RAHEJA QBE
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Group Loan Insurance
Policy Wordings

A. Preamble

This is a legal contract between the Company and the Policyholder which is subject to realization of full premium in advance by Us and the terms, conditions and exclusions to this Policy. This Policy has been issued on the basis of Disclosure to Information Norm, including the information provided by the Policyholder in respect of the Insured Persons in the Proposal and the Policy Schedule/Certificate of Insurance.

The Policy, the Schedule, the Certificate of Insurance and any Endorsement(s) shall be read together and any word or expression to which a specific meaning has been attached in any part of this Policy or of Schedule shall bear such meaning whenever it may appear.

B. Definitions

The following words or terms shall have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine shall include references to the plural and to the feminine wherever the context so permits:

1. **Accident/Accidental** means sudden unforeseen and involuntary event caused by external, visible and violent means.
2. **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 and maintain an adequate level of cleanliness and personal hygiene.
   - 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 lying position in a bed to a sitting position in an upright chair or wheelchair 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, food from a plate or bowl to the mouth once food has been prepared and made available.
   - Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.
3. **Adventure Activities/ sports** means any activity which involves high level of inherent danger to the Insured Person, whether he/she is trained in such sport or activity, or not. These activities/ sports may involve speed, height, high level of physical exertion and/or require highly specialized gear. These may include action sports, speed contest or racing (other than on foot) or horseback, big game hunting, mountaineering or rock-climbing necessitating the use of guides or ropes, pot holing, winter sports, skiing, ice hockey, Parachuting, ballooning, skydiving, hang gliding, scuba diving, Riding or Driving in races or rallies, hunting or equestrian activities, or other under water activities, river rafting or canoeing involving white water rapids, yachting or boating outside coastal waters (2 miles), polo, paragliding, parasailing, bungee jumping, base jumping, hand gliding, ski jumping, abseiling, deep sea diving using hard helmet and breathing apparatus, adventure racing on water, snorkeling, kayaking, surfing and other snow and ice sports and activities of similar type.
4. **Age** or Aged means the completed years as at the Commencement Date of the Policy Period.
5. **AYUSH Treatment** - “AYUSH treatment” refers to the medical and / or hospitalization

treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

6. **Bank** means a banking company which transacts the business of banking in India or abroad.
7. **Beneficiary** in case of death of the Insured Person, the Beneficiary means, unless stipulated otherwise by the Insured Person, the surviving Spouse of the Insured Person, mentally capable and not divorced, followed by the children recognized or adopted, followed by the Insured Person's legal heirs. For all other benefits, the Beneficiary means the Insured Person himself unless stipulated otherwise.
8. **Break in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
9. **Compensation** means Sum Insured, Total Sum Insured or percentage of the Sum Insured, as appropriate and mentioned in Policy Schedule/Certificate of Insurance.
10. **Commencement Date** means the commencement date of this Policy as specified in the Policy Schedule/Certificate of Insurance.
11. **Condition Precedent** means a policy term or condition upon which the insurer's liability under the policy is conditional upon.
12. **Congenital Anomaly** refers to a condition which is present since birth, and which is abnormal with reference to form, structure or position.

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

13. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:
    a. has qualified nursing staff under its employment;
    b. has qualified medical practitioner/s in charge;
    c. has fully equipped operation theatre of its own where surgical procedures are carried out;
    d. maintains daily records of patients and will make these accessible to the insurance company's
    e. authorized personnel.
14. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    a. undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hours because of technological advancement, and
    b. which would have otherwise required hospitalization of more than 24 hours
    c. Treatment normally undertaken on an out-patient basis is not included in the scope of this definition
15. **Disclosure to information** norm means 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.
16. **Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
17. **EMI or EMI Amount** means and includes the amount of monthly payment required to repay the principal amount of Loan and/or interest by the Insured Person as set forth in the amortization chart referred to in the loan agreement (or any amendments thereto)

between the Bank/Financial Institution and the Insured Person prior to the date of occurrence of the Insured Event under this Policy. For the purpose of avoidance of doubt, it is clarified that any monthly payments including additional interest thereon that are overdue and unpaid by the Insured Person prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured.

18. **Financial Institution** shall have the same meaning assigned to the term as per the Reserve Bank of India Act, 1934 and shall include a Non-Banking Financial Company as defined under section 45 I of the Reserve Bank of India Act, 1934.
19. **Grace period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits pertaining to all the credits (Sum Insured, No claim bonus, Specific waiting periods and waiting period for pre-existing diseases, moratorium period, etc.) accrued under the policy. Coverage will not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.
    Provided we shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
20. **Hospital** means any institution established for in-patient care and day care treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration& Regulation) Act 2010 or under enactments specified under the Schedule of Section 56 (1) and the said act Or compliance with all minimum criteria as under
    a. has qualified nursing staff under its employment round the clock;
    b. has at least 10 inpatient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    c. has qualified medical practitioner(s) in charge round the clock;
    d. has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e. maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel
21. **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.
22. **Illness** means a sickness, or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
    a. Acute Condition - is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.
    b. Chronic Condition - is defined as a disease, illness, or injury that has one or more of the following characteristics:
        i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
        ii. it needs ongoing or long-term control or relief of symptoms
        iii. it requires your rehabilitation for the patient or for the patient to be specially trained to cope with it
        iv. it continues indefinitely
        v. it recurs or is likely to recur.
23. **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

24. **Insured Person** means the member named in the Policy Schedule/Certificate, who is/are covered under this Policy, for whom the insurance is proposed, and the appropriate premium received and realized.
25. **Insured Event** means any event specifically mentioned as covered under this Policy.
26. **Insurer** means Us/Our/We/Raheja QBE General Insurance Company Limited.
27. **Injury** means Accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.
28. **Loan/Credit** means the sum of money lent at interest or otherwise to the Insured Person by any Bank/Financial Institution as identified by the Loan Account Number(s) or any such identification number.
29. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
30. **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.
31. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    a. is required for the medical management of the illness or injury suffered by the insured;
    b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity.
    c. must have been prescribed by a medical practitioner.
    d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
32. **Nominee** means the person(s) named in the Policy Schedule / Certificate who is nominated to receive the benefits in respect of an Insured person under the Policy in accordance with the terms and conditions of Policy, if the Insured Person is deceased.
33. **Notification of claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
34. **OPD Treatment** means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
35. **Permanent Total Disablement** means disablement as a result of bodily Injury, which –
    a. continues for a period of twelve (12) months, and
    b. is confirmed as total, continuous and permanent by a Physician after twelve (12) consecutive months, and
    c. entirely prevents an Insured Person from engaging in or giving attention to gainful occupation of any and every kind for the remainder of his/her life.
36. The physical separation means separation of limbs, at or above the wrist or ankle level limbs as a result of injury or disease.
37. **Pre-existing Disease** means any condition, ailment, injury or disease:
    a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement or
    b. For which medical advice or treatment was recommended by, or received from, a physician within 36 months prior to the effective date of the policy of the policy issued or its reinstatement.
38. **Principal Outstanding** means the principal amount of the Loan outstanding as on the date of occurrence of the Insured Event less the portion of principal component included in the EMIs payable but not paid from the date of the loan agreement till the date of the

Insured Event/s. For the purpose of avoidance of doubt, it is clarified that any EMIs including additional interest thereon that are overdue and unpaid to the Bank/Financial Institution prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured Person.

