

DUAL INSURANCE

(Health Plus Life Combi Product from Universal Sampo General Insurance Company Ltd. and Go Digit Life Insurance Ltd.)

UIN- UNIHLGP27044V012627

Policy Wordings

DUAL INSURANCE is a Group Combi Product, a combination of Health Insurance Product (i.e. I. Group Health Insurance Policy- UIN: UNIHLGP26043V062526, offered by Universal Sampo General Insurance Company Limited) and Life Insurance Product (i.e. II. Digit Life Group Long Term Plan- UIN: 165N002V01, offered by Go Digit Life Insurance Limited).

I. Health Insurance component- Group Health Insurance Policy

1. SCHEDULE 2. PREAMBLE

This policy is a contract of insurance between You and Universal Sampo General Insurance Company Limited (hereinafter called the 'Company') and contains all the details of the cover that we provide.

Your policy comprises:

- The preamble [the current part] which introduces the policy document, describes the structure of the document and sets the general rules;
- The policy wording which lists and details the available coverage, benefits, claims and grievance redressal procedure, exclusions and other terms and conditions of cover;
- The proposal, which is the information You provide to us and which forms the basis for this insurance cover;
- The policy schedule - a separate document customized for you showing the cover details opted for by You and offered by Us to You. It is to be noted that the schedule may amend the policy and only those Parts shown as covered in your schedule are insured;
- Any other written alteration otherwise issued by us in writing (such as an endorsement) that varies or modifies the above documents.

3. Group and Membership

Eligibility for a 'Group' and for 'Membership' thereof [Policy-holder and Beneficiary in Employer-Employee cases and Policy-holder and Insured-Beneficiary in Non-Employer-Employee cases] shall be basis the IRDAI Circular. "Group" shall mean a group of Members who assemble together with a purpose of engaging in a common economic activity and not formed with the main purpose of availing insurance cover.

4. Policy Period

The policy period shall normally be an annual period [of 12 months] starting from the date of commencement of policy. This policy can be issued for a term of one year, except credit linked products where the term can be extended up to the loan period not exceeding five years

5. Payment of Premium

- i. Premium for the policy must be paid in full in advance. We will assume risk and the cover will incept not earlier than the date of payment of full premium.
- ii. The policy-holder will have the option of premium payment in instalments as mentioned in the Policy Schedule / Certificate of Insurance in which case the chargeable premium will be loaded as per our instalment premium payment rules basis the frequency chosen by the policy-holder.

6. Operative Clause

If during the policy period insured person is required to be **hospitalized** for treatment of an Illness or Injury at a Hospital/ Day Care Centre following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify medically necessary expenses towards the Coverage mentioned in the policy schedule.

Provided further that, any amount payable under the policy shall be subject to the terms of coverage (including any co-pay, sub limits), exclusions, conditions and definitions contained herein. Maximum liability of the Company under all such Claims during each Policy Year shall be the Sum Insured (Individual or Floater) opted specified in the Schedule.

7. Definitions:

7.a. Standard Definitions:

Definitions of **all the covers** along with those of key associated terms are given below. When used in this Policy, the Policy Schedule, and Endorsements, they will always carry **such specific meanings** as in the following definitions.

Where **the context so requires**, references to the singular shall also include references to the plural and references to any gender shall include references to all genders.

1. **Accident** means a sudden, unforeseen, and involuntary event caused by external, visible and violent means.
2. **Any One Illness** means continuous period of illness and it includes relapse within forty five days from the date of last consultation with the hospital where treatment has been taken.
3. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
4. **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 in-patient services and must comply with all the following criterion:
 - Having qualified registered AYUSH Medical Practitioner(s) in charge;
 - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
5. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
6. **Bank Rate** means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.
7. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.
8. **Condition Precedent** means a Policy term or condition upon which the Company's liability under the Policy is conditional upon.
9. **Cancer of Specified Severity**

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.

b. 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 and CIN-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 classification T2N0M0;
- v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- vi. Chronic lymphocytic leukemia less than RAI stage 3;
- 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 5/50 HPFs.

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

Internal Congenital Anomaly

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

External Congenital Anomaly

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

11. **Co-payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured.
12. **Complaint or Grievance** means written expression (includes communication in the form of electronic mail or voice based electronic scripts) of dissatisfaction by a complainant with respect to solicitation or sale or purchase of an insurance policy or related services by insurer and /or by distribution channel.
13. **Complainant** means a policyholder or prospect or nominee or assignee or any beneficiary of an insurance policy who has filed a complaint or grievance against an insurer and/ or distribution channel.
14. **Day Care Centre** means any institution established for day care treatment of disease/ injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:
- has qualified nursing staff under its employment;
 - has qualified medical practitioner (s) in charge;
 - has a fully equipped operation theatre of its own where surgical procedures are carried out
 - maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
15. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
- undertaken under general or local anesthesia in a hospital/day care centre in less than twenty four hours because of technological advancement, and
 - which would have otherwise required a hospitalization of more than twenty four hours. [Treatment taken on an out-patient basis is not included in the scope of this definition.]
16. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.
17. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
18. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually undertaken while confined at home under medical advice and under any of the following compelling 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.

19. **Emergency Care:** Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.
20. **Family** means, the Family that consists of the proposer and any one or more of the family members as mentioned below:
Legally wedded spouse, Parents and Parents-in-law, Dependent Children (i.e. natural or legally adopted) between the age 3 months to no max limit.
(If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewals)
Brother, Sister and Live in Partner.
21. **Grace period** means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
22. **Hospital** means any institution established for in-patient care and day care treatment of disease/ 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 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 ten inpatient beds, in those towns having a population of less than ten lakhs and fifteen 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 shall make these accessible to the Company's authorized personnel.
23. **Hospitalization** means admission in a hospital for a minimum period of twenty four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty four (24) consecutive hours.
24. **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.
25. **Acute Condition** means a disease, illness or injury that is likely to response 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.
26. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
 - it requires rehabilitation for the patient or for the patient to be special trained to cope with it
 - it continues indefinitely
 - it recurs or is likely to recur
27. **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.
28. **In-Patient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
29. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

30. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses on a per day basis 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.
31. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.
32. **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.
33. **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 the license.
34. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which is required for the medical management of illness or injury suffered by the insured; must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity; must have been prescribed by a medical practitioner; must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
35. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
36. **Mis-selling** includes sale or solicitation of policies by the insurer or through distribution channels, directly or indirectly by
- a. exercising undue influence, use of dominant position or otherwise, or
 - b. making a false or misleading statement or misrepresenting the facts or benefits, or
 - c. concealing or omitting facts, features, benefits, exclusions with respect to products, or
 - d. not taking reasonable care to ensure suitability of the policy to the prospects/policyholders.
37. **Maternity expenses** means:
Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
Expenses towards lawful medical termination of pregnancy during the policy period.
38. **New Born Baby** means baby born during the Policy Period and is aged up to 90 days.
39. **Network Provider** means hospitals enlisted by insurer, TPA or jointly by an insurer and TPA to provide medical services to an insured by a cashless facility.
40. **Non- Network Provider** means any hospital that is not part of the network.
41. **Notification of Claim** means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.
42. **Out-Patient (OPD) Treatment** means treatment 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 in-patient.
43. **Pre-Existing Disease (PED):** Pre-existing disease (PED) means any condition, ailment, injury or disease:
a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.
44. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

45. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that:
Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
The In-patient Hospitalization claim for such. Hospitalization is admissible by the Insurance Company.
46. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the insured person is discharged from the hospital provided that:
Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
The inpatient hospitalization claim for such hospitalization is admissible by the Insurance Company.
47. **Proposal form** means a form to be filled in by the prospect in physical or electronic form, for furnishing the information including material information, if any, as required by the insurer in respect of a risk, in order to enable the insurer to take informed decision in the context of underwriting the risk, and in the event of acceptance of the risk, to determine the rates, advantages, terms and conditions of the cover to be granted.
48. **Prospect** means any person who is a potential customer and likely to enter into an insurance contract either directly with the insurer or through the distribution channel involved.
49. **Prospectus** means a document either in physical or electronic format issued by the insurer to sell or promote the insurance product.
50. **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.
51. **Renewal:** 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.
52. **Room Rent** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.
53. **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 of suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
54. **Specific waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/ treatments (except due to an accident) are not covered. On completion of the period, diseases/ treatments shall be covered provided the policy has been continuously renewed without any break.

7.b. Specific Definitions:

1. **Age** means age of the Insured person on last birthday as on date of commencement of the Policy.
2. An **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
3. Central or State Government AYUSH Hospital or
4. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
5. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
 - a. Having at least 5 in-patient beds;
 - b. Having qualified AYUSH Medical Practitioner in charge round the clock;
 - c. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - d. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
6. **Insured Person** means person(s) named in the schedule of the Policy.

7. **Non-Ambulatory condition** means a condition in which Insured person is physically or mentally unable to walk or traverse a normal path to safety without the physical assistance of any other person/caretaker.
8. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.
9. **Policy period** means period of one policy year as mentioned in the schedule for which the Policy is issued.
10. **Policy Schedule** means the Policy Schedule attached to and forming part of Policy
11. **Policy year means** a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule
12. **Sub-limit** means a cost sharing requirement under a health insurance policy in which an insurer would not be liable to pay any amount in excess of the pre-defined limit.
13. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.
14. **Third Party Administrator (TPA)** means a Company registered with the Authority, and engaged by an insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.
15. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
16. **We/Us/Company** means Universal Sompo General Insurance Company Limited

8. Base Covers:

- I. The option to allow the covers and vary the available benefits lies with the Insurer.
- II. The expenses that are not covered in this policy are placed under **List-I of Annexure A**. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under **List-II, List-III and List-IV of Annexure A** respectively.
- III. Opting any of 1 base cover under the Policy is Mandatory
- IV. The term of the policy would be minimum 1 year to maximum 5 years for Loan Linked products including base coverage and optional benefits.

8.a. Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured or as specified in the policy schedule, for,

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home.
- ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses.
- iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor / surgeon or to the hospital.
- iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.
- v. Expenses incurred on Road [including expenses incurred by rescuers of accident victims on ambulances and hired transportation like cabs] subject to 2% of sum insured or a maximum of Rs. 10000
- vi. Mental illness - We shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following and they are covered after a waiting period of <<>> months with a sub-limit up to <<>> per policy period as mentioned under Policy Schedule / Certificate of Insurance.

Special Provisions

- a) The Company shall indemnify medical expenses incurred for inpatient care treatment under the **AYUSH** systems of medicines during each Policy Year up to the limit of sum insured in any AYUSH Hospital.
[Payable as per AYUSH guidelines on procedure charges]
- b) Expenses of Hospitalization for a minimum period of 24 consecutive hours as in-patient only shall be admissible. The in-patient requirement shall stand waived in case of **Domiciliary Hospitalization**. The time limit of 24-consecutive-hours-hospitalization shall stand waived in case of **Day Care Procedures**.
- c) Limit under any specific cover 8.a. (i) to 8.a.(v) if any is as mentioned in the Policy Schedule / Certificate of Insurance.

8.a.1. Domiciliary Hospitalization / Treatment

The company shall indemnify the Medical Expenses incurred on the Domiciliary Hospitalization / Treatment of an Insured Person during the Coverage Period which would otherwise have been covered under Section 8.a provided that if a claim has been accepted under this section, a consolidated claim post full recovery, shall be considered and no separate post-hospitalization medical expenses shall be payable.

8.a.2. Day Care Procedures

The day care procedures [listed later and forming part of this document as **Day Care Procedures Annexure III**] will be covered (Where medically indicated subject to other specific or permanent exclusion mentioned in policy) as part of day care treatment in a hospital up to the limit of SI.

8.a.3. Pre-Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period as opted for by the insured and as mentioned in policy schedule prior to the date of admissible hospitalization covered under the policy.

8.a.4. Post-Hospitalization

The company shall indemnify post-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period from the date of discharge from the hospital as opted for by the insured and as mentioned in policy schedule, following an admissible hospitalization covered under the policy.

8.a.5. Coverage for Modern Treatments Or Procedures

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified in the Policy Schedule / Certificate of Insurance against each procedure during the policy period.

- 1 Oral Chemotherapy
- 2 Immunotherapy – Monoclonal Antibody to be given as injection
- 3 Intra vitreal injections
- 4 Uterine Artery Embolization and HIFU
- 5 Balloon Sinuplasty
- 6 Deep Brain stimulation
- 7 Robotic Surgeries
- 8 Stereotactic radio surgeries
- 9 Bronchial Thermoplasty
- 10 Vaporisation of the prostate (Green Laser treatment or holmium laser treatment)
- 11 IONM – (Intra Operative Neuro Monitoring)

- 12 Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered
- 13 Any other treatment using advanced technology as specified in the policy schedule

8.b. Top Up Cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay the Medical Expenses in excess of deductible stated in the Policy Schedule on per admissible claim basis.

However, the total liability of the Company under this Policy for payment of any admissible claim during the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule / Certificate of Insurance.

Plans available under the cover are mentioned under 'SUM INSURED FOR TOP UP & SUPER TOP UP COVER ANNEXURE IV'.

8.c. Super Top Up Cover

The Company hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to pay the Medical Expenses in excess of deductible stated in the Policy Schedule on per year basis.

However, the total liability of the Company under this Policy for payment of any and all admissible Claims in aggregate during the Policy Period shall not exceed the Sum Insured as stated in the Policy Schedule.

Plans available under the add-on cover are mentioned under 'SUM INSURED FOR TOP UP & SUPER TOP UP COVER ANNEXURE IV'.

9. Extensions:

Unless otherwise specified or restricted, the Company's liability under these Extensions shall be part of the limit of liability under Section **8.a.**

9.1. Pre-Existing Disease Waiting Period Waiver

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, waiting period applicable to all Pre-Existing Diseases for each Insured Person before benefits are payable under the Policy is waived off.

For the purpose of this extension, Exclusion Code 01 shall not be applicable.

The extent of reimbursement of hospitalization expenses arising out of this waiver and chosen by the insured shall be as mentioned in the policy schedule.

9.2. Specific Waiting Period Waiver

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, specific waiting period applicable for any claims in relation to listed conditions, surgeries/treatments as mentioned under Exclusion Code 02:

a) Is waived off

Or

b) Is modified to 12 months.

The Insured will have the choice of choosing between 9.2.[a] and 9.2.[b].

9.3. Initial Waiting Period for Hospitalization Waiver

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, 30 days waiting period applicable for any claims in relation to a Hospitalization of the Insured Person including any Medical Expenses incurred there of:

a) Is waived off

Or,

b) Is modified to 15 days.

The Insured will have the choice of choosing between 9.3.[a] and 9.3.[b].

9.4. Obesity/ Weight Control Expenses Extension

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, Exclusion Code 06 is deleted.

For the purpose of this extension, expenses related to the surgical treatment of obesity are included under the scope of cover up to the limit specified in Policy Schedule.

9.5. Change-of-Gender Treatments Expenses Extension

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, Exclusion Code 07 stands deleted.

For the purpose of this extension, expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex are included under the scope of cover up to the limit specified in Policy Schedule.

Surgery for both (Female to Male) and (Male to Female) shall be payable under this extension, provided below of the criteria are met.

- The individual is at least 18 years of age.
- The individual has been diagnosed by certified Medical Practitioner with the Gender Identity Disorder (GID) or Gender Dysphoria of transsexualism.
- The individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real life experience) without returning to the original gender.

When a covered benefit for gender reassignment surgery exists and all of the above criteria are met, the following surgeries are medically necessary for **transwomen (male to female)**

1. Orchiectomy
2. Penectomy
3. Vaginoplasty
4. Colovaginoplasty
5. Clitoroplasty
6. Labiaplasty
7. Breast Augmentation (Note: augmentation mammoplasty (including breast prosthesis if necessary) if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 12 months is not sufficient for comfort in the social role)
8. Trachea shave/ reduction thyroid chondroplasty: reduction of the thyroid cartilage

When a covered benefit for gender reassignment surgery exists and all of the above criteria are met, the following surgeries are medically necessary for **transmen (female to male)**

- Breast reconstruction (e.g. mastectomy, reduction mammoplasty)
- Hysterectomy
- Salpingo-oophorectomy
- Colpectomy/ Vaginectomy
- Metoidioplasty
- Phalloplasty
- Urethroplasty
- Scrotoplasty

Other forms of Cosmetic surgery related to Gender Affirmation surgery are excluded.

The following procedures are considered cosmetic services and are non-covered:

1. Abdominoplasty
2. Brow ptosis surgery

3. Cervicoplasty
4. Chemical exfoliations, peels, abrasions (or dermabrasions or planning for acne, scarring, wrinkling, sun damage or other benign conditions)
5. Correction of variations in normal anatomy including augmentation mammoplasty, mastopexy, and correction of congenital breast asymmetry
6. Dermabrasion
7. Ear Piercing or repair of a torn earlobe
8. Excision of Excess Skin or Subcutaneous Tissue
9. Hair Transplants; Hair Removal (including electrolysis epilation)
10. Inverted nipple surgery
11. Laser treatment for acne and acne scars
12. Osteoplasty - Facial Bone Reduction
13. Otoplasty
14. Procedures to correct visual acuity including, but not limited to, cornea surgery or lens implants
15. Removal of Asymptomatic Benign Skin Lesions
16. Repeated cauterizations or electrofulguration methods used to remove growths on the skin
17. Rhinoplasty
18. Rhytidectomy
19. Scar Revision, regardless of symptoms
20. Sclerotherapy for Spider Veins
21. Subcutaneous Injection of Filling Material
22. Suction assisted Lipectomy
23. Tattooing or Tattoo Removal (except tattooing of the nipple/areola related to a mastectomy)
24. Testicular prosthesis surgery
25. Treatment of vitiligo
26. Voice modification surgery
27. Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics

9.6. Cosmetic or Plastic Surgery Expenses Extension

Notwithstanding anything to the contrary in the Policy it is hereby declared and agreed that, on payment of additional premium, Exclusion Code 08 stands deleted.

For the purpose of this extension, expenses for cosmetic or plastic surgery or any treatment to change appearance other than for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured are included under the scope of cover up to the limit specified in Policy Schedule.

9.7. Hazardous or Adventure Sports Expenses Extension

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, Exclusion Code 09 stands deleted.

For the purpose of this extension, 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, are included under the scope of cover up to the limit specified in Policy Schedule.

9.8. Sterility and Infertility Treatment Expenses Extension

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, Exclusion Code 17 stands deleted.

For the purpose of this extension expenses related to sterility and infertility which include:

- Any type of contraception, sterilization
- Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

- Gestational Surrogacy
- Reversal of sterilization

are included under the scope of cover up to the limit specified in Policy Schedule.

9.9. Maternity Expenses Extension with Baby-Day-One Cover

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, Exclusion Serial No 2.E.15 / Exclusion Code 18 stands deleted.

a) Without waiting period

Or,

b) With waiting period of 9 months.

The Insured will have the choice of choosing between 9.9.[a] and 9.9.[b].

For the purpose of this extension,

- Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- Expenses towards miscarriage and the related lawful medical termination of pregnancy during the policy period are included under the scope of cover up to the limit specified in Policy Schedule.

In-patient Medical Expenses incurred towards the Hospitalization of an Insured Person's New Born Baby which is born during the policy period are also covered under this extension provided that:

- Only those Medical Expenses which are incurred for the New-Born Baby during birth or post birth up to 90 days from the date of delivery shall be covered up to limit mentioned in Policy Schedule.
- Subsequent [to 'i' above] coverage of such New Born Baby will be available till expiry of the Policy subject to addition of the New Born Baby into the Policy by way of an endorsement on payment of the requisite premium.

9.10. OPD Expenses Extension

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, Specific Exclusion (E.2.1) stand deleted.

For the purpose of this extension, medical expenses [excluding expenses related to pregnancy and child-birth] incurred by the Insured as an Outpatient are included under the scope of cover up to the limit specified in Policy Schedule.

Outpatient means an insured who visits a clinic / hospital or associated facility like a consultation room for diagnosis (including Pharmacy) and treatment based on the advice of a Medical Practitioner.

9.11. Maternity OPD Expenses Extension

Notwithstanding anything to the contrary in the Policy, it is hereby declared and agreed that, on payment of additional premium, Specific Exclusion (E.2.1) stands deleted.

For the purpose of this extension, maternity-related medical expenses incurred by the Insured as an Outpatient are included under the scope of cover up to the limit specified in Policy Schedule subject to the Insured opting for Cover 9.9. Maternity Expenses Extension with Baby-Day-One Cover.

Outpatient means an insured who visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner.

9.12. Global Coverage

The Company will reimburse for Medical Expenses of the Insured Person incurred outside India for not more than 180 consecutive days up to the sum insured, provided that

- the diagnosis was made in India and referred by Medical Practitioner for which the insured member(s) travels abroad for treatment and
- prior approval from the Company is taken before travelling abroad for treatment. The Medical Expenses payable shall be limited to Inpatient and day care Hospitalization. Insured member(s) can contact us for any claim assistance. The payment of any claim under this benefit will be in Indian Rupees based on the rate of exchange as on the date of invoice, published by Reserve Bank of India (RBI) and shall be used for conversion

of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion. Only sum insured can be used for this and not the restored sum insured.

For the purpose of this extension, Specific exclusion number 2 shall not be applicable.

Subject to terms and conditions of the policy.

9.13. Non-medical Expenses Cover

Notwithstanding anything to the contrary contained in the Policy, it is hereby declared and agreed that, on payment of additional premium, expenses otherwise not payable as specified under List-I of Annexure A mentioned shall be considered and paid by the Company.

Subject to terms and conditions of the policy.

9.14 Treatments related to maternity complications and life-threatening conditions

Notwithstanding anything to the contrary contained in the Policy, it is hereby declared and agreed that, on payment of additional premium, in-patient hospitalisation expenses related to maternity complications and life-threatening conditions shall be payable under this extension.

Exclusion Maternity Expenses (Code – Excl 18) stands deleted for the purpose of this extension.

Subject to terms and conditions of the policy.

9.15 Loss of Job due to illness and injury and/or Retrenchment

The Company will pay an amount as specified in the Policy Schedule / Certificate of insurance, equal to the EMI Amount which is due on the Insured's outstanding Loan in the number of months immediately following loss of active employment, till the reinstatement of employment with the same employer or new employer, during the policy period either due to

a) Medically Necessary hospitalization due to Illness/Injury/Disability which renders the insured person unable to perform his duties as an employee.

or

b) Involuntary Termination, Lay-offs, Downsizing, Organization Closure.

This benefit can be paid once in a Policy Year for the Maximum number of EMI's Specified in the Policy Schedule / Certificate of Insurance and cannot exceed the overall Sum Insured limit. The payout under this benefit can be any one out of above Point (a) or point (b)

Specific definitions applicable to section 9.15

Retrenchment is defined as the termination of a service of a workman by an employer for any reason whatsoever, other than as punishment inflicted by way of disciplinary action. It does not include:

- When a workman voluntarily retires.
- When a workman retires upon reaching the age of superannuation, provided that the employment contract includes such a provision.
- When a workman's service is terminated because the employment contract expires and is not renewed or if the contract contains a provision for termination in such cases.

Condition precedent to Section 9.15

- A claim under this section is valid only if the Insured Person has been retrenched and remained unemployed for at least 30 consecutive days ("Retrenchment Period").
The coverage is available only for jobs under which regular salary or regular remuneration is provided.
- The coverage is not applicable for Self-employed persons or for jobs which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer.

- The coverage is not applicable for employees on Probation/ Training period or similar meaning terminologies where the employment is unconfirmed or of non-permanent nature and the employee must have been in continuous employment with the current employer for at least 6 months including the Probation/ Training period.
- The coverage for a specific Insured Person will end if any claims for that person are accepted by the Company under this Section during the policy period.
- Retrenchment/ Termination Letter from the organization is mandatory to be produced in case of Retrenchment/ Termination/ Lay-off/ Downsizing.

Specific exclusions applicable to section 9.15

The Company shall not be liable to make any payment under this Section in the event of termination, dismissal, temporary suspension or retrenchment from employment of the Insured person being attributed to

- Unemployment at the time of inception of the Policy Period or arising within the first 30 days of inception of the Policy Period as specified in the Policy Schedule.
- Voluntary separation/ resignation or voluntary retirement.
- Retrenchment due to dishonesty or fraud or poor performance on the part of the Insured person or his willful violation of any rules of the employer or laws for the time being in force or any disciplinary action against the Insured person by the employer.
- Discharge from duties due to physical unfitness or ill health.
- Transfer Into subsidiary company with employee consent that includes retrenchment compensation.
- Suspension from employment on account of any pending enquiry.
- Any prior market knowledge with regards to the organization closure/ downsizing/ lay-offs prior to purchasing the policy.

10. Add-Ons:

Unless otherwise specified, the liability under these add-on sections shall be over and above the limit of liability under 8. Base Cover.

10.1. Critical Illness

On payment of additional premium, We will pay the Critical Illness [CI] Sum Insured for the chosen CI Plan [Gold, Silver, Platinum and Diamond as listed below] as a lump sum in addition to pay-out under this Policy provided that:

- a) The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and the Insured Person survives at-least 30 days following such diagnosis,
- b) This benefit is payable once during the Policy Period and would terminate on the occurrence of the first Critical Illness. The Insured Person shall receive the sum insured as per applicable guidelines post which the benefit will cease and coverage under this benefit would not be renewed any further. However, the other insured members (if any) will continue to be covered under this benefit if opted.
- c) This benefit is offered only on Individual Sum Insured basis.

The combinations the insured can choose from are as per the following Plan Table:

SI No.	Particulars	Silver	Gold	Platinum	Diamond
1	Cancer of Specified Severity	Yes	Yes	Yes	Yes
2	Kidney Failure Requiring Regular Dialysis	Yes	Yes	Yes	Yes
3	Multiple Sclerosis With Persisting Symptoms	Yes	Yes	Yes	Yes
4	Major Organ / Bone Marrow Transplant	Yes	Yes	Yes	Yes
5	Open Heart Replacement	Yes	Yes	Yes	Yes

6	Coronary Artery Bypass Graft	Yes	Yes	Yes	Yes
7	Permanent Paralysis Of Limbs	Yes	Yes	Yes	Yes
8	First Heart Attack – Of Specified Severity	Yes	Yes	Yes	Yes
9	Stroke Resulting In Permanent Symptoms	Yes	Yes	Yes	Yes
10	Benign Brain Tumor	No	Yes	Yes	Yes
11	Parkinson's disease	No	Yes	Yes	Yes
12	Coma of Specified Severity	No	Yes	Yes	Yes
13	End Stage Liver Disease	No	No	Yes	Yes
14	Alzheimer's Disease	No	No	Yes	Yes
15	Surgery of Aorta	No	No	Yes	Yes
16	Major Burns	No	No	No	Yes
17	Deafness	No	No	No	Yes
18	Loss of Speech	No	No	No	Yes

Definitions:

Critical Illness means any one of the following illnesses or conditions that occurs or manifests itself during the Policy Period as a first incidence and the insured survives the defined survival period.

(i) 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 and CIN-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 classification T2N0M0
- v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- vi. Chronic lymphocytic leukaemia less than RAI stage 3
- 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 5/50 HPFs;

(ii) Myocardial Infarction (First Heart Attack of specific severity)

I. 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) Open Chest CABG

- 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.

(iv) 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.

(v) 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.

(vi) Kidney Failure Requiring Regular Dialysis

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.

(vii) Stroke Resulting in Permanent Symptoms

- I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial 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.

(viii) Major Organ /Bone Marrow Transplant

- 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 haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

(ix) Permanent Paralysis of Limbs

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.

(x) 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. Neurological damage due to SLE is excluded.

(xi) 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.

(xii) 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 90decibels across all frequencies of hearing” in both ears.

(xiii) 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.

(xiv) 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.

(xv) Third Degree Burns

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.

(xvi) Parkinson’s Disease

The occurrence of Parkinson’s disease where there is an associated neurological deficit that results in permanent inability to perform independently at least three of the activities of daily living as defined below.

- i. Transfer: Getting in and out of bed without requiring external physical assistance
- ii. Mobility: The ability to move from one room to another without requiring any external physical assistance
- iii. Dressing: Putting on and taking of all necessary items of clothing without requiring any external physical assistance
- iv. Bathing/Washing: The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by other means
- v. Eating: All tasks of getting food into the body once it has been prepared

(xvii) Alzheimer's Disease

Clinically established diagnosis of Alzheimer’s Disease (presenile dementia) resulting in a permanent inability to perform independently three or more activities of daily living- bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication- or resulting in need of supervision and permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months

(xviii) Surgery of Aorta

The actual undergoing of medically necessary Surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

10.2. Additional Ambulance Charges

The company will pay the ambulance expenses incurred for Ambulance Expenses up to the maximum amount as specified in Policy Schedule per valid hospitalization claim for transferring the Insured member(s) to the nearest Hospital with adequate facilities, if a claim is accepted under In-patient hospitalization.

This coverage will be in addition to the limit mentioned under Section 8.a.V.

10.3. Corporate Buffer

The Company will provide additional Sum Insured specified in the Policy Schedule available to the Insured Members of the Policy who have exhausted their Sum Insured for the Policy Year. This Sum Insured will be available at the Group level on a Floater basis as per the conditions specified in the Policy Schedule, provided that:

- a) Any Benefit accrued under this cover cannot be carried forward to the subsequent Coverage Period.
- b) All other terms, exclusions and conditions contained in the Policy or endorsed thereon remains unchanged.

10.4. Organ Donor Expenses

The Company will pay the in-patient Hospitalization Medical Expenses for a successful organ transplant including pre-transplant medical tests for legitimate donor and for harvesting the organ up to the sum insured mentioned in policy schedule, provided that:

- i. The organ donor is any person whose organ has been made available in compliance with The Transplantation of Human Organ Act 1994, The Transplantation of Human Organs Act (Amendment) 2011(or any amendments thereafter); and other applicable Central / State Rules / Regulations, as applicable, in respect of transplantation of human organs.
- ii. The organ donated is for the use of the Insured Person who has been medically advised to undergo organ transplant, and
- iii. The Company has accepted an In-patient Hospitalization claim for the Insured member under medical expenses.
- iv. The policy will not cover expenses towards the donor in respect of:
 - (a) Any Pre-Hospitalization Medical Expenses or Post Hospitalization Medical Expenses other than pre-transplant medical test for legitimate organ donor and cost of organ harvesting;
 - (b) Costs directly or indirectly associated to the acquisition of the organ/ or cost of organ.
 - (c) Any other medical treatment or complication in respect of the donor, consequent to harvesting.
 - (d) Claims which have NOT been admitted under in-patient Hospitalization Medical Expenses for the insured

10.5. Daily Cash Cover

If an Insured Person requires Hospitalization due to an Illness or Injury, as specified in the Policy Schedule, suffered or contracted during the Coverage Period, then We will pay the daily benefit amount subject to deductible, specified against this Benefit in the Policy Schedule, for each continuous and completed period of 24 hours of Hospitalization to cover incidental expenses related to hospitalization like [but not restricted to] attendants' accommodation, food and transport

This benefit will be payable provided that:

- a) Our liability to make any payment under this benefit shall commence only after a continuous and completed 24 hours of Hospitalization of the Insured Person for each claim.
- b) This Benefit shall not be payable in respect of the Insured Person for more than the maximum number of days specified in the Policy Schedule for each Coverage Period.

