain liable for any claim which arose prior to the date of cancellation. The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given here below) provided no claim has occurred during the policy period up to date of cancellation.

| <b>Period on Risk</b> | <b>Rate of premium to be charged</b> |
|-----------------------|--------------------------------------|
| Upto 1 Month          | 1/4th of the annual rate             |
| Upto 3 Months         | 1/2 of the annual rate               |
| Upto 6 Months         | 3/4th of the annual rate             |
| Exceeding 6 months    | Full annual rate                     |

## **5.2 BONUS- LOW CLAIM RATIO DISCOUNT / MALUS - HIGH CLAIM RATIO LOADING**

**BONUS- LOW CLAIM RATIO DISCOUNT** Low claim ratio discount at the following scale will be allowed on the total premium at renewal only, depending upon the incurred claims ratio for the entire group insured under the group Medclaim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the group medclaim insurance policy has not been in force for three completed years, such shorter period of completed years excluding the year immediately preceding the date of renewal will be taken into account.

| <b>Incurred Claims Ratio under Group Policy</b> | <b>Discount</b> |
|---|-----------------|
| Not exceeding 60%                               | 5%              |
| Not exceeding 50%                               | 15%             |
| Not exceeding 40%                               | 25%             |
| Not exceeding 30%                               | 35%             |
| Not exceeding 25%                               | 40%             |

**5.3 MALUS - HIGH CLAIM RATIO LOADING** The total premium payable at renewal of the group policy will be loaded at the following scale depending upon the incurred claims ratio for the entire group insured under the group Medclaim insurance policy for the preceding three completed years excluding the year immediately preceding the date of renewal. Where the group Medclaim policy has not been in force for three completed years, such shorter period of completed years, excluding the year immediately preceding the date of renewal will be taken into account.

| <b>Incurred Claims Ratio under Group Policy</b> | <b>Loading</b>       |
|---|----------------------|
| Between 70% and 100%                            | 25%                  |
| Between 101% and 125%                           | 55%                  |
| Between 126% and 150%                           | 90%                  |
| Between 151% and 175%                           | 120%                 |
| Between 176% and 200%                           | 150%                 |
| Above 200%                                      | cover to be reviewed |

Note: Low claim ratio discount (Bonus) or High Claim ratio loading (Malus) will be applicable to the premium at renewal of the policy depending on the incurred claim ratio for the entire group insured.

Incurred claims would mean claims paid plus claims outstanding in respect of the entire group insured under the policy during the relevant period.

**6 GROUP DISCOUNT:** The Group Discount depending upon total number of insured persons (families) at inception of the policy is allowed at the following scale.

- a) No discount is offered for a group consisting of less than 101 members.
- b) Addition / deletion during currency will not be considered for change in discount. Discount is applicable on number of persons on renewal / inception date only.

| <u>No. Of persons / Families</u> | <u>Discount %</u> |
|----------------------------------|-------------------|
| 101-1000                         | 10.00             |
| 1,001-5,000                      | 12.50             |
| 5,001-15,000                     | 15.00             |
| 15,001-25,000                    | 20.00             |
| 25,001-50,000                    | 25.00             |

**Family Package Policy Clause and Family discount not applicable.**

**7 PRE -ACCEPTANCE HEALTH CHECKUP:** Any person beyond 45 years of age desiring to take insurance cover has to submit following medical reports from listed Network Diagnostic Centre or any other medical reports required by the company in case of fresh proposal and renewal where there is a break in policy period.

| <b>Age</b>          | <b>45-55</b>                               | <b>ABOVE 55 Years</b>                       |
|---------------------|--|---|
| <b>MEDICAL TEST</b> | PHYSICAL EXAMINATION                       | PHYSICAL EXAMINATION                        |
|                     | URINE(MICROALBUMIN UREA)                   | URINE(MICROALBUMIN UREA)                    |
|                     | GLYCOCYLATED, HAEMOGLOBIN                  | GLYCOCYLATED HAEMOGLOBIN                    |
|                     | ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS) | ULTRASONOGRAPHY (WHOLE ABDOMEN AND PELVIS)  |
|                     | ELECTRO CARDIO GRAM                        | X RAY BOTH KNEES (ANTEPOSTERIOR AND LATREL) |
|                     | COMPLETE EYE TEST INCLUDING FUNDUS ETC     | COMPLETE EYE TEST INCLUDING FUNDUS ETC      |
|                     |  | STRESS TEST (TMT)                           |

**8 SUM INSURED:** The Company's liability in respect of all claims admitted during the period of Insurance shall not exceed the sum insured opted by the Insured person. Minimum sum insured is Rs 50,000/- and in multiples of Rs 25,000/- upto Rs 2, 00,000/- . Beyond the Sum Insured of Rs. 200000/- in multiples of Rs. 50000/- upto Rs 500000/-.

**9 PREMIUM REVISION CLAUSE:** The above rates are valid for a period of 1 year only. The company may revise the premium rates and / or the terms & conditions of the policy upon renewal thereof as per IRDA guidelines prevailing at that time.

