DUAL INSURANCE

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

UIN - UNIHLGP27044V012627

Prospectus

Product Introduction

Universal Sompo General Insurance Company Limited and Go Digit Life Insurance Limited have joined hands together to offer "DUAL INSURANCE", a product having dual benefits of health insurance and life insurance in a single plan. This Policy will provide complete health care to you and your family. Also, this will provide financial protection by providing life insurance coverage to you.

Health Insurance component - Group Health Insurance Policy

1. 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 Ref: IRDAI/Reg/8/202/2024 as amended from time to time. "Group" consists of persons who join together with a commonality of purpose or engaging in a common economic activity and includes employer– employee group and non-employer–employee group:

a. Employer– employee group is a group where an employer-employee relationship exists between the master policyholder and the member in accordance with the applicable laws.

b. Non-Employer– employee group is a group other than employer– employee where a clearly evident relationship between the member and the group policyholder exists for services/activities other than insurance.

2. Eligibility

- Minimum Entry Age: 18 Years
- Maximum Entry Age: No limit (above 65 Years will be Underwriting Discretion)
- Entry Age for Dependent Children- 3 Months to 26 years
- Renewals are available for lifelong.
- Policy offers cover on Individual and Floater Sum Insured basis.
- This policy can be issued to an individual and/or family

a) Family member includes.
   - Self
   - Spouse
   - Dependent Children

- Dependent Parents
- Dependent Parents In Law
- Brother and Sister
- Live In Partner

b) Sum Insured & Benefits
   - Minimum Base Cover Sum Insured of the Policy Rs 5,000
   - Maximum Base Cover Sum Insured of the Policy Rs 1,00,00,000

c) Eligibility Group Size – 07

d) Policy Period:
   - The tenure of the Policy would be 1 year
   - 1 year to maximum 5 years for credit Linked products

3. Coverage

3.a Hospitalization

The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured specified 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 Ambulance [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.

3.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 3.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.

3.a.2. Day Care Procedures

The day care procedures [listed later and forming part of this document as **Day Care Procedures Annexure III of Policy Wording]** 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.

3.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.

3.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.

3.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

3.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 of the Policy wordings'.

3.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 of the Policy Wordings'.

4. Extensions:

Unless otherwise specified or restricted, the Company's liability under these Extensions shall be part of the limit of liability under Section **3.a**

4.1 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.

4.2 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 4.2.[a] and 4.2.[b].

4.3 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 4.3.[a] and 4.3.[b].

4.4 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.

4.5 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

Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics

4.6 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.

4.7 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.

4.8 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.

4.9 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 4.9.[a] and 4.9.[b].

For the purpose of this extension,

i Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

ii 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:

i 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.

ii 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.

4.10 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.

4.11 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 4.9. 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.

4.12 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

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.

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

Subject to terms and conditions of the policy.

4.13. 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.

4.14 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.

4.15 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 4.15

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 4.15

- 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 4.15

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

5. Add-Ons:

Unless otherwise specified, the liability under these add-on sections shall be over and above the limit of liability under 3. Base Cover.

5.1 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:

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

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 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.

(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.

5.2 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 3.a.V.

5.3 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.

5.4 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

5.5 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.

5.6 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.

5.7 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. 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

6. 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.

5.8 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.

5.9 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 5.9 [a] to 5.9.[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 (5.9.[a] / 5.9.[b] and 5.9.[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.

5.9.[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.

5.9.[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

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.

5.9.[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.

5.9.[d]

Contingency Description	Limit/Extent of Benefit

Temporary Total Disablement [TTD]	Per week benefit not exceeding the Capital Sum Insured as mentioned in the Schedule

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 Practioner, 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 Practioner mutually appointed by You and Us.

5.10 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.

5.11 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 '3. Base Cover'. This benefit shall be limited to maximum amount as mentioned in Policy Schedule.

Subject to terms and conditions of the policy.

5.12 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)

5.13 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 4.1. Extensions – PED Waiting Period waiver - will be applicable for payment of benefits under this optional coverage.

Subject to terms and conditions of the policy.

5.14 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.

5.15 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

5.16 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.

5.17 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.

5.18 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.

5.19 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 advices 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.

5.20 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.

5.21 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.

5.22 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.

5.23 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 4.4.12 then the above cover shall not be applicable. Insured person has an option to opt any one of the benefits from "Global Coverage" section 4.4.12 or "Global coverage including Travelling cost, Boarding and Lodging for treatment outside of India" section 5.5.23.
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.

5.24 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.

5.25 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 arising in such regard, 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.

5.26 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 5.5.1 or “Addition of Critical Illness” section 5.5.26.