10.6. Restoration of Sum Insured

The Company will provide a 100% restoration of Sum Insured unlimited times in a policy year or as mentioned in the policy schedule, if the opted Sum Insured is exhausted or rendered insufficient as a result of previous claims in that policy year, provided that:

- a) Restoration of Sum Insured will be in addition to opted Sum Insured.
- b) The restored Sum Insured can only be used for all future claims within the same policy year, may or may not be related to the illness/disease/injury for which a claim has been paid in that policy year for the same Insured member(s)
- c) The claim will be admissible under the restored Sum Insured only if the claim is admissible under section "Base Cover – Hospitalisation (8.a)"
- d) Restoration will not trigger for the first claim.
- e) For individual policies, restored Sum Insured will be available on individual basis whereas for floater policies, it will be available on floater basis
- f) Any unutilized restored Sum Insured will not be carried forward to subsequent policy year
- g) Automatic restoration of Sum Insured will be available unlimited times during a Policy year to each insured in case of individual policy and can be utilized by insured persons who stand covered under the Policy before the Sum Insured was exhausted.

10.7. Wellness Benefits

The Company covers below listed benefits to help the Insured person(s) maintain his/her health and wellness by offering services and incentivizing with rewards.

1. Everyday Care

The insured person can avail discounts on outpatient consultation, pharmaceuticals and diagnostics tests through our empanelled Network providers. The list of such network providers will be updated from time to time and can be obtained from Our website, mobile application or by calling our call centre. *The Company will* assist in scheduling appointments for consultation and diagnostic test as per time convenience of the insured person. Alternatively, the insured person may also schedule his/her own appointment themselves by contacting the Network Provider or through the mobile application. The insured person(s) can avail these facilities as many number of time as he/she wishes to avail.

- i. **OPD Consultation:** The Company offers family/general physician as well as special consultations at discounted rates from the Network Providers. The insured person(s) can also store the prescription letters and bills in the electronic health portal system provided by the Company.
- ii. **Diagnostic Services:** The Company offers diagnostic facilities at discounted rates from the Network Providers. The insured person(s) can also store these medical test reports and bills in the electronic health portal system provided by the Company.
- iii. **Pharmacies:** If the insured person(s) want to obtain medicines and consumables prescribed by a medical practitioner, he/she can avail the same at discounted rates subject to a valid prescription from the Network providers. The medicines can be also ordered through the Mobile App or our Web portal.

2. Complete Wellness & Healthcare

The Company offers a comprehensive program to maintain the health and overall wellbeing of the insured person. The insured person is provided with an individual access to web based Health portal at Company's website and/or a Wellness mobile application by the Company where he/she can perform various healthcare activities as listed below.

- i. **Health Risk Assessment (HRA):** HRA is process of health risk assessment with the help of a questionnaire, by collecting the information from the insured in a systematic manner and evaluate their health risks. The Health Risk Assessment generates a statistical estimate of insured person's overall health risk status and quality of lifestyle. The HRA shall be self-performed by the insured person. We will aid the insured person to complete the HRA whenever required.

ii. **Electronic Health Records:** the Insured person can store the medical test reports, prescriptions and other consultation papers in the personalized portal which gets digitized to help create a complete health profile of the insured person. The medical test reports along with HRA as specified above will provide a health score to depict the health status of the insured person.

iii. **Health Screening:** Basis the health score of the insured person, the insured person shall be categorized as Healthy, in which case there will be no trigger for medical screening. If the score depicts unhealthy status, medical screening is advised to the insured person along with a “Health Goal” which is identified post identification of risk factors for improving insured person’s overall well-being. “Health Goal”, which basically takes a deep dive in the identified risk areas to establish the focus points in that particular risk area.

3. Health Coach

The insured person will be assigned a dedicated Health Coach who will take care of the complete wellbeing of the Insured Person(s). The service will offer immediate and complete assistance to the Insured Person looking after his/her day-to-day health care. Post the complete health profile building of the Insured Person, Health Coach will interact with the Insured Person as per Health requirement.

4. AI Powered Wellness Services:

The insured will be offered the below mentioned AI based Health monitoring wellness services designed to enhance the overall health and wellness experience for insured’s by offering personalized and data-driven insights.

1. Health Monitoring: Tracks vital signs (heart rate, SpO2, BP, etc.) using face scan technology in under 40 seconds.
2. AI-Generated Health Score: Provides actionable health insights based on facial analysis.
3. Dietary Assistant: Offers personalized dietary recommendations using meal photos or voice inputs for accurate nutrient tracking. - Nutrition Calculator: Calculates nutritional values of meals from uploaded images.
4. Digital Health Coach: Design’s diet and health plans tailored to user profiles, health goals, and cultural preferences.
5. Recipe AI Tool: Suggests customized recipes based on ingredients and health objectives.
6. AI-Based X-Ray Scan Reader: Detects abnormalities in X-rays, aiding quick and precise diagnostics.
7. Recovery Support: A 90-day program using AI algorithms to help patients recover post-discharge and prevent readmissions.
8. Any other diagnostic/wellness related services which would be available on AI platform.

5. Teleconsultation

The company offers the consultations with general practitioner conducted remotely via video, audio, or text, focusing on preventive care, health education, and early detection of potential health risks.

6. Elderly care

I. Elder App

Access to the Elder Care App of our service provider available for seniors, providing them with a platform to manage their health and wellness needs. Through the app, they can book health check-ups, order medicines, arrange for nurses or attendant support, and access a 24/7 emergency helpline. Additionally, the app offers ambulance support to ensure timely medical assistance in emergencies. The app ensures convenience and reliable access to essential healthcare services, all tailored to promote overall well-being.

II. Assistance

Dedicated Daughters: Providing personalized telephonic assistance focused on health and well-being, addressing clinical needs, offering guidance, and acting as a care coordinator with a compassionate approach.

III. Emergency Coordination

- a) **24 X 7 Emergency Coordination:** Our dedicated team is available around the clock to triage emergencies online, ensuring prompt and efficient support for elders.
- b) **Doctor on Call:** Instantly connect with a doctor for teleconsultations during medical emergencies, ensuring peace of mind and immediate care for elders (one emergency cover included)
- c) **Ambulance Cover:** Swiftly schedule an ambulance to the nearest hospital during medical emergencies, guaranteeing rapid and reliable transport for elders. Enjoy peace of mind (one emergency cover included)

IV. Elder Helpdesk

Elder Concierge Service: Access our online helpdesk for seamless support with everything from medicine delivery and lab tests to hospital visits, everything you need for overall well being, all in one place.

Emoha Companion is a support for elders for their needs, like going to hospital along with them. (3 hr visit)

Special Discounts -

1. upto 18% off on medicine orders
2. upto 25% off on diagnostic services
3. upto 10% off on physiotherapy sessions
4. upto 10% off on nursing services - first 30 days

V. Elder Healthcare

Electronic Health Records

I. **Elder Health Profile** - Bring all your personal doctors, hospital registrations and health insurance details online in one place

II. **Digital Health Records** - Store all diagnostics, lab reports & vitals online

Assisted Living Care

Elders will get a priority in waitlist in case they need to secure a room at one of the Epoch Centres

Geriatric Teleconsultations

Get tailored teleconsultations from specialists to expertly manage chronic conditions and enhance your health, right from the comfort of home.

Nursing/Attendants at home

Enjoy compassionate, professional care with our skilled nurses and attendants, providing personalized post-hospitalization support right at home, tailored specifically for seniors. (12 hr visit)

Annual Body Check-up

One annual Body Check-up containing a list of 70 tests

Physiotherapist Sessions

Physiotherapist sessions in case of doctor recommended post hospitalization only

Doctor Home Visits

Physical Doctor home visits for at home consultations

Psychologist Sessions

Receive expert mental health counselling tailored for elders dealing with dementia, Parkinson's, and other conditions, providing compassionate support to enhance well-being and quality of life.

Wearable Device

Elders get a wearable to regularly monitor important vitals

7. Vision Care

The company will provide Charges incurred towards vision tests and related expenses for the Medical Expenses listed below, in respect of the Insured Person, if specified under the Policy Schedule/ Certificate of Insurance:

- A single examination of the eyes by an optometrist or ophthalmologist per Policy Year;
- Expenses for lens, eyeglass frames, prescription sunglasses to correct vision.

This Benefit will exclude:

- sunglasses, unless medically prescribed by a Medical Practitioner.
- Medical Treatment or Surgical Treatment of the eye/s;
- lenses which are not a medical necessity and are not prescribed by an optometrist or ophthalmologist or frames for such lenses. The cover is available up to Sum Insured/ limit specified under the Policy Schedule/ Certificate of Insurance.

10.8. Emergency Assistance Services

The company will provide the below services which will be available when the Insured/Insured member(s) is/are more than 150 kilometers away from their residential address as provided in the Proposal Form. The services would be provided by the company or through an appointed Service provider, with prior intimation and acceptance by the Company.

- a) **Medical Consultation, Evaluation and Referral-** In case of any emergency situation, The Company/our Service Provider will evaluate, troubleshoot and make immediate recommendations including referrals to qualified doctors and/or hospitals.
- b) **Medical Monitoring and Case Management-** A team of doctors, nurses, and other medically trained personnel would be in regular communication with the attending physician and hospital, monitors appropriate levels of care and relay necessary and legally permissible information to the members of the Family / employer.
- c) **Emergency Medical Evacuation** - If the Insured / Insured member/s becomes ill or injured in an area where appropriate care is not available, the Company /via Service Provider will intervene and use available transportation, equipment and personnel necessary to evacuate the Individual safely to the nearest facility for medical care. This shall also include Air Ambulance services if required.
- d) **Medical Repatriation (Transportation):** When medically necessary, as determined by Company and the consulting Medical Practitioner, transportation under medical supervision shall be provided in respect of the Insured Person to the residential address as mentioned in the Schedule, provided that the Insured Person is medically cleared for travel via commercial carrier, and provided further that the transportation can be accomplished without compromising the Insured Person's medical condition.
- e) **Compassionate Visit:** When an Insured Person/s is/are hospitalized for more than seven (7) consecutive days, The Company/ Service Provider will arrange for a family member or a personal friend to travel to visit the Insured Person/s, by providing an appropriate means of transportation.
- f) **Care of Minor Child (ren):** One-way economy common carrier transportation with attendants, if required, will be provided to the place of residence of minor child(ren) when they are left unattended as a result of medical emergency or death of an eligible participant.
- g) **Return of Mortal Remains:** In case of an Eligible Participant's death, we will arrange and pay for the return of Mortal Remains to an authorized funeral home proximate to the Eligible Participant's legal residence.
- h) **Foreign Hospital Admission Assistance:** We shall assist in either issuing a prompt financial guarantee to facilitate admittance to a foreign medical facility and/ or validate Eligible Participant's medical Insurance; provided that the eligible medical participant commits in writing to repay all funds within 45 days.
- i) **Prescription Assistance:** If an eligible participant needs replacement prescription medicine while travelling, we shall help with replacing the prescription when possible and legally permissible.
- j) **Interpreter & Legal Referrals:** Upon request provide referrals to interpreters, counsellors or legal personnel.
- k) **Lost Luggage & Document Assistance:** Helps eligible participant locate lost luggage, document, personal belongings or assist with the replacement of travel tickets.
- l) **Pre-trip Information:** Helps Eligible Participants web-based and app-based country profiles that include visa requirements, immunization and inoculation recommendations, embassy, and consulate information, country specific details and security advisories as well as other patient information for travel destinations.

- m) **Mobile App Services:** Offers Mobile App services including embassy and consulate locator, tap to call feature service descriptions, electronic identification cards and Assist alerts.

10.9. Accident Benefit Cover

If during the period of insurance an insured person sustains any bodily injury or affliction because of **Accident**, which solely and directly causes any of the contingencies opted for as cover from amongst the sub-sections listed under 10.9 [a] to 10.9.[d], We would pay the benefit as specified in the attached Schedule in accordance with terms, conditions and exclusions of the Policy.

- i. Choosing **at least one** out of Death/Disappearance , Permanent Total Disablement and Permanent Partial Disablement (10.9.[a] / 10.9.[b] and 10.9.[c]) covers is compulsory.
- ii. The option to allow the covers and vary the available benefits lies with the Insurer.
 - 'What we cover' is given under the heading 'Contingency Description'.
 - The benefits of the cover available are captured in the 'Limit/Extension of Benefit' column. The column indicates the amount recoverable [**the limit of liability** under a particular cover during the policy period].
 - The special conditions, if any, pertaining to each cover, are also mentioned.

10.9.[a]

Contingency Description	Limit/Extent of Benefit
Death/Disappearance	Capital Sum Insured [CSI]

Death means cessation of blood circulation and breathing – the two criteria necessary to sustain life in a human being

Disappearance means the un-traceability of the insured person for a continuous period of 365 days following disappearance, sinking or wreckage of the conveyance he was provably travelling in, leading to a case of declared-death-in-absentia or legal presumption of death

Special Conditions for the Cover

- I. If payment has been already made under Permanent Total Disablement, then no benefit/claim shall be due under this cover.
- II. If payment has been already made under Permanent Partial Disablement [PPD], then benefit recoverable under this cover will be reduced by the amount paid under PPD.
- III. Once a claim has been accepted and paid under this Benefit, this Policy will immediately and automatically cease in respect of that Insured Person. Benefits under covers linked to the Death cover, if opted and payable, will be paid along with the above.
- IV. The Disappearance Benefit will be payable provided that:
 - i. The legal heirs/representatives of the Insured Person's estate provide Us with a signed agreement stating that if it transpires later that the Insured Person did not die, or did not die due to an Accident during the Policy Period, the amount paid will be reimbursed to Us immediately and without any deductions.
 - ii. The Insured Person's legal representative must intimate such disappearance to Us immediately upon happening of the event and shall carry the onus of proof of the claimed disappearance.

10.9.[b]

Contingency Description	Limit/Extent of Benefit
Permanent Total Disablement [PTD]	As opted for by the Insured at inception of policy

	Percentage of CSI [100%/125%/150%/175%/200%] as stated in the Schedule
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Permanent Total Disablement means any of the following happening within 365 days of the accident:

- a) Total Paralysis
- b) Total and irrecoverable loss of sight of both eyes
- c) Total and irrecoverable physical separation of or the loss of ability to use two Limbs (both hands or both feet or one hand and one foot)
- d) Total and irrecoverable loss of sight of one eye and physical separation of or the loss of ability to use a limb (either one hand or one foot)
- e) Total and irrecoverable loss of speech
- f) Loss/Removal of lower jaw
- g) Third degree burn injury to 10% or more of the head surface area / 25% or more of the surface area of body other than the head
- h) Compound fracture of the skull with damage to brain tissues
- i) Permanent and incurable insanity
- j) Total 'brain dead' cases - the permanent total loss of the central nervous system
- k) Permanent total loss of thoracic or abdominal organs rendering the insured completely incapable to carry out daily living activities without full-time assistance
- l) Total and permanent loss of vocation/employment caused by any one or more of the above or by any combination of permanent partial disabilities

For the purpose of this definition,

- a. **Total Paralysis** means complete and irreversible loss of motor function leading to the total loss of function of the entire body from neck down due to an accidental injury to the spinal cord.
- b. **Limb** means a hand at or above the wrist or foot above the ankle.
- c. **Loss of Limb** means the physical separation of or the loss of ability to use a limb above the wrist and/or ankle respectively.

Special Conditions for the Cover

- I. The Permanent Total Disablement is liable to be proved and a disability certificate issued by a civil surgeon or equivalent appointed by the District, State or Government Board is made available to us.
- II. If the Insured Person suffers death before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit; however benefit under accidental Death shall become payable, if opted.
- III. Once a claim has been accepted and paid under this Benefit, this Policy will immediately and automatically cease in respect of that Insured Person. Benefits under covers linked to the PTD cover, if opted and payable, will be paid along with the above.
- IV. If the Insured Member suffers Accidental Injuries resulting in more than one of the Permanent Total Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum assured mentioned in the policy schedule against this coverage.

10.9.[c]

Cover Description	Limit/Extent of Benefit
Permanent Partial Disablement [PPD]	As in the following Table

Nature of Injury	% of Capital Sum Insured
a. Permanent and total loss of hearing	75

b. Loss of sight of one eye	50
c. Loss of one limb	50
d. Loss of toes-all	20
e. Great-both phalanges	5
f. Great-one phalanx	2
g. Other than great, for each of the others	1
h. Non-union of fractured leg or knee-cap	10%
i. Shortening of the leg by at least 2 inches	7.5%
j. Stiffening of elbow, hip or knee joints due to rigidity/fusion of bones	20
k. Loss of hearing – one ear	15
l. Loss of four fingers and thumb of one hand	40
m. Loss of four fingers	35
n. Loss of thumb-both phalanges	25
o. Loss of thumb-one phalanx	10
p. Loss of index finger	
i. Three phalanges	10
ii. Two phalanges	8
iii. One phalanx	4
q. Loss of middle finger	
i. Three phalanges	6
ii. Two phalanges	4
iii. One phalanx	2
r. Loss of ring finger	
i. Three phalanges	5
ii. Two phalanges	4
iii. One phalanx	2
s. Loss of little finger	
i. Three phalanges	4
ii. Two phalanges	3
iii. One phalanx	2
t. Any other permanent partial disablement [including disablement caused by the elements]	As assessed by Medical Practitioner appointed by us and not exceeding 75%

Permanent Partial Disability means the bodily Injury that results in total, irrevocable, absolute and continuous loss or impairment of a body part or sensory organ as elaborately specified above.

Special Conditions for the Cover

- I. The PPD is liable to be proved and a disability certificate issued by a civil surgeon or equivalent appointed by the District, State or Government Board is made available to us.
- II. If the Insured Person suffers death before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit; however benefit under accidental Death shall become payable, if opted.
- III. If the Insured Member suffers accidental Injuries resulting in more than one of the Permanent Disablements, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Capital Sum Insured mentioned in the policy schedule.

10.9.[d]

Contingency Description	Limit/Extent of Benefit
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Temporary Total Disablement [TTD]	Per week benefit not exceeding the Capital Sum Insured as mentioned in the Schedule
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Temporary Total Disablement means the bodily Injury or affliction that prevents you from engaging in your occupation as certified by Medical Practitioner and attested by employer, if any.

Special Conditions for the Cover

- I. The Temporary Total Disablement is liable to be certified by a Medical Practitioner and Employer, if any. Submission of supporting documents/reports is a pre-requisite for consideration of any claim under this cover.
- II. We will stop making payments when We are satisfied that You can engage in Your occupation again or when We have made payments for number of weeks mentioned in the Policy Schedule for any one injury calculated from the date of commencement the temporary total disablement as certified by the treating Medical Practitioner, whichever is earlier.
- III. We shall not be liable to make any payment under this Benefit in respect of the Insured Person for more than the Total Number of weeks mentioned in the Policy Schedule for any and all claims arising within the Policy Period.
- IV. The benefit shall not be paid for the Time Excess mentioned in the Policy Schedule i.e. for the number of days mentioned in the Policy Schedule calculated from the date of commencement of TTD.
- V. In case of any dispute with respect to the duration of Temporary Total Disablement, the duration shall be finally determined by a Doctor/Medical Practitioner mutually appointed by You and Us.

10.10. Dental Treatment Cover

The Company will reimburse the medical expenses related to dental treatment and cost of denture incurred by the Insured during the Policy Period. This benefit shall be limited to maximum amount as mentioned in Policy Schedule. The 24-hour hospitalization requirement under the policy will stand waived for this cover.

Subject otherwise to the terms and conditions of the policy.

10.11. Medically Advised Support Devices

The Company will reimburse the charges incurred by Insured during the Policy Period on account of procuring medically necessary prosthetic or artificial devices or any other medical device prescribed by the Registered Medical Practitioner as arising due to admission claim under '8. Base Cover'. This benefit shall be limited to maximum amount as mentioned in Policy Schedule.

Subject to terms and conditions of the policy.

10.12. Benefit Cover for Pandemic/Epidemic Diseases (including COVID-19)

The Company will pay the Sum Insured as a lump sum amount mentioned in the Policy Schedule in case the Insured Person is diagnosed as suffering from the Pandemic / Epidemic diseases provided it occurs or manifests itself during the policy period as a first incidence.

The benefit will be payable after waiting period as mentioned in the Policy Schedule.

Subject to terms and conditions of the policy.

For the purpose of above optional coverage:

Pandemic / Epidemic Disease means infectious disease that can greatly increase morbidity and mortality over a wide geographic area and cause significant economic, social, and political disruption. (As declared by World Health Organization / Government of India)

10.13. External Congenital Ailment Cover

The Company will indemnify the medical expenses incurred by the Insured Person for External Congenital Disease or Defects or anomalies up to the maximum amount as mentioned in Policy Schedule.

The waiting period of pre-existing diseases – if not waived off by availing section 9.1. Extensions – PED Waiting Period waiver - will be applicable for payment of benefits under this optional coverage.

Subject to terms and conditions of the policy.

10.14. Cost of Health Check up

The Company will reimburse the expenses incurred for the preventive health check-ups for Insured Person specified in the Policy Schedule / Certificate of Insurance.

10.15. Hospital Cash to Parents

The Company will pay In case of Hospitalization of Children up to Age 12 years, Cash allowance of per day subject to a maximum limit as specified in Policy Schedule, will be given to Parent Insured Person.

The overall limit under the Policy shall be Specified per Policy period and forms part of Sum Insured under the Policy

10.16. Funeral Expenses

The Company will pay In case of death of any of the insured persons following hospitalization with valid claim under the Policy, Funeral expenses of upto Sum Insured will be paid under the Policy. This amount will be over and above base Sum Insured under the Policy.

10.17. No Claim Bonus

a) Enhancement In Sum Insured

The company will increase the Base Annual Sum Insured by 10% at the end of the Policy Year if the Policy is renewed with Us provided that:

>No claim has been made under the Policy, including for the optional benefits, and the Policy is renewed with the Company without any break. The maximum Cumulative Bonus shall not exceed 50% of the Base Annual Sum Insured under the Policy

>In case of a Family floater the Cumulative Bonus so applied will only be available in respect of claims made by those Insured Members(s) who were Insured Member(s) in the immediate preceding claim free Policy Year and continue to be Insured Member(s) in the subsequent Policy Year.

>If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 10% of the Base Annual Sum Insured in that following Policy Year. There will be no impact on the Base Annual Sum Insured

b) Discount in Premium

No Claim Discount will be offered to an Insured Person at the renewal, in the event of no claim made in the policy year. This discount will be offered as per the defined grid mentioned below for every renewal where there is no claim, this will be available for maximum up to 5 years.

If a claim is made in any particular year, the discount accrued shall be reduced at the same rate at which it has accrued.

10.18. Second Opinion

The Company will reimburse expenses incurred by Insured Person towards a second opinion from Network Medical Practitioner if an Insured Person is diagnosed with the below mentioned Illnesses during the Policy Period.

The expert opinion would be directly sent to the Insured Person.

1. First Heart Attack - Of Specified Severity
2. Cancer of specified severity
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. Major Organ /Bone Marrow Transplant
8. Stroke resulting in permanent symptoms
9. Kidney Failure requiring regular dialysis
10. Permanent Paralysis Of Limbs
11. Motor Neurone Disease With Permanent Symptoms

This benefit can be availed by an Insured Person once during a Policy Year & can be claimed under this benefit only.

10.19. Home Care Treatment

The Company will reimburse the cost incurred towards Home Care Treatment up to the sum insured mentioned in the Policy Schedule. For the purpose of this benefit, Home Care Treatment means a treatment availed by the Insured Person at home which in normal course would require care and treatment at a Hospital, but it is actually taken at home, provided that:

Applicability: Only for Pandemic Disease.

- a. The Medical Practitioner advises the Insured Person to undergo Treatment at Home;
- b. There is a continuous active line of treatment with monitoring of the Health status by a Medical Practitioner for each day through the duration of the Home Care Treatment.
- c. Daily monitoring chart including records of treatment administered duly signed by the treating Doctor is maintained.

10.20. Loss of Income

The Company will pay to an Insured Person for loss of Income if they cannot engage in their primary occupation and lose their source of income due to an Illness or Injury during the Policy Period and amount as specified in the Policy Schedule / Certificate of Insurance.

10.21. EMI Protection

The Company will pay an amount as specified in the Policy Schedule / Certificate of insurance, equal to the EMI Amount which is due on the Insured's outstanding Loan in the number of months immediately following the date of such occurrence where Insured Person undergoes Medically Necessary hospitalization during the Policy Period. This benefit can be paid once in a Policy Year for the Maximum number of EMI's Specified in the Policy Schedule / Certificate of Insurance.

10.22. Errors & Omissions

The Company will consider number of lives as specified and subject to conditions mentioned in Policy Schedule / Certificate of Insurance to add in Mid Term of the Policy on account of Error & Omissions, Subject to availability of the Premium.

10.23. Global coverage including Travelling Cost, Boarding and Lodging for treatment outside India

The company will reimburse the cost of medical treatment along with the travelling cost and cost pertaining to boarding and lodging attendant in a country outside India for not more than 180 consecutive days up to the sum insured, provided that:

- a) the diagnosis was made in India and referred by Medical Practitioner for which the insured member(s) travels abroad for treatment and
- b) prior approval from the Company is taken before travelling abroad for treatment. The Medical Expenses payable shall be limited to Inpatient and day care Hospitalization. Insured member(s) can contact us for any claim assistance. The payment of any claim under this benefit will be in Indian Rupees based on the rate of exchange as on the date of invoice, published by Reserve Bank of India (RBI) and shall be used for conversion of foreign currency into Indian Rupees for claims payment. If these rates are not published on the date of invoice, the exchange rate next published by RBI shall be considered for conversion. Only sum insured can be used for this and not the restored sum insured.
- c) If the insured has opted for "Global Coverage" section 9.9.12 then the above cover shall not be applicable. Insured person has an option to opt any one of the benefits from "Global Coverage" section 9.9.12 or "Global coverage including Travelling cost, Boarding and Lodging for treatment outside of India" section 10.10.23.
- d) The applicability of this cover should be limited to the insured person travelling abroad for the treatment and only one person accompanying the insured person.

10.24. Annual cancer screening for Cancer diagnosed patients

The company will reimburse the Medical Expenses incurred up to the limit specified in the Policy Schedule for an Annual Screening Package for the Insured Person(s) subject to below mentioned conditions:

- i. Insured must be a diagnosed with "Cancer of Specified Severity" as defined in Section 7.a.8 (Definitions). This diagnosis must be evidenced by histological evidence of malignancy and confirmed by a pathologist.
- ii. The add on will only cover medically prescribed diagnostics used to monitor vitals or to evaluate the risk of recurrence of the patients.
- iii. Expenses can be claimed under this Optional Cover on a reimbursement basis only.

10.25 Preferred Hospital Coverage

If this Optional Benefit is opted, then Policyholder is entitled for a reduction in the total premium (which includes premium of Base Benefits, Optional Benefits payable as specified in the Policy Schedule, subject to following conditions:

- (i) If the Insured Person takes Medical Treatment in hospitals other than those listed in Annexure – III to the Policy Terms and Conditions, then the Policyholder/Insured Person shall bear a Co-Payment of 10% on each and every Claim, which will be in addition to any other co-payment (if any) applicable in the Policy.
- (ii) However, no such additional co-payment shall be applicable if treatment is availed in the hospitals listed in Annexure III to the Policy Terms and Conditions.

10.26 Addition of Critical Illness

On payment of additional premium, We will pay the Critical Illness [CI] Sum Insured as a lump sum in addition to pay-out under this Policy provided that:

- a) The Insured Person is first diagnosed as suffering from a Critical Illness during the Policy Period, and the Insured Person survives at-least 30 days following such diagnosis,
- b) This benefit is payable once during the Policy Period and would terminate on the occurrence of the first Critical Illness. The Insured Person shall receive the sum insured as per applicable guidelines post which the benefit will cease and coverage under this benefit would not be renewed any further. However the other insured members (if any) will continue to be covered under this benefit if opted.
- c) This benefit is offered only on Individual Sum Insured basis.

- d) The insured person has an option to opt any one out of two covers “Critical Illness” section 10.10.1 or “Addition of Critical Illness” section 10.10.26.

List of Critical Illness		
Sr. No.	Particulars	Major
1	Cancer and Blood Disorders	Cancer of Specified Severity
2		Bone Marrow Transplant
3		Aplastic Anaemia
4		Primary Myelofibrosis
5	Heart and Blood Vessel	Refractory Heart Failure
6		Myocardial Infarction (First Heart Attack – Of Specified Severity)
7		Open Chest CABG
8		Open Heart Replacement Or Repair Of Heart Valves
9		Surgery of Aorta
10		Primary (Idiopathic) Pulmonary Hypertension
11	Major Organs	Systemic Lupus Erythematosus with Renal Involvement
12		Scleroderma
13		Good Pastures Syndrome with Lung or Renal Involvement
14		Myasthenia Gravis
15		End Stage Lung Failure
16		Kidney Failure Requiring Regular Dialysis
17		Medullary Cystic Kidney Disease
18		Fulminant Hepatitis
19		End Stage Liver Failure
20		Major Organ / Bone Marrow Transplant
21		Chronic Relapsing Pancreatitis
22	Nervous System	Stroke Resulting In Permanent Symptoms
23		Permanent Paralysis Of Limbs
24		Motor Neuron Disease With Permanent Symptoms
25		Parkinson’s disease
26		Benign Brain Tumor
27		Alzheimer’s Disease
28		Multiple Sclerosis With Persisting Symptoms
29		Creutzfeldt-Jakob disease
30		Muscular Dystrophy
31		Coma of Specified Severity
32		Apallic Syndrome
33		Major Head Trauma
34		Deafness
35		Loss of Speech
36		Blindness
37		Poliomyelitis
38		Tuberculous Meningitis
39	Others	Loss of independent Existence
40		Loss of Limbs
41		Third Degree Burns

10.27 E consultation Services

The Company will offer e-consultations with qualified General Physicians at our network during the Policy Year through any mode of communication (Voice/Video Call /Chat /Email Chat/etc.)

The Limits for the same will be as mentioned in the policy schedule.

10.28 Bereavement Cover

1) 100% of the claim amount up to the Sum Insured will be paid to the legal heir of the employee in case of death during Hospitalization.

2) There should not be any deductions in the claim amount due to Non-medical expenses, Co Payment, and any deductible if applicable.

3) This benefit is only applicable to an employee covered under the group employer-employee relationship and shall not be applicable to the dependent family members covered under the policy.

4) The maximum liability under this benefit would be restricted up to the Sum Insured of the employee as mentioned in the Policy Schedule.

10.29 Snake Bite Cover

We will cover the medical expenses for Outpatient treatment (OPD) and Hospitalization related to the snake bite up to the Sum Insured limit as mentioned in the policy schedule.

10.30 Caretaker Charges

The company will cover the caretaker charges for Post Hospitalization related expenses if the insured person is in a non-ambulatory condition. This add on can only be utilized in case of Post Hospitalization only and limits for this coverage cannot exceed the base Sum Insured.

The limits for the same will be as mentioned in the policy Schedule.

11. BENEFIT RESTRICTION OPTIONS

11.1. Only Accidental Hospitalization Cover

Notwithstanding anything herein to the contrary, the operative clause of the policy and, consequently, coverage under Sections 8.a as well as the related Extensions and Add-ons will be available **only for injury** [as per definition by IRDAI] during the policy period. The Company will pay reasonable and customary charges that are medically necessary and incurred by you in respect of an admissible claims as per the policy terms and conditions.

Hospitalization **for illness** [as per definition by IRDAI] shall stand excluded from cover.

