TERMS & CONDITIONS

Every DETAIL matters to your HEALTH.

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POLICY TERMS & CONDITIONS

CignaTTK GLOBAL HEALTH GROUP POLICY

Customer Information Sheet

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief			Refer to the following Policy Section number in the Policy Wording for more details on each cover
Product Name	**CignaTTK Global Health Group Policy**			
Areas of Coverage	The Policy is available in following Areas of Cover i) India, Africa, Middle East, Oceania, Asia (excluding China, HongKong, Singapore, Japan, Taiwan) ii) India, Europe, Canada, Latin America, Caribbean iii) Worldwide Excluding United States iv) Worldwide Including United States* *For 'Worldwide Including US', a minimum Sum Insured of ₹ 25000000 must be selected			II.15
Basic Cover This section lists the Basic Benefits available on the Plan	**Identify your Plan**	**Ruby**	**Diamond**	II.1 to II.14
	Identify your Opted Sum Insured	₹ 50,00,000 ₹ 2,50,00,000	₹ 1,50,00,000 ₹ 3,00,00,000 ₹ 4,50,00,000 ₹ 6,00,00,000 ₹ 9,00,00,000 ₹ 12,00,00,000	
	In-patient Hospitalization	**Ruby**	**Diamond**	
	Room Type	Upto ₹ 12000 per day	Upto Private Room	
	Hospitalization Charges	Upto Sum Insured		
	Operating Theatre Costs	Upto Sum Insured		
	Surgical Appliance / Medical Appliance	Upto Sum Insured		
	Surgical Procedures	Upto Sum Insured		
	ICU Charges	Upto Sum Insured		
	HDU Charges	Upto Sum Insured		
	Surgeon Fee	Upto Sum Insured		
	Assistant Surgeon Fee	Upto Sum Insured		
	Anaesthetists Fee	Upto Sum Insured		
	Specialist / Medical Practitioner Fee	Upto Sum Insured		
	Medication	Upto Sum Insured		
	Diagnostic Expenses	Upto Sum Insured		
	Medically necessary Termination of Pregnancy	Upto Sum Insured		
	Surgical Contraception / Sterlisation / Vasectomy	Upto Sum Insured		
	Minor Surgical Procedures	Upto Sum Insured		
	Radiology	Upto Sum Insured		
	Pathology	Upto Sum Insured		
	Physiotherapy	Upto Sum Insured		
	Pre-existing Diseases	Covered from Day 1		
	Nursing Home Charges	Not Covered	Upto Sum Insured	
	Organ Transplant Expenses	Upto Sum Insured		
	Parental Accommodation	Upto Sum Insured		
	New Born Cover	Upto Sum Insured		
	AIDS / HIV	Upto Sum Insured		
	Psychiatric & Psychological Care	Not Covered	Upto Sum Insured	
	Private Ambulance	Upto Sum Insured		
	Out of Area 30 day cover - Emergency Treatment only	Upto Sum Insured		
	Emergency Evacuation	Upto Sum Insured		
	Medical Repatriation	Upto Sum Insured		
	Repatriation of Mortal Remains	Upto Sum Insured		
	Out-Patient Cover			
	Out-Patient Cover - Annual Limit	Annual Out-patient Limit ₹ 1,25,000	Annual Out-patient limit is within the Sum Insured of Diamond Plan	

Policy Wordings: Cigna TTK Lifestyle Protection Group Policy UIN: CTTHLGP18101V021718

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief			Refer to the following Policy Section number in the Policy Wording for more details on each cover
	Consultations with Medical Practitioners & Specialists	Upto Out-patient cover limit		
	Prescribed Medicines, Drugs, Dressings & Diagnostic Tests	Upto Out-patient cover limit		
	Complimentary treatments - Physiotherapy, Accupunture, Chiropody,Osteopathy, Homeopathy	Not covered	100% upto ₹ 7500 per visit, upto 30 visits per year	
	Non-Surgical & Minor Surgical Procedures & Treatment	Upto Out-patient cover limit		
	Hormone Replacement Therapy	Upto Out-patient cover limit		
	Child - Annual Eye & Hearing Tests	Upto Out-patient cover limit		
	Travel Vaccinations	Upto Out-patient cover limit		
	Emergency Dental Treatment	100% upto ₹ 25,000	Upto Out-patient cover limit	
	Psychiatric & Psychological Care	Not covered	Upto ₹ 1,00,000	
	Any Treatment that arises from or is in any way connected with attempted suicide or any injury or illness that the Insured Person or dependant inflicts upon himself is covered under the above, up to an upper lifetime limit of ₹10000000 per Insured Person.			
Optional Covers This section lists the Optional covers available under the plan. The optional covers are available to be selected either individually or in combination and apply to all persons in the group without any individual selection.	**The following Optional Covers are available under this Policy**			
	A. Pre-existing Diseases Waiting Period Addition	The policy provides an option to add a waiting period towards Pre-existing diseases until 48 months of continuous covers have elapsed since inception of the first Policy with Us.		III.1 to III.8
	B. Deductible The Policy provides the following options of Deductibles under the Policy	Option I - ₹ 15,000 Option II - ₹ 30,000 Option III - ₹ 60,000 Deductible shall not apply to Optional Covers under F, G, H wherever opted		
	C. Co-pay	The Policy provides an option of 20% Co-payment under the Policy. Co-pay shall not apply to Optional Covers under F, G, H wherever opted		
	D. Maximum limit on Out of Pocket The Policy provides the following options of Out of Patient Maximum under the Policy	Option I - ₹ 60,000 Option II - ₹ 90,000 Option III - ₹ 120,000		
	E. Maternity Expenses The policy provides the following options for coverage of Maternity Expenses under the Policy	**Annual Limit Options** Option I - ₹ 120,000 Option II - ₹ 600,000 Option III - ₹ 1,200,000 **Coverage** • Routine or Elective Caesarean • Complicated Pregnancy • Pre & Post Natal Care • New born cover • Maternity Assistance & Mid-wife charges • Birthing classes charges		
	F. Wellness The policy provides the following options of payment of medical expenses incurred on Wellness tests of an Insured person	**Annual Limit Options** Option I - ₹ 15,000 Option II - ₹ 30,000 **Coverage** • Routine Adult Physical Exams • Wellness tests for children • Child Immunizations • Pap Smear • Prostate Cancer Screening • Mammograms for Breast Cancer Screening or Diagnostic Purposes		
	G. Dental The policy provides the following options of coverage of costs incurred towards Dental treatment wherever prescribed by a Medical Practitioner	**Annual Limit Options** Option I - ₹ 20,000 Option II - ₹ 50,000 Option III - ₹ 100,000 **Coverage** • Class 1 (Investigative & Preventative Treatment) • Class 2 (Basic Restorative, Periodontal Treatment) • Class 3 (Major Restorative & Orthodontic Treatment)		
	H. Vision The Policy provides coverage for the following costs incurred towards Vision tests	**Coverage is available under two options - Option I & II** • Eye examination 1 per year of insurance • Expenses for lens, eyeglass frames, prescription sunglasses		

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief	Refer to the following Policy Section number in the Policy Wording for more details on each cover
What are the Major exclusions in the Policy This section provides a brief list of the major charges/ treatments which will not be covered under the Policy permanently.	Please note that this is an indicative list of exclusions; please refer to the Policy wording and clauses for the complete list of exclusions. • Any Treatment in any way connected with attempted suicide or injury which exceed the limits under the Policy • Treatment for or in connection with speech and/or occupational therapy unless recommended by a specialist • Dental or orthodontic treatment unless benefit is specifically in force under the Policy for the Insured Person • Treatments in nature cure clinics, health spas and nursing homes(excluding nursing homes in India) • Charges for residential stays in hospitals which are arranged wholly or partly for domestic reasons • Treatment directly related to surrogacy • Treatment needed because of or relating to infertility or any type of fertility treatment • Any Treatment by way of the intentional Termination of Pregnancy unless recommended by two Medical Practitioners to be life threatening • Any Treatment related to changing the refraction of one or both eyes • Injury or disability directly or indirectly caused or contributed to whilst engaging in or taking part in war or invasion • Any expenses for international emergency services which were not approved in advance by the medical assistance service • Sex change operations or any treatment needed to prepare for or recover from these operations • Treatment for or in connection with non-medical counselling or ancillary services for learning disabilities or disorders • Any form of plastic, cosmetic or reconstructive surgery or treatment, even for psychological reasons, unless it is of medical necessity as a direct result of the patient having an accident • Any form of Unproven/Experimental Treatment • Treatment for learning disabilities, developmental delays, autism or cognitive or developmental disabilities/ disorders	IV.2
Waiting Period This sections lists the applicable period before a claim for the listed diseases/ treatments will be covered	A waiting period of 48 months will apply in case of Opting for a "Pre-existing diseases Exclusion", in which case the Pre-existing diseases will be covered after 48 months of continuous coverage with Us.	IV. 1
Payout Basis This section lists the applicable period before a claim for the listed diseases/treatments will be covered	Pay-out under this policy will be on reimbursement of actual expenses either by way of Cashless to the Hospital/ Network provider when a cashless facility is availed or directly to the Insured person as a reimbursement against the bills when the Insured has paid for the expenses.	V
Cost Sharing This sections lists the various circumstances under which the Insured person will bear some portion of the claim out of their pocket	a. A deductible will be applicable per Insured person per policy year on the aggregate of all claims, if opted for a "Deductible" option under the plan. All payable claims up to the opted deductible amount will be borne by the Insured. Any claim over and above this limit will become payable under the Policy. b. A Co-pay of 20% will be applicable on admissible claim amount (final payable claim amount after assessment) for every claim if the Insured has opted for a "Co-pay" option under the plan. To know the applicable deductible on your Policy please refer to the Policy Schedule.	III.2 III.3
Renewal Conditions This section lists the terms of renewals under the Policy	a. This Policy is ordinarily renewable on mutual consent, subject to application of Renewal and realisation of Renewal premium. b. Continuity will be provided if renewed within 30 days from the date of expiry of previous policy. If there is a break in the policy, any claim occurring within the break in period will not be covered under the Policy. c. Renewals will not be denied except on grounds of any fraud, misrepresentation or suppression by the Insured or anyone acting on his behalf.	VI.20
Cancellation The section explains the Policy cancellation process in brief	a. Cancellations may be intimated to us by giving 15 days' notice wherein we shall refund the premium for the unexpired term on the short period scale as mentioned in the Policy wordings. The Premium shall be refunded only if no claim has been made under the Policy. b. This Policy can be cancelled on grounds of misrepresentation, fraud, non-disclosure of material fact or non-cooperation by the Policyholder/ Insured, upon giving 15 days' notice without refund of premium.	VI.21
How to claim This section gives a brief on the procedure to make a claim	a. In the event of a Claim under the policy, the Insured Person must notify us either at the call centre or in writing with the required details as mentioned in the Policy wording. b. In case of Planned Hospitalization, please intimate us at least 3 days prior to the planned date of admission. c. In case of Emergency Hospitalization, Please intimate us within 48 hours of such admission but not later than discharge. d. In case of reimbursement of expenses, the Insured person should send the documents not later than 90 days from the date of discharge from hospital. e. All Claims in respect of International Emergency Services must be pre-authorised by us. For any claims related query, information or assistance you can contact our Healthline 1-800-10-24462 or visit our website www.cignattkinsurance.in or email us at customercare@cignattk.in. Please refer to the Policy wordings for complete process on claims.	V

Legal disclaimer: The information mentioned above is illustrative and not exhaustive. Information must be read in conjunction with the product brochures and Policy document. In case of any conflict between the Prospectus and the Policy document the terms and conditions mentioned in the Policy document shall prevail.

CignaTTK LIFESTYLE PROTECTION GROUP POLICY

TERMS & CONDITIONS

PREAMBLE & OPERATING CLAUSE

This is a legal contract between the Policyholder and Us subject to the receipt of full premium, Disclosure to Information Norm including the information on the Insured Persons provided by the Policyholder in the Group Proposal Form and the terms, conditions and exclusions of this Policy.