List of Critical Illnesses		
Sr No	**Particulars**	**Major**
1	**Cancer and blood disorders**	Cancer of Specified severity(Major Cancer)
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		Cardiomyopathy of specified severity
8		Open Chest CABG
9		Open Heart Replacement Or Repair Of Heart Valves
10		Surgery Of Aorta
11		Primary (Idiopathic) Pulmonary Hypertension
12	**Major Organs**	Systemic Lupus Erythematous With Renal Involvement
13		Scleroderma
14		Good Pastures Syndrome With Lung or Renal Involvement
15		Myasthenia Gravis
16		End Stage Lung Failure
17		Kidney Failure Requiring Regular Dialysis
18		Medullary Cystic Kidney Disease
19		Fulminant Hepatitis
20		End Stage Liver Failure
21		Major Organ transplant
22		Chronic Relapsing Pancreatitis
23	**Nervous System**	Stroke Resulting in Permanent Symptoms
24		Permanent Paralysis of Limbs
25		Motor Neuron Disease With Permanent Symptoms
26		Parkinson's Disease
27		Benign Brain Tumor
28		Alzheimer's Disease
29		Multiple Sclerosis with Persisting Symptoms
30		Creutzfeldt-Jakob Disease
31		Muscular Dystrophy
32		Coma of Specified Severity
33		Apallic Syndrome
34		Major Head Trauma
35		Deafness
36		Loss Of Speech
37		Blindness
38		Poliomyelitis
39		Tuberculousis Meningitis
40	**Others**	loss of independent existence
41		loss of limbs
42		Third Degree Burns

5.27 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.

5.28 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.

5.29 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.

5.30 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.

6. BENEFIT RESTRICTION OPTIONS

6.1. Only Accidental Hospitalization Cover

Notwithstanding anything herein to the contrary, the operative clause of the policy and, consequently, coverage under Sections 3.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.

6.2. Only Illness Hospitalization Cover

Notwithstanding anything herein to the contrary, the operative clause of the policy and, consequently, coverage under Sections 3.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.

6.3. Limited Hospitalization Cover

Notwithstanding anything contained herein to the contrary, clauses i] and ii] of Section **3.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.

6.4. 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:

6.4.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)

6.4.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

6.4.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.

6.4.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

6.4.v – Cancer

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

6.4.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 Sugery [surgery concerned with disorders of the musculo-skeletal system – spines, joints and their repair].

Subject to limits, terms and conditions of the policy.

6.4.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.

6.4.viii – Named Illness

The Company shall specify the covered illness as mentioned in the Policy Schedule towards 3.a. Hospitalisation Cover.

6.4.IX - Specified Named Illness

The Company shall specify the named illness & Surgeries as mentioned in the Policy Schedule on benefit basis towards 3.a. Hospitalisation Cover.

6.5. Capped Compensation Cover

It is hereby declared and agreed that illness claims under Section 3.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.

6.6. 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.

6.7. Voluntary Excess

It is hereby declared and agreed that the Insured/Claimant shall bear the first Rs……. of each and every claim under sections 3.a for which the Insured is to be indemnified by this policy

The voluntary excess shall apply per event per insured person.

6.8. 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.

7. 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 (BMl);

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 heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- 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 dioptres 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.

8. General Terms and Conditions:

8.1. 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;

6. 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 policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Insurer shall

a. refund proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

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. lf 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. lf such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an lndian 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. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected. The same is applicable for both Indemnity and Benefit products

4.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.

5. 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.

6. 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 policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected. The same is applicable for both Indemnity and Benefit products.

iii. If the premium is paid in installments during the policy period, coverage will be available during such Grace period.

iv. 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.

v. No interest will be charged If the instalment premium is not paid on due date.

vi. In case of instalment premium due not received within the grace period, the policy will get cancelled.

vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

viii. 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

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.

8.2. 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 ill 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 ill 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.

9. 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 Sompo

Step V: Universal Sompo 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 with in 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:

- **ii** Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
- **iii** 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 financer, 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.

Life Insurance component - Digit Life Group Long Term Plan

No matter what your area of work is, the value that individual members bring to your group cannot be underestimated. While being an important part of the group or organization, your members or employees are also an essential part of their family. It hence becomes your responsibility to ensure financial security for them against death and range of other risks. Any untoward incident can derail the plans a group member has for his / her family and leave them exposed and vulnerable to life's hardships. Wouldn't it be good if an employee or a group member can be given peace of mind by financially securing him or her against such untoward incidents?

Presenting Digit Life Group Long Plan

Digit Life Group Long Term Plan is a non-linked, non-participating, group pure risk premium life insurance plan that provides life insurance cover to insured members and in case of unfortunate event, financially protect their families with death benefit either by paying lumpsum benefit or in form of stream of income or provides combination of both as per the chosen option. This plan also offers a range of inbuilt optional benefits like financial protection against accidental death and disability, critical Illness, multi-stage cancer conditions, terminal illness, hospitalization to create a customized and comprehensive protection solution.

Key Features of the Plan

- Can be offered to both Employer-Employee and Non-Employer-Employee or Affinity groups.
- Provides a high degree of customization and flexibility to create a tailormade solution.
  - Option to choose death benefit as lumpsum or regular income or combination of both basis members' financial needs.
  - Inbuilt optional benefits for financial protection against Terminal Illness, Critical Illnesses, Multi-Stage Cancer conditions, Hospitalization, death and disability due to accident
  - Flexibility to choose single life cover / joint life cover
  - Flexibility to choose coverage type – level cover, decreasing cover, flexi cover
  - Flexibility to choose premium payment options - Single Premium, Limited Premium and Regular Premium payment options
  - Option to pay the premium as per preferred premium payment frequency (Single, monthly, quarterly, half-yearly, or annually)
- Availability of Profit-sharing option to master policyholder
- Wellness benefits to insured members

An individual member will get the choice to opt from the various options made available by the master policyholder under the policy with respect to applicable benefit options, coverage term, coverage options, single or joint life cover, premium payment term, premium payment frequency, sum assured, other applicable options, if any, subject to terms and conditions of the master policy, scheme rules and prevailing underwriting policy of Company.