Subject to limits, terms and conditions of the policy.

11.2. Only Illness Hospitalization Cover

Notwithstanding anything herein to the contrary, the operative clause of the policy and, consequently, coverage under Sections 8.a. as well as the related Extensions and Add-ons will be available **only for illness** [as per definition IRDAI] during the policy period. The Company will pay reasonable and customary charges that are medically necessary and incurred by you in respect of an admissible claims as per the policy terms and conditions.

Hospitalization **for injury** [as per definition IRDAI] shall stand excluded from cover.

Subject to limits, terms and conditions of the policy.

11.3. Limited Hospitalization Cover

Notwithstanding anything contained herein to the contrary, clauses i] and ii] of Section **8.a.** shall be modified to read as under:

- i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home – With a per day limit of 0.50% / 1%/ 2% of Sum Insured

- ii. Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses - With a per day limit of 1%/ 2%/ 4% of Sum Insured

All other terms and conditions of the policy shall remain unaltered.

11.4. Restricted Contingency Cover

Notwithstanding anything herein to the contrary, the operative clause of the policy and, consequently, coverage under Sections 8.a as well as the related Extensions and Add-ons will be available **only for the named illness** during the policy period. The Company will pay reasonable and customary charges that are medically necessary and incurred by you in respect of an admissible claim as per the policy terms and conditions.

Hospitalization **for injury** [as per definition IRDAI] and **illness other than the one named** shall stand excluded from cover.

The named illness and restricted contingency can be any of the following:

11.4.i – Pandemics/Epidemics

Pandemic / Epidemic Disease shall mean infectious disease [including Covid-19] that can greatly increase morbidity and mortality over a wide geographic area and cause significant economic, social, and political disruption. (As declared by World Health Organization / Government of India)

11.4.ii – Infectious Diseases - Vector-borne Vector-borne diseases shall mean human illnesses caused by parasites, viruses and bacteria that are transmitted by vectors as listed below:

Vector		Disease caused	Type of pathogen
Mosquito	Aedes	Chikungunya	Virus
		Dengue	Virus
		Lymphatic filariasis	Parasite
		Rift Valley fever	Virus
		Yellow Fever	Virus
		Zika	Virus
	Anopheles	Lymphatic filariasis	Parasite
		Malaria	Parasite
	Culex	Japanese encephalitis	Virus
		Lymphatic filariasis	Parasite
West Nile fever		Virus	
Aquatic snails		Schistosomiasis (bilharziasis)	Parasite
Blackflies		Onchoceriasis (river blindness)	Parasite
Fleas		Plague (transmitted from rats to humans)	Bacteria
		Tungiasis	Ecto parasite
Lice		Typhus	Bacteria
		Louse-borne relapsing fever	Bacteria
Sandflies		Leishmaniasis	Bacteria
		Sandfly fever (phlebotomus fever)	Virus
Ticks		Crimean-Congo haemorrhagic fever	Virus
		Lyme disease	Bacteria
		Relapsing fever (borreliosis)	Bacteria
		Rickettsial diseases (eg: spotted fever and Q fever)	Bacteria
		Tick-borne encephalitis	Virus
		Tularaemia	Bacteria
Triatome bugs		Chagas disease (American trypanosomiasis)	Parasite
Tsetse flies		Sleeping sickness (African trypanosomiasis)	Parasite

11.4.iii – Infectious Diseases – Other Than Vector-borne

This category would include diseases caused by infectious pathogens – bacteria, viruses, fungi, parasites and prions – and propagated by means other than vectors.

11.4.iv – Critical Illness Combos

Critical Illness shall mean the illness listed below and defined as per ‘Definition Section’.

The insured shall have the option to choose any of the combo plans listed below:

Sl No	Particulars	Silver	Gold	Platinum	Diamond
1	Cancer of Specified Severity	Yes	Yes	Yes	Yes
2	Kidney Failure requiring regular dialysis	Yes	Yes	Yes	Yes
3	Multiple Sclerosis with Persisting Symptoms	Yes	Yes	Yes	Yes
4	Major Organ/ Bone Marrow Transplant	Yes	Yes	Yes	Yes
5	Open Heart Replacement	Yes	Yes	Yes	Yes
6	Coronary Artery Bypass Graft	Yes	Yes	Yes	Yes
7	Permanent Paralysis of Limbs	Yes	Yes	Yes	Yes
8	First Heart Attack of Specified Severity	Yes	Yes	Yes	Yes
9	Stroke resulting in Permanent Symptoms	Yes	Yes	Yes	Yes
10	Benign Brain Tumor	No	Yes	Yes	Yes
11	Parkinson's Disease	No	Yes	Yes	Yes
12	Coma of Specified Severity	No	Yes	Yes	Yes
13	End Stage Liver Disease	No	No	Yes	Yes
14	Alzheimer's Disease	No	No	Yes	Yes
15	Surgery of Aorta	No	No	Yes	Yes
16	Major Burns	No	No	No	Yes
17	Deafness	No	No	No	Yes
18	Loss of Speech	No	No	No	Yes

11.4.v – Cancer

Cancer shall mean the group of diseases involving malignancy and uncontrolled growth of abnormal cells in the human body.

11.4.vi – Named Surgeries Cover

Named Surgeries would include Heart Surgeries [Aortic surgery, Aortic valve surgery, Arrhythmia surgery, CABG, Heart Transplant, Surgical Ventricular Restoration, Myectomy, Transmyocardial Revascularization, Valvular Surgery and the like], Neuro-surgeries [surgeries of the Brain and Spine] and Orthopedic Surgery [surgery concerned with disorders of the musculo-skeletal system – spines, joints and their repair].

Subject to limits, terms and conditions of the policy.

11.4.vii – Eye Disorders

Eye Disorders shall mean diseases and disorders of eye and vision including [but not limited to] Refractive Errors, Age-Related Macular Degeneration, Cataract, Diabetic Retinopathy, Glaucoma, Amblyopia and Strabismus.

11.4.viii – Named Illness

The Company shall specify the covered illness as mentioned in the Policy Schedule towards 8.a. Hospitalisation Cover.

11.4.IX - Specified Named Illness

The Company shall specify the named illness & surgeries as mentioned in the Policy Schedule on benefit basis towards 8.a. Hospitalisation Cover.

11.5. Capped Compensation Cover

It is hereby declared and agreed that illness claims under Section 8.a of the Policy shall be subject to the disease-wise agreed capped percentage or maximum amount [whichever is less] as specified in Annexure - III. Subject otherwise to the terms and conditions of the Policy.

11.6. Co-payment

It is hereby declared and agreed that each and every claim under the Policy shall be subject to an agreed Co-payment of __% [as specified in the schedule] applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

11.7. Voluntary Excess

It is hereby declared and agreed that the Insured/Claimant shall bear the first Rs..... of each and every claim under sections 8.a for which the Insured is to be indemnified by this policy

The voluntary excess shall apply per event per insured person.

11.8. Reimbursement Only Cover

It is hereby declared and agreed that payment of hospitalization claims under the policy shall be through the reimbursement mode and cashless facility shall neither be sought nor extended.

12. Exclusions:

a. Standard Exclusions:

Waiting Period

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

1. Pre-Existing Diseases (Code- Excl01)

- a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.
- 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 (Insurance Product) regulations, 2024 then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. Specific Waiting Period: (Code- Excl02)

- a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured Person is continuously covered without any break under the policy, then waiting period for the same would be reduced to the extent of prior coverage.

i 24 Months waiting period

- 1. Benign ENT disorders
- 2. Tonsillectomy
- 3. Adenoidectomy
- 4. Mastoidectomy

5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers

ii 36 Months waiting period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis & Osteoporosis
3. Age-related Macular Degeneration (ARMD),
4. All Neuro degenerative disorders

3. First Thirty Days Waiting Period (Code- Excl03)

- i 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.
- ii This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- iii The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

1. Investigation & Evaluation(Code- Excl04)

- a) Expenses related to any admission primarily for diagnostics and evaluation purposes.
- b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

2. Rest Cure, Rehabilitation and Respite Care (Code- Excl05)

- a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
 - i Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
 - ii Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

3. Obesity/ Weight Control(Code- Excl06)

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

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member has to be 18 years of age or older and
- 4) Body Mass Index (BMI);
 - a) greater than or equal to 40 or
 - b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - i. Obesity-related cardiomyopathy

- ii. Coronary heart disease
- iii. Severe Sleep Apnea
- iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender Treatments: (Code- Excl07)

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

5. Cosmetic or plastic Surgery: (Code- Excl08)

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

6. Hazardous or Adventure sports: (Code- Excl09)

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.

7. Breach of law: (Code- Excl10)

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

8. Excluded Providers: (Code-Excl11)

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 or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

9. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.(Code- Excl12)

10. Treatments received in health spas, 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- Excl13)

11. 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- Excl14)

12. Refractive Error:(Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries or as specified in the policy schedule/ certificate of insurance

13. Unproven Treatments:(Code- Excl16)

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

14. Sterility and Infertility: (Code- Excl17)

Expenses related to sterility and infertility. This includes:

- (i) Any type of contraception, sterilization
- (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- (iii) Gestational Surrogacy
- (iv) Reversal of sterilization

15. Maternity Expenses (Code – Excl 18):

- i Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
- ii Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

E.2. Specific Exclusions:

1. Any expenses incurred on OPD treatment.
2. Treatment taken outside the geographical limits of India.
3. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.
4. 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 and CIN-3.
5. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
6. Malignant melanoma that has not caused invasion beyond the epidermis;
7. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
8. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
9. Chronic lymphocytic leukaemia less than RAI stage 3
10. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
11. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
12. Other acute Coronary Syndromes
13. Any type of angina pectoris
14. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.
15. Angioplasty and/or any other intra-arterial procedures
16. Transient ischemic attacks (TIA)
17. Traumatic injury of the brain
18. Vascular disease affecting only the eye or optic nerve or vestibular functions.
19. Other stem-cell transplants
20. Where only islets of langerhans are transplanted
21. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse.
22. Other causes of neurological damage such as SLE.
23. 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.
24. Traumatic Injury of the aorta.
25. Parkinson's disease secondary to drug and/or alcohol abuse.
26. Any kind of Psychological counselling, cognitive / family / group / behaviour / palliative therapy, or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.
27. 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.
28. 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 causing any 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.

29. Treatment of any Injury due to Suicidality shall not be covered.

Exclusions Applicable to All Sub-sections of 10.9.d

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

- I. Disease, illness, sickness, ill-health, infection and ailment of all kinds unless proximately caused by accident
- II. Suicide or attempted Suicide, intentional self-inflicted injury, acts of self- destruction whether the Insured Person is medically sane or insane.
- III. Any **Pre-existing** condition or any complication arising from the same.
- IV. Pregnancy or childbirth or any consequence thereof.
- V. Consequential losses of any kind or actual or alleged legal liability
- VI. Certification by a Medical Practitioner who shares the same residence as the Insured Person or who is a member of the Insured Person's Family.
- VII. Foreign invasion, act of foreign enemies, hostilities, warlike operations (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), participation in any naval, military or air-force operation, civil war, public defense, rebellion, revolution, insurrection, military or usurped power.
- VIII. Medical or surgical treatment except as necessary solely and directly as a result of an Accident.
- IX. Any change of profession after inception of the Policy which results in the enhancement of Our risk under the Policy, if not accepted and endorsed by Us.
- X. The Insured Person committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanour or civil commotion with criminal intent.
- XI. Use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen.
- XII. Insured Persons whilst engaging in any Adventure Sports and activities unless otherwise specifically modified by the Policy.
- XIII. Ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
 - a) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
 - b) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) microorganisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

F. General Terms and Conditions:

F.1. Standard Terms and Conditions:

1. Disclosure of Information

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

2. Condition Precedent to Admission of Liability

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

3. Complete Discharge

Any payment to the 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 in all cases be a full, valid and an effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Conditions Applicable for Reducing SI covers (applicable only for Credit- Linked policies)

The Sum Insured under the Policy on the date of occurrence of the Event covered under the benefits where Reduction Sum Insured is applicable for the purpose of calculation of claim shall be the least of the following:

1. The Principal Outstanding in the books of the Bank/ Financial Institution as on the date of occurrence of the Insured Event; or
2. The Principal Outstanding as per the amortization schedule prepared by Bank/Financial Institution. In the event the Sum Insured as appearing against the benefit as mentioned in Policy Schedule/ Certificate of Insurance is less than the total of the actual Loan disbursed up to the date of the occurrence of the Insured Event, then the Amortization schedule shall be calculated as if the actual Loan disbursed was equivalent to the Sum Insured.; or
3. The Sum Insured as appearing against the benefit as mentioned in Policy Schedule/ Certificate of Insurance.

Note: We will not consider any of below items while calculating our claim liability

- a. Any Top-Ups or Enhancement of Initial Approved Loan amount
- b. Any penalty, fee levied by the bank or financial institution
- c. Increase in outstanding loan amount due to overdue payment or non-payment of EMI on timely basis

5. Assignment (If opted) – It is Hereby Declared & Agreed That:

- a. from the Policy Start Date, the claim amount payable by Us to the Insured and all rights, title, benefits and interest of the Insured under this Policy stand assigned in favour of a person or an Institution or a company as named in the Policy Schedule/ Certificate of Insurance;
- b. upon any claim amount becoming payable under this Policy the same shall be paid by Us to assignee as named in Policy Schedule/ Certificate of Insurance, without any reference/ notice to the Insured;

The receipt of such claim amount by the assignee as named in the Policy Schedule/ Certificate of Insurance and the Insured shall completely discharge Us from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.

6. Special conditions related to Group policies

All group policies are subject to the following conditions:

- a. The insured will maintain sufficient deposit or provide a Bank Guarantee to comply with the requirement of section 64VB.
- b. New names can be added to the existing group policies by charging premium as agreed between Group Manager and Us.
- c. For deletion of names from Group Policies during the Policy Period, refund of premium can be allowed only if there is no claim in respect of the particular insured Person as on date when request for deletion of name has been received

7. Fraud

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

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

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

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

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

8. Cancellation

The Insured may cancel this Policy by giving 7 days' written notice, and in such an event, the Company shall refund premium for the unexpired Policy Period as per the rates detailed below.

- a) If no claim has been made during the policy period, a proportionate refund of the premium will be issued based on the number of unexpired days. The date of cancellation request will be considered as expiry date of coverage
- b) If the claim has been made in the current policy year, the premium for the remaining policy year(s) will be refunded on cancellation

9. Migration:

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per the IRDAI guidelines on Migration at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. The insurer may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.

10. Portability

The insured person will have the option to port the policy to other insurers as per IRDAI guidelines related to portability at least 30 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.

11. Renewal of Policy

- 1. A health insurance policy shall be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured, provided the policy is not withdrawn and also subject to conditions stated at clause 8 of this schedule.
- 2. An insurer shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy.
- 3. The insurer shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.
- 4. For individual products, the loadings on renewal premium shall be at portfolio and not based upon any individual policy claim experience. However, discount in premium may be provided by insurers to individual policyholders for good claims experience.
- 5. No insurer shall resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in sum insured offered. Provided that where there is an improvement in the risk profile, the insurer may endeavour to recognize that for removal of loadings at the point of renewal.

12. Premium Payment in Instalments

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

- i. The grace period of fifteen days (where premium is paid on a monthly instalments) and thirty days (where premium is paid in quarterly/half-yearly/annual instalments) is available on the premium due date, to pay the
- ii. If the premium is paid in installments during the policy period, coverage will be available during such Grace period.
- iii. The insured person will get the accrued continuity benefit in respect of the “Waiting Periods”, “Specific Waiting Periods” in the event of payment of premium within the stipulated grace Period.
- iv. No interest will be charged If the instalment premium is not paid on due date.
- v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

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

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

14. Nomination:

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

15. Moratorium

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

16. Migration and Portability

1. In case of migration of one policy to another with the same Insurer, the policyholder (including all members under family cover and group insurance policies) can transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, Specific Waiting periods, waiting period for pre-existing diseases, Moratorium period etc. in the previous policy to the migrated policy. We will underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months.
2. A Policyholder has the choice to port his/ her policies from one Insurer to another. The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.

17. Free Look Period

A period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy. This option is available in case of policies with a term of one year or more.

18. Redressal of Grievance

If You have a grievance about any matter relating to the Policy, or Our decision on any matter, or the claim, you can address Your grievance as follows:

Resolving Issue

Write to :

Customer Service Universal Sompo General Insurance Co.Ltd.

Unit No. 601 & 602, 6th Floor, Reliable Tech Park,
Thane-Belapur Road, Airoli, Navi Mumbai,
Maharashtra – 400708

Email: grievance@universalsompo.com

For More details, visit – www.universalsompo.com

Visit Branch Grievance Redressal Officer (GRO) - Walk into any of our nearest branches and request to meet the GRO.

Grievance Redressal Officer

In case, the customer is not satisfied with the decision/resolution of the above office or have not received any response, he/she may write or email/mail to:

Customer Service

Universal Sompo General Insurance Co.Ltd.

Unit No. 601 & 602, 6th Floor, Reliable Tech Park,
Thane-Belapur Road, Airoli, Navi Mumbai,
Maharashtra – 400708

Email ID: GRO@universalsompo.com

Insurance Ombudsman

Bima Bharosa Portal link : <https://bimabharosa.irdai.gov.in/>

The customer can approach the Insurance Ombudsman depending on the nature of grievance and financial implication, if any.

The updated contact details of the Insurance Ombudsman offices can be referred by clicking on the Insurance ombudsman official site: <https://www.cioins.co.in/Ombudsman>.

Information about Insurance Ombudsmen, their jurisdiction and powers is available on the website of the Insurance Regulatory and Development Authority of India (IRDAI) at www.irdai.gov.in, or of the General Insurance Council at <https://www.gicouncil.in/>, the Consumer Education Website of the IRDAI at <http://www.policyholder.gov.in>, or from any of Offices of the Company.

19.Change in Sum Insured

Sum Insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the company. For increase in SI, the waiting period if any shall start afresh only for the enhanced portion of the sum insured.

F.2. Specific Terms and Conditions:

1. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

2. Terms and conditions of the Policy

The terms and conditions contained herein and in the Policy Schedule shall be deemed to form part of the Policy and shall be read together as one document.

3. Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

4. Notice & Communication

- i Any notice, direction, instruction or any other communication related to the Policy should be made in writing.
- ii Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule.
- iii The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the schedule.

5. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only (except in case of Global cover).

6. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

7. Arbitration

- i. If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising 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, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).
- ii It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy. It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

G. Claims Procedure

1. Procedure for Cashless claims:

Follow below steps to avail Cashless facility through our In house Health Claims Management:

Step I: Locate nearest Hospital by visiting our website or web portal or call our Health Helpline 1800 200 4030.

Step II: Visit Network hospital and show your Health Serve Card issued by the company along with Valid Photo ID proof and get 'Cashless Request Form' from Insurance helpdesk of the hospital.

Step III: Fill your details in the 'Cashless Request Form' & submit it to the Hospital Insurance helpdesk.

Step IV: Hospital verifies the patient details and sends duly filled Cashless Request Form to Universal Sampo

Step V: Universal Sampo Health team will review and judge the admissibility of the Cashless Request as per Policy Terms & Conditions and the same will be communicated to Insured and Hospital within 60 mins for Initial Cashless request & 3 hrs for discharge request on their registered mobile number & Email ID respectively.

Cashless Anywhere

You can now avail cashless facility from non-network hospitals.

To avail the treatment under cashless from non-network hospitals, please find the below steps.

Prior Intimation is required for processing cashless from non-network hospitals:

- Inform us (Toll Free Helpline – 1800 200 4030) minimum 48 hours before admission for planned hospitalization and with 24 hours of admission for emergency hospitalization across India.
- Mail us at contactus@universalsompo.com

2. Procedure for reimbursement of claims:

Follow below steps to avail reimbursement facility through our In house Health Claims Management:

Step I: Visit our Web Portal to register claim or Call our Health Helpline 1800 200 4030 or email us at contactus@universalsompo.com and inform about your claim.

Step II: Visit hospital and undergo your treatment. Settle your hospitalization bill and collect all the documents after discharge from the hospital.

Step III: Fill in Reimbursement Claim Form and submit all original documents to our below mention office for reimbursement.

Universal Sompo General Insurance Company Limited,
Health Claims Management Office,
1st FloorC-56- A/13,
Block- C Sector- 62,
Noida,
Uttar Pradesh, Pincode: 201309

Step IV: On receipt of document your claim will processed as per Terms & Conditions of policy and the same will be communicated over SMS & Email.

Step V: Outcome of the claim will be communicated within 15 days from date of Submission of claim.

3. Notification of Claim

Notice with full particulars shall be sent to the Company as under:

- i Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
- ii At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

4. Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

- I. Claim form duly filled and signed by the Insured
- II. Certificate from attending medical practitioner mentioning the first symptoms and date of occurrence of ailment.
- III. All treatment papers of current ailment including previous treatment papers if any.
- IV. Original Discharge Card from the hospital, Indoor Case Papers.
- V. All original medical Investigation reports (viz. X-ray, ECG, Blood test etc).
- VI. Original hospital bill and receipts.
- VII. Original bills of chemist, medical practitioner, medical investigation, etc. supported by the doctor's prescription.
- VIII. NEFT details and Personalized cancelled cheque/ Passbook copy in the name of proposer for electronic fund transfer.

- IX. Valid Photo ID Proof of the patient.
- X. For accident Cases: MLC (Medico Legal Certificate) / FIR (First Information report).
- XI. Copy of latest valid address proof of proposer like electricity bill, water bill or telephone bill or updated bank statement along with copy of PAN card & Aadhaar Card as per AML/KYC Norms.
- XII. Latest Loan account statement(s) with NEFT of Financial institution if applicable
- XIII. Current outstanding Loan certificate(s) from financier, along with the documents submitted if applicable
- XIV. Loan disbursement letter(s) along with the payment record till the date of Accident if applicable
- XV. Repayment schedule showing the EMI details if applicable
- XVI. Certificate from the employer of the Insured person confirming the retrenchment from employment of the Insured person furnishing the date of retrenchment from employment of the Insured person if applicable
- XVII. Details of severance remuneration by the employer if applicable

The above list of documents is indicative. In case of any further document requirement, our team shall contact you on receipt of your claim documents by us.

Note:

1. Documentation consistent with Telemedicine Practice Guidelines [2020] circulated by the Medical Council of India shall also be allowed under this policy along with the ones involving standard, in-person consultation with a medical practitioner.
2. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
3. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
4. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

5. Claim Settlement (provision for Penal Interest)

- i The Company shall settle or reject a claim, as the case may be, within 15 days from the date of submission of the claim.
- ii In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt date of receipt of intimation to till the date of payment.
- 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 15 days from the date of submission of claim.
- iv In case of delay beyond stipulated 15 days the company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of intimation to till the date of payment.

6. Payment of Claim

All claims under the policy shall be payable in Indian currency only.

Annexure I

List I — Items for which coverage is not available in the policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER

37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II — Items that are to be subsumed into Room Charges

SI No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES

6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III — Items that are to be subsumed into Procedure Charges

SI No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES

7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV — Items that are to be subsumed into costs of treatment

SI No.	Item
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALIZATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP— COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	Glucometer& Strips
18	URINE BAG

Annexure II

The contact details of the Insurance Ombudsman offices are as below-

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	Dr. Pranai Prabhakar Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02 Email: oio.ahmedabad@cioins.co.in
Karnataka.	Ms Neerja Kapur Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: oio.bengaluru@cioins.co.in
Madhya Pradesh Chattisgarh.	Shri Ajay Kumar Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor, "Jeevan Shikha", 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 / 2769203 Email: oio.bhopal@cioins.co.in
Orissa.	Shri Rashmi Raman Singh Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 / 2596455/2596429/2596003 Email: oio.bhubaneswar@cioins.co.in
Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh	Ms Alka Jha Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172-2706468 Email: oio.chandigarh@cioins.co.in
Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).	Shri K.Vinayak Rao Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: oio.chennai@cioins.co.in

Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.	Shri K.Vinayak Rao Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: oio.chennai@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	Shri Ajay Kumar Sharma Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Near Pan Bazar , S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 / 2631307 Email: oio.guwahati@cioins.co.in
Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	Ms G Shobha Reddy Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp.Hyundai Showroom , A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 / 23376991 / 23376599 / 23328709 / 23325325 Email: oio.hyderabad@cioins.co.in
Rajasthan.	Shri Satyajeet Rajan Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363 Email: oio.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	Shri Pradeep Kumar Jain Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: oio.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	Ms. Manju Bagga Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: oio.kolkata@cioins.co.in
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda,	Shri Sanjai Singh Insurance Ombudsman Office of the Insurance Ombudsman,

Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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.	6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: oio.lucknow@cioins.co.in
List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumbai.	Ms Sarojini S Dikhale Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: oio.mumbai@cioins.co.in
State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Shri Rajiv Talwar Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-4027589 Email: oio.noida@cioins.co.in
Bihar, Jharkhand.	Shri Inderjeet Singh Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001.

	Tel.: 0612-2547068 Email: io.patna@cioins.co.in
State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region	Ms. Rachna Khare Insurance Ombudsman 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.: 020-24471175 Email: io.pune@cioins.co.in
Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."	Shri Umesh Sinha Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Chintamani Building, 2nd Floor, Near New RTO Office, Louis Wadi, Vasant Rao Naik Mahamarg, Thane (West)- 400604 Tel.: 022-20812868/69 Email: io.thane@cioins.co.in

Annexure III : Day Care Procedures

A. Cardiology:

1. Coronary Angiography

B. Critical Care:

1. Insert Non - Tunnel CV Cath
2. Insert PICC CATH (Peripherally Inserted Central Catheter)
3. Replace PICC CATH (Peripherally Inserted Central Catheter)
4. Insertion Catheter, Intra Anterior
5. Insertion of Portacath

C. Dental :

1. Suturing Lacerated Lip
2. Suturing Oral Mucosa
3. Oral Biopsy In Case Of Abnormal Tissue Presentation
4. FNAC

D. ENT :

1. Bronchical Thermoplasty for Asthma
2. Myringotomy With Grommet Insertion
3. Tympanoplasty (closure Of An Eardrum Perforation reconstruction Of The Auditory Ossicles)
4. Removal Of A Tympanic Drain
5. Keratosis Removal Under GA
6. Operations On The Turbinates (nasal Concha)
7. Removal Of Keratosis Obturans
8. Stapedotomy To Treat Various Lesions In Middle Ear
9. Revision Of A Stapedectomy
10. Other Operations On The Auditory Ossicles
11. Myringoplasty (post-aural/endaural Approach As Well As Simple Type-I Tympanoplasty)
12. Fenestration Of The Inner Ear
13. Revision Of A Fenestration Of The Inner Ear
14. Palatoplasty
15. Transoral Incision And Drainage Of A Pharyngeal Abscess
16. Tonsillectomy Without Adenoidectomy
17. Tonsillectomy With Adenoidectomy
18. Excision And Destruction Of A Lingual Tonsil
19. Revision Of A Tympanoplasty
20. Other Microsurgical Operations On The Middle Ear
21. Incision Of The Mastoid Process And Middle Ear
22. Mastoidectomy Reconstruction Of The Middle Ear
23. Other Excisions Of The Middle And Inner Ear
24. Incision (opening) And Destruction (elimination) Of The Inner Ear
25. Other Operations On The Middle And Inner Ear
26. Excision And Destruction Of Diseased Tissue Of The Nose
27. Other Operations On The Nose
28. Nasal Sinus Aspiration
29. Foreign Body Removal From Nose
30. Other Operations On The Tonsils And Adenoids
31. Adenoidectomy
32. Labyrinthectomy For Severe Vertigo
33. Stapedectomy Under GA
34. Stapedectomy Under LA
35. Tympanoplasty (type IV)

36. Endolymphatic Sac Surgery For Meniere's Disease
37. Turbinectomy
38. Endoscopic Stapedectomy
39. Incision And Drainage Of Perichondritis
40. Septoplasty
41. Vestibular Nerve Section
42. Thyroplasty Type I
43. Pseudocyst Of The Pinna - Excision
44. Incision And Drainage - Haematoma Auricle
45. Tympanoplasty (Type II)
46. Reduction Of Fracture Of Nasal Bone
47. Thyroplasty Type II
48. Tracheostomy
49. Excision Of Angioma Septum
50. Turbinoplasty
51. Incision & Drainage Of Retro Pharyngeal Abscess
52. Uvulo Palato Pharyngo Plasty
53. Adenoidectomy With Grommet Insertion
54. Adenoidectomy Without Grommet Insertion
55. Vocal Cord Lateralisation Procedure
56. Incision & Drainage Of Para Pharyngeal Abscess
57. Tracheoplasty
58. Total excision of Pinna
59. Middle ear polypectomy
60. Nasal septum cauterisation (and bilateral)
61. Excision of lesion of Internal nose
62. Balloon Sinuplasty

E. Gastroenterology :

1. Cholecystectomy And Choledocho-jejunostomy/Duodenostomy / Gastrostomy / Exploration Common Bile Duct
2. Esophagoscopy, Gastroscopy, Duodenoscopy With Polypectomy/Removal Of Foreign Body/diathermy Of Bleeding Lesions
3. Pancreatic Pseudocyst Eus & Drainage
4. RF Ablation For Barrett's Oesophagus
5. ERCP And Papillotomy
6. Esophagoscope And Sclerosant Injection
7. EUS + Submucosal Resection
8. Construction Of Gastrostomy Tube
9. EUS + Aspiration Pancreatic Cyst
10. Small Bowel Endoscopy (therapeutic)
11. Colonoscopy, Lesion Removal
12. ERCP
13. Colonoscopy Stenting Of Stricture
14. Percutaneous Endoscopic Gastrostomy
15. EUS And Pancreatic Pseudo Cyst Drainage
16. ERCP And Choledochoscopy
17. Proctosigmoidoscopy Volvulus Detorsion
18. ERCP And Sphincterotomy
19. Esophageal Stent Placement
20. ERCP + Placement Of Biliary Stents

21. Sigmoidoscopy W / Stent
22. EUS + Coeliac Node Biopsy
23. UGI Scopy And Injection Of Adrenaline, Sclerosants Bleeding Ulcers

F. General Surgery:

1. Robotic surgeries
2. Incision Of A Pilonidal Sinus / Abscess
3. Fissure In Ano Sphincterotomy
4. Surgical Treatment Of A Varicocele And A Hydrocele Of the Spermatic Cord
5. Orchidopexy
6. Abdominal Exploration In Cryptorchidism
7. Surgical Treatment Of Anal Fistulas
8. Division Of The Anal Sphincter (sphincterotomy)
9. Epididymectomy
10. Incision Of The Breast Abscess
11. Operations On The Nipple
12. Excision Of Single Breast Lump
13. Incision And Excision Of Tissue In The Perianal Region
14. Surgical Treatment Of Hemorrhoids
15. Other Operations On The Anus
16. Ultrasound Guided Aspirations
17. Sclerotherapy, Etc.
18. Laparotomy For Grading Lymphoma With Splenectomy / liver/ lymph Node Biopsy
19. Therapeutic Laparoscopy With Laser
20. Appendicectomy With/without Drainage
21. Infected Keloid Excision
22. Axillary Lymphadenectomy
23. Wound Debridement And Cover
24. Abscess-decompression
25. Cervical Lymphadenectomy
26. Infected Sebaceous Cyst
27. Inguinal Lymphadenectomy
28. Incision And Drainage Of Abscess
29. Suturing Of Lacerations
30. Scalp Suturing
31. Infected Lipoma Excision
32. Maximal Anal Dilatation
33. Piles a. Injection Sclerotherapy b. Piles Banding
34. Liver Abscess- Catheter Drainage
35. Fissure In Ano-Fissurectomy
36. Fibroadenoma Breast Excision
37. Oesophageal Varices Sclerotherapy
38. ERCP - Pancreatic Duct Stone Removal
39. Perianal Abscess I&d
40. Perianal Hematoma Evacuation
41. UGI Scopy And Polypectomy Oesophagus
42. Breast Abscess I& D
43. Feeding Gastrostomy
44. Oesophagoscopy And Biopsy Of Growth Oesophagus
45. ERCP - Bile Duct Stone Removal
46. Ileostomy Closure
47. Colonoscopy