If any claim arising as a result of an Injury during the Policy Period solely and directly due to an Accident that occurred during the Policy Period or arising as a result of a Critical Illness that occurred during the Policy Period becomes payable, then We shall pay the Benefits specified below in accordance with terms, conditions and exclusions of the Policy. All limits mentioned in the Policy Schedule are applicable for each Policy Year of coverage.

PART I. GROUP PERSONAL ACCIDENT BENEFITS

The following Benefits will be payable in respect of an Insured Person only if the Benefit is specified in the Policy Schedule to be applicable for that Insured Person. The applicable Benefits and any applicable Optional Covers (as specified to be applicable in the Policy Schedule) will be available up to the Sum Assured subject to any limits specified in the Policy Schedule and subject further to the terms, conditions, limitations and specific and general exclusions.

Coverage under Section I A.1, Section I A.2 and Section I A.3 may be available either as an independent limit of Sum Insured or on Capital Sum Insured basis as opted by each group.

If an Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period and that Injury solely and directly results either in the Insured Person's death or in the Insured Person's disablement which is of the nature specified below within 365 days from the date of the Accident, We shall pay the corresponding Benefits specified below maximum up to the capital sum insured in respect of the Insured Person.

I.A. BASIC COVERS

I.A.1. Accidental Death Benefit

If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period and that Injury solely and directly results in the death of the Insured Person within 365 days from the date of the Accident, We will pay the Sum Insured as specified against this benefit in the Policy Schedule under Group Personal Accident Benefit, provided that once a claim has been accepted and paid under this Benefit in respect of an Insured Person, the Insured Person's insurance cover under this Section I.A. of the Policy including any optional section under I.B will immediately and automatically terminate. Any benefit towards an Optional Section under 1.B that qualifies to become payable in respect of Accident Death shall be paid along with the above.

I.A.2. Permanent Total Disablement Benefit

If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person which is of the nature specified in the table below, within 365 days from the date of the Accident, We will pay the Sum Insured as specified against this benefit in the Policy Schedule under Group Personal Accident Benefit.

Nature of Permanent Total Disablement	Percentage of the Sum Insured payable
Total and irrecoverable loss of sight in both eyes	100%
Loss by physical separation or total and permanent loss of use of both hands or both feet	100%
Loss by physical separation or total and permanent loss of use of one hand and one foot	100%
Total and irrecoverable loss of sight in one eye and loss of a Limb	100%
Total and irrecoverable loss of hearing in both ears and loss of one Limb/ loss of sight in one eye	100%
Total and irrecoverable loss of hearing in both ears and loss of speech	100%
Total and irrecoverable loss of speech and loss of one Limb/ loss of sight in one eye	100%
Permanent, total and absolute disablement (not falling under any one the above) which results in the Insured Person being unable to engage in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in Loss of Independent Living	100%

For the purpose of this Benefit,

- **Limb** means a hand at or above the wrist or a foot above the ankle;
- **Physical separation of one hand** or **foot** means separation at or above wrist and/or at or above ankle, respectively.

The Benefit as specified above will be payable provided that:

a. The Permanent Total Disablement is proved to Our satisfaction; and a disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board is given to us;

b. The Permanent Total Disablement continues for a period of at least 180 days from the commencement of the Permanent Total Disablement, and We are satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement and such disability is permanent at the end of this period;

c. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit; however benefit under Accidental Death shall become payable in lieu of this benefit, if opted.

d. Once a claim has been accepted and paid under this Benefit then the Insured Person's insurance cover under this section will lapse.. Any benefit towards an Optional Section under 1.B that qualifies to become payable in respect of a Permanent Total Disability shall be paid along with the above.

I.A.3. Permanent Partial Disablement Benefit

If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period and that Injury solely and directly results in the Permanent Partial Disablement of the Insured Person which is of the nature specified in the table below within 365 days from the date of the Accident, We will pay the amount specified in the table below maximum up to the Capital Sum Insured under Group Personal Accident Benefit:

Nature of Permanent Partial Disablement		Percentage of the Sum Insured payable
i.	Total and irrecoverable loss of sight in one eye	50%
ii.	Loss of one hand or one foot	50%
iii.	Loss of all toes - any one foot	10%
iv.	Loss of toe great - any one foot	5%
v.	Loss of toes other than great, if more than one toe lost, each	2%
vi.	Total and irrecoverable loss of hearing in both ears	50%
vii.	Total and irrecoverable loss of hearing in one ear	15%
viii.	Total and irrecoverable loss of speech	50%
ix.	Loss of four fingers and thumb of one hand	40%
x.	Loss of four fingers	35%
xi.	Loss of thumb- both phalanges	25%
xii.	Loss of thumb- one phalanx	10%
xiii.	Loss of index finger-three phalanges	10%
xiv.	Loss of index finger-two phalanges	8%
xv.	Loss of index finger-one phalanx	4%
xvi.	Loss of middle/ring/little finger-three phalanges	6%
xvii.	Loss of middle/ring/little finger-two phalanges	4%
xviii.	Loss of middle/ring/little finger-one phalanx	2%

The Benefit specified above will be payable provided that:

a. The Permanent Partial Disablement is proved to Our satisfaction; and a disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board is given to Us;

b. The Permanent Partial Disablement continues for a period of at least 180 days from the commencement of the Permanent Partial Disablement and We are satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement and such disability is permanent at the end of this period;

c. If the Insured Person dies before a claim has been admitted under this Benefit, then no amount will be payable under this Benefit; however benefit under Accidental Death shall become payable in lieu of this benefit, if opted.

d. If the Insured Person suffers a loss that is not of the nature of Permanent Partial Disablement specified in the table above, then a disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board will determine the degree of disablement and the amount payable, if any;

Note for Section I.A.1, Section I.A.2 and Section I.A.3 where Capital Sum Insured is Opted:

The maximum liability for any one or all claims under Section 1.A.1, Section 1.A.2 and Section 1.A.3 in a Policy Year will be limited to the Capital Sum Insured as specified under the Policy Schedule for that Insured Person.

Once a claim has been accepted and paid under Section I.A.2 and Section I.A.3, the Insured Person's insurance cover under this Policy shall continue, subject to availability of the Capital Sum Insured.

I.A.4. Temporary Total Disablement Benefit

If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period and that Injury solely and directly results in the Temporary Total Disablement (as defined below) of the Insured Person within 365 days from the date of the Accident, We will pay in respect of the Insured Person an amount equal to the lesser of 1% of the highest Sum Insured opted under Section I.A.1, Section I.A.2, Section I.A.3/ the Capital Sum Insured, as applicable or the fixed opted Sum Insured per week for the duration of the Temporary Total Disablement provided that We shall not be liable to make payment under this Benefit for more than a total of 100 weeks in respect of any one Injury calculated from the date of commencement of the Temporary Total Disablement, subject always to a maximum up to the Capital Sum Insured, provided that the Insured Person shall be absent from his occupation for at least 7 consecutive days (in which case benefit will be payable from day 1), post which if the Insured Person is disabled for a part of the week, then only a proportionate part of the weekly Benefit will be payable.

This weekly Benefit shall in no case exceed the Insured Person's base weekly income calculated on the earnings as on date of Accident, excluding overtime, bonuses, tips, commissions or any other special compensation.

For the purpose of this Benefit, Temporary Total Disablement means a disablement of an Insured Person such that he/she is totally disabled from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever on a temporary basis and a disability certificate is issued by a civil surgeon or the equivalent appointed by the District, State or Government Board.

This benefit will be payable at the end of recovery period of TTD. In case the disability continues for a period of more than 30 days then We will make payment of amount at the end of every calendar month until TTD ceases.

I.B OPTIONAL COVERS UNDER THE PERSONAL ACCIDENT BENEFIT

The Policy can be extended to include the following optional covers, subject to the policy conditions, by paying applicable additional premium. Wherever opted, such Optional Covers shall apply to all Insured Persons under a single policy without any individual selection. All covers available under optional covers are in addition to the Basic Covers opted and such optional cover benefits will only be payable upon conditions specified in the individual benefit sections. Wherever a claim qualifies under more than one benefit we will pay for all such eligible covers opted and in force at the time of such claim under the Policy.

I.B.1. Disappearance Benefit

If an Insured Person disappears during the Policy Period and is legally declared dead (declared death in absentia or legal presumption of death), We will pay the amount as specified against this benefit in the Policy Schedule to the Nominee provided that:

- It may reasonably be assumed that the disappearance of the Insured Person is due to an Accident followed by a forced landing, stranding, sinking or wrecking of a conveyance during the Policy Period;
- A period of at least 7 years has been completed since the date of the Insured Person's disappearance; and
- The legal representatives of the Insured Person's estate provide Us with a signed agreement stating that if it later transpires that the Insured Person did not die, or did not die due to an Accident during the Policy Period, the amount paid under this Optional Cover will be reimbursed to Us immediately and without any deductions.
- The Insured Persons legal representative must intimate such disappearance to Us immediately upon happening of the event. Insurer shall provide full benefit as per Sum Insured opted upon completion of such 7 years period.

I.B.2. Broken Bones Benefit

If an Insured Person sustains Broken Bones and results in conditions specified in the table below due to an Injury suffered during the Policy Period solely and directly due to an Accident that occurs during the Policy Period, We will pay the amount as specified against this benefit in the Policy Schedule:

Broken Bones resulting an injury to	**Percentage of the Sum Insured payable**
Vertebral body resulting in spinal cord damage	100%
Pelvis	100%
Skull (excluding nose and teeth)	30%
Chest (all ribs and breast bone)	50%
Shoulder (collar bone and shoulder blade)	30%
Arm	25%
Leg	25%
Vertebra – vertebral arch (excluding coccyx)	30%
Wrist (collies or similar fractures)	10%
Ankle (Potts or similar fracture)	10%
Coccyx	5%
Hand	3%
Finger	3%
Foot	3%
Toe	3%
Nasal bone	3%

For the purpose of this Optional Cover:

- **Broken Bones** means the breakage of one or more of bones of the Insured Person specified in the table above as evidenced by a Fracture but excluding any form of hair line fracture.
- **Pelvis** means all pelvic bones which shall be treated as one bone. The sacrum will be considered as part of the vertebral column.
- **Skull** means all skull and facial bones (excluding nasal bones and teeth) which shall be treated as one bone.

The Benefit specified above will be payable provided that:

- Any Fracture which results due to any Illness or disease (including malignancy) or due to osteoporosis shall not be payable under this Optional Cover;
- If an Insured Person suffers a Fracture not specified in the table above but the Fracture is due to an Injury that is suffered during the Policy Period solely and directly due to an Accident that occurs during the Policy Period, then Our medical advisors may request for a certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board to determine the amount payable, if any;
- Our maximum, total and cumulative liability under this Optional Cover shall be limited to the amount mentioned against this benefit on the Policy Schedule, irrespective of the number of Fractures that the Insured Person suffers due to the same or secondary or multiple Accidents during the same Policy Period.
- If a claim in respect of any Fracture of a whole bone and also encompasses some or all of its parts, Our liability to make payment will be limited to the amount payable in respect of the whole bone only and not for any of its parts.

I.B.3. Burns Benefit

If an Insured Person sustains Burns and results in conditions specified in the table below due to an Injury suffered during the Policy Period solely and directly due to an Accident that occurs during the Policy Period, We will pay the amount specified in the table below to the Insured Person up to the limit specified against this benefit in the Policy Schedule provided that:

- The Burns are not self-inflicted by the Insured Person in any way; and
- A Medical Practitioner has confirmed the diagnosis of the burn and the percentage of the surface area of the Burn to Us in writing.
- If the bodily injury results in more than one of the nature of burns specified below, We shall be liable to pay for only the highest benefit among all.