Eligibility Conditions

Entry Age (as per last birthday)	Minimum - 14 years Maximum - 80 years	
Maturity Age (as per last birthday)	Minimum - 14 years Maximum - 80 years	
Group Size	Minimum - 5 members Maximum - No limit	
Minimum Sum Assured (SA)	Lumpsum Sum Assured per person - ₹10,000 Income Benefit per person (applicable in case of death benefit) - ₹100/month (provided sum total of income payable is not less than ₹10,000)	
	Death Benefit	No Limit (Subject to prevailing underwriting policy of the Company)

Maximum Sum Assured (SA)	Inbuilt Optional Benefits	Terminal Illness Benefit Health Cover Benefit Hospitalization Cover Benefit Accidental Cover Benefit	No Limit (Subject to prevailing underwriting policy of the Company)
	Accelerated Benefits shall not exceed lumpsum sum assured chosen under death benefit		
Policy Term (Coverage Term)	Master policy will continue indefinitely until terminated. At member level, the policy term will be as per Premium Payment Option chosen		
	Premium Payment Option	Term Insurance under death benefit and inbuilt optional benefits	Term Insurance with Return of Premium (TROP) under death benefit
	Single Pay	1 month - 480 months	5 years – 40 years
	Limited Pay	3 months – 480 months	10 years – 40 years
	Regular Pay	2 months – 480 months	10 years – 40 years
	The coverage term at member level up to 3 years for Term insurance under death benefit and inbuilt optional benefits is applicable for lender-borrower schemes only.		
Premium Payment Term	Premium Payment Option	Term Insurance under death benefit and inbuilt optional benefits	Term Insurance with Return of Premium (TROP) under death benefit
	Single Pay	Single Premium Payment	Single Premium Payment
	Limited Pay	2 months – 479 months	5 years – 39 years
	Regular Pay	2 months – 480 months	10 years – 40 years
Premium Payment Frequency	Yearly, Half-Yearly, Quarterly, Monthly for Limited Pay and Regular Pay Single Pay for Single Premium option		

Coverage Term for inbuilt optional benefits can be less than or equal to coverage term for Death Benefit. In case of lender-borrower groups, maximum coverage term is same as outstanding loan term at inception.

What are the Benefits under this Plan?

A. Death Benefit

This is the base benefit and in case of unfortunate demise of the member during the coverage term, Death Benefit is payable to the nominee. Any one of the following death benefit options can be chosen by the member before coverage start date:

- Term Insurance - Death Benefit will be paid in the event of death of the insured member during the member coverage term, provided all premiums are paid as and when due. No survival benefit or maturity benefit shall be payable under this option.

- Term Insurance with Return of Premium (TROP) – Death Benefit will be paid 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 will be returned in lumpsum at the end of such member coverage term.

Death Benefit Payout Options

Master policyholder can choose to offer the members any one or combination of the any of the following death benefit payout
options subject to acceptance by the Company:

a. Lumpsum Sum Assured: Under this option (if chosen), a lumpsum amount will be paid following the death of insured member.
b. Income Benefit: Under this option (if chosen), regular income will be paid for chosen number of years (not exceeding 40 years minus coverage term) following date of member's death.

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 payouts.

In case of income benefit option mentioned above, for presentation purpose, sum assured shall be defined as the total income payable in the next 12 months following the death of insured member

Members of the same master policy can have different lumpsum sum assured amount and income benefit amount. The lumpsum sum assured or income benefit or combination of these two benefits, as chosen for each individual member will be specified on coverage inception date.

On payment of death benefit, insurance coverage for the insured member under this plan will immediately and automatically terminate.

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 member's coverage start date shall be payable. Decreasing and Flexi Cover will not be applicable for income benefit.

B. Inbuilt Optional Benefits -

The master policyholder can choose one or more of the following in-built optional benefits before master policy commencement date subject to Company's acceptance and members can choose from such available options under the master policy, subject to prevailing underwriting policy of the Company and terms and conditions of this master policy. Premium will vary depending upon the inbuilt optional benefit/(s) chosen.

i. Terminal Illness (TI) Benefit

Terminal Illness means an advanced or rapidly progressing incurable and un-correctable medical condition which, in the opinion of two independent Medical Practitioners, chosen by the Company and specializing in treatment of such illness, certify that the illness is expected to lead to death of the member within 6 months of the date of diagnosis of the Terminal Illness.

Accelerated Terminal Illness (TI) Benefit is offered under this benefit, which means payment of this benefit will not be in addition to lumpsum death benefit chosen and it only facilitates an earlier payment of lumpsum death benefit on prior occurrence of terminal illness. Accelerated TI benefit can be opted for when lumpsum death benefit is chosen (either as standalone or in combination with income benefit option). On diagnosis of a terminal illness, an amount equal to the TI Sum Assured will be paid. This benefit is payable only once during the lifetime of a member and shall not exceed lumpsum sum assured under death benefit.