48. Polypectomy Colon
49. Splenic Abscesses Laparoscopic Drainage
50. UGI Scopy And Polypectomy Stomach
51. Rigid Oesophagoscopy For FB Removal
52. Feeding Jejunostomy
53. Colostomy
54. Ileostomy
55. Colostomy Closure
56. Submandibular Salivary Duct Stone Removal
57. Pneumatic Reduction Of Intussusception
58. Varicose Veins Legs - Injection Sclerotherapy
59. Rigid Oesophagoscopy For Plummer Vinson Syndrome
60. Pancreatic Pseudocysts Endoscopic Drainage
61. Zadek's Nail Bed Excision
62. Subcutaneous Mastectomy
63. Excision Of Ranula Under GA
64. Rigid Oesophagoscopy For Dilation Of Benign Strictures
65. Eversion Of Sac -unilateral -bilateral
66. Lord's Plication
67. Jaboulay's Procedure
68. Scrotoplasty
69. Circumcision For Trauma
70. Meatoplasty
71. Intersphincteric Abscess Incision And Drainage
72. PSOAS Abscess Incision And Drainage
73. Thyroid Abscess Incision And Drainage
74. Tips Procedure For Portal Hypertension
75. Esophageal Growth Stent
76. Pair Procedure Of Hydatid Cyst Liver
77. Tru Cut Liver Biopsy
78. Photodynamic Therapy Or Esophageal Tumour And Lung Tumour
79. Excision Of Cervical Rib
80. Laparoscopic Reduction Of Intussusception
81. Microdochectomy Breast
82. Surgery For Fracture Penis
83. Sentinel Node Biopsy
84. Parastomal Hernia
85. Revision Colostomy
86. Prolapsed Colostomy- Correction
87. Testicular Biopsy
88. Laparoscopic Cardiomyotomy(Hellers)
89. Sentinel Node Biopsy Malignant Melanoma
90. Laparoscopic Pyloromyotomy(Ramstedt)

G. Gynecology:

1. Operations On Bartholin's Glands (cyst)
2. Incision Of The Ovary
3. Insufflations Of The Fallopian Tubes
4. Other Operations On The Fallopian Tube
5. Dilatation Of The Cervical Canal
6. Conisation Of The Uterine Cervix
7. Therapeutic Curettage With Colposcopy / Biopsy /Diathermy / Cryosurgery

8. Laser Therapy Of Cervix For Various Lesions Of Uterus
9. Other Operations On The Uterine Cervix
10. Incision Of The Uterus (hysterectomy)
11. Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas
12. Incision Of Vagina
13. Incision Of Vulva
14. Culdotomy
15. Salpingo-oophorectomy Via Laparotomy
16. Endoscopic Polypectomy
17. Hysteroscopic Removal Of Myoma
18. D&c
19. Hysteroscopic Resection Of Septum
20. Thermal Cauterisation Of Cervix
21. Mirena Insertion
22. Hysteroscopic Adhesiolysis
23. Leep
24. Cryocauterisation Of Cervix
25. Polypectomy Endometrium
26. Hysteroscopic Resection Of Fibroid
27. LLETZ
28. Conization
29. Polypectomy Cervix
30. Hysteroscopic Resection Of Endometrial Polyp
31. Vulval Wart Excision
32. Laparoscopic Paraovarian Cyst Excision
33. Uterine Artery Embolization
34. Laparoscopic Cystectomy
35. Hymenectomy(Imperforate Hymen)
36. Endometrial Ablation
37. Vaginal Wall Cyst Excision
38. Vulval Cyst Excision
39. Laparoscopic Paratubal Cyst Excision
40. Repair Of Vagina (Vaginal Atresia)
41. Hysteroscopy, Removal Of Myoma
42. TURBT
43. Ureterocoele Repair - Congenital Internal
44. Vaginal Mesh For POP
45. Laparoscopic Myomectomy
46. Surgery For SUI
47. Repair Recto- Vagina Fistula
48. Pelvic Floor Repair(Excluding Fistula Repair)
49. URS + LL
50. Laparoscopic Oophorectomy
51. Normal Vaginal Delivery And Variants
52. Excision of lesion of vulva
53. Amputation of cervix uteri

H. Neurology :

1. IONM – (Intra Operative Neuro Monitoring)
2. Facial Nerve Glycerol Rhizotomy
3. Spinal Cord Stimulation
4. Motor Cortex Stimulation

5. Stereotactic Radiosurgery
6. Percutaneous Cordotomy
7. Intrathecal Baclofen Therapy
8. Entrapment Neuropathy Release
9. Diagnostic Cerebral Angiography
10. VP Shunt
11. Ventriculoatrial Shunt
12. Deep Brain stimulation

I. Oncology :

1. Radiotherapy For Cancer
2. Cancer Chemotherapy
3. IV Push Chemotherapy
4. HBI-hemibody Radiotherapy
5. Infusional Targeted Therapy
6. SRT-stereotactic ARC Therapy
7. SC Administration Of Growth Factors
8. Continuous Infusional Chemotherapy
9. Infusional Chemotherapy
10. CCRT-concurrent Chemo + RT
11. D Radiotherapy
12. D Conformal Radiotherapy
13. IGRT- Image Guided Radiotherapy
14. IMRT- Step & Shoot
15. Infusional Bisphosphonates
16. IMRT- DMLC
17. Rotational Arc Therapy
18. Tele Gamma Therapy
19. FSRT-fractionated SRT
20. VMAT-volumetric Modulated Arc Therapy
21. SBRT-stereotactic Body Radiotherapy
22. Helical Tomotherapy
23. SRS-stereotactic Radiosurgery
24. X-knife SRS
25. Gammaknife SRS
26. TBI- Total Body Radiotherapy
27. Intraluminal Brachytherapy
28. Electron Therapy
29. TSET-total Electron Skin Therapy
30. Extracorporeal Irradiation Of Blood Products
31. Telecobalt Therapy
32. Telecesium Therapy
33. External Mould Brachytherapy
34. Interstitial Brachytherapy
35. Intracavity Brachytherapy
36. D Brachytherapy
37. Implant Brachytherapy
38. Intravesical Brachytherapy
39. Adjuvant Radiotherapy
40. Afterloading Catheter Brachytherapy
41. Conditioning Radiotherapy For BMT
42. Nerve Biopsy

43. Muscle Biopsy
44. Epidural Steroid Injection
45. Extracorporeal Irradiation To The Homologous Bone Grafts
46. Radical Chemotherapy
47. Neoadjuvant Radiotherapy
48. LDR Brachytherapy
49. Palliative Radiotherapy
50. Radical Radiotherapy
51. Palliative Chemotherapy
52. Template Brachytherapy
53. Neoadjuvant Chemotherapy
54. Adjuvant Chemotherapy
55. Induction Chemotherapy
56. Consolidation Chemotherapy
57. Maintenance Chemotherapy
58. HDR Brachytherapy
59. immunotherapy - Monoclonal Antibody to be given as injection
60. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for hematological conditions

J. Salivary Glands & Salivary Ducts:

1. Incision And Lancing Of A Salivary Gland And A Salivary Duct
2. Excision Of Diseased Tissue Of A Salivary Gland And A Salivary Duct
3. Resection Of A Salivary Gland
4. Reconstruction Of A Salivary Gland And A Salivary Duct
5. Other Operations On The Salivary Glands And Salivary Ducts
6. Open extraction of calculus from parotid duct

K. Skin & Subcutaneous Tissues:

1. Other Incisions Of The Skin And Subcutaneous Tissues
2. Surgical Wound Toilet (wound Debridement) And Removal Of Diseased Tissue Of The Skin And Subcutaneous Tissues
3. Local Excision Of Diseased Tissue Of The Skin And Subcutaneous Tissues
4. Other Excisions Of The Skin And Subcutaneous Tissues
5. Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues
6. Free Skin Transplantation, Donor Site
7. Free Skin Transplantation, Recipient Site
8. Revision Of Skin Plasty
9. Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues.
10. Chemosurgery To The Skin.
11. Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues
12. Reconstruction Of Deformity/defect In Nail Bed
13. Excision Of Bursitis
14. Tennis Elbow Release

L. Tongue:

1. Incision, Excision And Destruction Of Diseased Tissue Of The Tongue
2. Partial Glossectomy
3. Glossectomy
4. Reconstruction Of The Tongue
5. Other Operations On The Tongue

M. Ophthalmology :

1. Surgery For Cataract
2. Incision Of Tear Glands
3. Other Operations On The Tear Ducts

4. Incision Of Diseased Eyelids
5. Excision And Destruction Of Diseased Tissue Of The Eyelid
6. Operations On The Canthus And Epicanthus
7. Corrective Surgery For Entropion And Ectropion
8. Corrective Surgery For Blepharoptosis
9. Removal Of A Foreign Body From The Conjunctiva
10. Removal Of A Foreign Body From The Cornea
11. Incision Of The Cornea
12. Operations For Pterygium
13. Other Operations On The Cornea
14. Removal Of A Foreign Body From The Lens Of The Eye
15. Removal Of A Foreign Body From The Posterior Chamber Of The Eye
16. Removal Of A Foreign Body From The Orbit And Eyeball
17. Correction Of Eyelid Ptosis By Levator Palpebrae Superioris Resection (bilateral)
18. Correction Of Eyelid Ptosis By Fascia Lata Graft (bilateral)
19. Diathermy/cryotherapy To Treat Retinal Tear
20. Anterior Chamber Paracentesis / Cyclodiathermy /Cyclocryotherapy / Goniotomy Trabeculotomy And Filtering And Allied Operations To Treat Glaucoma
21. Enucleation Of Eye Without Implant
22. Dacryocystorhinostomy For Various Lesions Of Lacrimal Gland
23. Laser Photocoagulation To Treat Retinal Tear
24. Biopsy Of Tear Gland
25. Treatment Of Retinal Lesion
26. Curettage/cryotherapy of lesion of eyelid
27. Intra vitreal injections

N. Orthopedics :

1. Surgery For Meniscus Tear
2. Incision On Bone, Septic And Aseptic
3. Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
4. Suture And Other Operations On Tendons And Tendon Sheath
5. Reduction Of Dislocation Under GA
6. Arthroscopic Knee Aspiration
7. Surgery For Ligament Tear
8. Surgery For Hemoarthrosis/pyoarthrosis
9. Removal Of Fracture Pins/nails
10. Removal Of Metal Wire
11. Closed Reduction On Fracture, Luxation
12. Reduction Of Dislocation Under GA
13. Epiphyseolysis With Osteosynthesis
14. Excision Of Various Lesions In Coccyx
15. Arthroscopic Repair Of Acl Tear Knee
16. Closed Reduction Of Minor Fractures
17. Arthroscopic Repair Of PCL Tear Knee
18. Tendon Shortening
19. Arthroscopic Meniscectomy - Knee
20. Treatment Of Clavicle Dislocation
21. Haemarthrosis Knee- Lavage
22. Abscess Knee Joint Drainage
23. Carpal Tunnel Release
24. Closed Reduction Of Minor Dislocation
25. Repair Of Knee Cap Tendon

26. ORIF With K Wire Fixation- Small Bones
27. Release Of Midfoot Joint
28. ORIF With Plating- Small Long Bones
29. Implant Removal Minor
30. K Wire Removal
31. Closed Reduction And External Fixation
32. Arthrotomy Hip Joint
33. Syme's Amputation
34. Arthroplasty
35. Partial Removal Of Rib
36. Treatment Of Sesamoid Bone Fracture
37. Shoulder Arthroscopy / Surgery
38. Elbow Arthroscopy Amputation Of Metacarpal Bone
39. Release Of Thumb Contracture
40. Incision Of Foot Fascia
41. Partial Removal Of Metatarsal
42. Repair / Graft Of Foot Tendon
43. Revision/removal Of Knee Cap
44. Amputation Follow-up Surgery
45. Exploration Of Ankle Joint
46. Remove/graft Leg Bone Lesion
47. Repair/graft Achilles Tendon
48. Remove Of Tissue Expander
49. Biopsy Elbow Joint Lining
50. Removal Of Wrist Prosthesis
51. Biopsy Finger Joint Lining
52. Tendon Lengthening
53. Treatment Of Shoulder Dislocation
54. Lengthening Of Hand Tendon
55. Removal Of Elbow Bursa
56. Fixation Of Knee Joint
57. Treatment Of Foot Dislocation
58. Surgery Of Bunion
59. Tendon Transfer Procedure
60. Removal Of Knee Cap Bursa
61. Treatment Of Fracture Of Ulna
62. Treatment Of Scapula Fracture
63. Removal Of Tumor Of Arm/ Elbow Under RA/GA
64. Repair Of Ruptured Tendon
65. Decompress Forearm Space
66. Revision Of Neck Muscle (torticollis Release)
67. Lengthening Of Thigh Tendons
68. Treatment Fracture Of Radius & Ulna
69. Repair Of Knee Joint

O. Mouth & Face:

1. External Incision And Drainage In The Region Of The Mouth, Jaw And Face
2. Incision Of The Hard And Soft Palate
3. Excision And Destruction Of Diseased Hard And Soft Palate
4. Incision, Excision And Destruction In The Mouth
5. Other Operations In The Mouth
6. Operations on uvula

P. Pediatric Surgery :

1. Excision Of Fistula-in-ano
2. Excision Juvenile Polyps Rectum
3. Vaginoplasty
4. Dilatation Of Accidental Caustic Stricture Oesophageal
5. Presacral Teratomas Excision
6. Removal Of Vesical Stone
7. Excision Sigmoid Polyp
8. Sternomastoid Tenotomy
9. Infantile Hypertrophic Pyloric Stenosis Pyloromyotomy
10. Excision Of Soft Tissue Rhabdomyosarcoma
11. Mediastinal Lymph Node Biopsy
12. High Orchidectomy For Testis Tumours
13. Excision Of Cervical Teratoma
14. Rectal-myomectomy
15. Rectal Prolapse (delorme's Procedure)
16. Detorsion Of Torsion Testis
17. EUA + Biopsy Multiple Fistula In Ano

Q. Plastic Surgery :

1. Construction Skin Pedicle Flap
2. Gluteal Pressure Ulcer-excision
3. Muscle-skin Graft, Leg
4. Removal Of Bone For Graft
5. Muscle-skin Graft Duct Fistula
6. Removal Cartilage Graft
7. Myocutaneous Flap
8. Fibro Myocutaneous Flap
9. Breast Reconstruction Surgery After Mastectomy
10. Sling Operation For Facial Palsy
11. Split Skin Grafting Under RA
12. Wolfe Skin Graft
13. Plastic Surgery To The Floor Of The Mouth Under GA

R. Thoracic Surgery :

1. Thoracoscopy And Lung Biopsy
2. Excision Of Cervical Sympathetic Chain Thoracoscopic
3. Laser Ablation Of Barrett's Oesophagus
4. Pleurodesis
5. Thoracoscopy And Pleural Biopsy
6. EBUS + Biopsy
7. Thoracoscopy Ligation Thoracic Duct
8. Thoracoscopy Assisted Empyema Drainage
9. Operations for drainage of pleural cavity

S. Urology :

1. Vaporisation of the prostate (Green laser treatment or holmium laser treatment)
2. Haemodialysis
3. Lithotripsy/nephrolithotomy For Renal Calculus
4. Excision Of Renal Cyst
5. Drainage Of Pyonephrosis/perinephric Abscess
6. Incision Of The Prostate
7. Transurethral Excision And Destruction Of Prostate Tissue
8. Transurethral And Percutaneous Destruction Of Prostate Tissue

9. Open Surgical Excision And Destruction Of Prostate Tissue
10. Radical Prostatovesiculectomy
11. Other Excision And Destruction Of Prostate Tissue
12. Operations On The Seminal Vesicles
13. Incision And Excision Of Periprostatic Tissue
14. Other Operations On The Prostate
15. Incision Of The Scrotum And Tunica Vaginalis Testis
16. Operation On A Testicular Hydrocele
17. Excision And Destruction Of Diseased Scrotal Tissue
18. Other Operations On The Scrotum And Tunica Vaginalis Testis
19. Incision Of The Testes
20. Excision And Destruction Of Diseased Tissue Of The Testes
21. Unilateral Orchidectomy
22. Bilateral Orchidectomy
23. Surgical Repositioning Of An Abdominal Testis
24. Reconstruction Of The Testis
25. Implantation, Exchange And Removal Of A Testicular Prosthesis
26. Other Operations On The Testis
27. Excision In The Area Of The Epididymis
28. Operations On The Foreskin
29. Local Excision And Destruction Of Diseased Tissue Of The Penis
30. Amputation Of The Penis
31. Other Operations On The Penis
32. Cystoscopical Removal Of Stones
33. Lithotripsy
34. Biopsy Of Temporal Artery For Various Lesions
35. External Arterio-venous Shunt
36. AV Fistula - Wrist
37. URSL With Stenting
38. URSL With Lithotripsy
39. Cystoscopic Litholapaxy
40. ESWL
41. Bladder Neck Incision
42. Cystoscopy & Biopsy
43. Cystoscopy And Removal Of Polyp
44. Suprapubic Cystostomy
45. Percutaneous Nephrostomy
46. Cystoscopy And "SLING" Procedure.
47. TUNA- Prostate
48. Excision Of Urethral Diverticulum
49. Removal Of Urethral Stone
50. Excision Of Urethral Prolapse
51. Mega-ureter Reconstruction
52. Kidney Renoscopy And Biopsy
53. Ureter Endoscopy And Treatment
54. Vesico Ureteric Reflux Correction
55. Surgery For Pelvi Ureteric Junction Obstruction
56. Anderson Hynes Operation
57. Kidney Endoscopy And Biopsy
58. Paraphimosis Surgery
59. Injury Prepuce- Circumcision

60. Frenular Tear Repair
61. Meatotomy For Meatal Stenosis
62. Surgery For Fournier's Gangrene Scrotum
63. Surgery Filarial Scrotum
64. Surgery For Watering Can Perineum
65. Repair Of Penile Torsion
66. Drainage Of Prostate Abscess
67. Orchiectomy
68. Cystoscopy And Removal Of FB
69. Endoscopic anti-reflux procedure (and bilateral)
70. Excision of urethral caruncle
71. Dilatation of urethra (including cystoscopy)

ANNEXURE IV SUM INSURED FOR TOP UP & SUPER TOP UP COVER

Deductible	50,000												
Sum Insured	50,000	75,000	1,00,000	1,25,000	1,50,000	1,75,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000

Deductible	75,000												
Sum Insured	50,000	75,000	1,00,000	1,25,000	1,50,000	1,75,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000

Deductible	1,00,000												
Sum Insured	50,000	75,000	1,00,000	1,25,000	1,50,000	1,75,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000

Deductible	1,25,000												
Sum Insured	50,000	75,000	1,00,000	1,25,000	1,50,000	1,75,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000

Deductible	1,50,000												
Sum Insured	50,000	75,000	1,00,000	1,25,000	1,50,000	1,75,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000

Deductible	1,75,000												
Sum Insured	50,000	75,000	1,00,000	1,25,000	1,50,000	1,75,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000

Deductible	2,00,000												
Sum Insured	50,000	75,000	1,00,000	1,25,000	1,50,000	1,75,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000

Deductible	2,50,000													
Sum Insured	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000	6,00,000	7,00,000	8,00,000	9,00,000	10,00,000

Deductible	3,00,000													
Sum Insured	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000	6,00,000	7,00,000	8,00,000	9,00,000	10,00,000

Deductible	3,00,000		
Sum Insured	12,00,000	15,00,000	20,00,000

Deductible	4,00,000													
Sum Insured	1,00,000	1,50,000	2,00,000	2,50,000	3,00,000	3,50,000	4,00,000	4,50,000	5,00,000	6,00,000	7,00,000	8,00,000	9,00,000	10,00,000

Deductible	4,00,000		
Sum Insured	12,00,000	15,00,000	20,00,000

Deductible	5,00,000												
Sum Insured	2,50,000	5,00,000	7,50,000	10,00,000	15,00,000	20,00,000	25,00,000	30,00,000	45,00,000	50,00,000	75,00,000	95,00,000	1,00,00,000

Deductible	6,00,000											
Sum Insured	2,50,000	5,00,000	7,50,000	10,00,000	15,00,000	20,00,000	25,00,000	45,00,000	75,00,000	95,00,000	1,00,00,000	

Deductible	7,00,000											
Sum Insured	2,50,000	5,00,000	7,50,000	10,00,000	15,00,000	20,00,000	25,00,000	45,00,000	75,00,000	95,00,000	1,00,00,000	

Deductible	8,00,000											
Sum Insured	2,50,000	5,00,000	7,50,000	10,00,000	15,00,000	20,00,000	25,00,000	45,00,000	75,00,000	95,00,000	1,00,00,000	

Deductible	9,00,000											
Sum Insured	2,50,000	5,00,000	7,50,000	10,00,000	15,00,000	20,00,000	25,00,000	45,00,000	75,00,000	95,00,000	1,00,00,000	

Deductible	10,00,000												
Sum Insured	5,00,000	10,00,000	15,00,000	20,00,000	25,00,000	30,00,000	40,00,000	50,00,000	75,00,000	90,00,000	95,00,000	1,00,00,000	

Deductible	15,00,000												
Sum Insured	5,00,000	7,50,000	10,00,000	15,00,000	20,00,000	25,00,000	30,00,000	35,00,000	50,00,000	75,00,000	85,00,000	1,00,00,000	

Deductible	20,00,000											
Sum Insured	5,00,000	10,00,000	20,00,000	25,00,000	30,00,000	50,00,000	80,00,000	1,00,00,000				

Deductible	25,00,000										
Sum Insured	10,00,000	15,00,000	20,00,000	25,00,000	50,00,000	75,00,000	1,00,00,000				

Deductible	30,00,000									
Sum Insured	15,00,000	20,00,000	25,00,000	50,00,000	70,00,000	1,00,00,000				

Deductible	40,00,000										
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Sum Insured	20,00,000	25,00,000	50,00,000	60,00,000	1,00,00,000
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Deductible	50,00,000				
Sum Insured	20,00,000	25,00,000	50,00,000	75,00,000	1,00,00,000

ANNEXURE V MODERN TREATMENT OR PROCEDURES

Treatment	Limit
1. Oral Chemotherapy	As mentioned in Policy Schedule / Certificate of Insurance
2 Immunotherapy – Monoclonal Antibody to be given as injection	
3 Intra vitreal injections	
4 Uterine Artery Embolization and HIFU	
5 Balloon Sinuplasty	
6 Deep Brain stimulation	
7 Robotic Surgeries	
8 Stereotactic radio surgeries	
9 Bronchial Thermoplasty	
10 Vaporisation of the prostate (Green Laser treatment or holmium laser treatment)	
11 IONM – (Intra Operative Neuro Monitoring)	
12 Stem Cell Therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered	

Registered & Corp Office: Universal Sompo General Insurance Company Limited. 8th Floor & 9th Floor (South Side), Commerz International Business Park, Oberoi Garden City, Off Western Express Highway, Goregaon East, Mumbai 400063, Toll free no: 1800-22-4030/1800-200-4030, IRDAI Reg no: 134, CIN# U66010MH2007PLC166770 E-mail: contactus@universalsompo.com, website link www.universalsompo.com

II. Life Insurance component - Digit Life Group Long Term Plan

PART – B

Important Terms and Definitions

DEFINITIONS

In this Policy, unless the context requires otherwise, the following words and expressions shall have the meaning assigned to them respectively herein below:

1. **Accident, Accidental** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Accidental Death** The Accident shall result in Bodily Injury or injuries to the Insured Member independently of any other means. Such Injury or injuries shall, within 180 days of the occurrence of the Accident (in case of Additional Accidental Death Benefit as mentioned in Clause 6.2.4.a. in Part C of this Master Policy Document) and within 12 months of the occurrence of the Accident (in case of Accidental Death Benefit under Additional Personal Accident Benefit, as mentioned in Clause 6.2.4.c. in Part C of this Master Policy Document), directly and independently of any other means, cause the death of the Insured Member. Such a death is defined as "Accidental Death". The date of the Accident should be after the Risk Commencement Date and before the termination/ expiry of the Insured Member's Insurance Coverage.
3. **Age** shall be Age of the Member as at last birthday on the Risk Commencement Date for existing Insured Members, and age as on Entry Date for new Members and as recorded with the Company.
4. **Appointee** shall mean a person who is appointed by the Insured Member to receive the Benefits on behalf of the Nominee, if the Nominee is a minor on the date of the payment of such Benefit on the happening of the death of Insured Member.
5. **Assignee** is the person to whom the rights and Benefits under this Policy are transferred by virtue of an Assignment.
6. **Assignment** is the process of transferring the rights and Benefits to an "Assignee," in accordance with the provisions of Section 38 of Insurance Act, 1938, as amended from time to time.
7. **Assignor** means the person who transfers the rights and Benefits under this Policy to the Assignee by virtue of an Assignment.
8. **Authority** means Insurance Regulatory and Development Authority of India (IRDAI).
9. **Benefit/s** means the Death Benefit, Inbuilt Optional Benefits which are Terminal Illness Benefit, Health Cover Benefit, Hospitalization Cover Benefit, Accidental Cover Benefit, Return of Premium in Term Insurance with Return of Premium option under Death Benefit as specified in Clause 6.1 of Part C of this Policy Document, Surrender Benefit, or any other Benefit as applicable and availed under the terms of this Policy.
10. **Beneficiary** means the Master Policyholder or the Member or Nominee/(s).
11. **Certificate of Insurance** means in the case of Non-Employer Employee Group, a certificate issued by Us, on the basis of the Member's enrolment details provided, to each Member evidencing the acceptance of risk on the life of the Member under the Master Policy; The Certificate of Insurance shall be attached to and form part of this Master Policy for the respective Member. In the event of any inconsistency or contradiction between the Policy and the Certificate of Insurance, the terms and conditions contained in the Policy will prevail.

12. **Claimant** means the Master Policyholder or the Member or the Nominee who is entitled to register a claim for the insured event under the Master Policy; and where there is no Beneficiary(s), then the Insured Member's legal heir or legal representative or the holder of a succession certificate.
13. **Coverage End Date** The date of the expiry of Insurance Coverage as provided to the Insured Member under this Master Policy.
14. **Death Benefit** means the Benefit which is agreed to be paid by Us on occurrence of Member's death subject to Clause 6.1 in Part C of this Policy Document and as specified in the Certificate of Insurance/ Register of Insured Members.
15. **Disappearance** means if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months , following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such Insured Member was known to have been travelling as a fare paying passenger or in any event arising as a result of Act of God Perils during the Member Coverage Term, where it is reasonable to believe that such Insured Member has died as a result of an Accidental Injury. Disappearance shall be covered under Additional Accidental Death Benefit as specified in Clause 6.2.4.a of Part C of this Policy Document and Accidental Death Benefit under Additional Personal Accident Benefit as specified in Clause 6.2.4.c. of Part C of this Policy Document.
16. **Drowning** means if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the Member Coverage Term, where it is reasonable to believe that such Insured Member has died as a result of drowning. Drowning shall be covered under Additional Accidental Death Benefit as specified in Clause 6.2.4.a of Part C of this Policy Document and Accidental Death Benefit under Additional Personal Accident Benefit as specified in Clause 6.2.4.c. of Part C of this Policy Document.
17. **Critical Illness (CI) Condition** means the first diagnosis of any of the covered Critical Illnesses or undergoing any surgery, as per chosen CI variant listed in Clause 6.2.2 in Part C of this Policy Document.

Following are the definitions of such listed **Critical Illnesses / surgical procedures**:

I. Standard Definitions

1) Cancer Of Specified Severity

- a) 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.
- b) 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 and CIN-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 classification T2N0M0.
 - v) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below.
 - vi) Chronic lymphocytic leukaemia less than RAI stage 3.
 - 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 5/50 HPFs.

2) Myocardial Infarction (First Heart Attack of specific severity)

- a) 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.
- b) 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.

- 3) **Open Heart Replacement Or Repair Of Heart Valves**
 - a) 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.
- 4) **Primary (Idiopathic) Pulmonary Hypertension**
 - a) 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.
 - b) 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.
 - c) Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.
- 5) **Open Chest CABG**
 - a) 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 breastbone) 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.
 - b) The following are excluded:
 - i) Angioplasty and/or any other intra-arterial procedures
- 6) **End Stage Lung Failure**
 - a) 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 ($\text{PaO}_2 < 55\text{mmHg}$); and
 - iv) Dyspnoea at rest.
- 7) **End Stage Liver Failure**
 - a) 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.
 - b) Liver failure secondary to drug or alcohol abuse is **excluded**.
- 8) **Kidney Failure Requiring Regular Dialysis:** 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.
- 9) **Major Organ /Bone Marrow Transplant**
 - a) 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 haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
 - b) The following are excluded:
 - i) Other stem-cell transplants
 - ii) Where only Islets of Langerhans are transplanted
- 10) **Benign Brain Tumor**
 - a) 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.
 - b) 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.
 - c) The following conditions are **excluded**:

- i) 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.
- 11) **Coma Of Specified Severity**
 - a) 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.
 - b) The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.
- 12) **Major Head Trauma**
 - a) Accidental head injury resulting in permanent Neurological deficit is 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.
 - b) 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.
 - c) 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 vice versa;
 - 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.
 - d) The following are excluded:
 - i) Spinal cord injury
- 13) **Permanent Paralysis Of Limbs:** 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.
- 14) **Stroke Resulting In Permanent Symptoms**
 - a) Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial 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.
 - b) The following are excluded:
 - i) Transient ischemic attacks (TIA)
 - ii) Traumatic injury of the brain
 - iii) Vascular disease affecting only the eye or optic nerve or vestibular functions.
- 15) **Motor Neuron Disease With Permanent Symptoms:** 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.
- 16) **Multiple Sclerosis With Persisting Symptoms**
 - a) 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.
 - b) Other causes of neurological damage such as SLE are excluded.