Nature of Burns		**Percentage of the Sum Insured payable**
	1. Head	
a.	Third degree burns of 8% or more of the total head surface area	100%
b.	Second degree burns of 8% or more of the total head surface area	50%
c.	Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
d.	Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
e.	Third degree burns of 2% or more, but less than 5% of the total head surface area	60%
f.	Second degree burns of 2% or more, but less than 5% of the total head surface area	30%
	2. Rest of the body	
a.	Third degree burns of 20% or more of the total body surface area	100%
b.	Second degree burns of 20% or more of the total body surface area	50%
c.	Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
d.	Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
e.	Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
f.	Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
g.	Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
h.	Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

I.B.4. Coma Benefit

If an Insured Person suffers a Coma due to an Injury suffered during the Policy Period solely and directly due to an Accident that occurs during the Policy Period, We will pay an amount equal to the Sum Insured in respect of that Insured Person, provided that:

(a) This diagnosis of Coma by a Medical Practitioner is supported by 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 is assessed at least 30 days after the onset of the Coma.

(b) The condition of Coma is confirmed by a specialist Medical Practitioner in writing.

(c) The Coma does not result from alcohol/ drug abuse or due to an Illness.

For the purpose of this Benefit, **Coma** means a state of unconsciousness with no reaction or response to external stimuli or internal needs.

I.B.5. Accidental Death Benefit (Common Carrier)

If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs while the Insured Person is a fare paying passenger on a common carrier during the Policy Period and that Injury solely and directly results in the death of the Insured Person within 365 days from the date of the Accident, We will pay the amount as specified against this benefit in the Policy Schedule, in addition to the amount payable under Section I.A.1, provided that We have accepted a claim for Accidental Death in accordance with that Section.

Common carrier refers to an entity in the business of transporting goods or people for hire, as a public service.

I.B.6. Permanent Total Disablement Benefit (Common Carrier)

If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs while the Insured Person is a fare paying passenger on a common carrier during the Policy Period and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person which is of the nature specified in the table in Section I.A.2 within 365 days from the date of the Accident, We will pay the amount as specified against this benefit in the Policy Schedule, in addition to the amount payable under Section I.A.2, provided that We have accepted a claim for Permanent Total Disablement in accordance with that Section.

Common carrier refers to an entity in the business of transporting goods or people for hire, as a public service.

I.B.7. Permanent Total Disablement Double Benefit

If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period and that Injury solely and directly results in the Permanent Total Disablement of the Insured Person which is of the nature specified in Section I.A.2, within 365 days from the date of the Accident, We will pay the Sum Insured as specified against this benefit in the Policy Schedule, in addition to the amount payable under Section I.A.2, provided that We have accepted a claim for Permanent Total Disablement in accordance with that Section.

I.B.8. Cost of Support Items Benefit

If We have accepted a claim for Permanent Total Disablement, Permanent Partial Disablement or Temporary Total Disablement in accordance with Sections I.A.2, I.A.3 or I.A.4, respectively, in respect of an Insured Person, then in addition to any amount payable under that Section, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards: :

- Reasonable and Customary Charges for the purchase of support items such as artificial limbs, crutches, stretcher, tricycle, wheelchairs, intra-ocular lenses, spectacles or any other item which in the opinion of a Medical Practitioner is/ are necessary for the Insured Person due to the Injury sustained in the Accident;
- Reasonable and Customary Charges for additional lifesaving expenses incurred for special or imported medicines or for blood transfusion for treatment or Surgery for the Injury sustained, provided that the treatment is availed in a Hospital or Day Care Centre in India including on an out-patient basis or for Day Care Treatment
- Reasonable costs actually incurred on a chauffeur or taxi service to convey the Insured Person to and from work in the event the Insured Person is unable to travel to and from work using the method of transport he/she normally used prior to the Accident until Insured Person is well enough to resume using the same method of transport;
- Reasonable costs actually incurred for services taken from registered domestic helper for accomplishing activities of Daily living.

Activities of daily living are defined as below:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;

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

iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;

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

v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

I.B.9. Modification Allowance Benefit

If We have accepted a claim for Permanent Total Disablement, Permanent Partial Disablement or Temporary Total Disablement in accordance with Sections I.A.2, I.A.3 or I.A.4, respectively, in respect of an Insured Person and if the Insured Person is necessarily required to modify his/her vehicle or make modifications in his/her house to adjust to the disablement for which a claim has been accepted under the Policy, then in addition to any amount payable under that Section, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule.

I.B.10. Rehabilitation Benefit

If an Insured Person is subjected to an act of violence or suffers a traumatic Accident, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards the Reasonable and Customary Charges for counselling fees, specialist consultation and extended physiotherapy on an out- patient basis. This Optional Cover can be availed only once during thePolicy Period.

I.B.11. Animal Attack Benefit

If an Insured Person is Hospitalised on the advice of a Medical Practitioner due to an Injury caused solely and directly by an Animal attack occurring during the Policy Period then We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards the Reasonable and Customary Charges for Medical Expenses incurred towards medical treatment for the Injury sustained, provided the treatment is availed in a Hospital or Day Care Centre in India including on an out-patient basis or for Day Care Treatment.

This Optional Cover will be payable independent of any claim made under Section I.A of the Policy.

For the purpose of this Benefit, Animal means a mammal and excludes birds, reptiles, fishes, or insects.

I.B.12. Cost of Personal Protective Equipment (PPE) Damaged in the Accident Benefit

If We have accepted a claim for Permanent Total Disablement, Permanent Partial Disablement or Temporary Total Disablement in accordance with Sections I.A.2, I.A.3, I.A.4, respectively, in respect of an Insured Person, then in addition to any amount payable under that Section, We will pay the amount specified against this benefit in the Policy Schedule towards the costs of Personal Protective Equipment damaged in the Accident.

For the purpose of this Optional Benefit, Personal Protective Equipment means any equipment that controls or mitigates a risk to a person's health and safety. Personal Protective Equipment includes but is not limited to safety goggles, high visibility vests, work kneepads, tool vests to replace tool belts, safety boots, ear plugs or earmuffs, face masks, respirators, lead aprons and over the shoulder tool belts.

I.B.13. Funeral Expenses Benefit

If We have accepted a claim for Accidental Death in accordance with Section I.A.1 in respect of an Insured Person, then in addition to any amount payable under Section I.A.1, We will make a onetime lump sum payment of the amount specified in the Policy Schedule, towards:

a. expenses incurred for preparing the body of that Insured Person for burial or cremation and transportation to the address mentioned in the Policy Schedule;

b. funeral/cremation expenses in respect of that Insured Person

I.B.14. Emergency Road Ambulance Benefit

If the Insured Person is Hospitalized during the Policy Period for Medically Necessary treatment of an Accidental Injury, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards Ambulance Expenses.

For the purpose of availing this Benefit the Insured Person must have availed of Medically Necessary transportation through a registered Ambulance Service Provider to a Hospital immediately following the Accident.

I.B.15. Repatriation of Mortal Remains

If We have accepted a claim for Accidental Death in accordance with Sections I.A.1, in respect of an Insured Person, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards the costs associated with the transportation of mortal remains from the place of death to the home location.

In addition, assistance will be provided by Us or the Medical Assistance Service for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

I.B.16. Dependent Children Benefit

If We have accepted a claim for Accidental Death in accordance with Sections I.A.1, in respect of an Insured Person, then in addition to any amount payable under that Section, We will pay the amount as specified against this benefit in the Policy

Schedule, in respect of Dependent Child (children) under the age of 25 as on the date of occurrence, irrespective of whether the child (children) is an Insured Person under this Policy.

Any Claim towards this benefit that becomes admissible where the Dependent child (children) is a minor, shall be payable to the Legal Guardian.

If one child, the Sum Insured specified under this benefit shall be paid fully to the child. If more than one child, the Sum Insured specified under this benefit shall be paid equally among all eligible children.

I.B.17. Spouse Benefit

If We have accepted a claim for Accidental Death in accordance with Section I.A.1 in respect of an Insured Person, then in addition to any amount payable under that Section, We will pay the amount as specified against this benefit in the Policy Schedule, in respect of the widowed Spouse of the Insured Person, irrespective of whether the Spouse is an Insured Person under this Policy.

I.B.18. Dependent Parent Benefit

If We have accepted a claim for Accidental Death in accordance with Section I.A.1 in respect of an Insured Person, then in addition to any amount payable under that Section, We will pay the amount as specified against this benefit in the Policy Schedule, in respect of the surviving Dependent Parent (single or both parents) of the Insured Person, irrespective of whether the parent is an Insured Person under this Policy.

For the purpose of this Optional Benefit, the Insured Person's parent will be considered as a Dependent Parent only if the parent is financially dependent on the Insured Person. In case of a single surviving parent, he/she must be financially dependent on the Insured Person whereas in case of both parents surviving, both parents must be financially dependent on the Insured Person to be eligible for payment under this benefit.

I.B.19. Marriage Benefit for Dependent Children

If We have accepted a claim for Accidental Death or Permanent Total Disablement in accordance with Sections I.A.1 or I.A.2 in respect of an Insured Person, then in addition to any amount payable under that Section, We will pay the amount up to the limit specified against this benefit in the Policy Schedule, in respect of the Insured Person's Dependent Child (children) under the age of 25 and unmarried as on the date of occurrence, irrespective of whether the child (children) is an Insured Person under this Policy.

Any Claim towards this benefit that becomes admissible where the Dependent child (children) is a minor, shall be payable to the Legal Guardian.

If one child, the Sum Insured specified under this benefit shall be paid fully to the child. If more than one child, the Sum Insured specified under this benefit shall be divided equally among all eligible children.

I.B.20. Education Fund Benefit

If We have accepted a claim for Accidental Death or Permanent Total Disablement in accordance with Section I.A.1 or 1.A.2 in respect of an Insured Person, then in addition to any amount payable under that Sections, We will pay the amount up to the limit specified against this benefit in the Policy Schedule, in respect of the tuition fees paid towards the Dependent Child's education for the Policy Period, irrespective of whether the child (children) is an Insured Person under this Policy.

This benefit shall be payable subject to the dependent child being up to 25 years of age as on date of occurrence of the event and provided that the dependent child is pursuing an educational course as a full time student at an accredited educational institution and does not have any independent source of income.

Any Claim towards this benefit that becomes admissible where the Dependent child (children) is a minor, shall be payable to the Legal Guardian.

If one child, the Sum Insured specified under this benefit shall be paid fully to the child. If more than one child, the Sum Insured specified under this benefit shall be divided equally among all eligible children.

I.B.21. Re-training Expenses Benefit

If We have accepted a claim for Permanent Total Disablement or Permanent Partial Disablement in accordance with Sections I.A.2 or I.A.3 in respect of an Insured Person, then in addition to any amount payable under that Section, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards the reasonable costs actually incurred to re-train the Insured Person for an alternative occupation either in the business of the Policyholder or elsewhere.

I.B.22. Convalescence Benefit

If the Insured Person is hospitalised during the Policy Period for Medically Necessary treatment of an Accidental Injury that occurred during the Policy Period and the continuation of such Hospitalisation is Medically Necessary for at least 10 consecutive days, We will pay the amount as specified against this benefit in the Policy Schedule.

This benefit is payable only once in a Policy Year towards an Insured Person.

I.B.23. Hospital Cash Benefit

If the Insured Person is hospitalised during the Policy Period for Medically Necessary treatment of an Accidental Injury, We will pay the Hospital Cash Benefit amount specified against this benefit on the Policy Schedule for each continuous completed calendar day of Hospitalization.

This benefit is payable for maximum up to 30 days in a policy year, in excess of one day, provided that the Hospitalisation is for a minimum period of 24 hours.

Specific Limitation:

Hospital Cash Benefit is restricted to maximum 15 days for the accidental hospitalisations due to following conditions:

1. Coma
2. Burns

I.B.24. Loss of Earning Benefit

If We have accepted a claim for Permanent Total Disablement or Permanent Partial Disablement in accordance with Section I.A.2 or I.A.3 that results in a condition due to which the Insured Person is disabled from engaging in his/her primary occupation and loses his/her source of income generation as a consequence thereof, then We will pay the amount (as lump sum or monthly payout) as specified against this benefit in the Policy Schedule:

a. In case of salaried Insured Persons: A monthly income for 3 months, based on the average of last 3 months salary slip of the previous employer. This payout is limited to base monthly income excluding overtime, bonuses, tips, commissions or any other special compensation;

b. In case of self-employed Insured Persons: A monthly income for 3 months, based on the last income tax returns filed by the Insured Person with the income tax department. This payout will consider income from primary occupation only and does not include income from any other sources.