Where the TI Sum Assured is equal to the applicable lumpsum sum assured under Death Benefit and income benefit option is not chosen under death benefit additionally, the insurance coverage for all the benefits, including inbuilt optional benefits (if any) in respect of the insured member will terminate immediately upon diagnosis of terminal illness and payment of accelerated TI benefit. However, if in such case, income benefit option is also chosen additionally, on payment of such accelerated TI benefit, the member's insurance coverage will continue with respect to only income benefit option under death benefit.

Where the TI Sum Assured is less than the applicable lumpsum sum assured under Death Benefit, on payment of the TI sum assured, the applicable lumpsum death benefit will be reduced to the extent of the TI sum assured paid and this change will be effective from the date of payment of accelerated TI benefit. On payment of the accelerated TI benefit, the member's insurance coverage in respect of inbuilt optional benefits (if any) under this master policy will immediately and automatically terminate.

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 member's coverage start date, shall be payable.

ii. Health Cover Benefit

There are three sub-options under Health Cover Benefit. A member can choose only one of these three following sub-options:

a) Accelerated Critical Illness (CI) Benefit

On occurrence of one of the covered Critical Illness Conditions with respect to the insured member, subject to survival period of 30 days and waiting period of 90 days, an amount equal to the Accelerated CI sum assured shall be payable in lumpsum.

This is an accelerated Benefit and it's payment will 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 will

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 will terminate, however, member's insurance coverage shall continue with respect to income benefit under Death Benefit and other applicable 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 will be effective from the date of the payment of the Accelerated Critical Illness Benefit. Such member's insurance coverage under master policy in respect of other applicable inbuilt optional benefits (if any) will 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 member's coverage start date, shall be payable.

b) Additional Critical Illness (CI) Benefit

On occurrence of one of the covered Critical Illness Conditions with respect to the insured member, subject to survival period of 30 days and waiting period of 90 days, an amount equal to the Additional CI sum assured shall be payable in lumpsum.

This is an additional Benefit and on admission of a claim under the Additional CI Benefit, the CI Sum Assured will be payable to the member. 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 applicable Death Benefit and other applicable 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.	**Level Cover**: CI Sum Assured shall be payable. **Decreasing Cover & Flexi Cover:**

		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.	Prevailing CI Sum Assured as per agreed schedule chosen before member's coverage start date, shall be payable.

For both Accelerated CI Benefit and Additional CI Benefit: CI Sum Assured will not be paid on diagnosis of any of the covered critical illness condition 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.

There are following three variants offered under Accelerated and Additional Critical Illness Benefit and any one of them can be chosen by member before inception of insurance coverage.

Variant 1 – 14 Critical Illnesses
Variant 2 – 20 Critical Illnesses
Variant 3 – 34 Critical Illnesses

The Critical Illnesses offered under three variants are as given in the table below:

S.No	Critical Illness Variant			List of Critical Illness Covered
1.	**Variant 1**	**Variant 2**	**Variant 3**	Cancer of Specified Severity
2.				Myocardial Infarction
3.				Open Heart Replacement or Repair of Heart Valves
4.				Surgery to Aorta
5.				Open Chest CABG
6.				End Stage Lung Failure
7.				End Stage Liver Failure
8.				Kidney Failure Requiring Regular Dialysis
9.				Major Organ/ Bone Marrow Transplant
10.				Benign Brain Tumour
11.				Coma of Specified Severity
12.				Major Head Trauma
13.				Permanent Paralysis of Limbs
14.				Multiple Sclerosis with Persisting Symptoms
15.				Primary (Idiopathic) Pulmonary Hypertension
16.				Apallic Syndrome
17.				Stroke Resulting in Permanent Symptoms

18.	[redacted]	Motor Neurone Disease with Permanent Symptoms
19.		Loss of Independent Existence
20.		Aplastic Anaemia
21.		Aneurysm of Abdominal Aorta
22.		Cardiomyopathy
23.		Pulmonary artery graft surgery
24.		Parkinson's Disease
25.		Muscular Dystrophy
26.		Progressive Supranuclear Palsy
27.		Creutzfeldt-Jakob disease (CJD)
28.		Bacterial Meningitis
29.		Alzheimer's disease
30.		Encephalitis
31.		Systemic lupus erythematosus
32.		Goodpasture's syndrome
33.		Fulminant Viral Hepatitis
34.		Pneumonectomy

Definitions and exclusions with respect to Critical Illness Benefit are provided in General Policy Provisions.

c) Additional Multi-Stage Cancer (MSC) Benefit

Multi-stage Cancer (MSC) Benefit is an additional benefit and 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 will be admissible only if the member is diagnosed for the first ever occurrence of any of the listed conditions (provided in General Policy Provisions along with definitions and exclusions). 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 applicable Death Benefit and other applicable 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

iii. Hospitalization Cover Benefit

Under this option, Additional Hospitalization Benefit (HB) shall be offered. 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 his/her coverage start 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.