II. Specific Definitions:

- 1) **Surgery To Aorta:** The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction, or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.
- 2) **Abdominal Aorta Aneurysm**
 - a) An abdominal aortic aneurysm (AAA) is a swelling/dilatation (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body.
 - b) The diagnosis must be supported by a CT scans or CTA (Angiography) and requiring Endovascular aneurysm repair and the realization of surgery has to be confirmed by a cardiovascular surgeon.
 - c) Congenital conditions are excluded.
- 3) **Cardiomyopathy**
 - a) A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist). There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least Class 3 of the New York Heart Association classifications of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain) and LVEF of 40% or less.
 - b) The following conditions are excluded:
 - i) Cardiomyopathy secondary to alcohol or drug abuse.
 - ii) All other forms of heart disease, heart enlargement and myocarditis.
- 4) **Pulmonary Artery Graft Surgery:** The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
- 5) **Apallic Syndrome:** Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.
- 6) **Parkinson's Disease**
 - a) The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to us.
 - b) The diagnosis must be supported by all of the following conditions:
 - i) the disease cannot be controlled with medication;
 - ii) signs of progressive impairment; and
 - iii) inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months.
 - c) Parkinson's Disease secondary to drug and/or alcohol abuse is excluded.
- 7) **Muscular Dystrophy**
 - a) A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following four conditions:
 - i) Family history of muscular dystrophy;
 - ii) Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
 - iii) Characteristic electromyogram; or
 - iv) Clinical suspicion confirmed by muscle biopsy.
 - b) The condition must result in the inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months. Activities of daily living means:
 - i) Washing: the ability to wash in the bath or shower (including getting into and out of the 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 wheel chair and vice versa;
 - iv) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - v) Feeding: the ability to feed oneself, once food has been prepared and made available.
 - vi) Mobility: The ability to move indoors from room to room on level surfaces
- 8) **Progressive Supranuclear Palsy:** A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days.
- 9) **Creutzfeldt-Jakob Disease (CJD):** A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required. Social functioning is defined as the ability of the individual to interact in the normal or usual way in society. Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.
- 10) **Bacterial Meningitis:** Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6

weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living. This diagnosis must be confirmed by:

- i) The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
 - ii) A consultant neurologist certifying the diagnosis of bacterial meningitis.
- 11) Alzheimer's Disease:** Alzheimer's disease is a progressive degenerative illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our Appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Independent Living or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days
- a) The following conditions are however not covered:
- i) non-organic diseases such as neurosis and psychiatric illnesses;
 - ii) alcohol related brain damage; and
 - iii) any other type of irreversible organic disorder/dementia.
- 12) Encephalitis:** Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist). The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.
- 13) Loss Of Independent Existence:** Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of Activities of Daily Living.
- 14) Systemic Lupus Erythematosus:** A multi-system, multifactorial, autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. Systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specializing in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only hematological and joint involvement are however not covered. The WHO lupus classification is as follows:
- i) Class I: Minimal change – Negative, normal urine.
 - ii) Class II: Mesangial – Moderate proteinuria, active sediment.
 - iii) Class III: Focal Segmental – Proteinuria, active sediment.
 - iv) Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
 - v) Class V: Membranous – Nephrotic Syndrome or severe proteinuria.
- 15) Goodpasture's Syndrome:** Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for continuous period of at least **30 Days**. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist or Nephrologist).
- 16) Fulminant Hepatitis:** A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria. This diagnosis must be supported by all of the following:
- i) Rapid decreasing of liver size;
 - ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework;
 - iii) Rapid deterioration of liver function tests;
 - iv) Deepening jaundice; and
 - v) Hepatic encephalopathy.
- 17) Pneumonectomy:** The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured. The following conditions are excluded:
- i) Removal of a lobe of the lungs (lobectomy)
 - ii) Lung resection or incision
- 18) Aplastic Anaemia**
- a) Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:
- i) Blood product transfusion.
 - ii) Marrow stimulating agents.
 - iii) Immunosuppressive agents; or
 - iv) Bone marrow transplantation.
- b) The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:
- i) Absolute Neutrophil count of 500 per cubic millimetre or less;

- ii) Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- iii) Platelet count of 20,000 per cubic millimetre or less.

18. **Domiciliary Hospitalization**: Domiciliary Hospitalization means medical treatment for an illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances: i) the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or ii) the patient takes treatment at home on account of non-availability of room in a Hospital.
19. **Employer-Employee Group** means group where an employer-employee relationship exists between the Master Policyholder and the Member, in accordance with the relevant laws.
20. **Entry Date** means in relation to the Members admitted to this Master Policy and shall be the Risk Commencement Date.
21. **Eligible Member** means a person who meets and continues to meet all the eligibility criteria as detailed out in Clause 1 and 2 of Part C of this Policy Document.
22. **Free Cover Limit** means the amount of Sum Assured granted on life of the Member without any need for individual underwriting for assessment of risk on account of Benefits offered under this Master Policy. Sum Assured in excess of Free Cover Limit may be accepted subject to evidence of insurability satisfactory to the Company. Such Free Cover Limit shall be determined by the prevailing underwriting policy of the Company and subject to amendment from time to time.
23. **Grace Period** means the time granted by the Company from the due date for the payment of Premium without levy of any interest or penalty during which time the Policy or Member's Insurance Coverage, as the case may be, is considered to be In Force without any interruption. The Grace Period so granted is fifteen (15) days for monthly Premium payment frequency and thirty (30) days for other available Premium payment frequencies from the respective Premium payment due date.
24. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a Hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:
- a) has qualified nursing staff under its employment round the clock.
 - b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient 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.
25. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours. Inpatient care means treatment for which the Insured Member has to stay in a Hospital for more than 24 hours for an insured event.
26. **Inbuilt Optional Benefits** means Terminal Illness Benefit, Health Cover Benefit, Hospitalization Cover Benefit, Accidental Cover Benefit as described in Clause 6.2 of Part C of this Master Policy Document
27. **In Force** means status of the Policy / Member's Insurance Coverage being active, all due Premiums have been paid and the Policy / Member's Insurance Coverage is not terminated or in Lapsed Status.
28. **Injury / Bodily Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
29. **Insurance Coverage** means the risk cover under this Master Policy issued to the Member as per the Benefit/s In Force under the Master Policy.
30. **Lapsed Status** means state of a non-active life insurance contract on account of non-payment of Premium within the Grace Period.
31. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby

entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The registered practitioner should not be the insured or close member of the family. All medical professionals mentioned in this Master Policy Document, that is, cardiologist, neurologist, consultant neurologist, rheumatologist, nephrologist, specialist in respiratory medicine, pathologist shall be registered Medical Practitioners.

32. **Master Policy / Policy** means the contract of insurance entered into between the Master Policyholder and the Insurer as evidenced by the Master Policy Document.
33. **Master Policy Document / Policy Document** means this Digit Life Group Long Term Plan Policy comprising the necessary documents including terms and conditions, Master Policy Schedule, the signed Proposal Form, any endorsements in this document issued by Us from time to time and the annexures, if any.
34. **Master Policyholder** shall mean the owner of this Policy and is referred to as the proposer in the Proposal form and is named as such in the Master Policy Schedule.
35. **Master Policy Schedule** means the Policy Schedule set out above in Part A that We have issued, along with any annexures, tables and/or endorsements, attached to it from time to time and forming part of this Policy and if any updated Schedule is issued, then the Schedule which is latest in time.
36. **Member/Insured Member** means an individual who satisfies the eligibility criteria and is covered under this Master Policy.
37. **Member Coverage Term / Coverage Term** means duration of Insurance Coverage for Death Benefit and each of the Inbuilt Optional Benefits, respectively, with respect to Insured Member, from date of joining the Master Policy. Coverage Term of Inbuilt Optional Benefits will always be less than or equal to the Coverage Term of Death Benefit.
38. **Master Policy Commencement Date** is the Date, Month and Year the Master Policy comes into effect after We have accepted the risk under the Proposal Form and is as specified in the Master Policy Schedule.
39. **Multi-Stage Cancer Conditions** means first diagnosis of any of the covered minor or major conditions under Additional Multi-Stage Cancer Benefit mentioned in Clause 6.2 in Part C of this Policy Document. Following are the definitions of such minor and major conditions covered under Additional Multi-Stage Cancer Benefit:
- 1) **Carcinoma-in-Situ (CIS) of any organ (except skin)**
- a) It means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. Invasion means an infiltration and/or active destruction of normal tissue beyond the basement membrane.
 - b) The diagnosis of Carcinoma-in-Situ must always be supported by a histopathological report.
 - c) Furthermore, the diagnosis of Carcinoma-in-Situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard.
 - d) In the case of cervix uteri, Pap smear alone is not acceptable and should be accompanied with cone biopsy and colposcopy with the cervical biopsy report clearly indicating presence of CIS.
 - e) Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I and CIN II (where there is severe dysplasia without Carcinoma-in-Situ) does not meet the required definition and are specifically excluded.
 - f) All CIS of skin are specifically excluded.
 - g) This coverage is available to the first occurrence of CIS of same organ. Multiple claims from the same organ shall not be admissible.

2) **Early-Stage Cancers**

- a) Early-Stage Cancer shall mean first ever diagnosis with presence of one of the following malignant conditions:

- i) Any malignant tumor of the thyroid, positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of the tissue, which is histologically classified as T1N0M0 according to the TNM classification system, or another equivalent classification.
- ii) Prostate tumor should be histologically described as TNM Classification T1a or T1b or T1c or of another equivalent classification.
- iii) Chronic lymphocytic leukaemia classified as Rai Stage I or II.
- iv) Basal Cell and Squamous skin cancer that has spread to distant organs beyond the skin
- v) Hodgkin's lymphoma Stage I by the Cotswold's classification staging system
- vi) All tumors of urinary bladder histologically classified as T1N0M0 (TNM Classification)

The diagnosis must be based on histopathological features and confirmed by a pathologist. Pre-malignant lesions and conditions, unless listed above are excluded.

3) Cancer of Specified Severity As defined in Definition 17 (1) in this Part B

- 40. Nomination** is the process of nominating a person(s) in accordance with provisions of Section 39 of the Insurance Act, 1938 as amended from time to time.
- 41. Nominee/s** means a person nominated by the Member to receive the applicable Benefit/(s) under this Policy in case of death of the Member and whose name is mentioned in the Certificate of Insurance / Register of Insured Members.
- 42. Non-Employer-Employee Group** means group other than employer-employee, where a clearly evident relationship between the Member and the Master Policyholder, for services other than insurance, exist.
- 43. OPD Treatment**: OPD Treatment means the one in which the Insured Member visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
- 44. Policy Term** means the period for which Insurance Coverage is provided to each Insured Member by Us under this Master Policy and as specified in the Policy Schedule.
- 45. Policy Year or Coverage Year** means a period of twelve (12) consecutive months starting from the Master Policy Commencement Date or Risk Commencement Date respectively and ending on the day immediately preceding the following Policy anniversary date / Insurance Coverage anniversary date and each subsequent period of twelve (12) consecutive months thereafter, if applicable.
- 46. Premium/s** means the contractual amount payable by the Master Policyholder or the Insured Member during the Premium Payment Term on the Premium due date as set out in the Master Policy Schedule or Certificate of Insurance or Register of Insured Members, as applicable, to secure the Benefits under this Policy. Applicable tax, cess and other levies if any are payable in addition.
- 47. 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 Insurance Coverage issued by Us or;
 - b) for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Insurance Coverage or its Revival.
- 48. Premium Payment Term (PPT)** means the period in years or months during the Policy Term / Member Coverage Term during which Premiums are payable by the Policyholder / Insured Member under the Policy, as specified in the Master Policy Schedule / Certificate of Insurance / Register of Insured Members.
- 49. Proposal Form** means the form filled in and completed by You for the purpose of obtaining Insurance Coverage under this Master Policy.

50. **Register of Insured Members** means a record maintained by Us or the Master Policyholder containing details of each Insured Member including but not limited to unique identification number or membership number, name, Age, gender, Beneficiary, Entry Date, Premium payable, Premium Payment Term and instalment Premium due date (if applicable), Coverage and Benefit options chosen and Sum Assured under various Benefit options, as applicable and any special conditions applicable to the Insured Member.
51. **Regular Pay** means the Premium Payment Term is equal to Policy Term / Member Coverage Term and as specified in Master Policy Schedule / Certificate of Insurance/Register of Insured Members.
52. **Revival** means restoration of Insurance Coverage under a Master Policy / Insurance Coverage with respect to any Member, which is in a Lapsed Status or reduced paid-up status due to non-payment of due Premium (as stated in Clause 2 of Part D in this Policy Document), to the In-Force status as specified in Clause 4 of Part D in this Policy Document and subject to terms and conditions of the Master Policy.
53. **Risk Commencement Date** means the date on which the Insurance Coverage under the Master Policy in respect of the Insured Members commences which will be later of the date of realization of the full Premium by Us or the date of underwriting decision communicated by Us or the date specified towards the respective Insured Member in the Certificate of Insurance / Register of Insured Members.
54. **Single Pay** means the Policy / Insurance Coverage in which the Premium for the chosen Policy Term / Member Coverage Term is paid only once at the time before Master Policy Commencement Date / Risk Commencement Date, as applicable.
55. **Scheme Rules / Rules of Scheme** means the rules that may be framed by the Master Policyholder for the scheme and approved by Us from time to time, governing the grant of Benefits to the Insured Members of the scheme.
56. **Sum Assured** means an absolute amount of Benefit which is guaranteed to become payable on the occurrence of Death of Insured Member (lumpsum Sum Assured in case of Death Benefit) or other insured events with respect to inbuilt optional Benefits chosen in accordance with the terms and conditions of this Policy and is specified as such in the Certificate of Insurance or Register of Insured Members. For Income Benefit option, Sum Assured shall be defined as the total income payable in the next 12 months following the death of Insured Member for presentation purpose.
57. **Surrender** means complete withdrawal/ termination of the Master Policy or exit by the Member from the Master Policy before completion of Policy Term / Member Coverage Term, as the case may be, at the request of the Master Policyholder or the Member, as applicable.
58. **Survival Period** means the period of 30 days from the date of the first diagnosis of covered Critical Illness Condition that the Insured Member has to survive to be eligible for receiving Critical Illness Sum Assured (if opted for). Survival Period shall not be applicable for Additional Multi-Stage Cancer Benefit.
59. **Terminal Illness** means an advanced or rapidly progressing incurable and un-correctable medical condition which, in the opinion of two independent Medical Practitioners specializing in treatment of such illness, certifies that the illness is expected to lead to death of the Member within 6 months of the date of diagnosis of the Terminal Illness.
The Company reserves the right for an independent assessment by two different Medical Practitioners other than the Medical Practitioner whose diagnosis has been provided by the insured Member.
60. **Total Premiums Paid** means total of all the Premiums received, excluding any extra Premium, any rider premium and taxes.
61. **Unexpired Risk Premium Value (Surrender Value)** means an amount, if any, that becomes payable in case of Surrender, in accordance with the terms and conditions of the Policy as mentioned in Part D of this Policy Document.
62. **Waiting Period** means a period of 90 days for Accelerated Critical Illness, Additional Critical Illness Benefit, Additional Multi-Stage Cancer Benefit (all sub-options under Health Cover Benefit) and 45 days for Additional Hospitalization Benefit (under

Hospitalization Cover Benefit) starting from the Risk Commencement Date for the Member or from the date of Revival of Insured Member's Insurance Coverage. No amount shall be payable in case of occurrence of covered Critical Illness Condition or in case of occurrence of covered condition under Additional Multi-Stage Cancer Benefit or on Hospitalization under Additional Hospitalization Benefit within the Waiting Period. Waiting Period shall not be applicable in case Critical Illness condition/(s) or minor / major conditions under Additional Multi-Stage Cancer Benefit manifests due to an Accident. Similarly Waiting Period shall not be applicable in case of Member's Hospitalization due an Accident.

63. "We", "Us", "Our" "Ours", "Digit" "Digit Life" "Digit Life Insurance", "Insurer" and "Company" refers to Go Digit Life Insurance Limited.
64. "You", "Your", "Yours" refers to the Master Policyholder named in Master Policy Schedule and Insured Member named in Certificate of Insurance (if applicable).

PART - C

Product Core Benefits (Benefits Payable Under This Policy)

1. Eligibility Criteria For An Insured Member

- a) A person shall be eligible to become an Insured Member ("Eligible Member") if such person is:
 - i) above or equal to the minimum Age at Entry Date and below or equal to the maximum Age at Entry Date as specified in the Master Policy Schedule.
 - ii) Employees or contract staff or part time staff in case of Employer Employee (EE) groups.
 - iii) The Person forms part of the specified Group having a clearly evident relationship between him/her and the Master Policyholder.
 - iv) In case of joint life cover, both the persons under joint life cover shall individually satisfy the eligibility criteria.
- b) We will cover an Eligible Member from the Risk Commencement Date provided that:
 - i) We have received the Premium along with applicable taxes for such Eligible Member; and
 - ii) The Eligible Member satisfies underwriting criteria as per Our prevailing underwriting policy; and
 - iii) We have received all documentation in respect of that Eligible Member as required.
 - iv) The Eligible Member fulfils Eligibility Criteria as mentioned in Clause 1(a) above of this Part C.

The eligibility of a Member to join the scheme is subject to the Company receiving an intimation of eligibility of the Member and Premium amount preferably within 45 days of the Member becoming eligible.

2. Membership Provisions

- a) An Eligible Member will become an Insured Member only when We or the Master Policyholder has entered the member's details into the Register of Insured Members and as per the provisions defined in the Scheme Rules (if applicable), subject to terms and conditions of this Policy.
- b) Any Member shall have only one /single enrolment under the Master Policy unless agreed by the Company.
- c) Master Policyholder is responsible for providing the data on the Insured Members and for ensuring that it is accurate. Master Policyholder shall intimate Us of any change in the details of the Insured Members and addition of new member(s) and deletion of the Insured Member(s) in any month, within timelines as mentioned in the Scheme Rules.
- d) Master Policyholder agrees to indemnify and hold Us harmless from and against any and all losses, costs, expenses, actions or proceedings suffered by Us in relation to any error or deficiency in or in respect of providing the data on Members.
- e) We may seek additional information and/or documentation in respect of any Insured Member at any time. If the information and/or documentation for such Insured Member is not received by Us within timelines as mentioned in the Master Policy/ Scheme Rules, the name of the Insured Member shall be deemed to have been removed from the Register of Insured Members effective from the date of Our request of such information and/or documentation, and the Certificate of Insurance issued, if any, shall no longer be valid.

3. Insurance Coverage under Master Policy

- a) We may provide Insurance Coverage to a person under this Master Policy who satisfies the eligibility criteria as provided in Clause 1 and 2 above in this Part C.
- b) Every Member or Master Policyholder on behalf of Member shall produce evidence of insurability in the form and manner as prescribed by Us before effecting the Insurance Coverage on Member under this Master Policy or before effecting any change in the terms of Insurance Coverage extended including increase/decrease in Sum Assured, if any.
- c) After the Master Policy Commencement Date, an Eligible Member can become an Insured Member only after due intimation to Us and submission of all information and details in the form and manner specified by Us along with requisite Premium amount including applicable taxes.
- d) Subject to terms and conditions of the Master Policy, Rules of Scheme and prevailing underwriting policy of Company, Insured Member may have choice to opt from various options made available by the Master Policyholder under the Policy with respect to options under Death Benefit, Inbuilt Optional Benefits, Coverage Term, Premium Payment Term, Premium payment frequency, joint life cover option, coverage option, Sum Assured amount, any other option, if applicable.
- e) The Company shall have the right to vary the terms and conditions of the Master Policy including the Premium payable for new Members or to discontinue adding new Members to/terminate the Master Policy, by giving a written notice of 30 days

in advance. In case the Policy is terminated for any reason, the Company shall continue to cover the risk for lives of Members covered under the Policy till such termination subject to receipt of Premiums for the continuing Members as and when due.

4. Joint Life Cover

This Policy offers joint life cover option, under which two persons can be insured under a single lumpsum Sum Assured and / or Income Benefit under Death Benefit and under single Sum Assured for each of the applicable sub-options under Inbuilt Optional Benefits, if chosen. Both the individuals to be covered shall have insurable interest to avail the Insurance Coverage on joint life basis. The Premium, as applicable, shall be collected for both the insured persons under joint life cover during the Premium Payment Term. For joint life cover, Death Benefit shall be payable in accordance with Clause 6.1 of this Part C and Inbuilt Optional Benefits, if chosen, shall be payable in accordance with Clause 6.2 of this Part C on occurrence of respective insured events. The surviving Member shall receive the applicable Benefit payable on first occurrence of death under joint life cover. On payment of Death Benefit or on payment of Accidental Death Benefit (under Additional Accidental Death Benefit as mentioned in Clause 6.2.4.a. of this Part C or under Additional Personal Accidental Benefit as mentioned in Clause 6.2.4.c. of this Part C) or on payment of accelerated Benefits which leads to 100% exhaustion of applicable lumpsum Sum Assured under Death Benefit, provided income benefit option is not chosen, the Insurance Coverage for both the lives under Master Policy shall terminate and no further Benefits shall be payable under this Master Policy. On payment of 100% Sum Assured or 100% of applicable Benefit amount, as the case may be, for Additional Critical Illness Benefit/ Additional Multi-Stage Cancer Benefit/Additional Hospitalization Benefit/Additional Total and Permanent Disability Benefit/Additional Personal Accident Benefit, Insurance Coverage for these respective Benefits shall terminate for both the lives.

In case of simultaneous death of both the lives under joint life cover, Death Benefit and Accidental Death Benefit (under Additional Accidental Death Benefit as mentioned in Clause 6.2.4.a. of this Part C or under Additional Personal Accidental Benefit as mentioned in Clause 6.2.4.c. of this Part C), if applicable, shall be payable for one life only. In case of simultaneous or subsequent occurrence of insured events with respect to two lives for Inbuilt Optional Benefits, the total Benefit amount payable put together under each of the applicable sub-options under Inbuilt Optional Benefits (if chosen) shall be limited to 100% of the applicable respective Sum Assured or 100% of applicable respective Benefit amount, subject to terms and conditions of this Policy.

In case of simultaneous or subsequent claims under joint life cover, where claim against one life is repudiable, the claim on the other life shall prevail, if it is valid and subject to terms and conditions of this Policy.

5. Coverage Options

The Master Policyholder can choose any one or two or all three of the following Coverage Options at Master Policy Commencement Date and allow each Member to be covered in the Master Policy to choose any one of these options before Member's Risk Commencement Date.

- a. Level Cover – Under this Coverage Option, Sum Assured shall remain constant throughout the Member Coverage Term
- b. Decreasing Cover – Under this Coverage Option, Sum Assured as on Risk Commencement Date shall reduce over the Member Coverage Term as per the agreed schedule chosen before Risk Commencement Date and as specified in Certificate of Insurance.
- c. Flexi Cover – This option offers a combination of Level Cover and Decreasing Cover and shall be subject to agreed schedule chosen before Risk Commencement Date and as specified in Certificate of Insurance.

6. **Benefits:** Subject to this Master Policy / Member's Insurance Coverage, as the case may be, being In-Force and all due Premiums have been received at the time of occurrence of insured event and other terms and conditions mentioned in this Master Policy Document, We agree to pay to the Claimant, the Death Benefit and any other additional Benefit(s) depending upon the Coverage Option/s and Inbuilt Optional Benefit(s) (as explained respectively in Clause 5 and Clause 6 of Part C of this Policy Document) chosen and as specified in the Master Policy Schedule/Certificate of Insurance/Register of Insured Members. Maximum Sum Assured (and / or Income Benefit, if chosen, in case of Death Benefit) allowed for each Member under Death Benefit or each of the applicable sub-options under Inbuilt Optional Benefits (if any) shall be subject to prevailing underwriting policy of the Company.

6.1 Death Benefits & Death Benefit Payout Options: Death Benefit is the base Benefit under this Master Policy and shall be payable in case of death of the Insured Member. Any one of the following Death Benefit options can be chosen by the Member before Risk Commencement Date:

- Term Insurance - Death Benefit shall be payable in the event of death of the Insured Member during the Member Coverage Term, provided all Premiums are paid as and when due and Member's Insurance Coverage is In Force. No survival Benefit or maturity Benefit shall be payable under this option.
- Term Insurance with Return of Premium (TROP) – Death Benefit shall be payable in the event of death of the Insured Member during the Member Coverage Term, provided all Premiums are paid as and when due. In case of survival of the Member (or survival of both individuals under joint life cover) till the end of Member Coverage Term, Total Premiums Paid shall be returned in lumpsum at the end of such Member Coverage Term.

Any one or combination of the following pay out options can be chosen under Death Benefit subject to acceptance by the Company.

- a) Lumpsum Sum Assured: Under this option (if chosen), a lumpsum amount shall be payable following death of Insured Member.
- b) Income Benefit for a specified period: Under this option (if chosen), regular income shall be payable following date of Insured Member's death till the end of chosen number of years, which should not exceed 40 years less the chosen Member Coverage Term.

Income Benefit chosen can be level or increasing with income increasing at specified simple rate of up to 10% per annum. Any one of annual, half-yearly, quarterly or monthly mode can be chosen to receive the regular income pay-outs. Option to choose Income Benefit before Master Policy Commencement Date / Risk Commencement Date (as the case may be) shall be available in case of Death Benefit only.

For Income Benefit option mentioned above, Sum Assured shall be defined as the total income payable in the next 12 months following the death of Insured Member for presentation purpose.

The Death Benefit amount payable on death for an Insured Member shall be the chosen lumpsum Sum Assured and / or Income Benefit as per the options chosen for that Member. Insured Members of the same Master Policy can have different lumpsum Sum Assured amount and / or Income Benefit amount. The lumpsum Sum Assured and / or Income Benefit amount for each individual Insured Member will be specified at Risk Commencement Date.

On death of Insured Member

In the event of death of the Insured Member during the Member Coverage Term, and provided that the Master Policy/ Insurance Coverage to the Member under this Policy is In Force as on the date of death of the Member, Death Benefit as lumpsum Sum Assured or as Income Benefit or as combination of lumpsum Sum Assured and Income Benefit as chosen and as specified in the Certificate of Insurance or Register of Insured Members or any endorsement issued from time to time, shall be payable to the Claimant.

On payment of the Death Benefit, the Insurance Coverage for such Member for all the Benefits, including inbuilt optional Benefits (if any) under this Master Policy shall immediately and automatically terminate.

We shall not pay the Death Benefit when the Master Policy / Insurance Coverage to the Member is in Lapsed Status.

Death Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit

Death Benefit	Death	In case of death of the Member (on occurrence of first death in case of joint life cover) during the Member Coverage Term, lumpsum Sum Assured and / or income benefit (if any), shall be payable.	In case of Level Cover: Lumpsum Sum Assured and / or income benefit under Death Benefit shall be payable. Decreasing and Flexi Cover – Prevailing lumpsum Sum Assured under Death Benefit, as per agreed schedule chosen before Risk Commencement Date, shall be payable. Decreasing and Flexi Cover shall not be applicable for Income Benefit
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6.2 In-built Optional Benefits

The Master Policyholder can choose one or more of the following In-Built optional Benefits before Master Policy Commencement Date subject to Our acceptance and Members can choose from such available Inbuilt Optional Benefits under the Master Policy, subject to prevailing underwriting policy of the Company and terms and conditions of this Policy.

In case the Insured Member has to pay the Premiums for the Inbuilt Optional Benefits chosen by the Master Policyholder, he/she has the option to not opt for the same.

The Certificate of Insurance/Register of Insured Members will specify the Inbuilt Optional Benefits chosen under the Master Policy in respect of the Insured Member.

6.2.1 Terminal Illness (TI) Benefit

Accelerated Terminal Illness (TI) Benefit shall be offered under this Inbuilt Optional Benefit and subject to the terms and conditions of this Policy, TI Sum Assured as specified in the Certificate of Insurance/Register of Insured Members shall be payable as lump sum upon the occurrence of Terminal Illness condition in respect of the Insured Member, where such an occurrence happens while the Insured Member's TI Insurance Coverage is In Force.

Since TI Benefit is an Accelerated Benefit, payment of this Benefit shall not be in addition to lumpsum Sum Assured under Death Benefit chosen and it only facilitates an earlier payment of lumpsum Sum Assured under Death Benefit on prior occurrence of the Terminal Illness. Accelerated TI Benefit can be opted for when lumpsum Sum Assured under Death Benefit is chosen (either standalone or in combination with Income Benefit option). It is payable only once during the lifetime of the Insured Member and shall not exceed lumpsum Sum Assured under Death Benefit.

Where the TI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and no Income Benefit is chosen in addition to lumpsum Sum Assured under Death Benefit, the Insurance Coverage for all the Benefits, including Death Benefit and Inbuilt Optional Benefits (if any) in respect of the Insured Member shall terminate immediately upon diagnosis of Terminal Illness and payment of Accelerated TI Benefit.

Where the TI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and Income Benefit is also chosen in addition to lumpsum Sum Assured under Death Benefit, on payment of TI Sum Assured, Accelerated TI Benefit along with lumpsum Sum Assured under Death Benefit and other Inbuilt optional Benefits, if any, shall terminate, however, Member's Insurance Coverage shall continue with respect to the In Force Income Benefit under Death Benefit.

Where the TI Sum Assured is less than the lumpsum Sum Assured under Death Benefit, on payment of the TI Sum Assured, the lumpsum Sum Assured under Death Benefit will be reduced to the extent of the TI Sum Assured paid and this change shall be effective from the date of payment of accelerated TI Benefit. On payment of the accelerated TI Benefit, the Insurance Coverage for such Member in respect of other Inbuilt Optional Benefits (if any) under this Master Policy shall immediately and automatically terminate.

We shall not pay the accelerated TI Sum Assured when the Master Policy / Insurance Coverage to the Member is in Lapsed Status.

The Terminal Illness must be diagnosed and confirmed by Medical Practitioners. We reserve the right for an independent assessment by two different Medical Practitioners other than the Medical Practitioner whose diagnosis has been provided by the Insured Member.

Accelerated Terminal Illness (TI) Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Accelerated Terminal Illness Benefit	Terminal Illness (TI)	In case of diagnosis of Terminal illness, lumpsum Sum Assured is payable. In case of joint life cover, Benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Terminal Illness condition.	Level Cover: TI Sum Assured, which will be acceleration of the lumpsum Sum Assured under Death Benefit shall be payable. Decreasing & Flexi Cover: TI Sum Assured, which will be acceleration of lumpsum Sum Assured under Death Benefit, prevailing as per agreed schedule chosen before Risk Commencement Date, shall be payable.

6.2.2 Health Cover Benefit:

Under this Inbuilt Optional Benefit, the following three sub-options are available. Members can choose only one of these three sub-options before Risk Commencement Date.

a) Accelerated Critical Illness (CI) Benefit

This is an accelerated Benefit and subject to the Waiting Period, Survival Period, applicable exclusions referred under Critical Illness Condition in Part B and Annexure IV of this Master Policy and the other terms and conditions of this Policy, CI Sum

Assured as specified in the Certificate of Insurance/Register of Insured Members shall be payable as lumpsum upon the occurrence of covered Critical Illness Condition in respect of the Insured Member, where such an occurrence happens while the Insured Member's CI Insurance Coverage is In Force.

Since this is an accelerated Benefit, payment of this Benefit shall not be in addition to lumpsum Sum Assured chosen under Death Benefit and it only facilitates an earlier payment of such lumpsum Sum Assured under Death Benefit on prior occurrence of the Critical Illness. Accelerated CI Benefit can be opted for when lumpsum Sum Assured under Death Benefit is chosen (either standalone or in combination with Income Benefit option). Accelerated CI Benefit shall not exceed lumpsum Sum Assured under Death Benefit. On admission of claim under the accelerated CI Benefit:

Where the CI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and no Income Benefit is chosen in addition to lumpsum Sum Assured under Death Benefit, the Insurance Coverage for all the Benefits, including Death Benefit and Inbuilt Optional Benefits (if any) in respect of the Insured Member shall cease immediately upon diagnosis of Critical Illness and payment of Accelerated CI Benefit.