## **10 PORTABILITY**

THIS POLICY IS PORTABLE TO THE EXTENT THAT THE INSURED MEMBER MAY OPT OUT OF THE GROUP AND SWITCH FROM GROUP INSURANCE PLAN TO INDIVIDUAL/FAMILY INSURANCE

COVER WITH THE SAME INSURER(THE GROUP INSURER). PORTABILITY MAINTAINS THE CREDIT GAINED BY THE INSURED FOR PRE-EXISTING CONDITIONS AND TIME BOUND EXCLUSIONS.

IF THE INSURED DESIRES TO PORT HIS POLICY, REQUEST FOR THE SAME HAS TO BE MADE ATLEAST 45 DAYS PRIOR TO RENEWAL DATE.

#### **11 AUTHORITY TO OBTAIN RECORDS.**

a) The insured person hereby agrees to and authorizes the disclosure to the insurer or the TPA or any other person nominated by the insurer 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 either the insurer or the TPA in connection with any claim made under this policy or the insurer's liability thereunder.

b) The insurer and the 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 insurer's liability thereunder.

12. **QUALITY OF TREATMENT** : The insured hereby acknowledges and agrees that payment of any claim by or on behalf of the insurer shall not constitute on part of the insurance 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 policy holder that insurer is not in any way responsible or liable for the availability or quality of any services (Medical or otherwise) rendered by any institution (including a network hospital) whether pre-authorized or not.

13. **IRDA REGULATION NO. 5.** This policy is subject to regulation 5 of IRDA (Protection of Policy Holder interest) regulation.

14. **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 / illness / 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 or before discharge from Hospital / Nursing Home.

#### **15. PROCEDURE FOR AVAILING CASHLESS ACCESS SERVICES IN NETWORK HOSPITAL/NURSING HOME :**

i) Claim in respect of Cashless Access Services will be through the Company / TPA provided admission is in a listed hospital in the agreed list of the networked Hospitals / Nursing Homes 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-authorization letter / guarantee of payment letter to the Hospital / Nursing Home mentioning the sum guaranteed as payable, also the ailment for which the person is seeking to be admitted as in-patient.

ii) The Company /TPA reserves the right to deny pre-authorization 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 Access should in no way be construed as denial of claim. 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 for reimbursement within 7 days of the discharge from Hospital / Nursing Home.

iii) Should any information be available to the Company /TPA which makes the claim inadmissible or doubtful requiring investigations, the authorisation of cashless facility may be withdrawn. However this shall be done by the TPA before **the patient is discharged from the Hospital.**

**16. DISCLOSURE TO INFORMATION NORM**

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

**17 SCHEDULE OF PREMIUM : As per table attached**

| SUM INSURED | DOMICILIARY | AGE BAND |       |       |       |       |       |         |
|-------------|-------------|----------|-------|-------|-------|-------|-------|---------|
|             |             | 3m-20    | 21-35 | 36-45 | 46-55 | 56-60 | 61-70 | above70 |
| 50000       | 10000       | 609      | 677   | 809   | 1265  | 1799  | 2688  | 3600    |
| 75000       | 15000       | 883      | 981   | 1174  | 1836  | 2604  | 3886  | 5203    |
| 100000      | 20000       | 1179     | 1310  | 1566  | 2447  | 3483  | 5196  | 6960    |
| 125000      | 23750       | 1454     | 1615  | 1932  | 3026  | 4310  | 6436  | 8683    |
| 150000      | 27500       | 1728     | 1920  | 2295  | 3605  | 5136  | 7676  | 10405   |
| 175000      | 31250       | 1975     | 2194  | 2623  | 4142  | 5912  | 8846  | 12040   |
| 200000      | 35000       | 2221     | 2468  | 2951  | 4680  | 6687  | 10018 | 13678   |
| 250000      | 40000       | 2660     | 2956  | 3534  | 5672  | 8133  | 12222 | 16778   |
| 300000      | 45000       | 3100     | 3444  | 4117  | 6664  | 9581  | 14428 | 19878   |
| 350000      | 50000       | 3483     | 3870  | 4627  | 7573  | 10925 | 16494 | 22805   |
| 400000      | 50000       | 3867     | 4297  | 5138  | 8483  | 12267 | 18562 | 25735   |
| 450000      | 50000       | 4252     | 4724  | 5647  | 9392  | 13611 | 20628 | 28663   |
| 500000      | 50000       | 4635     | 5150  | 6157  | 10302 | 14955 | 22696 | 31590   |

Premium will be calculated on completed years e. g. a person who has completed 45 years and 1 day will fall under age band of 36-45 .

This Prospectus shall form part of your proposal form. Signatures hereunder confirm that you have noted the contents of the prospectus.

Name:  
Address:

Signature

Place:

Date:

Note: For legal interpretation only English version will be valid.

**INSURANCE ACT 1938 SECTION 41 - PROHIBITION OF REBATE**

Section 41 of the Insurance Act 1938 provides as follows:

Any person making default in complying with provision of this section shall be punishable with fine, which may extend to Rs.500/-.

**No person shall allow, or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy nor shall any person taking out or renewing or continuing a policy accept any rebate except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer.**