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 this benefit during the member coverage term, member's insurance coverage for this benefit under the master policy will terminate, however member's insurance coverage will continue in respect of applicable death benefit and other applicable 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	Level Cover – A lumpsum amount equal to 100% of Hospitalization Benefit Sum

		15 (as chosen by Member before member's coverage start date), a lumpsum 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.	Assured shall be payable on each hospitalization. Hospitalization Cover Benefit can be claimed only once in a 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

Exclusions with respect to Hospitalization Cover Benefit are provided in General Policy Provisions.

iv. Accidental Cover Benefit: Following three sub-options shall be offered under this inbuilt optional benefit:

a). Additional Accidental Death Benefit (ADB)

In case of accidental death of insured member, in addition to Death Benefit, an amount equal to the ADB Sum Assured will be paid in lumpsum and on such payment, insurance coverage for the insured member under this plan will terminate.

A claim under this Benefit Option shall be admitted provided that the death:

a. is caused by injury resulting from an accident,
b. occurs solely and directly due to the Injury, and independent of any other causes,
c. occurs within 180 days of the occurrence of accident and
d. is not a result from any of the causes listed in the exclusions for additional Accidental Death Benefit specified in general policy provisions.

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.

This benefit will be paid in following conditions as well:

a. **Disappearance**: 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.

b. **Drowning:** 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.

Additional Accidental Death Benefit payable under different Coverage Options

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

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 member's coverage start date, shall be payable.

Definitions and exclusions with respect to Additional ADB are provided in General Policy Provisions.

b). Additional Accidental Total And Permanent Disability (ATPD) Benefit

Accidental Total and Permanent Disability refers to a disability, which

a) Is caused by bodily injury resulting from an accident; and
b) Occurs solely and directly due to the said bodily injury and shall be independent ofany other cause; and
c) Occurs within 180 days of the occurrence of such accident; and
d) 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 permanentdisability.

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 date of inception of insurance coverage and before the termination/ expiry of the insured member's insurance coverage.

In case, the accident occurs while the insured member's additional ATPD benefit coverage is in force, but the 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 will be payable.

This is an additional benefit and on occurrence of accidental total & permanent disability (ATPD), an amount equal to the ATPD sum assured will be payable in lump sum. On payment of the additional ATPD sum assured, additional ATPD benefit for the member will terminate (in case it was chosen by the member), however the member's insurance coverage will continue for death benefit and all the other inbuilt optional benefits, if chosen, for the remaining member coverage term.

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	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.	**Level Cover** – A lumpsum amount equal to 100% of ATPD Sum Assured shall be payable. **Decreasing & Flexi Cover** – A

(ATPD) Benefit		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.	lumpsum amount equal to 100% of prevailing ATPD Sum Assured as on the date of Accident as per agreed schedule chosen before member's coverage start date shall be payable.

Definitions and exclusions with respect to additional ATPD benefit are provided in General Policy Provisions.

c). Additional Personal Accident Benefit

Personal Accident Benefit is an additional Benefit. Following set of Benefits will be paid 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. This benefit will be paid in following conditions as well: **a. Disappearance**, as defined under Additional Accidental Death Benefit. **b. Drowning** as defined under Additional Accidental Death Benefit.
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 Partial Disablement (APPD)	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 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 Accident	A Daily Hospital Cash Benefit equal to a fixed percentage of PA Sum Assured, which is 1%/2%/3%/4%/5% (as chosen my member before his/her coverage start date) shall 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 will 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, applicable Death Benefit, and all other applicable inbuilt optional benefits, if any, shall continue as applicable.

Definitions and Exclusions with respect to additional PA Benefit are provided in General Policy Provisions.

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 member's coverage start 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

Additional PA Benefit cannot be chosen by the member, in case, either of Additional ADB, Additional ATPD Benefit or Additional Hospitalization Benefit under Hospitalization Cover Benefit is chosen.

On occurrence of 'Disappearance' and 'Drowning' as mentioned under Additional Accidental Death Benefit and Additional Personal Accident Benefit above , Company will only pay, when the claimant provides a legally binding indemnity bond or any other document as required by the Company 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 the Company by the claimant.

Exclusions with respect to Additional Personal Accident Benefit are provided in General Policy Provisions.

C. Other Add-On Options available under the plan

i. Profit sharing: This plan also offers a profit-sharing option wherein in case of favourable 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.

D. Survival / Maturity Benefit

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	On survival of member (survival of both lives in case of joint life cover) till the end of member coverage term, total premiums paid will be returned on completion of such member coverage term.

E. Wellness benefit

We provide wellness benefits to the insured members which 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 Go Digit Life Insurance Limited. The list of benefits under this program and terms and conditions applicable to it are provided in Annexure I.

Other Plan Options

Joint Life Cover Option

- This plan 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 as mentioned above under Death Benefit section. Inbuilt optional benefits, if chosen, shall be payable as mentioned above under inbuilt optional benefits

section 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 or under Additional Personal Accidental Benefit) 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 will 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 or under Additional Personal Accidental Benefit), 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.

Coverage Options under this Plan

Member can choose any one of the following Coverage Options before member's coverage start date, provided they are selected by the Master Policyholder under Master Policy.