39. **Policy** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person
40. **Policy Schedule / Certificate of Insurance** means document issued by Us, which certifies that an insurance policy has been bought and shows an abstract of the most important provisions of the insurance contract forming part of the original Policy.
41. **Policy Period** means the period commencing with the commencement date of the Policy & terminating with the expiry date of the Policy as stated in the Policy Schedule / Certificate of Insurance.
42. **Policyholder** means the entity or person named as such in the Policy Schedule / Certificate of Insurance.
43. **Professional Sports** means a sport, which would remunerate a player in excess of 50% of his or her annual income as a means of their livelihood.
44. **Proposal** means application form or any supporting document(s) which the Insured duly fills in, signs and submits for this insurance to Us.
45. **Proposer** means the person furnishing complete details and information in the Proposal form for availing the benefits either for himself or towards the person to be covered under the Policy and consents to the terms of the contract of insurance by way of signing the same.
46. **Qualified Nurse** is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
47. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time bound exclusions and all waiting periods.
48. **Specific Waiting Periods** means a period up to 36 months from the commencement of a Health Insurance Policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
49. **Sum Insured** means the pre-defined limit specified in the Policy Schedule. Sum Insured and Cumulative Bonus represents the maximum, total and cumulative liability for any and all claims made under the Policy, in respect of that Insured Person (on Individual basis) or all Insured Persons (on Floater basis) during the Policy Year.
50. **Surgery/Surgical Procedure** means manual and/or operative procedures required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or day care center by a Medical Practitioner.
51. **Survival Period** means the benefits under the Policy shall be payable only if the Insured is first diagnosed as suffering from a defined Critical Illness during the Policy Period, and the Insured survives for at least 7 days following such diagnosis.
52. **Waiting Period** means a time-bound exclusion period related to condition(s) specified in the Policy Schedule / Certificate of Insurance which shall be served before a claim related to such condition becomes admissible. The waiting period will be computed from the date of commencement of policy period.
53. **You/Your** means the person(s) named as Insured in the Policy Schedule / Certificate of Insurance.
54. **We/Our/Ours/Us/ Company** means the Raheja QBE General Insurance Company Limited

C. Scope of Cover and Benefits

Section: 1 – Personal Accident

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, general exclusions stated in the Policy, to pay the Sum Insured in relation to the Insured Person as per the option selected and as stated under the Schedule / Certificate of Insurance to this Policy, on occurrence of the Insured Event as stated below:

Insured Event: For the purposes of this Section and the determination of the Company's liability under it, the Insured Event in relation to any Insured Person, shall mean Injury sustained during the Policy Period which shall be the sole and direct cause of a) Death or b) Permanent Total Disablement or c) Permanent Partial Disability, as applicable, as described hereunder.

1.A. COVERAGE

BASE COVER:

1. Accidental Death

If an Insured Person suffers on account of an injury arising out of an Accident, during the Policy Period and this is the sole and direct cause of the Insured Person's death within 12 months of such Injury sustained, then We will pay the Sum Insured as specified in the Schedule.

OPTIONAL ADD-ON BENEFITS UNDER SECTION 1

a. Permanent Total Disability (PTD)

If an Insured Person suffers on account of an injury arising out of an Accident, during the Policy Period and this is the sole and direct cause of his Permanent Total Disability in one of the ways detailed in the table below, within 12 months of occurrence such Injury sustained, then We will pay 100% of the Sum Insured for the benefits listed below.

The Disablement	Compensation Expressed as a Percentage of Sum Insured
1. Permanent Total Loss of Sight in both eyes 100%	100%
2. Permanent Total Loss of both hands above wrist 100%	100%
3. Permanent Total Loss of both feet above ankle 100%	100%
4. Permanent Total Loss of Sight of one eye and one hand	100%

b. Permanent Partial Disablement Benefit (PPD)

In case of Permanent Partial Disability of Insured Person due to an injury arising out of an Accident sustained during the Policy Period resulting in PPD within 12 months of occurrence of such injury, as described below, We will pay the percentage of Sum Insured, as specified below:

Permanent Partial Disablement	Percentage of Sum Insured
Loss of the sight of one eye or the actual loss by physical separation ofone entire hand or one entire foot.	50 %
Use of a hand or a foot without physical separation	50 %
Loss of toes – all	20 %
Loss of toes great – both phalanges	5%
Loss of toes great – one phalanx	2%
Loss of toes other than great, if more than one toe lost: each	2%
Loss of hearing – one ear	30 %
Loss of four fingers and thumb of one hand	50 %
Loss of four fingers of one hand	40 %
Loss of thumb – both phalanges	25 %
Loss of thumb – one phalanx	10 %
Loss of index finger – three phalanges	15 %
Loss of index finger – two phalanges	10 %
Loss of index finger – one phalanx	5%
Loss of middle finger or ring finger or little finger – three phalanges	10 %
Loss of middle finger or ring finger or little finger – two phalanges	7%
Loss of middle finger or ring finger or little finger – one phalanx	3%

Provided that, such disablement shall as a direct consequence thereof permanently disable the Insured person from resuming his normal occupation.

Special Conditions:

In the event of permanent disablement, the Insured will be under obligation to:

i. Have himself / herself examined by the Panel Doctors appointed by the Company and the Company will pay the costs involved thereof

ii. Authorize doctors providing treatment or giving expert opinion and any other authority to supply the Company any information that may be required on the condition of the Insured.

iii. The disablement must be confirmed prior to the expiry of a period of 3 months since occurrence of the disablement.

If the above obligation is not met with due to whatsoever reason, the Company shall be relieved of its liability to compensate under this benefit.

c. Child Education Benefit

If the Insured Person/s suffers Personal Accident - Death or Permanent Total Disablement (if opted) during the Policy Period for which a valid claim has been admitted under the Policy, We will pay, on

receipt of additional premium, towards this child education benefit of the Insured Person(s)' Dependent Child / children up to 10% of the Sum Insured, subject to maximum INR 50,000/-

In case of one child, the benefit payable would be the maximum Sum Insured specified under this option and in the case of more than one child, the benefit will be equally divided subject to maximum of 2 dependent children covered under this benefit.

Note:
The cover under this Policy, for the specific Insured Person, shall terminate in the event of claim in respect of that Insured Person becoming admissible and accepted by the Company under Section 1 of Death and / or Permanent Total Disablement (if opted).

1.B. CLAIMS SETTLEMENT PROCESS (APPLICABLE TO SECTION.1. PERSONAL ACCIDENT)

i. In the event of a claim arising out of an Insured Event covered under this Section, the Insured Event as described above shall be intimated to the Company as soon as possible but not later than 30 days from the date of its occurrence. However, the Company may condone the delay on merits of the claim subject to getting satisfied that the delay in notification was due to reasons beyond the control of the Insured Person/Nominee.
ii. The Insured Person/Nominee shall deliver to the Company, within 30 days of the date of occurrence of the Insured Event, a detailed statement in writing as per the claim form and any other material particular, relevant to the making of such claim.
iii. The Insured Person/Nominee shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.
iv. Proof satisfactory to the Company shall be furnished in connection with all matters upon which a claim is based. Any medical or other agent of the Company shall be allowed to examine the Insured Person on the occasion of any alleged Injury when and so often as the

same may reasonably be required on behalf of the Company. Such evidence as the Company may from time to time require shall be furnished and a post-mortem examination report wherever applicable, shall be furnished to the Company within a period of thirty days.

The Company shall not be liable to pay any claims under this Section II unless the claim under the Policy is accompanied by the following documents:

1. Duly completed claim form;
2. Medical Practitioner's Report;
3. First Information Report and Final Police report, wherever necessary;
4. Copy of Schedule/Certificate of Insurance
5. Death certificate, wherever applicable;
6. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury etc.
7. Disability certificate from a Medical Practitioner or Hospital confirming the extent and nature of disability.
8. Postmortem report, if the same was conducted wherever applicable;
9. Discharge voucher from the Insured Person, if applicable
10. Bills and receipt towards expenses relevant to funeral ceremony / repatriation of mortal remains;
11. Loan Certificate/Amortization Schedule prepared by the Bank/ Financial Institution at the time of disbursement of Loan showing details of the Loan/EMIs, Principal Outstanding, etc.,
12. Identity proof
13. Proof of travel by the Insured Person in listed public carrier in case the Double Indemnity Benefit is applicable. Additional documents will be called for when the above listed documents do not adequately corroborate admissibility of the claim under respective benefits as per the Policy terms.

CLAIM PROCEDURE for Child Education Benefit:

In the event of a claim under 'Child Education Benefit', the following documents are required in addition to the documents mentioned above in Section 2 as the case may be:

- Proof of number of Dependent Child / children substantiated by proof of identity documents.
- Age proof of the Dependent Child / children.