Where the CI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and Income Benefit is also chosen in addition to lumpsum Sum Assured under Death Benefit, on payment of CI Sum Assured, Accelerated CI Benefit along with the lumpsum Sum Assured under Death Benefit shall terminate, however, Member's Insurance Coverage shall continue with respect to the In Force Income Benefit under Death Benefit and other In Force Inbuilt Optional Benefits, if any, for remaining of the respective Member Coverage Terms.

Where the CI Sum Assured is less than the lumpsum Sum Assured under Death Benefit, on payment of the CI Sum Assured, the lumpsum Sum Assured under the Death Benefit will be reduced to the extent of the CI Sum Assured paid, and such change in the lumpsum Sum Assured under Death Benefit shall be effective from the date of the payment of the Accelerated Critical Illness Benefit. Such Member's Insurance Coverage under this Policy in respect of other In Force Inbuilt Optional Benefits (if any) shall continue for the remaining of the respective Member Coverage Terms.

Accelerated Critical Illness (CI) Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Accelerated Critical Illness (CI) Benefit	Critical Illness (CI)	In case of diagnosis of any one of the covered Critical Illnesses, basis the CI variant chosen, lumpsum Sum Assured is payable. In case of joint life cover, this Benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Critical Illness condition.	Level Cover: CI Sum Assured, which will be acceleration of the lumpsum Sum Assured under Death Benefit, shall be payable. Decreasing & Flexi Cover : CI Sum Assured, which will be acceleration of lumpsum Sum Assured under Death Benefit, prevailing as per agreed schedule chosen before Risk Commencement Date, shall be payable.

b) Additional Critical Illness (CI) Benefit

Subject to the Waiting Period, Survival Period, applicable exclusions referred under Critical Illness Condition in Part B and Annexure IV of this Master Policy and the other terms and conditions of this Policy, CI Sum Assured as specified in the Certificate of Insurance/Register of Insured Members shall be payable as lumpsum upon the occurrence of covered Critical Illness Condition in respect of the Insured Member, where such an occurrence happens while the Insured Member's CI Insurance Coverage is In Force.

This is an additional Benefit and on admission of a claim under the Additional CI Benefit, the CI Sum Assured shall be payable to the Claimant. On payment of Additional CI Benefit, Member's Insurance Coverage for this Benefit under the Master Policy shall terminate, however Member's Insurance Coverage shall continue in respect of In Force Death Benefit and other In Force Inbuilt Optional Benefits (if any) for the remaining of the respective Member Coverage Terms.

Additional Critical Illness (CI) Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Critical Illness (CI) Benefit	Critical Illness	In case of diagnosis of any one of the covered critical illnesses, basis the CI variant chosen, lumpsum Sum Assured is payable. In case of joint life cover, this Benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Critical Illness condition.	Level Cover: CI Sum Assured shall be payable. Decreasing Cover & Flexi Cover: Prevailing CI Sum Assured as per agreed schedule chosen before Risk Commencement Date shall be payable.

For both Accelerated CI Benefit and Additional CI Benefit: We shall not pay the CI Sum Assured when the Master Policy / Insurance Coverage to the Member is in Lapsed Status. The claim for Critical Illness Benefit shall be accepted only if covered Critical Illness condition has happened to Insured Member for the first time in life and is not a consequence of or arising out of any Pre- existing Condition/disease. Once a claim has been accepted under Critical Illness Benefit, Insurance Coverage for the Insured Member under this Policy with respect to CI Benefit shall cease and no further payment will be made for any consequent Critical Illness disease or any dependent Critical Illness/Illnesses.

At the time of Critical Illness claim payment, the Claimant will have an option to receive the additional / accelerated CI Benefit (as chosen) in the form of regular income over a period not exceeding 5 years. Such income payment can be chosen to be received in monthly, quarterly, half-yearly or annual mode. The first instalment pay-out shall be made immediately on acceptance of the CI claim by the Company. The lumpsum CI sum assured will be converted to the income amount as per chosen payment frequency and payment period using an effective interest rate of 5% p.a.

Critical Illnesses (CI) Variants: There are three CI variants offered under Accelerated CI Benefit / Additional CI Benefit and only one of them can be chosen by the Member before Risk Commencement Date, subject to terms and conditions of this Master Policy.

Variant 1 (14 Critical Illnesses)

Variant 2 (20 Critical Illnesses)

Variant 3 (34 Critical Illnesses)

Following is the list of Critical Illnesses /Surgical procedures covered under these three variants.

Sr. No	Category	Critical Illness	Variant 1	Variant 2	Variant 3
1	Cancer	Cancer of Specified Severity	Covered	Covered	Covered
2	Cardiovascular system	Myocardial Infarction	Covered	Covered	Covered
3		Open Heart Replacement or Repair of Heart Valves	Covered	Covered	Covered
4		Surgery to Aorta	Covered	Covered	Covered
5		Primary (Idiopathic) Pulmonary Hypertension	Not Covered	Covered	Covered
6		Aneurysm of Abdominal Aorta	Not Covered	Not Covered	Covered
7		Cardiomyopathy	Not Covered	Not Covered	Covered
8		Pulmonary artery graft surgery	Not Covered	Not Covered	Covered
9		Open Chest CABG	Covered	Covered	Covered
10	Major Organ Transplant	End Stage Lung Failure	Covered	Covered	Covered
11		End Stage Liver Failure	Covered	Covered	Covered
12		Kidney Failure Requiring Regular Dialysis	Covered	Covered	Covered
13		Major Organ/ Bone Marrow Transplant	Covered	Covered	Covered
14	Nervous System	Apallic Syndrome	Not Covered	Covered	Covered
15		Benign Brain Tumour	Covered	Covered	Covered
16		Coma of Specified Severity	Covered	Covered	Covered
17		Major Head Trauma	Covered	Covered	Covered
18		Permanent Paralysis of Limbs	Covered	Covered	Covered
19		Stroke Resulting in Permanent Symptoms	Not Covered	Covered	Covered
20		Motor Neurone Disease with Permanent Symptoms	Not Covered	Covered	Covered
21		Parkinson's Disease	Not Covered	Not Covered	Covered
22		Muscular Dystrophy	Not Covered	Not Covered	Covered
23		Progressive Supranuclear Palsy	Not Covered	Not Covered	Covered
24		Creutzfeldt-Jakob disease (CJD)	Not Covered	Not Covered	Covered
25		Bacterial Meningitis	Not Covered	Not Covered	Covered
26		Alzheimer's disease	Not Covered	Not Covered	Covered
27		Encephalitis	Not Covered	Not Covered	Covered
28		Multiple Sclerosis with Persisting Symptoms	Covered	Covered	Covered
29	Others	Loss of Independent Existence	Not Covered	Covered	Covered
30		Systemic lupus erythematosus	Not Covered	Not Covered	Covered
31		Goodpasture's syndrome	Not Covered	Not Covered	Covered
32		Fulminant Viral Hepatitis	Not Covered	Not Covered	Covered
33		Pneumonectomy	Not Covered	Not Covered	Covered
34		Aplastic Anaemia	Not Covered	Covered	Covered

c) Additional Multi-Stage Cancer (MSC) Benefit

Multi-stage Cancer (MSC) Benefit is an additional Benefit and subject to the Waiting Period, applicable exclusions mentioned under Additional Multi-Stage Cancer Condition in Part B and Annexure IV of this Master Policy and the other terms and conditions of this Policy, shall be payable in lumpsum as mentioned in table below upon diagnosis of the listed conditions during Multi-Stage Cancer Benefit's Coverage Term.

Level and covered conditions	Additional MSC Benefit payable in lumpsum (as percentage of MSC Sum Assured)
Minor Condition a. Carcinoma in-situ of any organ except skin b. Early-Stage Cancers	25%
Major Condition a. Cancer of specific severity	100% less minor condition claim earlier paid, if any

On diagnosis of one of the listed illnesses under minor conditions, 25% of MSC Sum Assured shall be payable in lumpsum and on diagnosis of any of the conditions under major condition category, 100% of MSC Sum Assured in lumpsum, less minor condition claim already paid, if any, shall be payable.

Claim shall be admissible only if the Member is diagnosed for the first ever occurrence of any of the listed conditions. Multiple claims for minor conditions shall be admissible during Additional Multi-Stage Cancer Benefit's Member Coverage Term as long as the total payout does not exceed 100% of the MSC Sum Assured. For multiple claims under minor conditions for a Member to be admissible, there needs to be a period of at least 6 months between the date of diagnosis of one minor condition claim and date of diagnosis of subsequent minor condition claim. However, this requirement of 6 months is not applicable in the case of diagnosis of major condition claim following a minor condition claim.

Multiple claims under minor conditions from the same organ shall not be admissible. For the purpose of claim, each group of the following sites are treated as one organ:

- Basal cell and squamous skin cancer
- Breast, where the tumor is classified as Tis according to the TNM Staging method
- Corpus uteri, vagina, fallopian tubes, cervix uteri, ovary
- Colon and rectum
- Penis, testis
- Stomach and esophagus

The total claims payable under this Benefit, including claims under minor and major conditions put together, shall not exceed 100% of the MSC Sum Assured. Upon payment of the 100% of MSC sum assured, Member's Insurance Coverage for this Benefit under the Master Policy shall terminate, however, Member's Insurance Coverage shall continue in respect of In Force Death Benefit and other In Force in-built optional Benefits (if any) for the remaining of the respective Member Coverage Terms.

Additional Multi-Stage Cancer Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Multi-Stage Cancer (MSC) Benefit	Minor or Major Conditions under Additional Multi-Stage Cancer Benefit	In case of diagnosis of minor or major conditions under Cancer, lump sum amount shall be payable. In case of joint life cover, lumpsum amount for minor conditions can be availed by both the lives separately. Minor condition Benefit already availed for any organ by one life shall be exhausted for both the lives. Lumpsum Benefit for major condition under cancer can be availed by any one of two lives, who is diagnosed first with such major condition.	Level Cover: 25% of MSC Benefit Sum Assured on diagnosis of minor condition. 100% of MSC Benefit Sum Assured, less claims earlier paid on account of minor condition(s), if any, shall be payable on diagnosis of a major condition. The Company's liability for payment of all the claims under additional MSC Benefit in aggregate during this Benefit's Coverage Term shall not exceed the 100% of MSC Sum Assured which includes multiple claims for minor conditions by the member (by both the lives put together in case of joint life cover) Decreasing & Flexi Cover – Not applicable

6.2.3 Hospitalization Cover Benefit:

Under this option, Additional Hospitalization Benefit (HB) shall be offered. Subject to terms and conditions of this Policy and applicable exclusions specified in Annexure V, a lumpsum amount equal to Additional Hospitalization Benefit (HB) Sum Assured shall be payable if a Member, on recommendation of a Medical Practitioner, is hospitalized, provided such Hospitalization happens for a continuous period of specified number of days between 1 to 15 days (number of days to be chosen by the Member before Risk Commencement Date) in a Coverage Year during Additional Hospitalization Benefit Coverage Term. For Insurance Coverage under Additional Hospitalization Benefit, completion of every 24 'in-patient care' hours in Hospital from the time of admission is considered to be a day.

It is important to note that Additional Hospitalization Benefit can be claimed only once in a Coverage Year, subject to maximum 5 times during this Benefit's Member Coverage Term.

Upon payment of maximum number of allowed claims, as applicable, under Additional Hospitalization Benefit during the Member Coverage Term, Member's Insurance Coverage for this Benefit under the Master Policy shall terminate, however Member's Insurance Coverage shall continue in respect of In Force Death Benefit and other In Force in-built optional Benefits (if any) for the remaining of the respective Member Coverage Terms.

Hospitalization Cover Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Hospitalization Cover Benefit	Hospitalization	In case of Hospitalization of an Insured Member for a continuous period for specified number of days between 1 and 15 (as chosen by Member before Risk Commencement Date), a lumpsum	Level Cover – A lumpsum amount equal to 100% of Hospitalization Benefit Sum Assured shall be payable on each Hospitalization. Hospitalization Cover Benefit can be claimed only once in a

		Benefit shall be payable in case of such Hospitalization, only once in a Coverage Year, subject to maximum 5 times during Member Coverage Term of this Benefit. In case of joint life cover, the Hospitalization Cover Benefit can be availed once by only one of the two lives in each Coverage Year during the Coverage Term, provided in each Coverage Year, it is claimed on occurrence of first such Hospitalization of only one of the two lives.	Coverage Year and not more than 5 times during the Member Coverage Term (across two lives put together in case of joint life cover). Decreasing & Flexi Cover: Not applicable
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6.2.4 Accidental Cover Benefit: Following three sub-options shall be offered under this Inbuilt Optional Benefit.

a) Additional Accidental Death Benefit (Additional ADB):

In the event of death of the Insured Member due to an Accident, provided that the Accident has occurred during the Member Coverage Term and Master Policy / Insurance Coverage of such Insured Member is In Force, in addition to the Death Benefit, the Accidental Death Benefit Sum Assured as specified in the Certificate of Insurance or Register of Insured Members shall be payable in lumpsum. A claim under this Benefit Option shall be admitted provided that the death:

- i. is caused by Injury resulting from an Accident,
- ii. occurs solely and directly due to the Injury, and independent of any other causes,
- iii. occurs within 180 days of the occurrence of Accident and
- iv. is not a result from any of the causes listed in the exclusions for Accidental Death Benefit specified in Annexure VI.

The date of the Accident should be after the Risk Commencement Date and before the termination/ expiry of the Insured Member's Insurance Coverage.

In case, the Accident occurs while the Insured Member's Additional ADB Insurance Coverage is In-Force, but the Accidental Death occurs after the end of the Member Coverage Term and within 180 days of the Accident, Additional ADB Sum Assured applicable at the time of such Accident shall be payable.

We shall be liable to pay this Benefit in following conditions as well

a. Disappearance, as defined in Part B of this Policy.

b. Drowning as defined in Part B of this Policy

On payment of the additional Accidental Death Benefit, the Insurance Coverage for such Member for all the Benefits, including inbuilt optional Benefits (if any) under this Master Policy shall immediately and automatically terminate.

We shall not pay the additional Accidental Death Benefit when the Master Policy / Member's Insurance Coverage is in Lapsed Status.

Additional Accidental Death Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
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Additional Accidental Death Benefit (ADB)	Death due to Accident	In case of death of Member due to Accident, where such Accident happens during the Member Coverage Term, a lumpsum amount shall be payable. In case of joint life cover, lumpsum Benefit shall be payable on happening of first death due to Accident.	Level Cover – A lumpsum amount equal to 100% of Additional ADB Sum Assured shall be payable. Decreasing & Flexi Cover – A lumpsum amount equal to 100% of prevailing ADB Sum Assured as on the date of Accident as per agreed schedule chosen before Risk Commencement Date, shall be payable.
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b) Additional Accidental Total and Permanent Disability (ATPD) Benefit

Subject to the Policy / Insurance Coverage for the Insured Member being In Force and applicable exclusions specified in Annexure VII and other terms and conditions of this Master Policy, ATPD Sum Assured which is in addition to Death Benefit and other Inbuilt Optional Benefits (if any) and as specified in the Certificate of Insurance/Register of Insured Members, shall be payable as lump sum upon occurrence of Accidental Total & Permanent Disability due to an Accident where such Accident happens while the Insured Member's ATPD Insurance Coverage is In Force.

For the purpose of Additional Accidental Total and Permanent Disability Benefit mentioned here, Accidental Total and Permanent Disability refers to a disability, which

- Is caused by Bodily Injury resulting from an Accident; and
- Occurs solely and directly due to the said Bodily Injury and shall be independent of any other cause; and
- Occurs within 180 days of the occurrence of such Accident; and
- Results in (i) Total and irrecoverable loss of sight of both eyes, or; (ii) Physical separation or loss of use of both hands or feet, or; (iii) Physical separation or loss of use of one hand and one foot, or; (iv) loss of sight of one eye and Physical separation or loss of use of hand or foot; (v) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Member from engaging in any employment or occupation of any description whatsoever.

The above is exclusive of and without prejudice to the other causes of total and permanent disability.

Where physical separation shall mean physical severance of the hand at or above the wrist or physical severance of the foot at or above the ankle.

The date of the Accident should be after the Risk Commencement Date and before the termination/ expiry of the Insured Member's Insurance Coverage.

In case, the Accident occurs while the Insured Member's Additional Accidental Total and Permanent Disability Benefit Insurance Coverage is In-Force, but the Accidental Total and Permanent Disability (ATPD) occurs after the end of the Member Coverage Term and within 180 days of the Accident, additional ATPD Sum Assured applicable at the time of such Accident shall be payable.

We shall not pay the Additional ATPD Benefit when the Master Policy/Insurance Coverage to the Member is in Lapsed Status.

On payment of the additional ATPD Benefit, Member's Insurance Coverage for this Benefit under Master Policy shall terminate, however, Member's Insurance Coverage under this Master Policy shall continue for In Force Death Benefit and other In Force in-built optional Benefits (if any) for the remaining of the respective Member Coverage Terms.

Additional Accidental Total and Permanent Disability Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Accidental Total and Permanent Disability (ATPD) Benefit	Total and Permanent Disability (ATPD) due to Accident	In case of ATPD due to accident, while such Accident happens during the Member Coverage Term, a lumpsum amount shall be payable. In case of joint life cover, lumpsum Benefit shall be payable on first occurrence of Total and Permanent Disability due to Accident to any one of the two lives.	Level Cover – A lumpsum amount equal to 100% of ATPD Sum Assured shall be payable. Decreasing & Flexi Cover – A lumpsum amount equal to 100% of prevailing ATPD Sum Assured as on the date of Accident as per agreed schedule chosen before Risk Commencement Date shall be payable.

c) Additional Personal Accident (PA) Benefit

Personal Accident Benefit shall be an additional Benefit and subject to terms and conditions of this Policy, following set of Benefits shall be payable under this sub-option on occurrence of specified insured events due to an Injury sustained by the Member on account of an Accident.

S.No.	Insured Event	Additional Personal Accident (PA) Benefit Payable
1	Accidental Death	100% of Additional PA Sum Assured shall be payable in lumpsum following death of Member, due to an Injury sustained in an Accident during the Member Coverage Term, provided that Member's death due to such Accident happens within 12 months from the date of such Accident. We shall be liable to pay this Benefit in following conditions as well a. Disappearance, as defined in Part B of this Policy. b. Drowning as defined in Part B of this Policy
2.	Accidental Total and Permanent Disability (ATPD)	100% of Additional PA Sum Assured shall be payable in lumpsum if Member suffers Total and Permanent Disability of the nature specified below, solely and directly due to an Accident during the Member Coverage Term, provided that the Total and Permanent Disability occurs within 12 months from the date of the such Accident: a) Total and irrecoverable loss of sight of both eyes, or; b) Physical separation or loss of use of both hands or feet, or; c) Physical separation or loss of use of one hand and one foot, or; d) loss of sight of one eye and Physical separation or loss of use of hand or foot; e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person from engaging in any employment or occupation of any description whatsoever. The above is exclusive of and without prejudice to the other causes of total and permanent disability. Where, physical separation shall mean physical severance of the hand at or above the wrist or physical severance of the foot at or above the ankle.
3.	Accidental Permanent	Benefits are payable in lumpsum, if the Member suffers Permanent Partial Disablement of the nature specified in the Table A given below, solely and directly

	Partial Disablement (APPD)	due to an Accident during the Member Coverage Term, provided that the Permanent Partial Disablement shall occur within 12 months of the date of such Accident.
4	Accidental Temporary Total Disablement (ATTD)	If the Insured Member sustains an Injury in an Accident during the Coverage Term and which completely incapacitates the Insured Member from engaging in any employment or occupation of any description whatsoever which the Insured Member was capable of performing at the time of the Accident (Temporary Total Disablement), compensation shall be payable, at the rate of 0.2% of the PA Sum Assured per week, till the time the Insured Member is able to return to work, provided that: a) Such period of ATTD exceeds 4 weeks, however Benefit shall be payable for the entire duration of disablement. b) The compensation payable under this Benefit mentioned under point (a) above, shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the PA Sum Assured. c). The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident. d). The compensation payable, shall be paid by the Company at quarterly intervals, after ascertaining the amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period. e). During the course of payment under this Benefit, the Company shall have right to call for a certification from an independent Medical Practitioner chosen by the Company, with regard to the continuity of temporary total disability specified under this ATTD.
5	Hospitalization due to Accident	A Daily Hospital Cash Benefit equal to a fixed percentage of PA Sum Assured, which is 1%/2%/3%/4%/5% (as chosen before Risk Commencement Date by the Member) shall be payable on Hospitalization due to an Accident. Daily Hospital Cash Benefit can be availed on Hospitalization of a minimum period of 24 hours and for a maximum period of up to 10 days per Coverage Year, subject to a maximum period of 30 days over the Member Coverage term, provided such Hospitalization happens due to an Accident. For Insurance Coverage under Hospitalization due to Accident, completion of every 24 'in-patient care' hours in Hospital from the time of admission is considered to be a day.

Table A

Losses under Accidental Permanent Partial Disablement (APPD)	Benefit payable as percentage of PA Sum Assured
1. Loss of Use/Physical Separation:	
One entire hand	50
One entire foot	50
2. Loss of Use of one eye	50
3. Loss of toes - all	20

Great both phalanges	5
Great –one phalanx	2
Other than great if more than one toe lost each	1
4. Loss of Use of both ears	50
5. Loss of Use of one ear	20
6. Loss of four fingers and thumb of one hand	40
7. Loss of four fingers	35
8. Loss of thumb – both phalanges	25
One phalanx	10
9. Loss of Index finger-three phalanges	10
Two phalanges	8
One phalanx	4
10. Loss of middle finger – three phalanges	6
Two phalanges	4
One phalanx	2
11. Loss of ring finger – three phalanges	5
Two phalanges	4
One phalanx	2
12. Loss of little finger – three phalanges	4
Two phalanges	3
One phalanx	2
13. Loss of metacarpus	
First or second (additional)	3
Third, fourth or fifth (additional)	2

Where, Losses under APPD shall be irrecoverable losses and result in loss of use or physical separation which arises solely and directly from an Injury, within 12 months from the date of Accident.

The Company's liability for payment of all claims under additional PA Benefit in aggregate during Coverage Term, in no case shall exceed 100% of PA Sum Assured with respect to the member.

If the Accident occurs during the Member Coverage Term, ADB, ATPD Benefit and APPD Benefit covered under Additional PA Benefit are payable, even if death or Total and Permanent Disability or Permanent Partial Disablement or any combination thereof occurs after the completion of Coverage Term, but within 12 months from the date of such Accident.

On payment of Accidental Death Benefit under Additional PA Benefit, the Member's Insurance Coverage under the Master Policy shall terminate and all other Benefits including Death Benefit shall also cease to exist with immediate effect.

On payment of 100% of PA Sum Assured on account of insured events other than Accidental Death under Additional PA Benefit, Additional Personal Accident (PA) Benefit terminates. However, In-Force Death Benefit, and all other In Force Inbuilt Optional Benefits, if any, shall continue as applicable.

Definitions and Exclusions with respect to additional PA Benefit are provided in Annexure VIII.

Additional Personal Accident Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Personal Accident (PA) Benefit	- Accidental Death	Accidental Death – Lumpsum amount on death of Member due to Accident (on occurrence of first death due to accident in case of joint life cover)	Level Cover: Accidental Death – 100% of PA sum assured shall be payable.
	- Accidental Total & Permanent Disability (ATPD)	ATPD – Lumpsum amount on occurrence of ATPD (on first occurrence to anyone of two lives in case of joint life cover)	ATPD – 100% of PA sum assured shall be payable.
	- Accidental Permanent Partial Disablement (APPD)	APPD – Lumpsum amount as a percentage of PA sum assured (on occurrence to any of the two lives separately under joint life cover)	APPD – a fixed percentage of PA Sum Assured for APPD losses as specified under Additional Personal Accident (PA) Benefit in Table A above shall be payable.
	- Accidental Temporary Total Disablement (ATTD)	ATTD – On occurrence of temporary total disablement due to an accident during the Coverage Term, a fixed amount shall be payable every week during the period of such disablement with respect to member (on occurrence to any of the two lives separately under joint life cover)	ATTD – Benefit shall be payable as 0.2% of PA Sum Assured every week provided such period of ATTD is more than 4 weeks. The Benefit payable shall be for a period not exceeding 100 weeks from date of commencement of ATTD.

	- Hospitalization due to Accident	Hospitalization due to Accident- On Hospitalization of the Member for at least 24 hours due to an Accident, a Daily Hospital Cash Benefit shall be payable (Hospitalization of any of the two lives separately in case of joint life cover)	Hospitalization due to Accident – A Daily Hospital Cash Benefit as a fixed percentage of PA sum assured (1%/2%/3%/4%/5%, as chosen by Member before Risk Commencement Date) shall be payable. This Benefit shall be payable on minimum 24 hours' Hospitalization and maximum for 10 days' Hospitalization in a Coverage Year (across two lives put together, in case of joint life cover), subject to maximum 30 days' Hospitalization during Coverage Term (across two lives put together in case of joint life cover). Completion of every 24 'in-patient care' hours in Hospital from the time of admission is considered to be a day. The claims payable on account all these insured events in aggregate under Additional PA Benefit shall not exceed 100% of PA sum assured in any case. (Including all the claims made by two lives put together in case of joint life cover) Decreasing & Flexi Cover: Not applicable
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Additional PA Benefit cannot be chosen by the Member, in case, either of Additional ADB (mentioned in Clause 6.2.4.a), Additional ATPD Benefit (mentioned in Clause 6.2.4.b.) or Additional Hospitalization Benefit under Hospitalization Cover Benefit is chosen.

On occurrence of 'Disappearance' and 'Drowning' as mentioned in Clause 6.2.4.a and Clause 6.2.4.c in this Part C , We will only pay, when the Claimant provides a legally binding indemnity bond or any other document as required by Us which guarantees, that, if at any time, after the payment of the Accidental Death Benefit, it is discovered that the Insured Member is still alive, all payments shall be repaid in full to Us by the Claimant.

Rights of Recovery: In the event when claim has been received by the Company for either Disappearance or Drowning (mentioned above) and against which payment has been made by the Company to the Claimant and it is discovered that the Insured Member is still alive, the Company shall be entitled to recover amounts paid towards such Claim. The Insured Member shall take all steps necessary or such steps as are required by the Company to recover the amounts paid towards Claim received under Disappearance or Drowning and preserve the rights and remedies available in this matter. The Company shall be subrogated to all the Insured Member's rights of recovery whether or not the Insured Member have received any compensation or Benefit out of the said Claim. The Company shall be entitled to pursue and enforce such rights in the name of Insured Member, and the Insured Member shall provide the Company with all reasonable assistance and co-operation in doing so, including the execution of any necessary instruments and papers. The Insured Member shall do nothing to prejudice the Company rights under this clause. Any amounts

recovered in accordance with this clause shall be applied in the following order: (i) to compensate the Company for the costs incurred in making the recovery; and (ii) to the Company up to the amount of the Claim paid by the Company; and (iii) to the Insured Member for the costs incurred in making the recovery. In its sole discretion, the Insurer may, in writing, waive any of its rights set forth in this Subrogation Clause.

6.3. Other Add-on options

6.3.1 Profit Sharing Option:

Digit Life Group Long Term Plan provides the option to the Master Policyholder to avail the Profit-Sharing Option at Proposal stage. If the profit-sharing option has been availed by the Master Policyholder, then the Master Policy Holder shall be entitled to profit sharing, where in case of favorable claims experience, the Master Policyholder would be refunded back a part of the Premium depending on the formula mutually agreed between Master Policyholder and the Company for the same. Any profit-sharing arrangement shall be as prescribed by IRDAI Circular No. IRDAI/ACTL/CIR/PRO/207/10/2022 dated 4th October 2022, as amended from time to time, as per the extant regulations/guidelines/circulars.

6.4 Other Benefits

6.4.1 Wellness Benefit Program:

This program intends to incentivize the Insured Member for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services. The applicability of the Wellness Benefit program and its features may be amended from time to time as per the prevailing underwriting policy of the Company. The list of Benefits under this program and terms and conditions applicable to it are provided in Annexure IX.

6.5. Survival/Maturity Benefits:

Benefit Options	Survival / Maturity Benefit
Death Benefit with Term Insurance or if any Inbuilt Optional Benefit is chosen	No Survival / Maturity Benefit shall be payable
Death Benefit with Term with Return of Premium (TROP) option	Provided all the due Premiums have been paid and on survival of Member (survival of both lives in case of joint life cover) till the end of Member Coverage Term, total Premiums paid shall be returned on completion of such Member Coverage Term.

7. **Premium under this Master Policy:** The Master Policyholder/Member, as the case may be, shall ensure that all due Premiums as calculated by the Company are paid in full, on each instalment Premium due date as per the In-Force Premium paying frequency or on Master Policy Commencement Date, as applicable. The Master Policyholder shall pay the Premium for new Members as per the Premium paying frequency selected on Processing Date or shall keep an advance deposit with Us.
- In case, Insurance Coverage under any of the Inbuilt Optional Benefits ceases before the completion of respective Member Coverage Term, while Member's Insurance Coverage for Death Benefit and other Inbuilt Optional Benefits (if any) if any, is still In-Force, no further Premium shall be payable for the remaining Premium Payment Term (if any), for corresponding Inbuilt Optional Benefit/(s) which have been terminated.

For Premium payment frequency other than annual, instalment Premiums payable are calculated by applying the loading factor as given below on annual premium:

Premium paying frequency	Loading factor
Semi-annual	2%
Quarterly	3%
Monthly	4%

Subject to the Policy / Insurance Coverage discontinuance and Revival provisions, We must receive all due Premiums in order for the Insurance Coverage with respect to a Insured Member to remain In Force.

The Insurance Coverage for the Members in respect of whom the Premium has been so calculated would commence on receipt of the full Premium in respect of such Members and on acceptance of risk on underwriting, if any, by Us.

8. Grace Period (applies to Master Policyholder and Insured Member)

In the event where the Master Policyholder or Insured Member (as applicable) fails to pay the due Premium on the instalment Premium due date, We will allow a Grace Period to pay the due Premium while continuing the applicable Insurance Coverage and Benefits under it. A Grace Period of 15 days in respect of monthly Premium payment frequency and 30 days in other applicable frequencies from the instalment Premium Due Date shall be provided for limited and regular pay Policy / Member's Insurance Coverage for paying overdue Premium to Us without any penalty/late fee during which Death Benefit and all the chosen Inbuilt Optional Benefits under Master Policy/Insurance Coverage of Insured Member will be considered to be In Force with the risk cover without any interruption as per the terms of the Master Policy.

If the contingent event of Death/ Terminal Illness/ Critical Illness/ minor or major conditions under Multi-Stage Cancer Benefit/ADB/ ATPD/ Hospitalization/insured events under Additional Personal Accident Benefit, as applicable or any other event, if applicable and covered under this Policy or Member's Insurance Coverage, occurs during the Grace Period, then Benefits as applicable shall be payable as mentioned under Part C subject to receipt of unpaid Premium for Master Policy in cases, where Premium is paid by the Master Policyholder.

However, in a Policy, where Premium is paid by the Member, the applicable Benefit shall be payable subject to deduction of unpaid due Premium for the respective Member. In case the Premium which was due with respect of any Insured Member, is collected by the Master Policyholder within Grace period but is not remitted to Us for some reason, then the Insurance Coverage for such Insured Member will continue even on expiry of Grace period, provided Member has the receipt of payment of such Premium to the Master Policyholder within Grace Period. The Company reserves the right to recover such Premium from the Master Policyholder.