This Optional Cover shall be available only once during the Policy Period.

I.B.25. Family Counselling Benefit

If We have accepted a claim for Accidental Death, Permanent Total Disablement or Permanent Partial Disablement in accordance with Sections -I.A.1, I.A.2 or I.A.3 in respect of an Insured Person, and such death or disablement results in mental trauma to any or all Immediate Family Members of the Insured Person, then We will pay the amount up to the limit specified against this benefit in the Policy Schedule towards the psychiatric counselling of the Immediate Family Members of such Insured Person provided the family members receive such counselling on an out patient basis in a Hospital.

I.B.26. Family Transportation Allowance Benefit

If We have accepted a claim for Permanent Total disablement, Permanent Partial Disablement or Temporary Total Disablement in accordance with Sections I.A.2, I.A.3 or I.A.4 in respect of an Insured Person and if the Insured Person is Hospitalized in a Hospital which is situated at a distance of at least 100 kilometre from his actual place of residence, and the attending Medical Practitioner recommends the personal attendance of an Immediate Family Member, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule, incurred in respect of any one Immediate Family Member of the Insured Person for transportation by one way airfare or one way first class railway ticket in a licensed common carrier to the place of Hospitalization of the Insured Person.

I.B.27. Medical Second Opinion

If We have accepted a claim for Permanent Total disablement, Permanent Partial Disablement or Temporary Total Disablement in accordance with Sections I.A.2, I.A.3 or I.A.4 in respect of an Insured, then the Insured Person may choose to secure a second opinion from Our network of Medical Practitioners for treatment of Permanent Total disablement, Permanent Partial Disablement or Temporary Total Disablement. Such request from Our network of Medical Practitioners shall be directly sent to the Insured Person.

The Insured Person understands and agrees that he/ she can exercise the option to secure an expert opinion, provided that:

a. We have received a written request from the Insured Person to exercise this option.

b. The expert opinion will be based only on the information and documentation provided by the Insured Person.

c. This Benefit can be availed only once, by each Insured Person during the lifetime of the Policy for a particular Permanent Total disablement, Permanent Partial Disablement or Temporary Total Disablement.

d. This Benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

e. The Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

f. We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any expert opinion or for any consequence of actions taken or not taken in reliance thereon.

g. The expert opinion under this Optional Cover shall be limited to covered disablements as listed in Sections I.A.2, I.A.3 or I.A.4 and shall not be valid for any medico legal purposes.

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

All claims under this Optional Cover shall be made in accordance with under Section III.3 of the Policy.

I.B.28. Wellness Benefit

a. The Insured Person may avail a health check-up with Our Network Provider as mentioned below. Health check-ups will be and arranged by Us and conducted at Our network providers only.

b. Original copies of all reports will be provided to the Insured Person, while a copy of the same will be retained by Us.

c. Coverage under this Optional Cover will not be available on reimbursement basis. All claims under this Benefit shall be made in accordance with Section III.3.14 of the Policy.

d.

Sum Insured	Age	List of tests
Less than ₹ 25 Lacs	>18 years	MER, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, Urine Routine, SGPT
₹25 Lacs - ₹100 Lacs	18 to 40 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid
	> 41 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid For females only - TSH, Pap smear, Mammogram For Males- PSA
More than ₹100 Lacs	18 to 40 years	MER, Lipid Profile, HbA1c, Sr. Creatinine, CBC-ESR, RUA, SGPT, ECG, SGOT, GGT, Uric Acid For females: Pap smear, TSH, Mammogram For males: PSA
	> 41 years (For males only)	MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric acid, TMT, USG Abdomen & Pelvis, PSA
	> 41 years (For females only)	MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, TMT, Uric acid, USG Abdomen & Pelvis, Pap smear, Mammogram, TSH

I.B.29. Accidental Medical Expenses

If We have accepted a claim for Death, Permanent Total Disablementor Permanent Partial Disablement in accordance with Sections I.A.1, I.A.2 or I.A.3 respectively as opted, in respect of an Insured Person, then in addition to any amount payable under that Section, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule, towards the Reasonable and Customary Charges for Medical Expenses incurred in respect of treatment or Surgery for the Injury sustained, provided that the treatment is availed in a Hospital or Day Care Centre in India or for Day Care Treatment up to the sum insured limit mentioned against this benefit on the Policy Schedule.

We shall not be liable to make any payment under this Optional Cover for or in respect of:

a) Pre-hospitalization Medical Expenses;

b) Post-hospitalisation Medical Expenses;

c) Out- patient expense

d) Alternative Treatments.

The coverage under this section will be limited to claim being payable under the Basic Cover opted as part of Section 1A.

I.B.30. Out-Patient Treatment Allowance

If We have accepted a claim for Permanent Total Disablement, Permanent Partial Disablement or Temporary Total Disablement in accordance with Sections I.A.2, I.A.3 or I.A.4, respectively, in respect of an Insured Person, then in addition to any amount payable under that Section, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule, towards the Reasonable and Customary Charges for Medical Expenses incurred in respect of medical treatment for the Injury sustained and availed in a Hospital as an Out-Patient.

I.B.31. In- Patient Medical Expenses

If an Insured Person is Hospitalised as an In-patient during the Policy Period on the advice of a Medical Practitioner due to an Accidental Injury sustained during the Policy Period then We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule, towards the Reasonable and Customary Charges for Medical Expenses incurred in respect of medical treatment or Surgery for the Injury sustained, provided that the treatment is availed in a Hospital or Day Care Centre.

We shall not be liable to make any payment under this Optional Cover for or in respect of:

a) Pre-hospitalization Medical Expenses;

b) Post-hospitalisation Medical Expenses;

c) Out- patient expense

d) Alternative Treatments.

I.B.32. Emergency Evacuation

Subject to the conditions set out below in case of an Emergency, arising out of an Accident in respect of an Insured Person, if adequate medical facilities are not available locally, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards the arrangement for an Emergency evacuation of the Insured Person to the nearest facility capable of providing adequate care provided that:

- Our medical assistance service will arrange for the transport of the Insured Person to the nearest Hospital offering the necessary treatment, under proper medical supervision.
- The Emergency medical evacuations is pre-authorised by the Our medical team. If it is not possible for pre-authorisation to be sought before the evacuation takes place, authorisation must be sought as soon as possible thereafter. We will only authorise medical evacuations after the evacuation has occurred where it was not reasonably possible for authorisation to be sought before the evacuation took place.
- The medical evacuations must be determined by Our medical team to be Medically Necessary to prevent the immediate and significant effects of Injury or conditions which if left untreated could result in a significant deterioration of health and it has been determined that the treatment is not available locally.
- In making Our determinations, We will consider the nature of emergency, Your medical condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered.
- The Insured Person's medical condition must require the accompaniment of a qualified healthcare professional during the entire course of the evacuation to be considered an emergency and requiring emergency evacuation.
- Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

I.B.33. Medical Repatriation

If We have accepted a claim under Optional Cover I.B.32 for Emergency evacuation of the Insured Person, We may request for the repatriation of the Insured Person to a Hospital in the Insured Person's country of domicile or to the original work location or the location from which the Insured Person was evacuated when a Medical Practitioner named by Our medical assistance service, after speaking with a local attending Medical Practitioner, decides that the Insured Person is fit to undertake the journey.

We will pay Reasonable and Customary Charges for the most economical cost of travel (transport only) for the Insured Person.

If any mode of transportation other than the above is determined by the attending Medical Practitioner and agreed by Our medical assistance service, We will arrange accordingly and such will be covered by Us.

Conditions:

- Medical repatriations must be pre-authorised by Our medical team. Where it is not possible for pre-authorisation to be sought before the repatriation takes place, this must be sought as soon as possible thereafter. We will only authorise medical repatriation after the repatriation has occurred where it was not reasonably possible for authorisation to be sought before the repatriation took place.
- Medical repatriation must be determined by Our medical team to be Medically Necessary to prevent the immediate and significant effects of Illness, Injury or conditions which if left untreated could result in a significant deterioration of health and it has been determined that the treatment is not available locally, and that it is necessary for medical reasons for the Insured Person to be returned to his/her country of domicile, the medical assistance service will arrange for the transport under proper medical supervision as soon as reasonably practicable.
- In making Our determinations, We will consider the nature of emergency, the Insured Person's medical condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered.
- Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

Our maximum liability under this Benefit shall be limited to the Sum Insured mentioned against this benefit on the Policy Schedule.

I.B.34. Adventure Sports Benefit

If an Insured Person suffers from an Accidental Injury resulting in Accidental Death or Permanent Total Disablement due to an Injury sustained while engaged in an adventure sport carried out in accordance with the guidelines, codes of good practice and recommendations for safe practices as laid down by a governing body or authority, then We will pay the amount as specified against this benefit in the Policy Schedule.

If this Optional Cover is in force in respect of the Insured Person, then Exclusion I.C.17 will deem to be inoperative for the purpose of this Optional Cover in respect of that Insured Person.

We shall cover the following in respect of this benefit:

a) Boxing, base jumping, canoeing, cliff diving, endurance races, flying (except passengers in licensed passenger-carrying aircraft), gorge swinging, hunting, ice caving, ice hockey, martial arts (competitions), mountaineering/free climbing (expeditions, or without use of ropes or guides), parachuting/skydiving

(extended free fall or acrobatics), power boating, private flying, rafting, scuba diving, sky surfing, trekking/walking, wreck diving, wrestling, zorbing; or

b) any professional or semi-professional sporting activity; or

c) any kind of racing; or

d) any kind of manual work.

I.C. PERMANENT EXCLUSIONS UNDER PERSONAL ACCIDENT BENEFIT AND OPTIONAL BENEFITS UNDER THE PERSONAL ACCIDENT BENEFIT

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

1. Any Pre-existing Disease or Disability arising out of a Pre-existing Diseases or any complication arising therefrom.

2. 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 Capital Sum Insured in respect of Basic Covers. This would not apply to payments made under Optional Covers.

3. Suicide or attempted Suicide, intentional self-inflicted injury, acts of self-destruction whether the Insured Person is medically sane or insane.

4. Mental illness or sickness or disease including a psychiatric condition, mental disorders of or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by mental reaction to the same.

5. 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.

6. 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 defence, rebellion, revolution, insurrection, military or usurped power.

7. Death or disablement directly or indirectly caused by or associated with any venereal disease, sexually transmitted disease

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

9. Bacterial infections (except pyogenic infection which occurs through a cut or wound due to Accident).

10. Medical or surgical treatment except as necessary solely and directly as a result of an Accident.

11. Death or disablement directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and any injury caused by and/or related to HIV.

12. Any change of profession after inception of the Policy which results in the enhancement of Our risk under the Policy, if not accepted and endorsed by Us on the Policy Schedule.

13. 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, misdemeanour or civil commotion with criminal intent.

14. 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.

15. Death or disablement resulting directly or indirectly, contributed or aggravated or prolonged by childbirth or from pregnancy or a consequence thereof including ectopic pregnancy unless specifically arising due to accident;

16. 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.

17. 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 Policy Schedule.

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

19. 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.

20. Any physical, medical or mental condition or treatment or service that is specifically excluded in the Policy.

PART I. GROUP CRITICAL ILLNESS BENEFITS UNDER THE POLICY

If an Insured Person is diagnosed to be suffering from a Critical Illness (as defined below), while the Policy is in force then We will pay the Critical Illness Sum Insured specified in the Policy Schedule provided that:

a. The Critical Illness, which the Insured Person is suffering from, occurs or first manifests itself during the Policy Period as a first incidence; and

b. The Insured Person survives for at least 30 days from the date of diagnosis of the Critical Illness; and

c. Upon Our admission of the first claim under this Section II.A. in respect of an Insured Person in any Policy Period, the cover under this Section II.A. including any optional covers under II.B. shall automatically terminate in respect of that Insured Person;

d. Our total and cumulative liability for an Insured Person under this Benefit will be limited to the Critical Illness Sum Insured.