1.C. EXCLUSIONS (APPLICABLE TO SECTION.1 PERSONAL ACCIDENT)

The Company shall not be liable under this Section for:

i. No claim shall be payable under this section in case of any PTD/PPD arising out of accident for which medical care, treatment or advice was recommended by or received from a Doctor or from which the Insured suffered disability and diagnosed before the commencement of the Policy Period.
ii. Any Pre-existing condition or Disability arising out of a Pre-existing Diseases or any complication arising therefrom. Pre-existing Disease means any condition, aliment, injury or disease / critical illness / disability:
    a. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement; or
    b. For which medical advice or treatment was recommended by, or received from, a Physician within 36 months Prior to the effective date of the police

issued by the insurer or its reinstatement

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 Insurer.

iii. Any payment in case of more than one claim under the Policy during any one Policy Period by which our maximum liability in that period would exceed the Sum Insured. This would not apply to payments made under Involuntary Loss of Job, Child Education Benefit fund or any other Ad – on pertaining to Personal Accident of the Policy.

iv. Suicide or attempted suicide, intentional self-inflicted injury or acts of self destruction.

v. 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.

vi. Death or disablement arising out of or attributable to 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.

vii. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement arising from Bacterial / Viral infections (except pyogenic infection which occurs through an Accidental cut or wound).

viii. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement arising from medical or surgical treatment except as necessary solely and directly as a result of an Accident.

ix. Death or disablement arising or resulting from the Insured Person committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion with criminal intent.

x. Death or disablement arising from or caused due to use, abuse or a consequence or influence of an abuse of any substance, intoxicant, drug, alcohol or hallucinogen unless administered by / prescribed on the advice of a physician / Medical Practitioner.

xi. Death or disablement caused by participation of the Insured Person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable.

xii. Insured Persons whilst engaging in a speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in competitions or professional sports, or involving a naval, military or air force operation and is specifically specified in the Schedule.

xiii. Working in underground mines, tunneling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities.

xiv. Death or disablement arising from or caused by 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.

xv. In respect of Insured Event which occurs whilst the Insured Person is operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft, or Scheduled Airlines or is engaging in aviation or ballooning, or whilst the Insured person is mounting into, or dismounting from or traveling in any balloon or aircraft other than as a passenger (fare-paying or otherwise) in any Scheduled Airline anywhere in the world;

xvi. In respect of death, injury or disablement of Insured Person (a) from engaging in or participation in adventure sports including but not limited to winter sports, skydiving/parachuting, hang gliding, bungee jumping, scuba diving, mountain climbing (where ropes or guides are customarily used), riding or driving in races or rallies using a motorized vehicle or bicycle, caving or pot-holing, hunting or equestrian activities, skin diving or other underwater activity, rafting or canoeing involving white water rapids, yachting or boating outside coastal waters, participation in any Professional Sports, any bodily contact sport or any other hazardous or potentially dangerous sport for which the Insured Person is untrained, unless specifically covered under the Policy (b) caused by venereal disease or insanity;

xvii. Congenital external diseases, defects or anomalies or in consequence thereof

xviii. Any Physical, medical condition or treatment or service that is specifically excluded in this policy.

xix. Death or disablement resulting caused by Medical treatment traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy. Any death or disablement resulting due to miscarriages (unless due to an accident) and lawful medical termination of pregnancy during the policy period

1.D. SPECIAL CONDITIONS (APPLICABLE TO SECTION 1. PERSONAL ACCIDENT)

The cover under this Policy, for the specific Insured Person, shall terminate in the event of claim in respect of that Insured Person becoming admissible and accepted by the Company under this Section for either PA – Death or Permanent Total Disablement. In consequence thereof no benefit shall be payable under this Section or any other Section of this Policy. However, in case of Permanent Partial Disablement (if opted) and if it occurs prior to Permanent Total Disablement, the risk cover under the Policy will continue with the remaining Sum Insured available under the Policy.

SECTION 2. CRITICAL ILLNESS

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, general exclusions stated in this Policy, to pay the benefit Sum Insured in relation to the Insured Person as per the option selected and as stated under Schedule to this Policy on the occurrence of an Insured Event as stated below, under this Section.

Insured Event: For the purposes of this Section and the determination of the Company's liability under it, the Insured Event in relation to the Insured Person, shall mean diagnosis of any Critical Illness (of the nature specified below) or Surgical Procedure, as specifically defined below and specified in Your Schedule/Certificate of Insurance, which first occur/commence / diagnosed more than 90 days after the commencement of Policy Period and shall include the following:

2.A. COVERAGE

We will pay the Insured Person the base Sum Insured as a lump sum for the listed critical illnesses subject to the following conditions:

1. The claim is admissible for first time diagnosis of listed Critical Illnesses or undergoing the listed surgical procedures for the first time.
2. Waiting Period: Insured event shall mean diagnosis of any Critical Illness (of the nature specified below) or Surgical Procedure, as specifically defined below and specified in Your Schedule/Certificate of Insurance, which first occur/commence / diagnosed after more than 90 days after the commencement of Policy Period.
3. Only one claim shall be payable to the insured regardless of the number of Critical Illness, incapacities or treatments suffered by him/her
4. Covered Critical Illness: A “Critical Illness” shall mean any one of the following critical illness with specific meaning as defined in the Policy.

Sr. No	Critical Illnesses	Silver - 05 Critical Illness	Gold - 13 Critical Illness	Gold Plus- 15 Critical Illness	Diamond - 20 Critical Illness	Platinum - 25 Critical Illness
1	Myocardial infarction (First heart attack of specific severity)	Yes	Yes	Yes	Yes	Yes
2	Cancer of specified severity	Yes	Yes	Yes	Yes	Yes
3	Stroke resulting in permanent Symptoms	Yes	Yes	Yes	Yes	Yes
4	Open Chest CABG	Yes	Yes	Yes	Yes	Yes
5	Kidney failure requiring regular dialysis	Yes	Yes	Yes	Yes	Yes
6	Coma of specified severity		Yes	Yes	Yes	Yes
7	Third degree burns		Yes	Yes	Yes	Yes
8	Multiple sclerosis with persisting symptoms		Yes	Yes	Yes	Yes
9	Permanent paralysis of limbs		Yes	Yes	Yes	Yes
10	End stage Liver failure		Yes	Yes	Yes	Yes
11	Major Organ Transplantation		Yes	Yes	Yes	Yes
12	Aorta Graft Surgery		Yes	Yes	Yes	Yes
13	Primary Pulmonary Arterial Hypertension		Yes	Yes	Yes	Yes
14	Heart Valve replacement			Yes	Yes	Yes
15	Parkinson's Disease			Yes	Yes	Yes
16	Alzheimer's Disease				Yes	Yes
17	Benign Brain Tumour				Yes	Yes
18	Loss of Speech				Yes	Yes
19	Deafness				Yes	Yes
20	Creutzfeldt Jakob Disease				Yes	Yes
21	Progressive Scleroderma					Yes
22	Motor Neutron Disease with permanent symptoms					Yes
23	Fulminant Hepatitis					Yes
24	Apallic syndrome					Yes
25	Aplastic anaemia					Yes

2.A.1 Survival period:

Survival period of minimum 07 days would be applicable from the date of diagnosis of any of the above listed Critical Illnesses to be eligible for this benefit (Refer Schedule for Survival Period applicable)

The Insured Event under this Section 2 and the conditions applicable to the same are more particularly defined below:

1. CANCER OF SPECIFIED SEVERITY

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

The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
vi. Chronic lymphocytic leukemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs

2. Myocardial infarction (first heart attack of specific severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

I. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
II. New characteristic electrocardiogram changes
III. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers. The following are excluded:
    a. Other acute Coronary Syndromes
    a. Any type of angina pectoris
    b. 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 Chest CABG

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.

The following are excluded:

Angioplasty and/or any other intra-arterial procedures

4. Open Heart Replacement or Repair of Heart Valves

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

5. 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 (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

6. Stroke resulting in permanent symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, hemorrhage 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.
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.

7. Major organ/bone marrow transplant

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

The following are excluded:

- Other stem-cell transplants
- Where only islets of Langerhans are transplanted

8. 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.

9. Multiple Sclerosis with persisting symptoms

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.
- Neurological damage due to SLE is excluded.