PART - D

Policy Servicing Related Aspects

1. Free Look Provisions:

- a) **At Master Policy Level:** If You do not agree with the terms and conditions of the Master Policy, You have the option to request for cancellation of the Master Policy by returning the original Master Policy Document along with a written request stating the reasons for objection to Us within 30 days from the date of receipt of Master Policy. Upon the receipt of such a cancellation request, the Company will cancel the Master Policy and refund the Premiums received after deducting proportionate risk premium for the period of Insurance Coverage and expenses incurred on medical examination of Members, if any and applicable stamp duty. All Insured Members' Insurance Coverage and Benefits under it will cease post the request for free look cancellation by the Master Policyholder.
- b) **At Member Level:** If the Insured Member does not agree with the terms and conditions specified in Certificate of Insurance, he/she has the option of returning the Certificate of Insurance (if applicable) to the Company stating the reasons thereof, within 30 days from the date of receipt of the Certificate of Insurance. Upon receipt of the free look cancellation request and Certificate of Insurance (if applicable), we shall refund the Premium received in respect of insured Member, subject to deduction of the proportionate risk premium for the period of Insurance Coverage, expenses incurred on medical examination of such Member, if any and applicable stamp duty for that Insured Member. The Insurance Coverage for the Insured Member will cease post the request for such free look cancellation.

For Administrative purposes, all free-look requests should be registered by the Master policyholder on behalf of the Insured Member.

2. Reduced Paid-up

For regular pay Death Benefit with Term Insurance option and regular pay Inbuilt Optional Benefits, if at any point of time during the Policy Term / Coverage Term, due Premium is not paid within Grace Period, the Master Policy / Member's Insurance Coverage shall lapse on expiry of Grace Period until it is revived as specified in Clause 4 of this Part D. No Benefits shall be payable when the Master Policy / Insurance Coverage is in Lapsed Status for these options.

In case of limited pay Death Benefit with Term Insurance option, limited pay Inbuilt Optional Benefits and limited or regular pay Death Benefit with TROP option, if the Premiums are not paid for at least first two Coverage Years, the Insurance Coverage shall lapse on expiry of Grace Period until it is revived as specified in Clause 4 of this Part D. For these options mentioned in this para, no Benefits except for Unexpired Risk Premium Value (Surrender Value), if any, shall be payable when Insurance Coverage is in Lapsed Status. However, under these options mentioned in this para, if the Premiums are paid for at least first two Coverage Years and if further due Premium is not paid within the Grace Period, the Policy / Member's Insurance Coverage attains reduced paid-up status, wherein, Benefits under all applicable Insurance Coverages (risk covers) become reduced paid-up. Reduced Paid-up Benefit shall be calculated as stated below:

Reduced Paid-up Sum Assured = Paid-up factor x Applicable Sum Assured

Reduced Paid-up Income Benefit = Paid-up factor x Income Benefit

Reduced Paid-Up survival / maturity Benefit = 100% of Total Premiums Paid for TROP option under Death Benefit (if TROP option is chosen)

Where,

Paid-up factor = Number of Premiums paid/Total number of Premiums payable over the Premium Payment Term

Applicable Sum Assured = Sum Assured as per Benefit and coverage option and as per agreed schedule (if any) chosen before Risk Commencement Date

Total Premiums Paid is the total of all the Premiums received, excluding any extra premium, any rider premium and taxes.

3. Surrender Provisions:

In case of Surrender of the Master Policy by the Master Policyholder, the Members shall have an option to continue the Insurance Coverage till the end of the respective Member Coverage Term(s). Such Insurance Coverage with the applicable Benefits shall continue with the same terms and conditions as the original Insurance Coverage with respect to such Members under Master Policy and Company/ intermediary, if any, shall continue to be responsible to serve such Members till their Insurance Coverage is terminated. Unexpired Risk Premium Value (Surrender Value) for such Members opting to continue the Insurance Coverage shall not be paid out.

Following Unexpired Risk Premium Value (Surrender Value) shall be payable on Surrender:

a) For Death Benefit with Term Insurance and Inbuilt Optional Benefits chosen, if any:

Benefit	Option / Sub-option	Level Cover	Decreasing Cover	Flexi Cover
Death Benefit	Lumpsum	50% x ((Total Premiums paid) – (Total Premiums payable over the Premium Payment Term x Expired Coverage Term in months/Coverage Term in months)))	50% x ((Total Premiums paid) – (Total Premiums payable over the Premium Payment Term x Expired Coverage Term in months/Coverage Term in months)))	x Current Sum Assured / Initial Sum Assured
	Income Benefit			
Terminal Illness Benefit	Accelerated Terminal Illness (TI) Benefit			
Health Cover Benefit	Accelerated Critical Illness Benefit			
	Additional Critical Illness Benefit			
	Additional Multi-Stage Cancer Benefit			
Hospitalization Cover Benefit	Additional Hospitalization Benefit (HB)			
Accidental Cover Benefit	Additional Accidental Death Benefit (ADB)			
	Additional Accidental Total and Permanent Disability (ATPD) Benefit			
	Additional Personal Accident (PA) Benefit			

b) For Death Benefit with Term Insurance with Return of Premium and Inbuilt Benefit Options chosen, if any

In such cases, the total premium paid could be expressed as A + B + C, where,

- A = Total premium paid corresponding to Term Insurance component under TROP
- B = Additional premium payable over A, corresponding to Return of Premium component under TROP
- C = Total premium paid for the Inbuilt Optional Benefits, if any

Unexpired Risk Premium Value on Surrender equals

- Cash value computed corresponding to A + C as per the formula provided above in 3 (a) of this Part D, *Plus*
- Discounted value of A+B, provided at least first two years' Premium is paid in full.

where

- The discount rate shall be based on prevailing annualised yields on 30-year G-Sec +150 basis points, rounded up to the nearest 25 basis points.
- The discount rates will be reviewed semi-annually and shall be revised using the above-mentioned formula and the change in the discount rates shall be effective from 25th February and 25th August each year. The revised discount rates shall apply to all Policies/Member Insurance Coverages including those which are already In-Force.
- Currently, the discount factors have been derived using interest rate of 8.75% p.a.
- Any change on basis of determination of interest rate for discounting can be done only after prior approval of the Authority.

In case of Surrender of entire Master Policy, the aggregate of Unexpired Risk Premium Value at Member level with respect to discontinuing Members shall be payable.

On Surrender, the Insurance Coverage for the Member terminate(s).

4. Revival

If the due Premium is not received by the end of the Grace Period, the Policy / Member's Insurance Coverage shall lapse / acquire reduced paid-up status as mentioned in Clause 2 of this Part D. The Company will consider requests to revive Policies / Member's Insurance Coverage in Lapsed Status / reduced paid-up status within five years from the due date of first unpaid Premium, provided such requests are received within the Policy Term / Member Coverage Term, as applicable. Any agreement to revive the lapsed or reduced paid-up Policy/ Member's Insurance Coverage would be subject to the Our prevailing underwriting policy. The Company shall collect all the due Premiums and other charges or late fee if any, as per the terms and conditions of the Policy for such Revival. The late fees shall be calculated at such interest rate as may be prevailing at the time of the payment.

The Revival interest rate compounding annually, will be set using prevailing interest rates. The prevailing interest rates will be derived from yields of the 30 years G-Sec security. Any change in the interest rate used will be in accordance with the formula below:.

Annualized Yield on reference government bond + 100 basis points, rounded up to the nearest 25 basis points. The Revival interest rate for the financial year 2023-24 is 8.25% p.a.

The Revival interest rate will be reviewed semi-annually and shall be revised using the above-mentioned formula and the change in the rate shall be effective from 25th February and 25th August each year.

Any change on basis of determination of interest rate for Revival can be done only after prior approval of the Authority.

5. **Loan:** This Policy does not offer loan facility.

6. **Addition of Member:** The Master Policyholder can choose to add new Members by paying the Premium for the Member Coverage Term for such Member. The Master Policyholder should inform or intimate the Company with the list of new joiners preferably within 45 days from the date of new joiners becoming eligible to be admitted under this Master Policy. The Risk Commencement Date for the new joiners shall be the date of joining of the Eligible Member or the date of intimation to Us, whichever is earlier. The Insurance Coverage for these Members shall commence only if the personal statement / declaration of good health, if any, or other factor relating to the insurability of a life is to the satisfaction to the Company. The Company shall communicate its decision on addition of Eligible Member based on its then prevailing underwriting policy. The Company's decision thereon shall be final and binding on the Master Policyholder and the Member. In case of inadequate Premium, the Insurance Coverage will begin from the date of receipt of the full Premium. Premium shall be deposited in advance for addition of new Members.. Any applicable levies, taxes, duties or surcharges will also be charged. We will have right to discontinue addition of new Members by giving a notice of 30 days to Master Policyholder of this effect.

7. **Deletion of Member:** In case, a Member leaves the scheme during the Member Coverage Term (due to reasons other than death), where Master Policyholder has paid the Premium, the Company will refund Unexpired Risk Premium Value (Surrender Value), as applicable with respect to such Member(s) to the Master Policyholder in accordance with Clause 3 of this Part D. The Master Policyholder should inform the Company of deletions for Members leaving the scheme. Such Members' Insurance Coverage will cease from the date of leaving the scheme. Member who has paid the Premium for his/her Insurance Coverage leaves the scheme, shall continue his/her Insurance Coverage as per original terms and conditions of the Master Policy unless such Member informs the Company about discontinuance of the Insurance Coverage.

8. Payment of Benefits All Benefits and other sums specified under this Master Policy / Certificate of Insurance/ Register of Insured Members shall be payable in the manner and currency allowed/permitted under the Regulations and shall be payable by NEFT, account payee cheque or other permissible modes. The Company shall pay the applicable Benefits and other sums payable under this Master Policy / Member's Insurance Coverage. Any discharge given by the Claimant, in writing in respect of the Benefits or the sums payable under this Master Policy / Member's Insurance Coverage, shall constitute a valid discharge to the Company in respect of such payment. The Company's liability under the Master Policy / Certificate of Insurance/Register of Insured Members shall be discharged by such payment.

a) Where the Master Policy is issued under Lender-Borrower category and Master Policyholder is one of the following entities:

- i) RBI regulated Scheduled Commercial Banks (including Co-operative Banks);
- ii) NBFCs having Certificate of Registration from RBI;
- iii) National Housing Bank (NHB) regulated Housing Finance Companies
- iv) National Minority Development Finance Corporation (NMDFC) and its State channelizing agencies
- v) Small Finance Banks regulated by RBI
- vi) Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies
- vii) Microfinance companies registered under section 8 of the Companies Act, 2013
- viii) Any other category as approved by the Authority., in accordance with IRDAI guidelines as amended from time to time,

the Insured Member may give Us a written authorization in the form specified by Us to make payment towards Insured Member's outstanding loan balance amount to the Master Policyholder from lumpsum Death Benefit and certain Inbuilt Optional Benefits (if any) payable on happening of respective insured events during Member Coverage Term under this Master Policy. This written authorization may be given to Us at the stage of Eligible Member's addition to the Master Policy as an Insured Member or at a later date. If We have received such written authorization from the Insured Member, then We will pay an amount to the extent of outstanding loan to the Master Policyholder from the lumpsum Death Benefit and from Additional Accidental Death Benefit (ADB), Accidental Death Benefit covered under Additional Personal Accident Benefit, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit (if any of these inbuilt optional Benefits are chosen by the Member) on occurrence of respective insured events, while Member's Insurance Coverage is In-Force and on providing documents as mentioned in Scheme Rules. The remainder of the lumpsum Death Benefit, Additional Accidental Death Benefit (ADB), Accidental Death Benefit covered under Additional Personal Accident Benefit, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any shall be payable to the Claimant other than the Master Policyholder. We shall, under no circumstance, pay any amount more than the outstanding loan to the Master Policyholder. In case, Benefits other than those mentioned above in this para under Clause 8 (a) of Part D, are chosen by the Member, 100% of such Benefits shall be paid directly to the Claimant other than the Master Policyholder. Where no such authorization is received by Us from the Insured Member or the Master Policyholder does not fall under the above-mentioned regulated entities, We shall pay the entire lumpsum Death Benefit and Additional Accidental Death Benefit (ADB), Accidental Death Benefit covered under Additional Personal Accident Benefit, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any, directly to the Claimant other than the Master Policyholder.

b) **Benefit on Foreclosure of loan** In case of Lender-Borrower Group, in the event where the Insured Member(s) makes a prepayment for closure of the loan to the Master Policyholder or where the lender borrower relationship between an Insured Member and the Master Policyholder comes to an end prior to Coverage End Date (other than due to death of Member), the Insurance Coverage provided to the Insured Member shall continue till the occurrence of covered insured event/s or end of the Coverage Term, whichever is earlier, as per applicable Sum Assured specified in the Certificate of Insurance, subject to the Master Policy being In-Force. The Insured Member has the option to terminate his/her Insurance Coverage at the time of foreclosure of loan by applying for Surrender and receive the Unexpired Risk Premium Value (Surrender Value) as per Clause 3 of this Part D.

c) In case of Lender-Borrower Group, Benefits payable shall not vary or be otherwise determined by the loan repayments, if any, already made by the Member or the outstanding loan amount, if any, of the Member, at the occurrence of an insured event giving rise to a claim under the Master Policy beyond the extent as provided in Sum Assured Schedule under Certificate of Insurance.

9. Policyholder Covenants (in case of Lender-Borrower Groups)

The Master Policyholder agrees to apply its prescribed norms and procedures for assessing all loan applications and apply its stipulated credit recovery procedures thereon, regardless of whether or not Insurance Coverage is sought on the lives of its borrowers. The Company reserves with it the right to call for the guidelines of Policyholder's credit criteria at any time, and Policyholder shall provide the same to the Company within the time limits if any specified therein. The Policyholder (or any of its affiliated organization / entity) in its capacity as Group Organizer / Group Manager, with whatsoever nomenclature may be, is prohibited from collecting any amount other than the Insurance Premium payable to the Company with regard to the underlying Group Insurance under this Policy.

Policyholder shall collect the duly valid and complete Declaration of Good Health (Evidence of Good Health) along with such other documents as it may require for the purpose of the loan given to the Member. The Policyholder shall preserve and maintain it as an integral part of such loan documentation. The Policyholder shall allow the officers of the Company (including representatives authorized in writing by the Insurer), to inspect and make copies of all/any relevant records for the purposes of this Policy, at reasonable hours on any day. It shall be the duty of the Policyholder to ensure that the Declaration of Good Health is duly filled in and signed by the Member. In case a claim is settled by the Company on a Member's life, which would not have been covered under the Policy due to incomplete Declaration of Good

Health submitted by the Policyholder, then the Policyholder shall indemnify the Company to the extent of the claim amount/payments made on such lives.

10. Termination

a) **Termination of Master Policy:** This Master Policy will terminate on the occurrence of the earliest of the following events:

- i) the date on which We receive a Freelook cancellation request; or
- ii) the Policy in Lapsed Status and has not been revived; or
- iii) the date of payment of the Unexpired Risk Premium Value (Surrender Value) under the Policy;

This Master Policy may be terminated by either You or by Us, by giving 30 days prior written notice. Upon termination of this Policy, no new enrollment forms for the Eligible Members will be accepted by Us. You will not add any new Eligible Member in the Register of Insured Members, from the date of such termination.

b) **Termination of Member's Insurance Coverage under this Master Policy:** An Insured Member's Insurance Coverage under the Policy shall terminate upon the occurrence of the earliest of the following:

- i) the date on which We receive a Freelook cancellation request from the Insured Member (for Non-Employer-Employee Group);
- ii) the date on which We receive a Freelook cancellation request from the Master Policyholder (in case of Employer-Employee group);
- iii) the Insured Member ceases to be an Eligible Member;
- iv) on Coverage End Date;
- v) on termination of Master Policy;
- vi) in case of the death of the Insured Member;
- vii) On payment of Accelerated TI/ Accelerated CI Benefit, where such Benefit is equal to lumpsum Sum Assured under Death Benefit (with no Income Benefit chosen under Death Benefit);
- viii) On expiry of Revival period for Member's Insurance Coverage in Lapsed Status;
- ix) on the date of payment of Unexpired Risk Premium Value (Surrender Value) on Member leaving the scheme before completion of Member Coverage Term;
- x) Member chooses to expressly discontinue the Insurance Coverage when the Master Policy is discontinued.

11. **Loss of Master Policy & Issuance of duplicate Master Policy:** In the event, if the Master Policy Document is lost or destroyed, You may make a written request for a duplicate Master Policy, which We will issue duly endorsed to show that it is in place of the original document, provided that, We receive the fee not exceeding Rs. 250 for issuing the duplicate Master Policy Document. Upon the issue of a duplicate Master Policy Document,

- a) the original one shall cease to have any legal force or effect.
- b) You agree that You shall indemnify and hold Us free and harmless from and against any and all claims, losses, costs expenses, awards, judgements, demands or damages that may arise under or in relation to the original Master Policy document.
- c) You will not be entitled to any free-look period cancellation on duplicate Master Policy document / Certificate of Insurance issued. However, we may permit free-look period cancellation in cases where after investigation, it is evident that You did not receive the original Master Policy document/Certificate of Insurance.

PART – E

All the Applicable Charges, Fund Name, Fund Options, etc. (Applicable especially for ULIP Policies)

- 1) Not Applicable as this is a non-linked product.

PART - F

General Terms and Conditions

- 1) **Fraud, Misstatement and forfeiture:** In case of fraud or misstatement or forfeiture, the Policy shall be treated in accordance with the provisions of Section 45 of the Insurance Act, 1938 as amended from time to time.

[A Leaflet containing the simplified version of the provisions of Section 45 is enclosed as Annexure I for reference]

- 2) **Misstatement of Age:** Subject to Section 45 of the Insurance Act, 1938 as amended from time to time. The Age of the Insured Member has been admitted on the basis of the declaration made by the Insured Member in Membership Form or the details of the Insured Members submitted by Master Policyholder based on which this Policy has been issued. If the Age of the Insured Member is found to be different from that declared, the Company may adjust the Premiums and/or the Benefits under this Policy and/or recover the applicable balance amounts, if any, along with interest thereon, as it deems fit. Insurance Coverage of the Insured Member shall however become void from Risk Commencement Date and We may refund the Premium as per provisions of Section 45 of the Insurance Act ,1938 as amended from time to time, if at any time the Age of the Insured Member is found to be higher than the maximum or lower than the minimum Entry Age that was permissible under this Master Policy at the time of Risk Commencement Date.

- 3) **Assignment:** Assignment should be in accordance with provisions of Section 38 of the Insurance Act 1938 as amended from time to time.

[A Leaflet containing the simplified version of the provisions of Section 38 is enclosed as Annexure II for reference].

- 4) **Nomination:** Nomination should be in accordance with provisions of Section 39 of the Insurance Act 1938 as amended from time to time.

[A Leaflet containing the simplified version of the provisions of Section 39 is enclosed as Annexure III for reference]

- 5) **Review, revision:** The Company reserves the right to review, revise, delete and/ or alter any of the terms and conditions of this Policy, including without limitation the Benefits, the Premiums with the prior approval of IRDAI.

- 6) **Taxes, duties and levies and disclosure of information:**

Taxes, duties and levies: It shall be the sole responsibility of the Master Policyholder/Claimant/Insured Member to ensure compliance with all applicable laws including Regulations, taxation laws, and payment of all applicable taxes in respect of the Premiums and Death Benefits or other payouts made or received by the Master Policyholder/Claimant under this Master Policy and the Company does not accept any liability or responsibility in this regard. Except as may be specifically required by the Regulations, the Company shall not be responsible for any tax liability arising in relation to this Master Policy, the Premiums payable or the Death Benefits or other payouts made in terms of this Master Policy. The Company shall be entitled to deduct such amounts towards taxes, duties or such other levies as may be required from any sum received by it or payable under this Master Policy, and deposit the amount so deducted with the appropriate government or regulatory authorities. Master Policyholder/Claimant/Insured Member acknowledge that they are solely responsible for understanding and complying with their respective tax obligations (including but not limited to, tax payment or filing of returns or other required documentation relating to the payment of all relevant taxes in all jurisdictions in which Your tax obligations arise and relating to the Services provided by Us.

We do not provide any tax advice. Master Policyholder/Claimant/Insured Member is advised to seek independent legal and/or tax advice. We have no responsibility in respect of Master Policyholder/Claimant's/Insured Member tax obligations in any jurisdiction including but not limited to those that relate specifically to the Services provided by Us. Tax benefits, if any, may be available as per extant tax laws.

- 7) **Notice by the Company under the Policy:** We will send you the Master Policy Document in accordance with the applicable laws. We will send the communication or notices to You either in physical at Your registered address or in electronic mode (including sms) at registered e-mail id or registered mobile number and / or through facsimile provided by You in Proposal Form/Membership Form or otherwise notified to Us, or by issuing general notice, including by publishing such notices in newspapers and / or on Company's website. Any change in the registered address /email or registered mobile number of Master Policyholder/Insured Member or Claimant must be notified to Us immediately. This will help Us to serve You better.

- 8) **Electronic Transactions:** All transactions carried out by the Master Policyholder through Internet, electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication will be valid and legally binding on the Master Policyholder / Insured Member / Claimants as well as the Company. This will be subject to the relevant guidelines and terms and conditions as may be made applicable by the Company.

- 9) **Governing Law and Jurisdiction:** This Policy shall be governed by and interpreted in accordance with the laws of India. All actions, suits and proceedings under this Policy shall be subject to the exclusive jurisdiction of the courts in India.

- 10) **Recovery:** We reserve the right to recover the amount from the Master Policyholder or the Insured Member or the Claimant or any other person, if it is found that the Benefits are erroneously paid due to the fault of the Master Policyholder or the Insured Member or the Claimant. However, the Master Policyholder will not be liable or responsible for any wrong payments made by the Company without any fault on the part of the Master Policyholder, however the Company shall be entitled to recover the amount paid erroneously from the Insured Member or any other person deriving the Benefit of the said error.

- 11) **Policy Currency:** All Contributions/Premiums and Benefits payable shall be paid in Indian Rupees only.

- 12) **Suicide Exclusion:**

- a) In case of schemes, where the Insurance Coverage is compulsory, suicide exclusion will not be applicable.

- b) In case of schemes other than those mentioned in 12 (a) above of this Part F, under which Eligible Members are covered on a voluntary basis and where the suicide exclusion clause is applicable, if the Insured Member commits suicide, whether sane or insane, within 12 (Twelve) months of continuous Insurance Coverage from the Risk Commencement Date or date of Revival, as the case may be, the Claimant shall be entitled to get at least 80% of the Total Premiums Paid till the date of death or the Unexpired Risk Premium Value (Surrender Value) available as on the date of death whichever is higher, provided the Policy or Member's Insurance Coverage, as applicable, is In-Force. Suicide exclusion shall not be applicable after 12 months from continuous Insurance Coverage from the Risk Commencement Date or from the date of Revival of Insurance Coverage with respect to Insured Member, while the Master Policy/Insured Member's Insurance Coverage is In Force.
- c) In case of joint life cover, on occurrence of first death due to suicide in the above -mentioned scenarios in Clause 12 (a) and (b), the above-mentioned respective benefits shall be payable to the surviving Member and the Insurance Coverage shall terminate for both the lives.

13) Audit:

In compliance with the Regulatory requirement prescribed under IRDAI Circular on Group Life Insurance Products and other operational matters dated 26/09/2019, as amended from time to time, as per the extant regulations/guidelines/circulars, the Policyholder shall obtain a Certificate of compliance from the Auditor of the group or the Manager of the group on every anniversary date of the Policy and submit the same to the Company at its request. Continuation of such Policy / Insurance Coverage will be subject to such submission of Certificate of compliance by the Policyholder to the Company. Or alternatively, the Company shall conduct the inspection of the books and records of the Policyholder to assess whether they are complying with the relevant IRDAI guidelines and in case of lender-borrower schemes, in regard to the accuracy of the Credit account statements of the Insured Members in respect of which claims were settled on the completion of every financial year in respect of outstanding loan balance being shown in the credit account statement/claim discharge form being correct.

14) Requirements for claims /Claim Procedure: In order to register a claim under the Master Policy, the Claimant shall endeavor to inform Us in writing with the following documents (as applicable) along with bank account details (Cancelled Cheque/copy of pass book with IFSC code) of the Claimant:

a) For Death Claim:

- i) Duly completed Claim Form signed by Claimant.
- ii) KYC document of Insured Member and Claimant
- iii) Appraisal/Promotion Letter in case of Sum assured revision during Member Coverage Term
- iv) In case of mid-term addition, Offer Letter or Appointment Letter
- v) Attested copy of Death Certificate of the Insured Member issued by Indian Government Authority.
- vi) Medical treatment records (discharge summary / death summary, investigation and treatment reports, post mortem report, etc) if Insured Member has taken treatment for illness leading to his/her death.

b) In case of Additional Accidental Death Benefit claim, the following documents need to be submitted, in addition to above requested documents:

- i) Police Records – Attested copy of First Information Report, Panchnama / Inquest Panchnama
- ii) Newspaper cutting/Photograph of the accident, in case of Accidental Deaths.
- iii) Attested Copy of Post Mortem Report (Only if conducted).
- iv) Attested Copy of Viscera report if any (Only if Post Mortem is conducted)

c) For Accelerated Terminal Illness Benefit claim:

- i) Duly completed Claim Form signed by Claimant.
- ii) Medical Report(s) including Investigation report(s), indoor case papers, Hospital Summary/Discharge Card
- iii) Medical Practitioner's Certificate confirming the Illness/Treatment advise/Medical Reference
- iv) KYC document of Claimant

d) For Critical Illness Benefit claim:

- i) Duly completed Claim Form signed by Claimant.
- ii) Medical Report(s)(Current and past) including Investigation test(s), treatment report(s) and indoor case papers
- iii) Hospital Summary/Discharge Card
- iv) Medical Practitioner's Certificate confirming the current health status (Details of diagnosed Illness/Treatment advise)
- v) KYC document of Claimant

e) Additional Documents Specific to Critical Illness Benefit claim (In case of Non-Survival of Insured Member till end of Member Coverage Term):

- i) KYC document of Claimant and Insured Member
- ii) Medical certificate confirming the cause of death (Form 4A)
- iii) Attested copy of Death Certificate of the Insured Member issued by Indian Government Authority.
- iv) Death Summary which confirms the treatment given prior to death and what all conditions led to death (in case of Hospitalization death)
- v) In case of death at home – all the consultation and treatment record prior to death, medical certificate/Attending Physician statement confirming possible reason of death

f) For Accidental Total and Permanent Disability / Accidental Permanent Partial Disablement / Accidental Temporary Total Disablement Benefit Claim:

- i) Claimants Statement For Disability Claim,
- ii) Attested copy of disability certificate from relevant Government Medical authority.
- iii) All investigation reports including Medical Records, Indoor Case papers, Lab tests reports confirming the disability.
- iv) Complete treatment record with follow-up documentation
- v) Attested copy of FIR (if required)
- vi) Discharge summary from the Hospital (if applicable)

- vii) Disability assessment report from Digit empanelled medical specialist (if required)
- viii) KYC document of Claimant
- ix) Additionally in case of Accidental Temporary Total Disablement, leave/absence certificate from the employer (if employed), Medical Practitioner's certificate confirming the Injury and advising rest / unfit to work for specified number of days, fitness certificate issued by the treating doctor.

g) For Multi-Stage Cancer Benefit Claim

- i) Duly completed Claim Form signed by Claimant
- ii) KYC document of the Claimant
- iii) Medical Reports to include initial Diagnosis / findings, investigation reports, further follow-up treatment report, medicine prescriptions from initial treatment till date, any other relevant medical report pertaining to the illness.
- iv) Evidence provided by independent practicing medical consultant acceptable to the Company, should include current health status.
- v) Appropriate Medical records and/or medical test or Investigation reports including, but not limited to, clinical treatment, radiological, histological and laboratory test evidence (e.g., 2D echocardiogram, treadmill test; USG etc.), indoor case papers, discharge summary
- vi) Histopathology Report in case of cancer group claims

h) For Hospitalization due to Accident under Additional PA Benefit / Additional Hospitalization Benefit Claim

- i) Duly completed Claim Form signed by Claimant
- ii) KYC document of Claimant
- iii) Medical and investigation reports, treatment and indoor case papers
- iv) Discharge summary of present and past Hospitalizations
- v) Treating Doctor's certificate
- vi) All follow-up and consultation notes with respect to the Hospitalization
- vii) Attested copy of FIR (if required)

Additionally, wherever applicable, following documents shall be submitted:

- i) Certificate of Insurance
- ii) Credit Account Statement from the lender, in case of claims under lender-borrower schemes

i) For Survival / Maturity Benefit Claim

- i) Discharge Voucher
- ii) KYC document of the Claimant
- iii) Certificate of Insurance, wherever applicable

Notwithstanding anything contained in Clause 14 above of this Part F, depending upon the cause or nature of the claim, the Company reserves the right to call for any other and/or additional documents or information, including documents/information concerning the title of the person claiming the Benefit/(s) under this Master Policy, to the satisfaction of the Company, for processing of the claim.

The claim should be intimated to the Company within a period of 90 days from the date of insured event, to treat the same as a valid claim. However, delay in intimation of claim or submission of documents should be supported by valid reasons for the Company to condone such delay.

15. Claims Intimation

- a) The claim can be notified with proof of claim to the Claims Department' at lifecclaims@godigit.com, and the claim documents to be simultaneously sent at Go Digit Life Insurance Limited, Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095.
- b) Claims can also be intimated at Our Helpline Number – **9960126126/18002962626** and claim documents to be simultaneously sent at Digit Life Office address as mentioned above in (a).
- c) Claim intimation to the Company can also be made in writing and delivered to the nearest branch office or Head Office address, which is currently as:

Claims department

Go Digit Life Insurance Limited

Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095

Helpline Number: **9960126126 /18002962626**

Email id: lifecclaims@godigit.com

Any change in the address or details above will be communicated by the Company to the Master Policyholder.

Our liability under the Master Policy will be automatically discharged on payment to the Claimant.

PART – G

Grievance Redressal Mechanism and Ombudsman Details

1) Contact Information for Complaints & Grievance Redressal

- a) Meet your Grievance Officer at Your nearest Digit Life Branch Office
- b) Write to life@godigit.com from Your registered email address.
- c) Call **9960126126/18002962626** from your registered mobile number.

2) Grievance Escalation Matrix

- a) **Level 1:** In case the complainant is not satisfied with the response, the complainant can escalate the grievance to Chief Grievance Redressal Officer within 8 weeks from date of complaint resolution at lifegro@godigit.com.

Address:

The Chief Grievance Redressal Officer
Go Digit Life Insurance Limited.

Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095

- b) **Level 2:** In case the complainant is not satisfied with the response or does not receive any response from the Chief Grievance Redressal Officer within 15 days, complainant may approach the grievance cell of the Insurance Regulatory and Development Authority of India (IRDAI):

IRDAI Grievance Call Centre (IGCC) Address:

Consumer Affairs Department, Insurance Regulatory and Development Authority of India
Survey No. 115/1, Financial District, Nanakramguda, Gachibowli, Hyderabad
Telangana State – 500032

Toll Free Number: 155255 (or) 1800 4254 732

Timings: 8 AM to 8 PM (Monday to Saturday)

Email: complaints@irdai.gov.in

Website: <https://bimabharosa.irdai.gov.in>

- c) **Level 3**

Manner of making complaints to Insurance Ombudsman: In case the complainant is not satisfied with the decision/resolution of the Company, or does not receive any response from the Company within 30 days of filing the complaint, the complainant may approach the nearest Insurance Ombudsman. Please refer the list of Insurance Ombudsman at the end of this section.