For the purpose of this Policy, **Critical Illness** means any Illness, medical event or Surgical Procedure as specifically defined below whose signs or symptoms first commence at least 90 days after the commencement of the Policy Period.

II.A. BASIC COVER UNDER GROUP CRITICAL ILLNESS

II.A.1. Cancer of specific severity

A malignant tumour characterised 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 leukaemia, 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 leukaemia less than RAI stage 3

vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix All tumors in the presence of HIV infection.

II.A.2. Myocardial Infarction (First Heart Attack – of Specific Severity)

I The first occurrence of heart attack or myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for myocardial infarction will 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; and

    iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

    i. Other acute Coronary Syndromes;

    ii. Any type of angina pectoris.

    iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

II.A.3. Open Chest CABG

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

II The following are excluded:

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

II.A.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.

II.A.5. 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:

a. No response to external stimuli continuously for at least 96 hours;

b. Life support measures are necessary to sustain life; and

c. 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 directly from alcohol or drug abuse is excluded.

II.A.6. Kidney Failure Requiring Regular Dialysis

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

II.A.7. Stroke Resulting in Permanent Symptoms

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

The following are excluded:

a. Transient ischemic attacks (TIA);

b. Traumatic Injury of the brain;

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

II.A.8. Major Organ/ Bone Marrow Transplant

The actual undergoing of a transplant of:

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

b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

The following are excluded:

i. Other stem-cell transplants;

ii. Where only islets of Langerhans are transplanted.

II.A.9. 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.

II.A.10. Motor Neurone Disease with Permanent Symptoms

Motor neurone 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.

II.A.11. Multiple Sclerosis with Persisting Symptoms

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

1. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis;
2. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

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

II.A.12. Primary Pulmonary Hypertension

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

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

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

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

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

Coverage under this Critical Illness shall not pay for any form of secondary causes of hypertension.

II.A.13. 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 Benefit, **Aorta** means the thoracic and abdominal aorta but not its branches.

You understand and agree that We will not cover:

a. Surgery performed using only minimally invasive or intraarterial techniques.

b. Angioplasty and all other intraarterial, catheter based techniques, “keyhole” or laser procedures.

c. Congenital narrowing of the aorta and traumatic injury of the aorta are specifically excluded.

II.A.14. Deafness (Loss of Hearing)

Total and irreversible Loss of hearing in both ears as a result of Illness or Injury.

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.

II.A.15. Blindness (Loss of Sight)

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

II. The Blindness is evidenced by:

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

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

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

II.A.16. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, 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 haematologist Medical Practitioner 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/mm³ or less;

b. Platelets count less than 20,000/mm³ or less;

c. Reticulocyte count of less than 20,000/mm³ or less.

We will not cover temporary or reversible Aplastic Anaemia under this Section.

II.A.17. Coronary Artery Disease

The first evidence of narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, regardless of whether or not any form of coronary artery Surgery has been performed. Coronary arteries herein refer to left main stem, left anterior descending circumflex and right coronary artery and not its branches which is evidenced by the following

a. evidence of ischemia on Stress ECG (NYHA Class III symptoms)

b. coronary arteriography (Hearth Cath)

II.A.18. End Stage Lung Disease

End Stage Lung Disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following:

a. FEVI(Forced Expiratory Volume) test results which are consistently less than 1 litre as measured on 3 occasions, 3 months apart;

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

c. Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2 <- 55 mm Hg); and

d. Dyspnoea at rest.

The diagnosis must be confirmed by a respiratory physician Medical Practitioner.

II.A.19. End Stage Liver Failure

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

a. Permanent jaundice;

b. Uncontrollable Ascites; and

c. Hepatic Encephalopathy.

d. Oesophageal or Gastric Varices and portal hypertension.

We will not cover liver disease secondary to alcohol or drug abuse.

II.A.20. Third Degree Burns (Major Burns)

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a consultant physician Medical Practitioner.

We will not cover burns arising due to self-infliction under this Section.

II.A.21. Fulminant 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:

a. Rapid decreasing of liver size;

b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;

c. Rapid deterioration of liver function tests;

d. Deepening jaundice; and

e. Hepatic encephalopathy.

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

II.A.22. Alzheimer's Disease

Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. 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 Medical Practitioner and supported by Our appointed Medical Practitioner.

The following conditions are however not covered:

a. non-organic diseases such as neurosis and psychiatric Illnesses;

b. alcohol related brain damage; and

c. any other type of irreversible organic disorder/dementia.

II.A.23. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and

b. A consultant neurologist Medical Practitioner.

We will not cover Bacterial Meningitis in the presence of HIV infection under this Section.

II.A.24. Benign Brain Tumour

A benign tumour in the brain where all of the following conditions are met:

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

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

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

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

The following conditions are however not covered by Us:

a. cysts;

b. granulomas;

c. vascular malformations;

d. haematoma;

e. Calcification;

f. Meningiomas;

g. Tumours of the pituitary gland or spinal cord; and

h. tumours of acoustic nerve (acoustic neuroma).

II.A.25. Apallic Syndrome

Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist Medical Practitioner acceptable to Us and the condition must be documented by such Medical Practitioner for at least one month.

II.A.26. Parkinson's Disease

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

The diagnosis must be supported by all of the following conditions:

a. the disease cannot be controlled with medication;

b. signs of progressive impairment; and

c. 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:

vii. 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;

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

ix. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;

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

xi. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

xii. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence

We will not cover Parkinson's disease secondary to drug and/or alcohol abuse under this Section.

II.A.27. Medullary Cystic Disease

A progressive hereditary disease of the kidneys characterised by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anaemia, polyuria and renal loss of sodium, progressing to chronic renal failure. The diagnosis must be supported by renal biopsy.

II.A.28. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist Medical Practitioner acceptable to Us, with confirmation of at least 3 of the following 4 conditions:

a. Family history of muscular dystrophy;

b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;

c. Characteristic electromyogram;

d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the 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:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;

ii. Dressing: the ability to put on, take off, secure and unfasten all garments

and, as appropriate, any braces, artificial limbs or other surgical appliances;

iii. Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;

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

v. Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available;

vi. Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence.

II.A.29. Loss of Speech

a. 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.

b. All psychiatric related causes are excluded.

II.A.30. Systemic Lupus Erythematous

A multi-system, multifactorial, autoimmune disorder characterised by the development of auto-antibodies directed against various self-antigens. Only those forms of systemic lupus erythematous which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification) will be covered by Us under this Section. The final diagnosis must be confirmed by a registered Medical Practitioner specialising in Rheumatology and Immunology acceptable to Us. Other forms of systemic lupus erythematous, discoid lupus and those forms with only haematological and joint involvement are however not covered:

The WHO lupus classification is as follows:

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

II.A.31. Loss of Limbs

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

II.A.32. Major Head Trauma

a. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident

must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

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

c. The Activities of Daily Living are:

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

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

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

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

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

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

d. The following are excluded:

a) Spinal cord injury; and

b) Head injury due to any other causes.

II.A.33. Brain Surgery

The actual undergoing of surgery to the brain, under general anaesthesia, during which a Craniotomy is performed. Burr hole and brain surgery as a result of an accident is excluded. The procedure must be considered necessary by a qualified specialist and the Benefit shall only be payable once corrective surgery has been carried out.

II.A.34. Cardiomyopathy

The unequivocal diagnosis by a consultant cardiologist of Cardiomyopathy causing impaired ventricular function suspected by ECG abnormalities and confirmed by cardiac echo of variable etiology and resulting in permanent physical impairments to the degree of at least Class IV of the New York Association (NYHA) Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment (Source: “Current Medical Diagnosis and Treatment – 39th Edition”):

a. Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnoea, or angina pain.

b. Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

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

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

We will not cover Cardiomyopathy related to alcohol abuse under this Section.

II.A.35. Creutzfeldt-Jacob Disease (CJD)

A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

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

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

II.A.36. Terminal Illness

An Insured Person shall be regarded as terminally ill only if he/ she is diagnosed as suffering from a condition which, in the opinion of two appropriate independent Medical Practitioners, is highly likely to lead to death within 12 months from the date of the diagnosis and the Insured Person is not receiving any active treatment for the terminal illness, other than that of the pain relief. The terminal illness must be diagnosed and confirmed by Medical Practitioners registered with the Indian Medical Association and approved by Us.

We will not cover terminal illness due to, arising from or attributable to AIDS under this Section.

II.B. OPTIONAL BENEFITS UNDER THE CRITICAL ILLNESS BENEFIT

The Policy can be extended to include the following optional covers, subject to the policy conditions, by paying applicable additional premium. Wherever opted, such Optional Covers shall apply to all Insured Persons under a single policy without any individual selection. All covers available under optional covers are in addition to the Basic Covers opted and such optional cover benefits will only be payable upon conditions specified in the individual benefit sections. Wherever a claim qualifies under more than one benefit we will pay for all such eligible covers opted and in force at the time of such claim under the Policy.

II.B.1. Survival Period Waiver Clause

If opted at the time policy inception, We shall waive the survival period applicable on Insured Persons and accept the claim as on the day of the occurrence of the event provided all the conditions related to the Critical Illness definition are satisfied.

II.B.2. Emergency Road Ambulance Benefit

If We have accepted a claim for Critical Illness in accordance with Section II.A in respect of an Insured Person, then in addition to any amount payable under that Section, We will pay the amount as specified against this benefit in the Policy Schedule, towards expenses incurred in respect of the Medically Necessary transportation of the Insured Person through a registered ambulance service provider to a Hospital immediately following an event related to the Critical Illness.

II.B.3. Emergency Evacuation

In the event of an Emergency arising in respect of the Critical Illness of an Insured Person and if adequate medical facilities are not available locally, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards the arrangement for an Emergency evacuation of the Insured Person to the nearest facility capable of providing adequate care provided that:

- The Emergency medical evacuations is pre-authorised by the Our medical team. If it is not possible for pre-authorisation to be sought before the evacuation takes place, authorisation must be sought as soon as possible thereafter. We will only authorise medical evacuations after the evacuation has occurred where it was not reasonably possible for authorisation to be sought before the evacuation took place.
- The medical evacuations must be determined by Our medical team to be Medically Necessary to prevent the immediate and significant effects of Injury or conditions which if left untreated could result in a significant deterioration of health and it has been determined that the treatment is not available locally.
- In making Our determinations, We will consider the nature of emergency, Your medical condition and ability to travel, as well as other relevant circumstances

including airport availability, weather conditions and distance to be covered.

- The Insured Person's medical condition must require the accompaniment of a qualified healthcare professional during the entire course of the evacuation to be considered an emergency and requiring emergency evacuation.
- Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

II.B.4. Medical Repatriation

If We have accepted a claim under Section II.B.3 for Emergency Evacuation of the Insured Person, We may request for the repatriation of the Insured Person to a Hospital in the Insured Person's country of domicile or to the original work location or the location from which the Insured Person was evacuated when a Medical Practitioner named by Our medical assistance service, after speaking with a local attending Medical Practitioner, decides that the Insured Person is fit to undertake the journey.

We will pay Reasonable and Customary Charges for the most economical cost of travel (transport only) for the Insured Person.

If any mode of transportation other than the above is determined by the attending Medical Practitioner and agreed by Our medical assistance service, We will arrange accordingly and such will be covered by Us.

Conditions:

- Medical repatriations must be pre-authorised by Our medical team. Where it is not possible for pre-authorisation to be sought before the repatriation takes place, this must be sought as soon as possible thereafter. We will only authorise medical repatriation after the repatriation has occurred where it was not reasonably possible for authorisation to be sought before the repatriation took place.
- Medical repatriation must be determined by Our medical team to be Medically Necessary to prevent the immediate and significant effects of Illness, Injury or conditions which if left untreated could result in a significant deterioration of health and it has been determined that the treatment is not available locally, and that it is necessary for medical reasons for the Insured Person to be returned to his/her country of domicile, the medical assistance service will arrange for the transport under proper medical supervision as soon as reasonably practicable.
- In making Our determinations, We will consider the nature of emergency, the Insured Person's medical condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions and distance to be covered.
- Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

Our maximum liability under this Benefit shall be limited to the Sum Insured mentioned against this benefit on the Policy Schedule.