10. Motor neuron disease with permanent symptoms

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

11. Primary (Idiopathic) Pulmonary Hypertension

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.

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.

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.

12. 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.

13. Creutzfeldt-Jacob Disease (CJD)

Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Registered Doctor who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

14. Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.
The following are excluded:

i. Localized scleroderma (linear scleroderma or morphea);
ii. Eosinophilic fasciitis; and
iii. CREST syndrome.

15. Benign Brain Tumor

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. 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.

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.

16. End Stage Liver Failure

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

- Permanent jaundice; and
- Ascites; and
- Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

17. Fulminant Viral Hepatitis

A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

i. Rapid decreasing of liver size;
ii. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
iii. Rapid deterioration of liver function tests;
iv. Deepening jaundice; and
v. Hepatic encephalopathy.

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

18. Aorta Graft Surgery

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

You understand and agree that we will not cover:

- Surgery performed using only minimally invasive or intra arterial techniques.
- Angioplasty and all other intra arterial, catheter based techniques, "keyhole" or laser procedures.

Aorta graft surgery benefit covers Surgery to the aorta wherein part of it is removed and replaced with a graft.

19. Coma of specified Severity

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.

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

20. Parkinson's disease

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

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 as listed below (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 are:

1. 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;
2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available.
7. Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

21. Alzheimer's Disease

Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain, characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging

tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a Neurologist and supported by our appointed Medical Practitioner.
The disease must result in a permanent inability to perform three or more Activities of daily living 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
The following conditions are however not covered:

- neurosis or neuropsychiatric symptoms without imaging evidence of Alzheimer's Disease;
- alcohol related brain damage; and
- any other type of irreversible organic disorder/dementia not associated with Alzheimer's Disease

The Activities of Daily Living are:

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

22. Loss of speech

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.

23. 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.

24. Apallic Syndrome or Persistent Vegetative State (PVS)

Apallic Syndrome or Persistent vegetative state (PVS) or unresponsive wakefulness syndrome (UWS) is a Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist acceptable to us and the patient should be documented to be in a vegetative state for a minimum of at least one month in order to be classified as UWS, PVS, Apallic Syndrome.

25. Aplastic Anemia

Chronic persistent bone marrow failure which results in anemias, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

a. Blood product transfusion.
b. Marrow stimulating agents.
c. Immunosuppressive agents; or
d. Bone marrow transplantation.

The diagnosis must be confirmed by a hematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

a. Absolute neutrophil count of less than 500/mm^3 or less
b. Platelets count less than 20,000/mm^3 or less
c. Reticulocyte count of less than 20,000/mm^3 or less

Temporary or reversible Aplastic Anemia is excluded

2.B. CLAIMS SETTLEMENT PROCESS (APPLICABLE TO SECTION. 2. CRITICAL ILLNESS)

In the event of a claim arising out of an Insured Event covered under this Section, the Insured Event as described above shall be intimated to the Company within 30 (thirty) days from the Date of Diagnosis of the Illness, date of Surgical Procedure or date of occurrence of the Insured Event as the case may be. However, the Company may condone the delay on merits of the claim subject to getting satisfied that the delay in notification was due to reasons beyond the control of the Insured Person / Nominee.

The Company shall not be liable to pay any claims under this Section 2 unless the claim under the Policy is accompanied by the following documents:

1. Duly completed claim forms;
2. Loan Certificate/Amortization Schedule prepared by the Bank/ Financial Institution at the time of disbursement of Loan showing details of the Loan/EMIs, Principal Outstanding, etc.,
3. Bank's document showing the details of the Loan borrower
4. Copy of Schedule/Certificate of Insurance
5. Copy of Discharge Certificate/ Card from the hospital/ Medical Practitioner, if applicable;
6. Certificate from the attending Medical Practitioner of the Insured Person evidencing diagnosis of Illness or Injury or occurrence of the Insured Event or the undergoing of the medical / surgical procedure in relation to the claim of the particular Insured Person, inter alia,
   a. name of the Insured Person;
   b. name, date of occurrence and medical details of the Insured Event
   c. Confirmation that the Insured Event does not relate to any Pre-Existing Disease or any Illness or Injury which existed within the first 90 (Ninety) or 180 (one hundred eighty) days of commencement of Policy Period.
7. Copy of investigation test reports and hospital receipts;
8. Letter from treating consultant stating presenting complaints with duration and the past medical history.
9. Bills including relevant stickers for implants, if applicable.
10. Death Certificate/ Post mortem report, if applicable
11. KYC (know your customer) documents, if the claim is more than 1 (One) lakh
12. Identity proof
13. Age proof

14. NEFT/Bank Details
15. Discharge voucher from the Insured Person
16. Additional documents will be called for when the above listed documents do not adequately corroborate admissibility of the claim under respective benefits as per the Policy terms.

2.C. EXCLUSIONS (APPLICABLE TO SECTION.2. CRITICAL ILLNESS)

The Company shall not be liable to make any payment arising out of the following events:

a. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy
b. Any claim with respect to any Critical Illness diagnosed prior to Policy start date or arising in the first 90 days of the Policy Period
c. Any Pre-existing Disease; Injury or any complication arising therefrom.

Pre-existing Disease means any condition, aliment, injury or disease / critical illness / disability:

1. That is/are diagnosed by a physician within 36 months prior to the effective date of the policy issued by the insurer or its reinstatement; or
2. For which medical advice or treatment was recommended by, or received from, a Physician within 36 months Prior to the effective date of the policy issued by the insurer or its reinstatement
3. 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 Insurer.

d. If the Insured Person does not submit a medical certificate from a doctor evidencing diagnosis of Illness or Injury or occurrence of the medical event or the undergoing of the medical / surgical procedure in relation to the claim of the particular Insured Person.
e. Any Critical Illness arising out of use, abuse or consequence or influence of any substance, intoxicant, drug, alcohol or hallucinogen unless administered by / prescribed on the advice of a physician / Medical Practitioner;
f. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner,
g. Any Critical Illness caused due to intentional self-injury, suicide or attempted suicide;
h. Any Critical Illness, caused by or arising from or attributable to a 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), civil war, public defense, rebellion, revolution, insurrection, military or usurped power;
i. Any Critical Illness caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
j. Working in underground mines, tunneling or involving electrical installations with high tension supply, or as jockeys or circus personnel;
k. Insured Persons whilst engaging in a speed contest or racing of any kind (other than on foot), bungee jumping, parasailing, ballooning, parachuting, skydiving, paragliding, hang gliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving using hard helmet and breathing apparatus, polo, snow and ice sports in so far as they involve the training for or participation in competitions or professional sports, or involving a naval, military or air force operation;
l. External Congenital Anomalies or disease or defects or any complications or conditions arising therefrom including any developmental conditions of the Insured;

m. Participation by the Insured Person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable.
n. Any Critical Illness based on certification/diagnosis/treatment from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for;
o. Any Critical Illness caused due to any treatment, including surgical management, to change characteristics of the body to those of opposite sex.
p. Any Critical Illness caused due to cosmetic or plastic surgery or any treatment to change the 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.
q. Any Critical Illness caused due to surgical treatment of obesity that does not fulfil all the below conditions:
    a. Surgery to be conducted is upon the advice of the Doctor
    b. The Surgery / Procedure conducted should be supported by clinical protocols
    b. The member has to be 18 years of age or older and
    c. Body Mass Index (BMI):

- greater than or equal to 40 or
- 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 Type 2 Diabetes

r. Any Critical Illness arising or resulting from the Insured Person committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion with criminal intent;
s. In the event of the death of the Insured Person within the stipulated survival period as set out above.
t. Any Critical Illness caused by Medical treatment traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy. Any Critical Illness caused due to miscarriages (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
u. Any Critical Illness caused by sterility and infertility. This includes:
    - Any type of contraception, sterilization
    - Assisted Reproductive services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    - Gestational Surrogacy
    - Reversal of sterilization
v. Any Critical Illness caused due to treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reason.
w. Any Critical Illness caused by any unproven/ experimental treatment, service and supplies for or in connection with any treatment. Unproven / experimental treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

2.D. SPECIFIC CONDITIONS (APPLICABLE TO SECTION.2. CRITICAL ILLNESS)

Critical Illness benefit is payable in respect of the first incidence of one of the specified illnesses and thereafter the cover terminates immediately.