As per the provisions of Rule 13(1) of Insurance Ombudsman Rules, 2017, the Ombudsman shall receive and consider complaints or disputes relating to:

- i) delay in settlement of claims
- ii) any partial or total repudiation of claims
- iii) disputes over premium paid or payable in terms of the policy
- iv) misrepresentation of policy terms and conditions
- v) legal construction of insurance policies in so far as the dispute relates to claim.
- vi) servicing related grievances against insurers, their agents and intermediaries
- vii) issuance of policy not in conformity with Proposal form submitted.
- viii) non-issuance of insurance policy after premium receipt; and
- ix) any other matter resulting from regulatory violation, related to issues mentioned at clauses a. to h.

As per the provisions of Rule 14 of Insurance Ombudsman Rules, 2017:

Rule 14(1), any person who has a grievance against an insurer, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer complained against or the residential address or place of residence of the complainant is located.

Rule 14(2), the complaint shall be in writing, duly signed by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

Rule 14(3), no complaint to the Insurance Ombudsman shall lie unless:

- i) the complainant makes a written representation to the insurer named in the complaint and
 - (1) either the insurer had rejected the complaint; or
 - (2) the complainant had not received any reply within a period of one month after the insurer received his representation; or
 - (3) the complainant is not satisfied with the reply given to him by the insurer
- ii) The complaint is made within one year—
 - (1) after the order of the insurer rejecting the representation is received; or
 - (2) after receipt of decision of the insurer which is not to the satisfaction of the complainant.
 - (3) after expiry of a period of one month from the date of sending the written representation to the insurer if the insurer named fails to furnish reply to the complainant.

Rule 14(4), the Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

Rule 14(5), no complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

List of Insurance Ombudsman Centers

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02 Email: oio.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: oio.bengaluru@cioins.co.in	State of Karnataka
BHOPAL Office of the Insurance Ombudsman,	States of Madhya Pradesh and Chattisgarh.

1st Floor, “Jeevan Shikha” 60-B, Hoshangabad Road, Opp Gayatri Mandir, Arera Hills, Bhopal -462 011. Tel.:- 0755-2769201/2769202/2769203 Email: oio.bhopal@cioins.co.in	
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneshwar-751009. Tel.:- 0674-2596461/2596455/2596429/2596003 Email: oio.bhubaneswar@cioins.co.in	State of Odisha.
CHANDIGARH Office of the Insurance Ombudsman, Jeevan Deep Building, S.C.O., 20-27 Ground Floor, Sector 17-A, Chandigarh-160 017. Tel.:- 0172-2706468 Email: oio.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding Gurugram, Faridabad, Sonapat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai-600 018. Tel.:- 044-24333668 /24333678 Email: oio.chennai@cioins.co.in	State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).
NEW DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi-110 002. Tel.:- 011- 46013992/23213504/23232481 Email: oio.delhi@cioins.co.in	Delhi and following districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.

GUWAHATI Insurance Ombudsman, Office of the Insurance Ombudsman, “Jeevan Nivesh”, 5th Floor, Near Pan Bazar, S.S. Road, Guwahati-781 001 (ASSAM). Tel:- 0361-2632204/2602205/2631307 Email: oio.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, Lane Oppo. Hyundai Showroom A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel : 040-23312122/23376991/23376599/23328709/23325325 Email: oio.hyderabad@cioins.co.in	States of Andhra Pradesh, Telangana and Union Territory of Yanam and a part of the Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II Building, Bhawani Singh Marg, Jaipur – 302005 Tel : 0141-2740363 Email: oio.jaipur@cioins.co.in	State of Rajasthan
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: oio.ernakulam@cioins.co.in	State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata - 700 072. Tel : 033-22124339/22124341	States of West Bengal, Sikkim, Union Territories of Andaman and Nicobar Islands.

Email:- oiio.kolkata@cioins.co.in	
LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazaratganj, Lucknow-226 001. Tel : 0522 - 4002082/ 3500613 Email: oiio.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareilly, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), Mumbai-400 054. Tel : 022 - 69038800/27/29/31/32/33 Email: oiio.mumbai@cioins.co.in	List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumbai.
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Gautam Buddh Nagar, U.P.-201301 Tel.: 0120-2514252 / 2514253 Email:- oiio.noida@cioins.co.in	States of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozabad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna - 800 001. Tel.: 0612 – 2547068 Email:- oiio.patna@cioins.co.in	States of Bihar and 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.: 020-24471175 Email: oiio.pune@cioins.co.in	State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad District and Mumbai Metropolitan Region

THANE Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Near New RTO Office, Louis Wadi, Vasantrao Naik Mahamarg, Thane (West)- 400604 Tel: 022-20812868/69 Email: oio.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T."
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Note: For further information or latest updated list of Ombudsman Office addresses, kindly visit the following website.
<https://www.cioins.co.in/Ombudsman>

IRDAI Notice - Beware of Spurious/Fraud Phone Calls: IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint.

Go Digit Life Insurance Limited. IRDAI Registration number: 165, CIN: U66000PN2021PLC206995, Registered Office: Go Digit Life Insurance Limited, Ananta One (AR One), Pride Hotel Lane, Narveer Tanaji Wadi, City Survey No. 1579, Shivajinagar, Pune-411005; Corporate Office: Go Digit Life Insurance Limited, Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095; Helpline Number **9960126126/18002962626** ; Website: www.godigit.com/life Email: life@godigit.com

ANNEXURE – I

Section 45 – Policy shall not be called in question on the ground of misstatement after three years

Provisions regarding Policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

- 1) No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 years from
 - a) the date of issuance of Policy or
 - b) the date of commencement of risk or
 - c) the date of revival of Policy or
 - d) the date of rider to the Policy,
whichever is later.
- 2) On the ground of fraud, a Policy of Life Insurance may be called in question within 3 years from
 - a) the date of issuance of Policy or
 - b) the date of commencement of risk or
 - c) the date of revival of Policy or
 - d) the date of rider to the Policy
whichever is later.

For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

- 3) Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance Policy:
 - a) The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
 - b) The active concealment of a fact by the insured having knowledge or belief of the fact;
 - c) Any other act fitted to deceive; and
 - d) Any such act or omission as the law specifically declares to be fraudulent.
- 4) Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
- 5) No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / claimant 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 claimant.
- 6) Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which Policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the Policy of life insurance is based.
- 7) In case repudiation is on ground of misstatement and not on fraud, the Premium collected on Policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.
- 8) Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance Policy would have been issued to the insured.
- 9) The insurer can call for proof of age at any time if he is entitled to do so and no Policy shall be deemed to be called in question merely because the terms of the Policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 45 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

ANNEXURE – II

Section 38 – Assignment and Transfer of Insurance Policies:

Provisions regarding assignment or transfer of a Policy in terms of Section 38 of the Insurance Act, 1938, as amended from time to time are as follows:

- 1) This Policy may be transferred/assigned, wholly or in part, with or without consideration.
- 2) An Assignment may be effected in a Policy by an endorsement upon the Policy itself or by a separate instrument under notice to the Insurer.
- 3) The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
- 4) The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
- 5) The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy thereof certified to be correct by both transferor and transferee or their duly authorized agents have been delivered to the insurer.
- 6) Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
- 7) On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
- 8) If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the Policy is being serviced.
- 9) The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
 - a) not bonafide or
 - b) not in the interest of the Policyholder or
 - c) not in public interest or
 - d) is for the purpose of trading of the Insurance Policy.
- 10) Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of Policyholder giving a notice of transfer or assignment.
- 11) In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.
- 12) The priority of claims of persons interested in an insurance Policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.
- 13) Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
 - a) where assignment or transfer is subject to terms and conditions of transfer or assignment OR
 - b) where the transfer or assignment is made upon condition that
 - c) the proceeds under the Policy shall become payable to Policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
 - d) the insured surviving the term of the Policy

Such conditional assignee will not be entitled to obtain a loan on Policy or surrender the Policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

- 14) In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
- shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
 - may institute any proceedings in relation to the Policy
 - obtain loan under the Policy or surrender the Policy without obtaining the consent of the transfer or assignor or making him a party to the proceedings.

- 15) Any rights and remedies of an assignee or transferee of a life insurance Policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act 2015 shall not be affected by this section.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 38 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

ANNEXURE – III

Section 39 – Nomination by Policyholder

Provisions regarding nomination of a Policy in terms of Section 39 of the Insurance Act, 1938, as amended from time to time are as follows:

- 1) The Policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the Policy shall be paid in the event of his death.
- 2) Where the nominee is a minor, the Policyholder may appoint any person to receive the money secured by the Policy in the event of Policyholder's death during the minority of the nominee. The manner of appointment is to be laid down by the insurer.
- 3) Nomination can be made at any time before the vesting of the Policy.
- 4) Nomination may be incorporated in the text of the Policy itself or may be endorsed on the Policy communicated to the insurer and can be registered by the insurer in the records relating to the Policy.
- 5) Nomination can be cancelled or changed at any time before Policy matures, by an endorsement or a further endorsement or a will as the case may be.
- 6) A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bona fide payment is made to the person named in the text of the Policy or in the registered records of the insurer.
- 7) Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.
- 8) On receipt of notice with fee, the insurer should grant a written acknowledgement to the Policyholder of having registered a nomination or cancellation or change thereof.
- 9) A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will get affected to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.
- 10) The right of any creditor to be paid out of the proceeds of any Policy of life insurance shall not be affected by the nomination.
- 11) In case of nomination by Policyholder whose life is insured, if the nominees die before the Policyholder, the proceeds are payable to Policyholder or his heirs or legal representatives or holder of succession certificate.
- 12) In case nominee(s) survive the person whose life is insured, the amount secured by the Policy shall be paid to such survivor(s).
- 13) Where the Policyholder whose life is insured nominates his
 - Parents, or
 - Spouse, or
 - Children, or
 - Spouse, and children
 - or any of them

The nominees are beneficially entitled to the amount payable by the insurer to the Policyholder unless it is proved that the Policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

- 14) If nominee(s) die after the Policyholder but before his share of the amount secured under the Policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
- 15) The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act 2015.
- 16) If Policyholder dies after maturity, but the proceeds and benefit of the Policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the Policy.
- 17) The provisions of Section 39 are not applicable to any life insurance Policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act 2015, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the Policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the Policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 39 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

Annexure IV

Exclusions to Critical Illness (CI) Benefit / Multi-Stage Cancer Benefit

Claim for Critical Illness Benefit shall be accepted subject to Survival Period of 30 days and Waiting Period of 90 days. Claim for

Multi-Stage Cancer Benefit shall be accepted subject to Waiting Period of 90 days.

Notwithstanding anything to the contrary stated herein and in addition to the foregoing exclusions, no Critical Illness Benefit / Multi-Stage Cancer Benefit will be payable if any of the covered conditions under Critical Illness / Multi-Stage Cancer occurs from, or is caused or aggravated, either directly or indirectly by, voluntarily or involuntarily, due to one of the following:

- 1) Congenital Condition: Any external congenital condition or related illness is not covered. In case any Internal congenital condition or related illness is known and was/is being treated, is disclosed at proposal stage and accepted, claims will be processed as per Policy terms and conditions.
- 2) Any covered condition or its signs or symptoms having occurred within the Waiting Period.
- 3) Drug Abuse: Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered independent medical practitioner.
- 4) Pre-existing Disease: means any condition, ailment, Injury or disease:
 - that is/are Diagnosed by a physician within 48 months prior to the effective date of the Insurance Coverage issued by Company or
 - for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Insurance Coverage or its Revival.
- 5) Self-inflicted Injury: Intentional self-inflicted injury by the Insured Member.
- 6) Suicide: If the condition covered under Critical Illness Benefit / Multi-Stage Cancer Benefit was contracted due to attempted suicide.
- 7) Criminal Acts: Insured Member involvement in criminal activities with criminal intent.
- 8) War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
- 9) Nuclear Contamination: Exposure to radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.
- 10) Biological, chemical or radioactive contamination.
- 11) Aviation: Participation by the Insured Member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However, Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.

- 12) Hazardous sports and pastimes: Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
- 13) Any treatment of the donor for the replacement of an organ.
- 14) Unreasonable failure to seek or follow medical advice or treatment by a Medical Practitioner leading to occurrence of the insured event or Member delaying medical treatment in order to circumvent the Waiting Period or other conditions and restrictions applying to this Policy.

Annexure V

Exclusions to Additional Hospitalization Benefit

No Benefits shall be payable with respect to any of the Hospitalization unless the entire period of confinement to Hospital and all the Hospital services rendered and performed there have been recommended by a registered medical practitioner and are in accordance with the diagnosis and treatment of the condition for which Hospitalization was required.

The Company shall not be liable to make any payment if Hospitalization or claims are attributable to, or based on, or arise out of, or are directly or indirectly connected to any of the following:

1. Pre-existing Disease: means any condition, ailment, Injury or disease:

- that is/are Diagnosed by a physician within 48 months prior to the effective date of the Insurance Coverage issued by Company or
- for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Insurance Coverage or its Revival.

2. Hospitalization / treatment within the Waiting Period and Hospitalization / treatment following the diagnosis within the Waiting Period. However, Waiting Period shall not be applicable for Hospitalization due to Accidental Injuries.

3. Hazardous sports and pastimes: Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.

4. Aviation: Participation by the Insured Member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However, Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.

5. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.

6. Criminal Acts: Insured Member involvement in criminal activities with criminal intent.

7. Nuclear Contamination: Exposure to radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature; Biological, chemical or radioactive contamination.

8. Any treatment due to any external congenital conditions.

9. Any dental surgery, extraction of impacted tooth/teeth, orthodontics or orthognathic surgery, or temporo-mandibular joint disorder except as necessitated by an accidental injury;
10. Treatment arising from or traceable to pregnancy which shall include childbirth, infertility, miscarriage, abortion, sterilization and contraception including complications related thereto / treatment to assist reproduction including IVF treatment.
11. Hospitalization primarily for investigatory purpose, diagnosis, X-ray examinations, general physical or routine medical examinations; preventive treatment or medicines, treatments/ examinations specifically for weight management regardless of whether the same is caused by a medical condition; or any treatment or study related to sleep disorder or sleep apnoea syndrome.
12. Convalescence, general debility, custodial, sanitaria, rehabilitation centre, nature care clinics, or respite care or long-term nursing care.
13. Stem cell implantation or surgery, harvesting/storage/any other treatment using stem cells, or any type of hormone replacement therapy.
14. Any form of plastic surgery except to the extent that such surgery is necessary for the treatment of cancer, burns or Accidental Injuries happened during the contract period ;
15. Cosmetic or aesthetic treatments, treatment or surgery for change of life / gender
16. Treatment of xanthelasma, syringoma, acne and alopecia;
17. Circumcision unless necessary for treatment of a disease or necessitated due to an Accident;
18. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health and/ or who has been declared brain dead, as demonstrated by:
- Deep coma and unresponsiveness to all forms of stimulation; or
 - Absent pupillary light reaction; or
 - Absent oculovestibular and corneal reflexes; or
 - Complete apnea
19. Treatment for accidental physical injury or illness caused by violation or attempted breach of the law, or resistance to arrest;
20. Hospitalization and treatment of any kind not actually performed, not necessary or reasonable, or any kind of elective surgery or treatment which is not medically necessary.
21. Any treatment for any sexually transmitted disease (STD), and its related complications (except for HIV / AIDS); treatment of any sexual problem including impotence (irrespective of the cause) and sex changes / gender reassignments or erectile dysfunction.
22. Treatment for or arising from an Injury that is intentionally self-inflicted, including attempted suicide.
23. Hospitalization due to use and abuse of any substance, drug (not prescribed by registered independent medical practitioner) or alcohol or treatment for de-addiction / smoking cessation programs or taking of poison.

24. 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.

25. Treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

26. Routine eye examinations and ear examinations, cochlear implants, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, hair fall treatment & products, and all other similar external appliances and / or devices whether for diagnosis or treatment.

27. Unreasonable failure to seek or follow medical advice or treatment by a Medical Practitioner leading to occurrence of the insured event or Member delaying medical treatment in order to circumvent the Waiting Period or other conditions and restrictions applying to this Policy.

28. Any treatment related to donor screening or treatment including surgery to remove organs of a donor for the replacement of an organ (where Member is donor)

29. Ayurvedic, Homeopathy, Unani, Yoga and naturopathy, Siddha, reflexology, acupuncture, bone-setting, herbalist treatment, hypnotism, Rolfing, massage therapy, aroma therapy or any other treatments other than Allopathy/ western medicines.

30. Hospitalization / any treatment received outside India

31. Treatment for developmental problems including learning difficulties e.g. Dyslexia, behavioral problems

32. The following diseases/surgeries and any complications arising out of them will not be covered during the first two years from the Risk Commencement Date or date of Revival:

- Deviated Nasal Septum/Nasal and Paranasal Sinus Disorders
- Diseases of Tonsils / Adenoids
- Surgery of Thyroid Gland excluding Malignancy
- All types of Hernia
- Hydrocele / Varicocele / Spermatocele
- Piles / Fissure / Fistula-in-Ano / Rectal Prolapse
- Benign Prostatic Hypertrophy
- Menstrual Irregularities, Dysfunctional Uterine Bleeding
- Hysterectomy with or without Bilateral Salpingo-oophorectomy excluding Malignancy
- Uterine Fibroid
- Calculus Diseases
- Prolapsed Intervertebral disc
- Retinopathy / Retinal detachment
- Peripheral Vascular Diseases due to diabetes / diabetic foot
- Renal failure due to diabetes
- Osteoporosis / Pathological Fracture
- Cataract
- Joint replacements except due to an accident (one knee or one hip replacement in a Coverage Year)
- Congenital Internal Disease or Anomalies or Disorder

Annexure VI

Exclusions to Additional Accidental Death Benefit (ADB)

No ADB Benefit will be payable on death of the Insured Member occurring directly or indirectly as a result of any of the following:

1. Infection: Death caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
2. Intentional self-inflicted injury, attempted suicide / suicide while sane or insane.
3. Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered independent medical practitioner.
4. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
5. Participation by the Insured Member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
6. Participation by the Insured Member in a criminal or unlawful act with criminal intent.
7. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
8. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.
9. Biological, chemical and radioactive contamination.

Annexure VII

Exclusions to Additional Accidental Total and Permanent Disability (ATPD) Benefit

No ATPD benefit will be payable, if ATPD to Insured Member is occurring directly or indirectly as a result of any of the following:

1. Infection: ATPD caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
2. Intentional self-inflicted injury, attempted suicide while sane or insane.
3. Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
4. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
5. Participation by the Insured Member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
6. Participation by the Insured Member in a criminal or unlawful act with criminal intent.
7. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
8. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.
9. Biological, chemical and radioactive contamination.

Annexure VIII

Exclusions to Additional Personal Accident Benefit

No Benefit under Additional Personal Accident Benefit shall be payable, if insured events under this Benefit occur directly or indirectly as a result of any of the following:

1. Infection : Insured events under Additional Personal Accident Benefit caused or contributed to by any infection except, infection caused by an external visible wound accidentally sustained.
2. Intentional self-inflicted injury, suicide / attempted suicide while sane or insane.
3. Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
4. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
5. Participation by the Insured Member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However, Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
6. Participation by the Insured Member in a criminal or unlawful act with criminal intent.
7. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
8. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.
9. Biological, chemical and radioactive contamination.
10. Hospitalization for treatment of accidental injuries which does not warrant Hospitalization, Domiciliary Hospitalization and OPD treatment are excluded.
11. Hospitalization / Treatment taken outside the geographical limits of India shall be excluded.
12. Hospitalization primarily for diagnostics and evaluation purpose.

Annexure IX

Wellness Benefit Program

Below listed Benefits will be made available under Wellness Benefit Program

1) Doctor on Call

Upon Insured Member's request, we will facilitate an appointment, through our empaneled Service Provider, with a Medical Practitioner who can help Insured Member by providing round-the-clock medical helpline services through an online portal as a chat service, a call back service or a voice call service or a video call service.

2) Wellness Coach

In order to educate, empower and engage Insured Member to become more aware of his/her health and proactively manage it, We will, through periodic communications like e-mailers, blogs, videos, webinar and online platform provide him/her information on wellness coaching including but not limited to the areas as provided below:

- a) Weight Management
- b) Activity and Fitness
- c) Nutrition
- d) Tobacco Cessation
- e) Alcohol Abuse de-addiction Program
- f) Information on various diseases
- g) Dietary Plans

3) Lab Services and Imaging (For Diagnostic Services)

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc or imaging for further testing and analysis. The cost of these tests and reports will have to be borne by the Insured Member.

4) Pharmacy (Home Delivery)

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner and nutritional supplement from the nearby Network Pharmacy, subject to copy of prescription being shared (where ever required) and availability of the medication with the Pharmacy.

The cost of the medication will have to be borne by the Insured Member.

5) Vital/Physical Activity Monitoring Services

Upon member's request, We will facilitate, through Our Empanelled Service Provider, the integration of his/her Health Device(s), or Digital Wearables or trackers such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, heart rate monitors, pulse oximeters, non-invasive wearable blood-sugar sensors, Smart Watches etc. to an online database that will track and assess his/her vitals as reported by the device. It can provide periodic updates and reports of Insured Member's health status. The cost of the device will have to be borne by the Insured Member.

6) Reminder Notifications

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to the Insured Member as a reminder to schedule his/her medical appointments and/or take daily dosage of his/her medicine as per the information shared by the him/her.

7) Medical Wallet

Upon Insured Member's request, We will arrange, through Our Empanelled Service Provider, for a medical wallet. This will be a digital cloud service which will allow the Insured Member to store all his/her medical reports online. It will provide easy access of Medical history and reports to the treating Medical Practitioners and to any other person with whom he/she may share the login and access codes, easing his/her need to physically carry documents with himself/herself.

8) Report Aggregation

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of his/her health status as per the medical records/reports/information or data shared by him/her. It will highlight his/her wellbeing or any areas of concern or deterioration in his/her health, allowing him/her to take necessary calls about his/her health.

9) Home Care Services

Upon Insured Member's request, We will facilitate, through our Empaneled Service Provider, Home Care Services for him/her in case he/she are in need of services, including but not limited to the following:

- a) Home Care Nursing
- b) Patient Assistant
- c) Physiotherapy
- d) Yoga Trainer
- e) Psychologist
- f) Palliative Care
- g) Renting Medical Equipment. For Example – Wheelchair, Patient Bed, Oxygen Cylinder etc.
- h) Doctor Visit
- i) Elderly care and senior living assistance related to their health conditions.

The cost of the Services/Equipment will have to be borne by the Insured Member.

10) Ambulance Arrangement Services

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, ambulance services for his/her transportation subject to availability of ambulance in the area where such service needs to be arranged. The cost of the transportation will have to be borne by the insured member.

11) Pick up and drop services for consultation

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, Pick-up and Drop Service, for his/her transportation to the Health Care Facility for treatment/Diagnostics subject to availability of vehicle/taxi in the area where such service needs to be arranged. The cost of the transportation will have to be borne by Insured Member.

12) Prioritizing Appointments

Upon Insured Member's request, We will facilitate through Our Empanelled Service Provider, prioritization of his/her appointment, based on the urgency, with the Network Providers offering the necessary consultation/ treatment/ diagnostics/ packages/ memberships/ risk assessment/ procedures subject to availability of the service(s). The cost of the Consultancy/Diagnostic will have to be borne by the Insured Member. These may include the following but not limited to:

- a) Doctor's services
- b) Nursing services
- c) Dietitian services

13) Mental wellbeing

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, self- assessments, therapy sessions, activities and educational/awareness blogs, videos and webinars. The cost of these sessions will have to be borne by the Insured Member.

14) Physiotherapy

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, consultation and treatment sessions/packages, pain management sessions, ergonomics sessions. The cost of these services will have to be borne by the Insured Member.

15) Childcare/Children's activities

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, recreational/developmental activities for children of different age groups. The cost of these services will have to be borne by the Insured Member.

16) Out-Patient (OPD) Services

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, outpatient care services like doctor consultation, pharmacy and diagnostics, both online and onsite. The cost of these services will have to be borne by the Insured Member.

17) Fitness

Upon Insured Member's request, we will facilitate, through our empanelled service provider, access to membership or classes of fitness activities like but not limited to sports, yoga, Zumba, Pilates, dance, fitness coach services at gymnasiums, health studios, fitness centres, sports centres and playgrounds. The cost of these services will have to be borne by the Insured Member.

Terms and Conditions applicable to Wellness Benefit Program

1) Any Information provided by the Insured Member shall be kept confidential.

2) For services which are provided through Our Empanelled Service Provider/Medical Experts/Centres, We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services. We will not charge any premium amount for the services. Insured Member needs to pay directly to the Service Provider/Medical Experts/Centres for the services availed.

3) All medical services are being provided by Empanelled Service Provider/Medical Experts/Centres who are empanelled after full due diligence. Insured Member may however consult their Personal/Family Doctor before availing the medical services. The decisions to utilise the services will solely be at the discretion of the Insured Member.

4) We or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured Member may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.

5) This shall not be deemed to substitute the Insured Member's visit or consultation to an Independent Medical Practitioner. The Insured Member is free to choose whether or not to undergo the same and if done whether or not to act on it.

6) We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

DISCLOSURES

1. The Combi Product is jointly offered by “Universal Sompo General Insurance Company Limited and “Go Digit Life Insurance Limited”. The underlying Health Insurance Product in Combi Product is Group Health Insurance Policy (UIN: UNIHLGP26043V062526) offered by Universal Sompo General Insurance Company Limited and it makes the health insurance component of the Combi Product. The underlying Life Insurance Product in Combi Product is Digit Life Group Long Term Plan (UIN: 165N002V01) offered by Go Digit Life Insurance Limited and it makes the life insurance component of the Combi Product.
2. You will receive the policy benefits as applicable for the two components of the Combi Product as per the standard terms & conditions of the respective underlying products.
3. The risks under the components of the Combi Product are distinct. Go Digit Life Insurance Limited shall assume/accept the risk only in relation to the life insurance component of the Combi Product and Universal Sompo General Insurance Company Limited shall assume/accept the risk only in relation to the health insurance component of the Combi Product.
4. The premium of the life insurance and health insurance components of the Combi Product are separate and have been separately identified and disclosed in the Combi Product policy document. The health insurance component of the Combi Product is entitled to be renewed at the option of the policyholder of Universal Sompo General Insurance Company Limited.
5. You shall pay the integrated premium for the Combi Product to either of Universal Sompo General Insurance Company Limited or Go Digit Life Insurance Limited. The insurer receiving the consolidated premium shall further transfer the relevant share of the premium to the other insurer. You shall be entitled to the underlying benefits of both life and health insurance components of the Combi Product from the date and time of acceptance of the integrated premium by Universal Sompo General Insurance Company Limited or Go Digit Life Insurance Limited.
6. The Combi Product shall have a free look option, which shall be applied to the Combi Product as a whole. Provided where an existing policyholder of any health insurance product has migrated to the Combi Product, such policyholder is entitled to all the rights of migration as per the applicable portability norms.
7. At any time during the validity of the Combi Product policy, you shall be entitled to continue with either part of the Combi Product policy, discontinuing the other.
8. The liability to settle the claim vests with respective Insurers, i.e., for life insurance benefits, Go Digit Life Insurance Limited and for health insurance benefits, Universal Sompo General Insurance Company Limited.
9. All policy servicing requests pertaining to the Combi Product shall be received by either of the Insurers. However, Universal Sompo General Insurance Company Limited, as the Lead Insurer of the Combi Product, shall play a facilitative role in policy servicing and shall be the nodal point for receiving the servicing requests, executing these requests and issuing acknowledgements as required.
10. All requests pertaining to the Combi Product impacting premium or policy terms of Health Insurance component shall be serviced by Universal Sompo General Insurance Company Limited. All requests pertaining to the Combi Product impacting premium or policy terms of Life Insurance component shall be serviced by Go Digit Life Insurance Limited.
11. Both Universal Sompo General Insurance Company Limited and Go Digit Life Insurance Limited shall fulfil servicing requests received by them in accordance with the IRDAI

(Protection of Policyholders' Interests) Regulations, 2024, as amended from time to time. Both Universal Sompo General Insurance Company Limited and Go Digit Life Insurance Limited shall be responsible for the pro-active and speedy settlement of claims and other obligations in accordance with the terms and conditions of their respective life insurance or health insurance components of the Combi Product. The claim process is available on the website of both Go Digit Life Insurance Limited and Universal Sompo General Insurance Company Limited.

- 12.** You may lodge a grievance with respect to either or both of the life insurance and health insurance components of the Combi Product at branches of either Universal Sompo General Insurance Company Limited or Go Digit Life Insurance Limited. Complaint belonging to any product shall be routed to the respective insurer viz. Universal Sompo General Insurance Company Limited and Go Digit Life Insurance Limited, who shall then respond/address to the Customer directly. Complaints shall be forwarded by Universal Sompo General Insurance Company Limited and Go Digit Life Insurance Limited to each other for their respective Product. In the event you are not satisfied with the resolution offered, you may also approach the Insurance Ombudsman in your region. Please refer to the relevant grievance redressal mechanism section mentioned under each component of the Combi Product.
- 13.** The legal/quasi legal disputes, if any, are dealt by Universal Sompo General Insurance Company Limited and Go Digit Life Insurance Limited for their respective benefits. The legal disputes pertaining to life insurance benefits shall be dealt with by Go Digit Life Insurance Limited and for health benefits all the legal disputes will be handled by Universal Sompo General Insurance Company Limited.
- 14.** You are to be advised to familiarize yourself with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.
- 15.** Withdrawal of tie up between the Insurers:
Universal Sompo General Insurance Company Limited or Go Digit Life Insurance Limited may terminate this tie up between them after obtaining the requisite approval from the IRDAI. Upon receipt of such approval from the IRDAI, Universal Sompo General Insurance Company Limited or Go Digit Life Insurance Limited may terminate this tie up with notice period of ninety (90) days, or such other period as may be prescribed by the IRDAI, from the date of such approval. The insurers may mutually decide to terminate the Agreement and intimate the same to the customer ninety (90) days prior to the termination of the relationship. However, the Policy will continue until the expiry or termination of the coverage in accordance with the policy wordings for respective coverage.
In case of withdrawal of tie-up between insurers, the customer may choose to continue with either of the policies (health or life). However, the same will be subject to Migration guidelines with respect to health part of the combi product.
In the event of termination of this tie up, Universal Sompo General Insurance Company Limited and Go Digit Life Insurance Limited shall mutually cooperate for providing customer support and policy servicing post termination of the tie up between Universal Sompo General Insurance Company Limited and Go Digit Life Insurance Limited. Further, Universal Sompo General Insurance Company Limited or Go Digit Life Insurance Limited, as the case may be, shall remain liable for its respective life insurance or health insurance components for all Combi Product policies in force at the time of termination of this tie up until their expiry.
- 16.** The cashless claim facility under the underlying health product in this Combi product is administered by Universal Sompo General Insurance Company Limited through its in-house claims management team, Health Serve. The updated list of network hospitals eligible for cashless treatment is available on the Company's website at www.universalsompo.com.
- 17.** Certain coverages / benefits are available under both I. the Health Insurance Component as well as under II. the Life Insurance Component of this Combi Product. However, such

coverages / benefits may be opted for under either I or II and shall not be permitted to be opted for under both components simultaneously.