II.B.5. Marriage Benefit for Dependent Children

If We have accepted a claim for Critical Illness in accordance with Section II.A in respect of an Insured Person, then in addition to any amount payable under that Section, We will pay the amount as specified against this benefit in the Policy Schedule, in respect of the Insured Person's Dependent Child (children) under the age of 25 and unmarried as on the date of occurrence, irrespective of whether the child (children) is an Insured Person under this Policy.

Any Claim towards this benefit that becomes admissible where the Dependent child (children) is a minor, shall be payable to the Legal Guardian.

If one child, the Sum Insured specified under this benefit shall be paid fully to the child. If more than one child, the Sum Insured specified under this benefit shall be divided equally among all eligible children.

II.B.6. Education Fund Benefit

If We have accepted a claim for Critical Illness in accordance with Section II.A in respect of an Insured Person, then in addition to any amount payable under that Section, We will pay the amount as specified against this benefit in the Policy Schedule, in respect of the Insured Person's Dependent Child (children) under the age of 25 as on the date of occurrence, irrespective of whether the child (children) is an Insured Person under this Policy.

This benefit shall be payable subject to the dependent child being up to 25 years of age as on date of occurrence of the event and provided that the dependent child is pursuing an educational course as a full time student at an accredited educational institution and does not have any independent source of income.

Any Claim towards this benefit that becomes admissible where the Dependent child (children) is a minor, shall be payable to the Legal Guardian.

If one child, the Sum Insured specified under this benefit shall be paid fully to the child. If more than one child, the Sum Insured specified under this benefit shall be divided equally among all eligible children.

II.B.7. Convalescence Benefit

If the Insured Person is Hospitalised during the Policy Period for Medically Necessary treatment of a Critical Illness covered under Section II.A Basic Cover, which is diagnosed during the Policy Period and the continuation of such Hospitalisation is Medically Necessary for at least 10 consecutive days, We will pay the amount as specified against this benefit in the Policy Schedule.

This benefit is payable only once in a Policy Year towards an Insured Person.

II.B.8. Hospital Cash Benefit

If the Insured Person is hospitalised during the Policy Period for Medically Necessary treatment of listed Critical Illness, We will pay the Hospital Cash Benefit amount specified against this benefit on the Policy Schedule for each continuous completed calendar day of Hospitalization.

This benefit is payable for maximum up to 30 days in a policy year, in excess of one day, provided that the Hospitalisation is for a minimum period of 24 hours.

Specific Limitation:

Hospital Cash Benefit is restricted to maximum 15 days for the accidental hospitalisations due to following conditions:

- Coma of Specified Severity
- Multiple Sclerosis with Persisting Symptoms
- Major Burns
- Systemic Lupus Erythematous
- Brain Surgery
- Major Head Trauma
- Creutzfeldt-Jacob Disease (CJD)
- Terminal Illness.

II.B.9. Rehabilitation Benefit

If We have accepted a claim for Critical Illness, in accordance with Section II.A in respect of an Insured Person, which results in mental trauma, then in addition to any amount payable under that Section,, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule towards the Reasonable and Customary Charges incurred for Medically necessary counselling and specialist consultation and extended physiotherapy on an out-patient basis,.

This Optional Cover can be availed only once during thePolicy Period.

II.B.10. Loss of Earning Benefit

If We have accepted a claim for Critical Illness in accordance with Section II.A in respect of an Insured person, that results in a condition due to which the Insured Person is totally unable to engage in his/her primary occupation and loses his/her source of income generation as a consequence thereof, then We will pay the amount (as lump sum or monthly payout) as specified against this benefit in the Policy Schedule:

a. In case of salaried Insured Persons: A monthly income for 3 months, based on the last 3 months salary slip of the previous employer. This payout is limited to base monthly income excluding overtime, bonuses, tips, commissions or any other special compensation;

b. In case of self- employed Insured Persons: A monthly income for 3 months, based on the last income tax returns filed by the Insured Person with the income tax department. This payout will consider income from primary occupation only and does not include income from any other sources.

This Optional Cover shall be available only once during thePolicy Period.

II.B.11. Family Counselling Benefit

If We have accepted a claim for Critical Illness in accordance with Section II.A in respect of an Insured Person and such Critical Illness results in mental trauma to any or all Immediate Family Members of the Insured Person, then then We will pay the amount up to the limits specified against this benefit in the Policy Schedule towards the psychiatric counselling of the Immediate Family Members of such Insured Person provided the family members receive such counselling on an out-patient basis in a Hospital.

II.B.12. Family Transportation Allowance Benefit

If We have accepted a claim for Critical Illness in accordance with Section II.A in respect of an Insured Person and the Insured Person is Hospitalized in a Hospital which is situated at a distance of at least 100 kilometre from his normal place of residence, and the attending Medical Practitioner recommends the personal attendance of an Immediate Family Member, We will reimburse the amount up to the limit specified against this benefit in the Policy Schedule, incurred in respect of any one Immediate Family Member of the Insured Person for transportation by one way airfare or one way first class railway ticket in a licensed common carrier to the place of Hospitalization of the Insured Person.

II.B.13. Medical Second Opinion

If We have accepted a claim for Critical Illness in accordance with Section II.A in respect of an Insured Person, then the Insured Person may choose to secure a second opinion from Our network of Medical Practitioners for the treatment of that Critical illness. The expert opinion so requested from Our network of Medical Practitioners shall be directly sent to the Insured Person.

The Insured Person understands and agrees that he/she can exercise the option to secure an expert opinion, provided that:

a. We have received a written request from the Insured Person to exercise this option.

b. The expert opinion will be based only on the information and documentation provided by the Insured Person.

c. This Benefit can be availed only once, by each Insured Person during the lifetime of the Policy for a particular Critical Illness.

d. This Benefit is only a value added service provided by Us and does not deem to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

e. The Insured Person is free to choose whether or not to obtain the expert opinion, and if obtained then whether or not to act on it.

f. We shall not, in any event be responsible for any actual or alleged errors or representations made by any Medical Practitioner or in any expert opinion or for any consequence of actions taken or not taken in reliance thereon.

g. The expert opinion under this Optional Benefit shall be limited to Critical Illnesses as listed n Section II.A and shall not be valid for any medico legal purposes.

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

All claims under this Optional Benefit shall be made in accordance with under Section III.3 of the Policy.

II.B.14. Wellness Benefit

a) The Insured Person may avail a health check-up with Our Network Provider as mentioned below. Health check-ups will be and arranged by Us and conducted at Our network providers only.

b) Original copies of all reports will be provided to the Insured Person, while a copy of the same will be retained by Us.

c) Coverage under this Optional Cover will not be available on reimbursement basis. All claims under this Benefit shall be made in accordance with Section III.3.14 of the Policy.

Sum Insured	Age	List of tests
Less than ₹25 Lacs	>18 years	MER, ECG, Total Cholesterol, FBS, Sr. Creatinine, CBC, Urine Routine, SGPT
₹25 Lacs - ₹100 Lacs	18 to 40 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid
	> 41 years	MER, ECG,CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric Acid For females only - TSH, Pap smear, Mammogram For Males- PSA
More than ₹100 Lacs	18 to 40 years	MER, Lipid Profile, HbA1c, Sr. Creatinine, CBC-ESR, RUA, SGPT, ECG, SGOT, GGT, Uric Acid For females: Pap smear, TSH, Mammogram For males: PSA
	> 41 years (For males only)	MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, Uric acid, TMT, USG Abdomen & Pelvis, PSA
	> 41 years (For females only)	MER, CBC-ESR, Lipid Profile, HbA1c, Sr. Creatinine, RUA, SGOT, SGPT, GGT, TMT, Uric acid, USG Abdomen & Pelvis, Pap smear, Mammogram, TSH

II.C. WAITING PERIODS & SURVIVAL PERIOD

We shall not be liable to make any payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following as set out below. All these waiting periods shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

II.C.1 First 90 days Waiting Period

We shall not be liable to make any payment in respect of any Critical Illness whose signs or symptoms first occur within 90 days of the Inception Date of the first Policy.

This exclusion does not apply for Insured Person having any health insurance policy in India at least for a period of 90 days prior to taking this Policy and accepted under portability cover, as well as for subsequent Renewals with Us without a break.

Calculation of 90 Days Waiting Period

90 days is calculated from the Date of inception of policy to the actual final diagnosis which confirms the Critical Illness or date on which the surgical procedure is done whichever is earlier.

In case an Insured Person is diagnosed with a critical illness during the waiting period he will not get paid if it is an illness/disease defined in the Policy as the diagnosis of the defined Illness is within the 90 day period.

However if a person is diagnosed with heart blockage during the waiting period but undergoes Coronary Artery Bypass Graft after the completion of waiting period the claim for Critical Illness will be paid for Coronary Artery Bypass Graft as the surgical procedure was carried out after the completion of the 90 days waiting period.

II.C .2 Survival Period

The benefit payment shall be subject to survival of the Insured Person for at least 30 days following the first diagnosis of the Critical Illness/undergoing the Surgical Procedure for the first time unless it has been specially waived on payment of additional premium.

II.D. PERMANENT EXCLUSIONS UNDER THE CRITICAL ILLNESS BENEFIT AND OPTIONAL BENEFITS UNDER THE CRITICAL ILLNESS BENEFIT

We shall not be liable to make any payment under the Critical Illness Benefit or any Optional Benefit under the Critical Illness Benefit for a Critical Illness, directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. Any Illness, sickness or disease other than those specified as Critical Illnesses under this Policy.
2. Any claim with respect to any Critical Illness diagnosed or which manifested prior to the Inception Date.
3. Any Pre-existing Disease or any complication arising therefrom.
4. Any Critical Illness directly or indirectly caused due to or associated with human T-call Lymph tropic virus type III (HTLV-III or IITLB-III) or Lymphadenopathy Associated Virus (LAV) and its variants or mutants, Acquired Immune Deficiency Syndrome (AIDS) whether or not arising out of HIV, AIDS related complex syndrome (ARCS) and all diseases/illness/injury caused by and/or related to HIV;
5. Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, whether or not arising out of conditions listed under Section II.D.3 above.
6. Any Critical Illness arising out of use, abuse or consequence or influence of any substance, intoxicant, drug, alcohol or hallucinogen.
7. Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner.
8. Any Critical Illness directly or indirectly caused due to intentional self-injury, suicide or attempted suicide whether the person is medically sane or insane.
9. Any Critical Illness directly or indirectly, 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), civil war, public defence, rebellion, revolution, insurrection, military or usurped power.
10. 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.
11. Working in underground mines, tunnelling or work involving electrical installations with high tension supply, or as jockeys or circus personnel.
12. Congenital Anomalies, inherited disorders or any complications or conditions arising therefrom including any developmental conditions of the Insured Person.
13. 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.
14. 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.
15. Any loss resulting directly or indirectly contributed or aggravated or prolonged by childbirth or from pregnancy except loss arising from ectopic pregnancy.
16. Any Critical Illness based on certification/diagnosis/treatment by a family member of the Insured Person, or a person who resides with the Insured Person, or from persons not registered as Medical Practitioners, or from a Medical Practitioner who is practicing outside the discipline that he is licensed for, or any diagnosis or treatment that is not scientifically recognized or Unproven/ Experimental Treatment, or is not Medically Necessary or any kind of self-medication and its complications.
17. Any treatment/surgery for change of sex, cosmetic or plastic surgery or any elective surgery or cosmetic procedure that improve physical appearance, surgical and non-surgical treatment of obesity, including morbid obesity (unless certified to be life threatening) and weight control programs, or treatment of an optional nature including complications/illness arising as a consequence thereof.
18. Any Critical Illness arising or resulting from the Insured Person or any of his family members committing any breach of law or participating in an actual or attempted felony, riot, crime, misdemeanour or civil commotion with criminal intent.
19. In the event of the death of the Insured Person within the survival period of 30 days from the date of diagnosis of the Critical Illness.