The cover under this Policy, for the specific Insured Person, shall terminate in the event of claim in respect of that Insured Person becoming admissible and accepted by the Company under this Section. In consequence thereof no benefit shall be payable under any other Section of this Policy.

The insured has to survive for a period of minimum 07 days from the date of diagnosis of any of the Critical Illnesses listed above to be eligible for the benefit under the policy. We will not be liable for payment of any claim in the scenario where the insured person dies within the survival period, if opted (Refer Schedule for Survival Period).

2.E Utility Bill (Addon Cover)

If we have accepted a claim under Critical Illness (2.A) benefit of this policy, then we will pay addition benefit amount towards utility bill expenses as lumpsum payment up to the Sum Insured opted by Insured and mentioned in the Policy Schedule/Certificate of Insurance against this Section.

Utility Bill includes, Telephone bill, Internet bill, electricity bill, DTH/Cable Bill, Water bill, Gas bill. This benefit is over and above the base Sum Insured.

SECTION 3: HOSPITAL DAILY CASH BENEFIT

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, general exclusions stated in the Policy and on payment of additional premium as applicable, to pay the fixed amount specified in the Schedule in respect of the Insured Person for each continuous and completed period of 24 hours that the Insured Person is Hospitalized due to an Injury or Illness first diagnosed during the Policy Period, for up to the number of days mentioned in the Policy schedule/certificate of insurance.
Insured Event: For the purposes of this Section and the determination of the Company's liability under it, Insured Event in relation to Insured Person shall mean each continuous and completed period of 24 hours of Hospitalization due to an Injury or Illness diagnosed during the Policy Period.

3.1.A. EXCLUSIONS UNDER HOSPITAL CASH BENEFIT

The Company shall not be liable to make any payment under this Policy towards Hospital Cash Benefit, caused by, arising out of or attributable to any of the following:

1. Any condition, ailment or injury or related condition(s) for which You had and / or were diagnosed, and / or received medical advice / treatment within 36 months to prior to the first policy issued by Us.
2. Routine eye tests, dental treatment or other examination and/or tests not incidental to

the treatment or diagnosis of an injury, sickness or disease,

3. Sleep disorder, Parkinson and Alzheimer's disease, external congenital diseases defects or anomalies, general debility, or exhaustion ("run-down condition"); stem cell implantation or surgery, or growth hormone therapy.
4. Sterility, treatment whether to effect or to treat infertility, any fertility, sub-fertility or assisted conception procedure, surrogate or vicarious pregnancy, birth control, contraceptive supplies or services including complications arising due to supplying services.
5. Dental treatment or other examination and/or tests not incidental to the treatment or diagnosis of an injury, sickness or disease.
6. Circumcisions unless required as a part of treatment of an illness or injury; laser treatment for correction of eye due to refractive error; aesthetic or change-of-life treatments of any description such as sex transformation operations, treatments to do or undo changes in appearance or carried out in childhood or at any other times driven by cultural habits, fashion or the like or any procedures which improve physical appearance.
7. Prostheses, cosmetic surgery or reconstructive surgery unless as a result of an accidental injury,
8. Custodial care, bed rest, convenience care, convalescence, general debility, rest cure,
9. Any treatment relating to obesity, weight reduction, weight improvement,
10. Self-inflicted injuries or attempted suicide,
11. War or any act of war, invasion, act of foreign enemy, war like operations (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defense, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons / materials, chemical and biological weapons, radiation of any kind, any epidemics recognized by government or WHO.
12. Any injury, sickness or disease received as a result of the insured person committing any breach of law,
13. Any injury, sickness or disease received as a result of the insured person being under the influence of alcohol or drugs other than in accordance with the directions of a registered medical practitioner,
14. Any injury, sickness or disease received as a result of the insured person taking part in any naval, military or air force operation,
15. Any injury, sickness or disease received as a result of the insured person participating in or training for any dangerous or hazardous sport or competition or riding or driving in any form of race or competition,
16. Any injury, sickness or disease received as a result of aviation, gliding or any form of aerial flight other than on a scheduled commercial airline as a bona fide passenger (whether fare paying or not), pilot or crew member
17. Experimental, investigational or unproven treatment devices and pharmacological regimens.
18. Any procedure primarily for diagnostic or preventive purposes, which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital.
19. Any treatment or part of a treatment that is not medically necessary.

3.1.B. CLAIMS SETTLEMENT PROCESS

In the event of a claim arising out of an Insured Event covered under this Section, the same shall be intimated to Us within 30 (THIRTY) days, except under genuine circumstances beyond your/ Insured person's control in our opinion and the Insured person shall arrange for submission of the necessary documents to Us. Submission of these documents to Our satisfaction is condition precedent to admission of any liability under the policy.

- Duly completed claim forms;
- Copy of Discharge Certificate/ Card from the Hospital / Medical Practitioner;
- Certificate from the attending Medical Practitioner of the Insured Person evidencing diagnosis of Illness or Injury or occurrence of the Insured Event or the undergoing of the medical / surgical procedure in relation to the claim of the particular insured person, inter alia,
  - name of the Insured person;
  - name, date of occurrence and medical details of the Insured Event
  - Confirmation that the Insured Event does not relate to any Pre-Existing Disease or any Illness or Injury which existed within the first 30 (Thirty) days of commencement of Policy Period.
- Copy of investigation test reports and hospital receipts;
- Letter from treating consultant stating presenting complaints with duration and the past medical history.
- First Information Report/ Final Policy Report, if applicable
- KYC (know your customer) documents
- Identity proof
- Age proof
- NEFT/Bank Details

3.2.C. SPECIFIC CONDITIONS (APPLICABLE TO SECTION 3. HOSPITAL DAILY CASH)

1. Hospital Cash Benefit is payable only for admission in Hospital for a minimum period of 24 consecutive inpatient care hours for each claim.
2. Waiting Period - An initial waiting period of 30 days from the commencement of the Policy Period (or first Policy Period in case of renewal without break) is applicable for hospitalization due to Sickness only, under this Policy.
2. Such a waiting period is not applicable to claims arising due to accident provided the accident occurs after the inception of the policy.
3. Not Liable to pay the daily amount for more than the maximum number of days as specified, during the Period of Cover.
4. More than one claim can be considered in respect of the Insured Person under this benefit during the Period of Cover, subject to the maximum number of days specified, and provided that the Illness/Accident causing the Injury is distinct and unrelated for each such claim. On exhaustion of the Sum Insured, the cover under this Benefit will terminate in relation to such Insured Person.
5. Once claim is considered admissible as per the terms and condition under this benefit, the Insured Person is eligible for the daily amount from the first day of Hospitalization, provided that the Insured Person is Hospitalized for a continuous period of 24 hours.
6. The amount payable under this Benefit will be calculated on the basis of the number of continuous and completed days of Hospitalization and will be given as a single lumpsum payment.
7. Specified disease/procedure waiting period - Code- Excl02
   In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
   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.
   The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

24 Months waiting period:

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumors, 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

36 months waiting period applies for

1. Treatment for joint replacement unless arising from accident.
2. Age-related Osteoarthritis & Osteoporosis

SECTION 4: INVOLUNTARY LOSS OF JOB

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions stated in the Policy and on payment of additional premium as applicable, to pay once during the Policy Period on occurrence of the Insured Event as stated below under this Section, in relation to the Insured Person's, EMI Amount(s) falling due in respect of the Loan (Loan account number as stated in Schedule to this Policy) after the commencement of the Insured Event till the reinstatement of employment with the same employer or new employer or expiry of Policy Period, whichever is earlier, subject to payment of a maximum of up to Three (3) or Six (6) EMIs as stated under Schedule to this Policy for the Insured Person.