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 member's coverage start date shall reduce over the member coverage term as per the agreed schedule chosen before member's coverage start date.
c. Flexi Cover – This option offers a combination of level cover and decreasing cover and shall be subject to agreed schedule chosen before member's coverage start date.

General Policy Provisions:

Digit Simplification: You didn't think you needed to know definitions since your time in school, right? Well, the good news is that you don't need to learn these by heart, as long as you understand them. Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them

Grace Period

A grace period of 15 days in respect of monthly frequency and 30 days in other applicable frequencies from the instalment premium due date will be provided for limited and regular pay policies for paying overdue premium to the Company without any penalty/late fee during which time the benefits under the master policy/insurance coverage of insured member will be considered to be continuing without any interruption as per the terms of the master policy.

If the insured events, as applicable, occurs during the grace period, respective benefit will be paid subject to receipt of unpaid due premium for the master policy in cases, where premium is paid by master policyholder. However, in policies, where premium is paid by the member, the applicable benefit will be paid subject to deduction of unpaid due premium for such 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 the Company for some reason, then the insurance coverage for such member will continue even on expiry of grace period, provided such 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.

Free Look Period:

At Master policy Level

In case the master policyholder does not agree with the terms and conditions of the master policy, the master policyholder has 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 the Company within 30 days from the date of receipt of master policy document. 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, if any and applicable stamp duty. All insured members' coverage will cease post the request for free look cancellation by the master policyholder.

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 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 original Certificate of Insurance, 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, if any and applicable stamp duty for that insured member. The 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.

Lapsation and Reduced Paid-Up Provisions

For regular pay death benefit with Term Insurance option and regular pay inbuilt optional benefits, if at any point of time during the 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. No benefits will be paid 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. For these options, no benefits except for unexpired risk premium value will be paid when insurance coverage is in lapsed status. However, for these benefits mentioned, 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 effective date of coverage
Total Premiums Paid is the total of all the premiums received, excluding any extra premium, any rider premium and taxes.

Surrender Provisions and Benefit payable on Surrender

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 their respective member coverage term, such insurance coverage will continue with the same terms and conditions as the original insurance coverage 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) will be payable on surrender:

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:

<table>
<tr><th>Benefit</th><th>Option / Sub-option</th><th>Level Cover</th><th>Decreasing Cover</th><th>Flexi Cover</th></tr>
<tr><td rowspan="2">Death Benefit</td><td>Lumpsum</td><td rowspan="10">50% x ((Total Premiums paid) – (Total Premiums payable over the Premium Payment Term x Expired Coverage Term in months/Coverage Term in months)))</td><td colspan="2" rowspan="10">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</td></tr>
<tr><td>Income Benefit</td></tr>
<tr><td>Terminal Illness Benefit</td><td>Accelerated Terminal Illness (TI) Benefit</td></tr>
<tr><td rowspan="3">Health Cover Benefit</td><td>Accelerated Critical Illness Benefit</td></tr>
<tr><td>Additional Critical Illness Benefit</td></tr>
<tr><td>Additional Multi-Stage Cancer Benefit</td></tr>
<tr><td>Hospitalization Cover Benefit</td><td>Additional Hospitalization Benefit (HB)</td></tr>
<tr><td rowspan="3">Accidental Cover Benefit</td><td>Additional Accidental Death Benefit (ADB)</td></tr>
<tr><td>Additional Accidental Total and Permanent Disability (ATPD) Benefit</td></tr>
<tr><td>Additional Personal Accident (PA) Benefit</td></tr>
</table>

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 (a), 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).

Revival: The Company will consider requests to revive lapsed / reduced paid-up policies or the member's insurance coverage, as applicable, within five years from the due date of first unpaid premium, provided such requests are received within policy or member coverage term, as applicable. Any agreement to revive the lapsed or reduced paid-up policy/ member's insurance coverage would be subject to Company's prevailing underwriting policy.

The Company shall collect all the premiums due and other charges or late fee if any, as per the terms and conditions of the Policy, to revive the lapsed / reduced paid-up policy or member's coverage term, as applicable.

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.

Policy Loan This policy does not offer loan facility.

Premium payment

In case insurance coverage under any of the inbuilt optional benefits ceases before the completion of member coverage term, though member coverage continues for death benefit and other inbuilt optional benefits, if any, no further premium shall be payable for the remaining premium payment term (if any), for inbuilt optional benefit which has terminated.

Premium Payment Frequency

- The premium may be paid monthly, quarterly, half-yearly or annually in advance for one-year renewable term and regular pay policy.
- For non-annual premium payment frequency, instalment premiums are calculated by applying the loading factor as given below on annual premium:

Premium frequency	Loading factor
Monthly	4%
Quarterly	3%
Half-yearly	2%

Policy changes/alterations:

Addition of members

- New members can join the policy during the year at any well-defined date. Premiums shall be collected in advance for insurance coverage being provided to such members. Any applicable levies, taxes, duties or surcharges will also be charged.
- 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 effective date of coverage for the new joiners shall be the date of joining of the member or the date of intimation whichever is earlier. The Company shall communicate its decision on addition of Member based on its then prevailing underwriting policy. In case of inadequate Premium, the insurance coverage will begin from

the date of receipt of the full premium.