20. Failure to seek or follow Medical Advice.

21. Birth control procedures and hormone replacement therapy.

22. Any mental illness, psychiatric or psychological disorders.

23. Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including Caesarean section), abortion or complications of any of these, except treatment arising from ectopic pregnancy.

PART II. CLAIM PROCEDURE

III.1. Conditions Preceding

The fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates) in so far as they relate to anything to be done or complied with by You or any Insured Person or any person acting on their behalf, including complying with the following steps, shall be the Condition Precedent to the admissibility of a claim.

Completed claim forms and the necessary processing documents must be furnished to Us within the stipulated timelines for all claims. Failure to furnish this documentation within the time required shall not invalidate nor reduce any claim if Policyholder/ Insured Person can satisfy Us in writing that it was not reasonably possible for the required forms/ documents to be submitted within such time.

The due notification, submission of necessary documents and compliance with requirements as provided under this Section III, shall be a Condition Precedent failing which We shall not be bound to accept a claim.

III.2. Policyholder/ Insured Person's Duty at the Time of Claim

On occurrence of an event which may lead to a claim under this Policy, the following shall be complied with:

a. Forthwith notify, file and submit the claim in accordance to the claims procedure set out under Section III.3 and 4 as mentioned below.

b. Follow the directions, advice or guidance provided by a Medical Practitioner. We shall not be obliged to make any payment(s) that are brought about or contributed to, as a consequence of failure to follow such directions, advice or guidance.

c. If so requested by Us, the Insured Person must submit himself/herself for a medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary. The cost of such examination will be borne by Us.

d. Allow the Medical Practitioner or any of Our representatives to inspect the medical and Hospitalization records, investigate the facts and examine the Insured Person as also verify the certificate of disability issued in respect of an Insured Person.

e. Assist and not hinder or prevent Our representatives in the pursuance of their duties for ascertaining the admissibility of the claim, its circumstances and its quantum under the provisions of the Policy.

III.3. Claim Process

III.3.1. Claim Intimation

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

Notify Us either at the call centre or in writing, within 10 days from the date of occurrence of such Accident/diagnosis of a Critical Illness. The following details are to be provided to Us at the time of intimation of Claim:

a) Policy Number

b) Name of the Policyholder

c) Name of the Insured Person in whose relation the Claim is being lodged

d) Nature of Accident/ Critical Illness

e) Name and address of the attending Medical Practitioner and Hospital (if admission has taken place)

f) Date of Admission if applicable

g) Any other information, documentation as requested by Us

III.3.2. Claim Documents - Group Personal Accident

Wherever Insured person has opted for a reimbursement of expenses, he/she may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense within 30 (thirty) days of occurrence of the event.

Documents required for all Claims:

- Photo Identity Proof - Voter ID, Passport, PAN Card, Driving License, Ration Card, Aadhar, or any other proof accepted by the KYC norms as approved by Us and which is admissible in court of law
- Duly completed and signed claim form in original as prescribed by Us.
- Copy of FIR/ Panchnama /Police Inquest Report (if conducted) duly attested by the concerned Police Station;
- Copy of Medico Legal Certificate(if conducted) duly attested by the concerned Hospital,

1) In case of Accidental Death Benefit:

a) Original Death certificate issued by the office of Registrar of Birth & Deaths

b) Copy of Post Mortem report, if conducted

c) Copy of chemical analysis / Forensic report, if applicable

d) Death Summary, if death in Hospital

e) Copies of Medical records, investigation reports, if admitted to hospital

f) Identity proof of Nominee or Original Succession Certificate/Original Legal Heir Certificate or any other proof to Our satisfaction for the purpose of a valid discharge in case nomination is not filed by deceased.

g) Any other document as may be deemed necessary by the Company to evaluate the claim

2) In case of Permanent Total Disability/ Permanent Partial Disablement Benefit:

a) Disability certificate issued by a civil surgeon or the equivalent appointed by the District, State or Government Board (or) certificate from the treating doctor certifying the extent of disability

b) Original treating Medical Practitioner's certificate describing the disablement;

c) Original Discharge summary from the Hospital;

d) Photograph of the Insured Person reflecting the disablement;

e) Copies of Medical records, investigation reports, if admitted to hospital

f) Any other document as may be deemed necessary by the Company to evaluate the claim

3) In case of Temporary Total Disablement Benefit(in addition to 2 above):

a) Leave/ Absence Certificate from Employer in case of salaried employees

b) Latest Salary slip or certificate from employer specifying the remuneration, in case of salaried employees

We may require Income Proof documents to be submitted on a case to cases basis

- Last 3 months' Salary Slip/Form 16 for salaried persons
- Last financial years ITR for self-employed persons
- If the Insured/Dependant Parent (where ever applicable) is not a tax Assessee the insured can submit Bank Statement of last 3 years as proof.

4) Additional Documents (as applicable under each section):

Disappearance Benefit	FIR/ Missing complaint Confirmation of Death/Certificate of Death (legal assumption) post completion of relevant period applicable under law
Broken Bones Benefit	X-Ray/MRI/CT-Scan/Radiology Films/ Reports confirming the extent of fracture
Burns Benefit	Certificate from the treating doctor certifying the extent of burns injury
Coma Benefit	Certificate from the treating doctor certifying the cause and severity of Coma
Accidental Death Benefit (Common Carrier)	Original Passenger Ticket / Boarding Pass issued in the name of the Insured Person from the Common Carrier (in case of death in a common carrier). Wherever a named ticket is not available, onus of proof of travel will be upon the Insured Person
Permanent Total Disablement Benefit (Common Carrier)	
Permanent Total Disablement Double Benefit	List of documents same as Permanent Total Disablement Benefit
Cost of Support Items Benefit	Prescriptions of treating Medical Specialist for support items and Original invoice of actual expenses incurred
Modification allowance benefit	Original invoice of actual expenses incurred
Rehabilitation Benefit	Original invoice of counseling by a professional counselor/ Physiotherapist

Animal Attack Benefit	Original copies of Hospital/ OPD bills, receipts, prescriptions and invoices
Cost of Personal Protective Equipment (PPE) Damaged in the Accident Benefit	Original invoices of incurred expenses towards replacement of Personal Protective Equipment
Funeral Expenses Benefit	Original invoice of expenses incurred during funeral
Emergency Road Ambulance Benefit	Original invoice of actual expenses incurred towards Ambulance
Dependent Children Benefit	Proof of relationship with the Insured and Age proof of the dependent child
Spouse Benefit	Proof of relationship with the Insured
Dependant Parent Benefit	Proof of relationship with the Insured and Last ITR of the dependent parent
Marriage Benefit for Dependent Children	Proof of relationship with the Insured and Age proof of the dependent child
Education Fund Benefit	Proof of expenses incurred towards tuition fees as a full time student at an accredited educational institution and Age proof of the dependent child
Retraining Expenses Benefit	Original invoices of incurred expenses towards re-training
Convalescence Benefit	Original copies of Hospital bills, receipts, prescriptions and invoices
Hospital Cash Benefit	
Loss of Earning Benefit	In case of salaried Insured Persons, Last 3 month's salary slips of the previous employer of the Insured Person In case of self-employed Insured Persons, Last income tax returns filed by the Insured Person with the income tax department
Family Counseling Benefit	Original invoice of counseling by a professional counselor
Family Transportation Allowance Benefit	Original invoice of travel expense incurred
Accidental Medical Expenses	Original copies of Consultations, Hospital bills, receipts, investigation reports & bills, prescriptions and invoices
Out Patient Treatment Allowance	
In- Patient Medical Expenses Benefit	
Adventure Sports Benefit	Same list of documents like Accidental Death or Permanent Total Disablement

III.3.3. Claim Documents – Group Critical Illness

The Insured person may submit the following documents for reimbursement of the claim to Our branch or head office at his/her own expense ninety (90) days of date of first diagnosis of the Illness/ date of surgical procedure or date of occurrence of the medical event, as the case may be

- Duly completed and signed claim form in original as prescribed by Us.
- Medical Certificate confirming the diagnosis of critical illness
- Certificate from attending Medical Practitioner confirming that the claim does not relate to any Pre-existing Illness or Injury or any Illness or Injury which was diagnosed within the first 90 days of the Inception of the Policy.
- Discharge Certificate/ Card from the hospital, if any
- Investigation test reports confirming the diagnosis,
- First consultation letter and subsequent prescriptions
- Indoor case papers if applicable
- KYC Documents
- Specific documents listed under the respective Critical Illness
- Any other documents as may be required by Us
- In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate will be required wherever conducted.

We may call for any additional documents/information as required based on the circumstances of the claim wherever the case in under further investigation or available documents do not provide clarity.

Additional Documents (as applicable under each section):

Emergency Road Ambulance Benefit	Original invoice of actual expenses incurred towards Ambulance
Marriage Benefit for Dependent Children	Proof of relationship with the Insured and Age proof of the dependent child
Education Fund Benefit	Proof of expenses incurred towards tuition fees as a full time student at an accredited educational institution and Age proof of the dependent child
Convalescence	Original copies of Hospital bills, receipts, prescriptions and invoices
Hospital Cash Benefit	
Rehabilitation Benefit	Original invoice of counseling by a professional counselor/ Physiotherapist
Loss of Earning Benefit	In case of salaried Insured Persons, Last 3 month's salary slips of the previous employer of the Insured Person. In case of self-employed Insured Persons, Last income tax returns filed by the Insured Person with the income tax department.
Family Counseling Benefit	Original invoice of counseling by a professional counselor
Family Transportation Allowance Benefit	Original invoice of travel expense incurred

The above list is indicative and We may call for any additional documents/ information/ subject the Insured Person to additional medical examinations as required to ascertain the admissibility of any Benefit including Optional Covers under the relevant Section of the Policy, based on the circumstances of the claim on a case to case basis.

Our branch offices shall give due acknowledgement of collected documents. In case there is a delay in the submission of claim documents, then in addition to the documents mentioned above, the claimant is also required to provide Us the reasons for such delay in writing. We shall condone delay on merit for delayed claims where delay is proved to be for reasons beyond the control of the Policyholder or Insured Person or the claimant, as the case may be.

III.3.4. Scrutiny of Claim Documents

a) We shall scrutinize the claim and accompanying documents. Any deficiency of documents shall be intimated to Insured Person and the Network Provider, as the case may be, within 5 days of their receipt.

b) If the deficiency in the necessary claim documents is not met or are partially met in 10 working days of the first intimation, We shall remind the Insured Person of the same and every 10 (ten) days thereafter.

c) We will send a maximum of 3 (three) reminders.

d) We may at Our sole discretion decide to deduct the amount of claim for which deficiency is intimated to the Insured Person or settle the claim if We observe that such a claim is otherwise valid under the Policy.

e) In case a reimbursement claim is received when a pre-authorisation letter has been issued, before approving such a claim, a check will be made with the Network Provider whether the pre-authorisation has been utilised as well as whether the Insured Person has settled all the dues with the Network Provider. Once such check and declaration is received from the Network Provider, the case will be processed.

III.3.5. Claim Assessment

We will pay fixed or indemnity amounts as specified in the applicable for Basic or Optional Benefits in accordance with the terms of this Policy.

For Group Critical Illness Claims, if Lump sum Pay out is opted at the time of Policy inception then full Sum Insured will be paid at one time and the claim will be settled. In case Staggered Pay out option is opted, on occurrence of a covered Critical Illness Event - 25% of Sum Insured will be paid as Lump sum. The balance 75% + 10% additional Sum Insured will be paid in 60 equated monthly instalments starting from beginning of the next month.

We are not liable to make any payments that are not specified in the Policy.

III.3.6. Claims Investigation

We may investigate claims at our Own discretion to determine the validity of a claim. Such investigation shall be concluded within 15 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.

III.3.7. Settlement & Repudiation of a Claim

We shall settle the claim within 30 days from the date of receipt of last necessary document in accordance with the provisions of Regulation 27 of IRDAI (Health Insurance) Regulations, 2016.

In the case of delay in the payment of a claim We 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.

However, where the circumstances of a claim warrant an investigation in Our opinion, We 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, We shall settle the claim within 45 days from the date of receipt of last necessary document.

In case of delay beyond stipulated 45 days We 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..