Insured Event: For the purposes of this Section and the determination of the Company's liability under it, Insured Event in relation to Insured Person shall mean involuntary termination from employment of the Insured Person or his/her permanent dismissal, temporary suspension or retrenchment or lay off from employment imposed on him/her by the employer during the Policy Period due to any of the following:

i. First time diagnosis of any of the covered Critical Illness for which a claim is admissible and payable under Critical Illness benefit, during the Policy Period, or
ii. Permanent Total Disability occurring due to an Accident during the Policy Period for which a claim is admissible and payable under Permanent Total Disability benefit (if Opted).

as per the employer's rules /regulations or executed/implemented by the employer in compliance of any laws for the time being in-force or any directives by any Public Authority;

The payout for Loss of Job benefit is as fixed at the outset and shall not be affected by any midterm change in EMI / interest rates.

4.1.B. CLAIMS SETTLEMENT PROCESS (APPLICABLE TO SECTION 4. INVOLUNTARY LOSS OF JOB)

In the event of a claim arising out of an Insured Event covered under this Section, the Insured Event as described above shall be intimated by the Insured to the Company within thirty (30) days from the date of termination from employment of the Insured Person or his dismissal, temporary suspension or retrenchment from employment as the case may be and the Insured Person shall arrange for submission of the following documents to the Company:

1. Duly completed claim form;
2. Certificate if applicable from the Bank stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.
3. Certificate from the employer of the Insured Person confirming the termination, dismissal temporary suspension or retrenchment from employment of the Insured person furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured Person with the reasons for the same. In case of temporary suspension the period of suspension should also be mentioned in such certificate.
4. In case of Loss of Job due to Critical Illness or PTD, then in addition to the above mentioned documents all relevant documents as mentioned in the respective section.
5. Any other document as may be required by the Company.

However, the Company may condone the delay on merits of the claim subject to getting satisfied that the delay in notification was due to reasons beyond the control of the Insured Person/Nominee.

4.1.C. EXCLUSIONS (APPLICABLE TO SECTION 4. INVOLUNTARY LOSS OF JOB)

1. No benefit shall be payable under this benefit in the event of termination, dismissal, temporary suspension or retrenchment from employment of the insured being attributed to any dishonesty or fraud or poor performance on the part of the insured 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 by the employer.
2. No benefit shall be payable under this benefit in connection with or in respect of:
   a. Self-employed persons;
   b. Any claim relating to unemployment from a job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer;
   c. Any voluntary unemployment;
   d. Unemployment due to downsizing; cost cutting closure etc. OR due to CI arising within the first 90 days of inception of the policy period of each Insured.
3. No benefit shall be payable due to any unemployment from a job under which no salary or any remuneration is provided to the insured
4. No benefit shall be payable due to any suspension from employment on account of any pending enquiry being conducted by the employer / Public Authority
5. No benefit shall be payable due to any unemployment due to resignation, retirement whether voluntary or otherwise
6. No benefit shall be payable due to any unemployment due to non-confirmation of employment after or during such period under which the insured was under probation.

4.1.D. SPECIFIC CONDITIONS (APPLICABLE TO SECTION 4. INVOLUNTARY LOSS OF JOB)

1. The benefit under this Section is available only for salaried employees within India.
2. Waiting Period - An initial waiting period of 90 days after the commencement of the Policy Period (or first Policy Period in case of renewal without break).
3. A claim shall be admissible under this Section if the Insured Person loses his job within 12 months from the Date of Diagnosis of a covered Critical Illness payable under SECTION 2 - CRITICAL ILLNESS or the date of Accident leading to the Permanent Total Disablement payable under SECTION 1- PERSONAL ACCIDENT - subject to the policy being in force at the time of unemployment.
4. A claim under this Section shall become admissible provided the period of termination, layoff, retrenchment or permanent dismissal from employment of the Insured Person is not less than 30 consecutive days ("Retrenchment Period"). Any payment shall be made after 30 (thirty) consecutive days from the last day of employment of the Insured Person.
5. The payout for this benefit is as fixed at the outset and shall not be affected by any midterm change in EMI/interest rates, irrespective of whether You/ Insured person has opted for Fixed Sum Insured or Reducing Sum Insured.
6. The cover under this Section shall terminate after 3 or 6 EMIs (as stated under Schedule to this Policy for the Insured Person) have been admissible and paid, whether in one or more claims within a single Policy Period.
7. In the event the Sum Insured as appearing against Section 2 (Critical Illness) & Section 1 (Personal Accident and Permanent Total Disablement) of the Policy is less than the total of the actual Loan disbursed up to the date of the occurrence of the Insured Event, then the EMI payable shall be in the same proportion as the actual Loan disbursed to the Sum Insured.

D. GENERAL EXCLUSIONS APPLICABLE TO ALL THE SECTIONS THE POLICY (unless waived off under specific Section):

The Company shall not be liable for any loss or damage under this Policy:

1. arising or resulting from the Insured Person committing any breach of the law with criminal intent.
2. due to, or arising out of or connected with or traceable to, War, invasion, act of foreign enemy, hostilities (whether war be declared or not) Civil War, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of all Heads of State and citizens of whatever nation and of all kinds and acts of Terrorism, Riots, Strike, Malicious Acts etc.
3. Caused by or contributed to by or arising from ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self- sustaining process of nuclear fission.
4. Caused by or contributed to by or arising from nuclear weapon materials.
5. arising out of or as a result of any act of self-destruction or self-inflicted Injury, attempted suicide or suicide.
6. arising out of or resulting while serving in any branch of the Military or Armed Forces of any country during War or warlike operations.
7. arising out of or resulting or caused by, resulting from or in connection with any act of terrorism/sabotage regardless of any other cause or event contributing concurrently or in any other sequence to the loss. The Policy also excludes loss, damage, cost or expenses of whatsoever nature caused by, resulting from or in

connection with any action taken in controlling, preventing, suppressing or in any way relating to action taken in respect of any act of Terrorism/sabotage.

8. Any Claim of the Insured Person while driving any vehicle without a valid Driving License.

Reference links:
For Claims visit: https://www.rahejaqbe.com/claims/health-claims
List of Blacklisted hospitals - https://www.rahejaqbe.com/hospital-locator

D.1 Condition Precedent to the contract

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.
(Note: "Material facts" for the purpose of this policy shall mean all important, essential and relevant information sought by the company in the proposal form and other connected documents to enable him to take informed decision in the context of underwriting the risk)

2. Condition Precedent to Admission of Liability

The due observance and fulfilment of the terms and conditions of the Policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment for claim(s) arising under the Policy.

3. No Constructive Notice

Any knowledge or information of any circumstances or condition in relation to the Insured Person which is in the possession of the Company other than that expressly disclosed in the Proposal Form or otherwise in writing to, shall not be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

4. Electronic Transactions

The Insured agrees to adhere to and comply with policy terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or
by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.
Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/ confirmed by the Insured.

5. Age Limit

To be eligible to be covered under the Policy or get any benefits under the Policy, the Insured Person should have attained the age of at least 18 years and shall not have completed the age of 65 years on the date of commencement of the Policy Period as applicable to such Insured Person unless it is renewal of Policy.

6. Insured Person

Only those persons named as an insured person in the policy schedule / certificate of insurance shall be covered under this policy.

D.2 Condition applicable during the contract

1. 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.

2. Notice & Communication

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

3. Territorial Limit

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

4. Multiple Policies

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

5. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.
Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.
For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y acting on

behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

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

6. Grace Period

I. A Grace Period of 30 days is available for Renewal of the Policy. Any Illness, disease or condition contracted during Grace Period will not be covered and will be treated as Pre-existing diseases.

II. Policies for which Premium is received after the Grace Period shall be considered as a fresh policy.

7. Premium Payment Options:

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

i. Grace Period of as per the following Days would be given to Pay the instalment premium due for the Policy.
ii. The Benefits provided under – “Waiting Periods”, “Specific Waiting Periods” Sections shall continue in the event of payment of Premium within the stipulated grace Period.
iii. No interest will be charged If the installment premium is not paid on due date.
iv. In case of installment premium due not received within the grace period, the Policy will get cancelled.