- Company will have right to discontinue addition of new members by giving a notice of 30 days to master policyholder of this effect.

Deletion of Members

- 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 applicable unexpired risk premium value (surrender value) with respect to such members to the master policyholder. Such members' insurance coverage will cease from the date of leaving.
- 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.

In case of Lender-Borrower Schemes

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, Additional Accidental Death Benefit (ADB), Accident Death Benefit covered under Additional Personal Accident Benefit, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any payable on happening of respective insured events. Under no circumstance, we will pay any amount more than the outstanding loan to the master policyholder from these respective benefits. 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.

Benefit on Foreclosure of loan

In case of lender-borrower schemes, 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.

Actively at Work

Subject to prevailing underwriting policy, Company may require that the members covered under the Employer-Employee Scheme are not absent from work for more than 7 days immediately prior to commencement of insurance coverage.

Suicide Exclusion (in case of base death benefit)

- In case of schemes, where the insurance coverage is compulsory, suicide exclusion will not be applicable.

- In case of other schemes, under which members are covered on a voluntary basis and where the suicide exclusion clause is applicable, if the member commits suicide, whether sane or insane, within 12 (Twelve) months of continuous coverage from the date of inception of risk cover or from date of revival, as applicable, the nominee or beneficiary shall be entitled to get at least 80% of the total premiums paid till the date of death or unexpired risk premium value (surrender value) available as on the date of death, whichever is higher, provided such member's insurance coverage is in force.
- In case of joint life cover, on occurrence of first death due to suicide in the above -mentioned scenarios, the respective benefits as mentioned above in two scenarios will be paid to the surviving member and the insurance coverage will terminate for both the lives.

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 referred to in Digit Life Group Long Term Plan, that is, cardiologist, neurologist, consultant neurologist, rheumatologist, nephrologist, pathologist, specialist in respiratory medicine shall be registered Medical Practitioners.

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.

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 effective date of insurance coverage for the member or from the date of revival of 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.

Definitions and Exclusions - Additional Accidental Death Benefit, Additional Accidental Total & Permanent Disability Benefit (ATPD Benefit) and Additional Personal Accident Benefit

"Accident" is defined as "A sudden, unforeseen and involuntary event, caused by external, visible and violent means.

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 (in case of Additional Accidental Death Benefit) and within 12 months (in case of Accidental Death under Additional Personal Accident Benefit) of the occurrence of the Accident, 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 start of insurance cover and before the termination/ expiry of the insured member's insurance cover.

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

Exclusions to additional Accidental Death Benefit (ADB) and additional Accidental Total and Permanent Disability (ATPD) Benefit

No ADB benefit will be payable on death of the insured member or no ATPD benefit will be payable on occurrence of total and permanent disability to the insured member which happens directly or indirectly as a result of any of the following:

1) Infection: Death or ATPD 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 or radioactive contamination.

Exclusions to additional Personal Accident (PA) 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.

Critical Illness Benefit and Multi-Stage Cancer Benefit – Definitions and Exclusions

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) under the master policy. Survival period is not applicable for Additional Multi-Stage Cancer Benefit.

Critical Illness (CI) Condition means the first diagnosis of any of the covered Critical Illnesses or undergoing any surgery explained and defined below:

1. 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 –

- 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.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- 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
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
- 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)

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:
   - A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   - New characteristic electrocardiogram changes
   - Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   - Other acute Coronary Syndromes
   - Any type of angina pectoris
   - 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**

I. 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.

II. Catheter based techniques including but not limited to balloon valvotomy/valvuloplasty are excluded.

4. **PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION**

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

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

   - Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   - Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary

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

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

II. The following are excluded:

- Angioplasty and/or any other intra-arterial procedures

6. END STAGE LUNG FAILURE

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

- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
- Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
- Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
- Dyspnoea at rest.

7. END STAGE LIVER FAILURE

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

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

8. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

9. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:
- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner

II. The following are excluded:
- Other stem-cell transplants
- Where only Islets of Langerhans are transplanted

10. 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.

- Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least

90 consecutive days or
- Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:
- Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

11. 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:
- no response to external stimuli continuously for at least 96 hours;
- life support measures are necessary to sustain life; and
- permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

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

12. MAJOR HEAD TRAUMA

I. 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.

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

III. The Activities of Daily Living are:
- 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;
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
- Mobility: the ability to move indoors from room to room on level surfaces;
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:
- Spinal cord injury;

13. PERMANENT PARALYSIS OF LIMBS

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

14. 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 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.

II. The following are excluded:
- Transient ischemic attacks (TIA)
- Traumatic injury of the brain

- Vascular disease affecting only the eye or optic nerve or vestibular functions.

15. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

16. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   - investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   - there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

Specific Definitions:

17. SURGERY TO AORTA

I. 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.

18. ABDOMINAL AORTA ANEURYSM

I. 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.
   - 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.
   - Congenital conditions are excluded

19. CARDIOMYOPATHY

I. 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.

II. The following conditions are excluded:
   - Cardiomyopathy secondary to alcohol or drug abuse.
   - All other forms of heart disease, heart enlargement and myocarditis.