Option	Instalment Premium Option	Grace Period
Option 1	Yearly	30 days
Option 2	Half Yearly	30 Days
Option 3	Quarterly	30 Days
Option 4	Monthly	15 Days

v. In case of failure of transaction in ECS mode of payment and/or instalment premium due not received within the grace period, the policy will get cancelled and fresh policy would be issued with fresh waiting periods after obtaining consent from the customer.
vi. In case of change in terms and conditions of the policy contract or in premium rate, the ECS authorization shall be obtained afresh ensuring an informed choice to the policy holder.
vii. The insurer can withdraw ECS mode of payment by giving 15 days’ notice prior to the due date of premium payable.

viii. All terms and conditions for this product is as per the Insurance Regulatory and

Development Authority of India (Insurance Products) Regulations, 2024 read with Master Circular on IRDAI (Insurance Products) Regulations 2024 - Health Insurance or any amendment thereof from time to time in respect of break in policy.

8. Cancellation

A. Cancellation by Insured (By You)

i. The Insured may cancel this Policy by giving 7days' written notice, and in such an event, the Company shall refund proportionate premium for the unexpired policy period on prorate basis where no claims are made.
ii. In the event of full prepayment of the Loan by the Insured, We shall refund proportionate premium for the unexpired policy period on prorate basis where no claims are made.
iii. In event of part prepayment of the Loan, no refunds of premium shall be made under this Policy.
iv. No refunds of premium shall be made where any claim has been admitted by the Company or has been lodged with the Company.

B. Cancellation by Insurer (By Us)

Policy may be cancelled by Us on the grounds of misrepresentation, fraud, non-cooperation, or non-disclosure of material facts by sending to You fifteen days' notice by recorded delivery at last known address/e- mail ID without refund of premium.

Note: Please note KYC documents (Photo ID card) shall be required at the premium refund to the Insured Member exceeds threshold limit of Rs. 1 Lakhs per premium refund.

9. Free Look Period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of thirty days from date of receipt of the Policy, whether received electronically or otherwise, to review the terms and conditions of the Policy. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges; or
ii. where the risk has already commenced and the option of return of the Policy is exercised by the insured, a deduction towards the proportionate risk premium for period of cover or
iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period

10. Group Administrator

The Group Administrator i.e. Policyholder shall take all reasonable steps to cover their members or employees of the company and ensure timely payment of premium in respect of the persons covered. The Group administrator will collect premium from members wherever applicable as mentioned in the Group/Master policy issued to the Group administrator. The Group administrator will neither charge more premium nor alter the scope of coverage offered under the Group/Master policy.

Group/Master policy will be issued to the group administrator and all members wherever required will be provided with the certificate of insurance by Us. Wherever mutually agreed group administrator will issue the certificate of insurance to its member as per agreed terms and conditions and in the format prescribed by us and shall keep the record of such issuance. We

reserve the right to inspect the record at any time to ensure that terms and conditions of group policy and provisions of IRDAI group guidelines contained in circular ref: Master Circular on Operations and Allied Matters of Insurers 2024 - Health Insurance & Insurance Regulatory and Development Authority of India (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations, 2024 and any amendments thereto are being adhered.
We may also require submission of certificate of compliance from Your Group Administrator auditors.
The Group administrator will provide all possible help to its member and facilitate any service required under the Policy including claims. Notwithstanding this a member of the group covered under the Policy shall be free to contact Us directly for filing the claim or any assistance required under the Policy.

11. Automatic change in Coverage under the policy

The coverage for the Insured Person shall automatically terminate: In the case of his/ her (Insured Person) demise.
However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardian appointed by Court. All relevant particulars in respect of such person (including his/her relationship with the Insured person) must be submitted to the Company along with the application. Provided no Claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective. Upon exhaustion of sum insured and cumulative bonus, for the Policy year. However, the Policy is subject to renewal on the due date as per the applicable terms and conditions.

12. Territorial Jurisdiction

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

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 before the changes are effected.

14. Withdrawal of Policy
The product will be withdrawn only after due approval from the Authority. We will inform the Policyholder in the event We may decide to withdraw the product.
In such cases, where Policy is falling due for Renewal within 90 days from the date of withdrawal, We will provide the Policyholder one time option to renew the existing Policy with us or migrate to modified or new suitable health insurance policy with Us. Any Policy falling due for Renewal after 90 days from the date of withdrawal will have to migrate to a modified or new suitable health insurance policy with Us.
Individual members will also have an option to opt for suitable health insurance Policy with Us subject to applicable Portability norms in vogue.

15. Moratorium Period
After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no 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 sum insured of the first policy. Wherever the Sum Insured is enhanced, the completion of sixty continuous months would be applicable from date of enhancement of sum insured only on the enhanced limits.

16. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved, evidenced by a written endorsement signed and stamped by the Company.

17. Change of Sum Insured

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

18. Terms and condition 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.

19. Nomination:

The policy holder 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 policy holder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. For claims settlement under reimbursement, the Company will pay the policy holder. In the event of death of policy holder, the company will pay the nominee (as named in the policy schedule/Policy Certificate/Endorsement 9if any)) and incase there is no subsisting nominee, to the legal heirs or legal representatives of the policy holder whose discharge shall be treated as full and final of its liability under the policy.

D.3 Condition applicable during renewal of the policy

1. Renewal of Policy

The Policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person provided that the policy is not withdrawn and also subject to conditions stated under clause D.2.14. The renewal premium shall be paid to the Company on or before the date of expiry of the Policy or of the subsequent renewal thereof.

i. The Company shall endeavor to give notice for renewal. However, the Company is not bound to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.
iii. Request for renewal along with requisite premium shall be received by the Company before the

end of the policy period.
iv. At the end of the policy period, the policy shall terminate and can be renewed within the

Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.

v. If not renewed within Grace Period after due renewal date, the Policy shall terminate.
vi. No loading shall apply on renewals based on individual claims experience.

2. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the premium due date of his/her existing policy as per extant guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per extant guidelines on portability.
For Detailed Guidelines on portability, kindly refer the link -
https://www.rahejaqbe.com/frontend/images/health-basic-guideline/pdf/download/Portability_Migration_Guideline.pdf

3. Migration

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

For Detailed Guidelines on migration, kindly refer the link -
https://www.rahejaqbe.com/frontend/images/health-basic-guideline/pdf/download/Portability_Migration_Guideline.pdf

D.4 Condition when a claim arises

1. Claim Intimation

Upon the discovery or occurrence of an event or Hospitalization that may give rise to a claim under this Policy, Insured Person or the Nominee as the case may be shall undertake the following:

- In case of Hospitalization, notify Us either at Our call center or in writing within 48 hours of the Hospitalization but not later than discharge from the Hospital.
- In case of diagnosis or actual undergoing of procedure, notify Us either at the call center or in writing, within 10 days from the date of occurrence of such event. The following details are to be provided to Us at the time of intimation of Claim:
- Policy Number
- Name of the Policyholder
- Date and Time of Loss Location of Accident
- Name of the Insured Person in whose relation the claim is being lodged
- Nature of claims, Accidental death, Accidental Hospitalization, Critical Illness
- Name and address of the attending Medical Practitioner and Hospital (if admission has

taken place)
- Date of admission if applicable
- Any other information, documentation as requested by Us

Intimation about an event or occurrence that may give rise to a claim under this Policy must be given within 30 days of its happening. We will examine and relax this time limit mentioned herein depending upon the merits of the case.

2. Claim Notification

It is a condition precedent to Our liability hereunder that written notice of claim must be given by You Us within seven (7) days after an actual or potential loss begins or as soon as reasonably possible and in any event no later than (30) Days after an actual or potential loss begins. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if you can satisfy us that it was not reasonably possible for you to give proof within such time.
We may accept claims where documents have been provided after a delayed interval only in special circumstances and for the reasons beyond the control of the Insured Person.

3. Scrutiny of Claim Documents

a. We shall scrutinize the Claim and accompanying documents. Any deficiency in documents shall be intimated within five (7) days of its receipt.
b. If the deficiency in the submitted Claim documents is not furnished or partially furnished within ten (10) working days of the first notification, We shall send a reminder of the same every ten (15) days thereafter.
c. We will send a maximum of three (3) reminders following which, We will send a rejection letter after 15 days from last reminder.

4. Claim Assessment

We will pay fixed amounts as specified in the applicable Sections for Basic or Optional Benefits in accordance with the terms of this Policy.
We are not liable to make any payments that are not specified in the Policy.

5. Claims Investigation

We may investigate claims at our Own discretion to determine the validity of a claim. Such investigation shall be concluded within 21 days from the date of assigning the claim for investigation and not later than 6 months from the date of receipt of claim intimation. Verification carried out, if any, will be done by individuals or entities authorized by Us to carry out such verification/investigation(s) and the costs for such verification/investigation shall be borne by Us.

6. Payment terms

I. All Claims will be payable in India and in Indian rupees.
II. We will only make payment to the Insured Person / Policyholder under this Policy. The receipt of payment by the Insured Person / Policyholder shall be considered as a complete discharge of Our liability against any claim under this Policy. In the event of Your death, We will make payment to the Nominee / Assignee (as named in the Policy Schedule/ Certificate of Insurance).
III. Our total liability in aggregate for all claims under the Policy for a specific Insured Person shall not exceed the respective Sum Insured of that Insured Person as mentioned in Policy Schedule.
IV. In case of claims for accidental death of the Insured Person, where a Nominee(s)/Assignee has not been mentioned in the Proposal Form, the claim payment shall be made as per Indian succession law.

V. If premium is payable in installments and not paid on or before the due date then We will not pay for any claim that occurs during the relaxation period unless the installment premium is paid by You within the relaxation period. We shall have the rights to recover and deduct the pending installment premium towards the insured person who has claimed prior to the installment due date from the claim amount due under the Policy.

7. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital/Nursing Home, as the case may be, for any benefit under the policy shall in all cases be a full, valid and effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

8. Claim Settlement (provision for Penal Interest)

I. The Company shall settle or reject a claim, as may be the case, within 30 days from the date of receipt of last necessary document.

II. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from

the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

III. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. . In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.

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

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

9. 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 the claim under the Policy, within reasonable time limit and within the time limit specified in the Policy.

10. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital/Nursing Home, as the case may be, for any benefit under the policy shall in all cases be a full, valid and effectual discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

11. Disclaimer

If the Company shall disclaim liability to the insured person for any claim hereunder and if the insured person shall not within twelve calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

F. ADDITIONAL CLAUSES TO BE ATTACHED TO THE POLICY

A. FOR REDUCING SUM INSURED COVERS:

Notwithstanding anything contrary stated in the Policy, the Sum Insured under the Policy on the date of the Insured Event covered under Sections 1 and 2 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 under Section 1 and 2 of the Policy is less than the total of the actual Loan disbursed upto 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 under the Policy with respect to Sections 1 and 2.

B. ASSIGNMENT CLAUSE

It is hereby declared and agreed that:

1. from the Policy Start Date, the monies payable by Us to the Insured Person and all rights, title, benefits and interest of the Insured Person under this Policy stand assigned in favor of the “Bank / Financial Institutions named in the Schedule of this Policy”;
2. upon any monies becoming payable under this Policy the same shall be paid by Us to the “Bank/Financial Institution as named in Schedule of this Policy” without any reference / notice to the Insured, but not exceeding the Principal Outstanding as defined under the Policy. In the event of any monies payable under this Policy exceeding the Principal Outstanding, We shall pay such monies as exceeding the Principal Outstanding to the Insured;
3. the receipt of such monies in the manner aforesaid by the Bank/Financial Institution as named in the Schedule of this Policy and the Insured Person 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 Person, as the case may be.

That any adjustment, settlement or compromise in connection with any dispute between Us and the Insured Person or any of them arising under or in connection with this Policy if made by the Bank/Financier shall be valid and binding on all parties insured hereunder but not so as to impair rights of the Bank/Financier to recover the full amount of any claim it may have on other parties insured hereunder.

G. REDRESSAL OF GRIEVANCE

In case of any grievance the Insured Person may contact the company through

Website: www.rahejaqbe.com
Toll free: 1800-102- 7723 (9 am to 8 pm, Monday to Saturday)
E-mail: customercare@rahejaqbe.com
Telephone: 022 – 69155050

For Senior Citizen: 1800-102- 7723 (9 am to 8 pm, Monday to Saturday)
E-mail: seniorcitizencare@rahejaqbe.com
Courier: Any branch office or the correspondence address, during normal business hours

Insured person may also approach the grievance cell at any of the company’s branches with the details of grievance. If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at:

RAHEJA QBE GENERAL INSURANCE COMPANY LIMITED
Fulcrum, 501 & 502, A Wing, 5th Floor, IA Project Road, Sahar
Andheri East, Mumbai 400059, India
Tel: 022 - 69155050
Website: www.rahejaqbe.com

Email: complaintsofficer@rahejaqbe.com

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

If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance.

The contact details of Ombudsman offices are mentioned below:

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, UT of Dadra and Nagar Haveli, Damanand Diu	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06, Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan soudha Building, PID No.57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1stPhase, Bengaluru 560078. Tel.: 080-26652048/26652049, Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, 1st floor, Jeevan Shikha, 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462011. Tel.: 0755-2769201/2769202, Email.: bimalokpal.bhopal@cioins.co.in
Odisha	Office of the Insurance Ombudsman, 62, Forest Park,Bhubaneswar – 750009. Tel.: 0674-2596461/2586455. Email.: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh),, Himachal Pradesh, Jammu and Kashmir, UT of Chandigarh	Office of the Insurance Ombudsman, Jeevan Deep Building, SCO 20-27, Ground Floor, Sector- 17 A, Chandigarh - 160017 Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@cioins.co.in

Tamil Nadu, UT-Puducherry Town and Karaikal (which are part of UT of Puducherry)	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor,453, Anna Salai, Teynampet, Chennai 600 018. Tel. 044 – 24333668/ 24333678. Email.: bimalokpal.chennai@cioins.co.in
Delhi	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110002. Tel. 011- 23239633/23237532, Email.: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, ArunachalPradesh, Nagaland and Tripura	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM). Tel.: 0361 - 2632204 / 2602205, Email.: bimalokpal.guwahati@cioins.co.in
Andhra Pradesh, Telangana and UT of Yanam-apart of the UT of Puducherry	Office of the Insurance Ombudsman, 6-2-46, 1st Floor, "Moin court",Lane Opp., Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, Hyderabad – 500004. Tel.: 040 - 23312122, Email.: bimalokpal.hyderabad@cioins.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg, Gr. Floor, Bhawani Singh Marg, Jaipur – 302005. Tel.: 0141- 2740363/2740798, Email.: bimalokpal.jaipur@cioins.co.in
Kerala, UT of (a) Lakshadweep, (b) Mahe-a part of UT of Puducherry	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College, M.G. Road, Kochi- 682011., Tel.: 0484–2358759 Email.: bimalokpal.ernakulam@cioins.co.in
West Bengal, UT of Andaman and Nicobar Islands, Sikkim	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072.. Tel. 033 - 22124339 / 22124341 Email.: bimalokpal.kolkata@cioins.co.in
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda,	Office of the Insurance Ombudsman, 6th Floor, Jeevan bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow – 226001. Tel.: 0522-2231330/2231331. Email: bimalokpal.lucknow@cioins.co.in

Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	Office of the Insurance Ombudsman, 3rd Floor, Jeevan seva Annexe, S.V. Road, Santacruz (W), Mumbai – 400054. Tel.: 022 - 69038800/27/29/31/32/33. Email: bimalokpal.mumbai@cioins.co.in

State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	Office of the Insurance Ombudsman, Bhagwansahai Palace, 4th floor, Main Road, Naya Bans, Sector 15, Distt: gautambhuddh Nagar, U.P – 201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in
Bihar, Jharkhand	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region	Office of the Insurance Ombudsman, Jeevan Darshan Bldg, 3rd floor, C.T.S. No.s 195 to198, N.C. Kelkar Road, Narayan Peth, Pune- 411030 Tel: 020-24471175, Email: bimalokpal.pune@cioins.co.in

The details of Insurance Ombudsman are available on website: https://www.cioins.co.in/Ombudsman

On the website of General Insurance Council: www.gicouncil.in and our website www.rahejaqbe.com or from any of the Our offices.