20. PULMONARY ARTERY GRAFT SURGERY:

I. 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.

21. APALLIC SYNDROME

I. 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.

22. PARKINSON'S DISEASE

I. The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to Us.

II. The diagnosis must be supported by all of the following conditions:
- the disease cannot be controlled with medication;
- signs of progressive impairment; and
- 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.

III. Parkinson's Disease secondary to drug and/or alcohol abuse is excluded.

23. MUSCULAR DYSTROPHY

I. 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:
- Family history of muscular dystrophy;
- Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
- Characteristic electromyogram; or
- Clinical suspicion confirmed by muscle biopsy.

II. 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:

- Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means
- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- Transferring: The ability to move from a bed to an upright chair or wheel chair and vice versa;
- Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- Feeding: the ability to feed oneself, once food has been prepared and made available.
- Mobility: The ability to move indoors from room to room on level surfaces

24. PROGRESSIVE SUPRANUCLEAR PALSY:

I. 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.

25. CREUTZFELDT-JAKOB DISEASE (CJD)

I. 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.

II. Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.

III. Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

26. BACTERIAL MENINGITIS

I. 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.

II. This diagnosis must be confirmed by:
- The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
- A consultant neurologist certifying the diagnosis of bacterial meningitis.

27. ALZHEIMER'S DISEASE

I. 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.

II. 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

III. The following conditions are however not covered:
- non-organic diseases such as neurosis and psychiatric Illnesses;
- alcohol related brain damage; and
- any other type of irreversible organic disorder/dementia.

28. ENCEPHALITIS

I. 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)

II. The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.

29. LOSS OF INDEPENDENT EXISTENCE

I. 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 .

30. SYSTEMIC LUPUS ERYTHEMATOUS

I. 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:

II. The WHO lupus classification is as follows:
- Class I: Minimal change – Negative, normal urine.
- Class II: Mesangial – Moderate proteinuria, active sediment.
- Class III: Focal Segmental – Proteinuria, active sediment.
- Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
- Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

31. GOODPASTURE`S SYNDROME

I. 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 atleast 30 Days. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (*Rheumatologist or Nephrologist*).

32. FULMINANT HEPATITIS

I. A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure.

II. This diagnosis must be supported by all of the following:
- Rapid decreasing of liver size;
- Necrosis involving entire lobules, leaving only a collapsed reticular framework;
- Rapid deterioration of liver function tests;
- Deepening jaundice; and
- Hepatic encephalopathy.

III. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

33. PNEUMONECTOMY

I. 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.

II. The following conditions are excluded:
- Removal of a lobe of the lungs (lobectomy)
- Lung resection or incision

34. APLASTIC ANAEMIA

I. Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:
- Blood product transfusion;
- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

II. The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:
- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

Additional Multi-Stage Cancer Conditions - Definitions and Exclusions

Multi-Stage Cancer Conditions means first diagnosis of any of the covered minor or major conditions under Additional Multi-Stage Cancer Benefit. 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)

- 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.
- The diagnosis of Carcinoma-in-Situ must always be supported by a histopathological report.
- 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.
- 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.
- 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.

- All CIS of skin are specifically excluded.
- 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

- 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 are 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 (1) under Critical Illness conditions

Accelerated / Additional Critical Illness Benefit and Additional Multi-Stage Cancer Benefit – General Exclusions

Claim for Critical Illness Benefit will be accepted subject to survival period of 30 days and waiting period of 90 days. Claim for Additional Multi-Stage Cancer Benefit will be accepted subject to waiting period of 90 days. Waiting period shall not be applicable if critical illness condition manifests due to an accident.

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.

Additional Hospitalization Benefit – General Exclusions

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 tempero-

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) Articial 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 re-exes; or
    - Complete apnea

19) Treatment for accidental physical injury or illness caused by violation or attempted beach 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 / Pathologiocal 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

Nomination Provisions: The nomination shall be subject to Section 39 of the Insurance Act, 1938, as amended from time to time.

Assignment Provisions: Assignment shall be as per the provisions of Section 38 of the Insurance Act, 1938 as amended from time to time.

Section 41: Prohibition of Rebate: Under the provisions of Section 41 of the Insurance Act, 1938 as amended from time to time

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

2. Any person making default in complying with the provisions of this section shall be punishable with fine which may extend to ten lakh rupees.

Section 45 of the Insurance Act, 1938 as amended from time to time

Fraud, misstatement and forfeiture would be dealt with in accordance with provisions of Sec 45 of the Insurance Act 1938 as amended from time to time. For provisions of this Section, please contact the Insurance Company or refer to the policy contract of this product.

***Please Note**: In the event of any inconsistency or contradiction between the sales brochure and policy terms & conditions, the terms and conditions contained in the policy will prevail.*

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 – 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 empanelled 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 Empanelled 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 - Wheel-Chair, Patient Bed, Oxygen Cylinder etc.
h. Doctor Visit
i. Elderly care and senior living assistance related to their health condition

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 :-

- Doctors' services
- Nursing services
- 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.

Annexure II – Grievance Redressal Mechanism

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. For latest updated list of Ombudsman Office addresses, kindly visit this website https://www.cioins.co.in/Ombudsman

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.

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.