III.3.8. Representation against Rejection

Where a rejection is communicated by Us, the claimant may if so desired within 15 days of the communication of the rejection, represent to Us for reconsideration of the decision.

III.3.9. Claims falling in 2 policy periods

If a hospitalisation claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods for each policy period subject to limit of Sum Insured provided that the Policyholder has renewed the Policy with Us for the subsequent year.

III.3.10. Payment Terms

a. All claims will be payable in India and in Indian rupees.

b. Once a claim has been paid in respect of any of the Insured Persons for the full Sum Insured or Capital Sum Insured, the Policy will terminate.

c. Wherever the claim paid for a percentage of the Sum Insured the Policy will continue for the remaining period for the balance Sum Insured.

d. If at the time a claim arises under this Policy the Insured Person has changed his occupation without Us being notified, then Our maximum liability will be limited to the amount that would have been payable for the premium paid and the new occupation.

e. In the event of any claim being lodged under the Policy for any cause whatsoever during the Revival Period, all subsequent premium instalments shall immediately become due and payable notwithstanding anything to the contrary contained hereinabove. We shall have the right to recover and deduct any or all the pending instalments from the claim amount due under the Policy

f. The payment will be made to You or the Insured Person as specified in the benefit Sections above. In the unfortunate event of Your death, We will pay the Nominee (as named in the Policy Schedule) and in case of no Nominee to Your legal heir who holds a succession certificate or an indemnity bond to that effect, whichever is available and whose discharge shall be treated as full and final discharge of Our liability under the Policy.

III.3.11. Emergency evacuation, Medical repatriation and Repatriation of Mortal Remains

a) In the event of an Insured Person requiring Emergency evacuation and repatriation, Insured Person, must notify Us immediately either at Our call centre or in writing.

c) Emergency medical evacuations shall be pre-authorized by us

d) Our team of Medical specialists in association with the Emergency Assistance Service Provider shall determine the Medical Necessity of such Emergency Evacuation or Repatriation post which the same will be approved.

III.3.12. Medical Second Opinion

Medical Second Opinion is available only in the event of the Insured Person being diagnosed with Covered Disability or Critical Illness.

Policy holder/ Insured can submit request for an expert opinion by calling Our call centre or register request through email. We will schedule an appointment or facilitate delivery of Medical Records of the Insured Person to a Medical Practitioner.

III.3.13. Access to Online Wellness Program

Cigna TTK Health Insurance's customized health and wellness program is available to all customers. It caters to the varied health needs of customers through specialized tools. The service is available on our Website to all customers taking forward our proposition of being their partner in 'illness and wellness'. It consists of online customized programs like Health Risk Assessment, Target Risk Assessment, Lifestyle Management Programs, Nutrition Programs, access to health articles through the Cigna TTK Website.

III.3.14. Health Check up

Policy holder/ Insured shall seek appointment by calling Our call centre. We will facilitate his/her appointment and guide him/her to the nearest Network Provider for conducting the medical examination. Reports of the Medical Tests can be collected directly from the centre. A copy of the medical reports will be retained by the medical centre which will be forwarded to Us along with the invoice for reimbursement.

PART III. GENERAL TERMS AND CONDITIONS

IV.1. Duty of Disclosure

The Policy shall be null and void and no Benefit or Optional Benefit shall be payable hereunder in the event of an untrue or incorrect statement, misrepresentation, mis-description or non-disclosure of any material particular in the Group Proposal Form, personal statements, declarations, medical history and connected documents, or any material information having been withheld by the Policyholder or any one acting on their behalf, under this Policy. Under such circumstances We may at Our sole discretion cancel the Policy and the premium paid shall be forfeited to Us.

IV.2. Observance of Terms and Conditions

The due observance and fulfilment of the terms and conditions of the Policy (including the realisation of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any of the Insured Persons, shall be the condition precedent to Our liability under this Policy.

IV.3. Alterations in the Policy

This Policy constitutes the complete contract of insurance between the Policyholder and Us. No change or alteration will be effective or valid unless approved in writing which will be evidenced by a written endorsement, signed and stamped by Us. All endorsement requests will be made by the Group Policy Holder only.

IV.4. Material Information for Administration

The Insured Person and/ or the Policyholder must give Us all the written information that is reasonably required to work out the premium and pay any benefit provided under the plan. Billing for the plan will be processed on the exact number of Insured Persons covered under the policy. You must give Us written notification specifying the details of the Insured Persons to be deleted and the details of the Eligible persons proposed to be added to the Policy as Insured Persons.

We reserve the right to apply additional options, exclusions or to reflect any circumstances the Policyholder or Insured person advises in their application form or declares to Us as a material fact.

Material information to be disclosed includes every matter that the Insured person and/or the Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk of insurance and if so on what terms. It is a condition precedent to the Company's liability under the Policy that the Policyholder or the Insured Person shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense. The Insured person/ Policyholder must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the contract.

IV.5. Eligibility

To be eligible for coverage under the plan, the Insured Person must be-

- A Group Member/ Employee of the Policyholder or Non-Employer Group Enrolled Member who is nominated by the Policyholder.
- In the age group of 18 to 75 years.
- Dependants as defined in the Policy will be eligible for coverage under the Plan.
  - o Dependant Spouse/ Parents/ Parent- in- laws can be covered from age 18 years to 75 years at the time of entry.
  - o Unmarried Dependent Children/ Unmarried Grandchildren/ Unmarried siblings can be covered from:
    - 5 years up to 25 years of age for Group Personal Accident
    - From 18 years to 25 years of age for Group Critical Illness

IV.6. Short Period Cover

For Group Personal Accident Section only, Policy can be issued for a period more than one day. The Premium charged for such policies will be as below.

Policy in force up to	Premium %
7 days	10%
15 days	12.5%
25 days	20%
1 Month	25%
3 months	50%
6 months	75%
More than 6 months	100%

Cancellation Clause of Policy is not applicable to such policies.

IV.7. On- Duty Cover

For Group Personal Accident Section only, Policy can be issued for restricted time period of the day i.e. Work duty hours only.

IV.8. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to You/ Insured Person in Our possession or in the possession of any of Our official shall not be deemed to be notice or be held to bind or prejudicially affect Us, or absolve the You/ Insured Person from their duty of disclosure, notwithstanding subsequent acceptance of any premium.

IV.9. Geography

This Policy applies to events or occurrences taking place anywhere in the world unless limited under this Policy in a particular Benefit or definition or by Us through an endorsement.

IV.10. Dispute Resolution & Applicable Law

Any and all disputes or differences under or in relation to this Policy shall be determined by the Indian courts and subject to Indian law without reference to any principle which would result in the application of the law of any other jurisdiction.

IV.11. Premium

The premium payable under this Policy shall be paid in accordance with the schedule of payments agreed between the Policyholder and Us in writing. No receipt for premium shall be valid except on Our official form signed by Our duly authorized official. The due payment of premium and the observance and fulfilment of the terms, provisions, conditions and endorsements of this policy by the Policyholder in so far as they relate to anything to be done or complied with by the Policyholder shall be a condition precedent to any liability of Insurer to make any payment under this policy. Premium payments under this Policy will be allowed monthly/ quarterly/ half yearly/ yearly.

Premium will be subject to revision at the time of renewal of the Policy and as approved by the IRDAI. Further, premium shall be paid in Indian Rupees and in favour of CignaTTK Health Insurance Company Ltd.

IV.12. Free Look Period

A period of 15 days from the date of receipt of the Policy document is available to review the terms and conditions of this Policy. The Policyholder has the option of cancelling the Policy by stating to Us the reasons for cancellation in writing. If there are no claims reported (paid/outstanding) under the Policy then We shall refund the premium after deducting the risk premium on pro rata basis and after retaining 50% of costs for any medical tests if conducted.. All Your/Insured Person's rights under this Policy shall immediately stand extinguished on the free look cancellation of the Policy.

The aforesaid Free Look Period shall not be available on any Renewal of this Policy.

IV.13. Nominee

The Insured Person can, on the Effective Date or at any time before the expiry of the Policy make a nomination for the purpose of payment of claims.

Any change of nomination shall be communicated to Us in writing and such change shall be effective only when an endorsement to the Policy is made by Us.

In case of death of any Dependent of an Insured Person where such Dependent is covered under this Policy, for the purpose of payment of claims, the Nominee would be the Insured Person.

IV.14. Parties to the Contract

The only parties to this contract are the Policyholder and Us.

IV.15. Currency

The monetary limits applicable to this Policy will be in INR.

IV.16. Midterm Addition and Deletion of a Member

We shall include/exclude a Group Member/ Employee of the Policyholder or Non-Employer Group Enrolled Member or Dependant as an Insured Person under the Policy in accordance with the following procedure:

(a) Additions

Any Person may be added to Policy as an Insured Member during the Policy period provided that the application of cover has been accepted by Us, additional premium, on pro-rata basis in respect of such Member has been received by Us and We have issued an endorsement confirming the addition of such persons as an Insured Person.

(b) Deletions

Any Insured Person who is covered under the Policy may be deleted upon Your request during the Policy Period. Refund of premium can be made on pro-rata basis, provided that no claim is paid/outstanding in respect of that Insured Person or his/ her dependants.

In case of refund of premium being generated on the policy due to deletions the same will be refunded or adjusted against future premium instalments due on the policy.

In case of addition under NonEmployer groups additional premium will be charged as per the rates applicable for coverage under full term of the policy, similarly for deletions the refunds will be calculated on short period basis.

Throughout the Policy Period, the Policyholder will notify Us of all and any changes in the membership of the Policy in the same month in which the change occurs. However, We may commence or terminate cover retrospectively for Insured Persons for a period not exceeding 2 months from the date when the Policyholder advises Us in writing.

IV.17. Endorsements

The Policy will allow the following endorsements during the Policy Period. Any request for endorsement must be made only in writing by the Policyholder. Any endorsement would be effective from the date of the request received from You, or the date of receipt of premium, whichever is later other than for change in date of birth or gender which will be with effect from the Inception Date.

a) Non-Financial Endorsements – which do not affect the premium.

- Rectification in name of the proposer / Insured Person.
- Rectification in gender of the proposer/ Insured Person.
- Rectification in relationship of the Insured Person with the proposer.
- Rectification of date of birth of the Insured Person (if this does not impact the premium).
- Change in the correspondence address of the proposer.
- Change/updation in the contact details viz., phone number, E-mail ID, etc.
- Updation of alternate contact address of the proposer.
- Change in Nominee details.

b) Financial Endorsements – which result in alteration in premium

- Deletion of Insured Person on death or upon separation or Policyholder/ Insured Person leaving the country only if no claims are paid / outstanding.
- Change in Age/date of birth.
- Addition of member (New Born Baby or newly wedded Spouse).
- Change in address (resulting in change in zone).
- Rectification in gender of the proposer/ Insured Person.

All endorsement requests may be assessed by the underwriting team and if required additional information/documents may be requested.

IV.18. Multiple Policies

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i. In case of multiple policies which provide fixed benefits,6on occurrence of the insured event in accordance with the terms and conditions of the Policies, We shall make the claim payments independent of payments received under similar policies.

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

1. In all such cases where We have issued the chosen policy, We 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.
2. Claims under other policy/ies may be made after exhaustion of Sum Insured in the earlier chosen policy / policies
3. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

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

IV.19. Grace Period & Renewal

The Policy may be renewed by mutual consent and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy or from the date of next instalment due date. We will not be liable to pay for any claim arising out of an Injury/ Accident/ Condition that occurred during the Grace Period. The provisions of Section 64VB of the Insurance Act, 1938 shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

For Contributory Policy

We shall not be bound to give notice that such Renewal premium is due. A Policy shall be ordinarily renewable unless any fraud, moral hazard, misrepresentation or non-cooperation by the Insured Person or on his behalf is found either in obtaining insurance or subsequently in relation thereto.

Where such behaviour has been noticed by an individual insured we will terminate the cover for the specific insured and his/her dependants including further renewals and continue the cover for the remaining group members while bringing such instances to the knowledge of the Policyholder. Where it is found that the Policyholder is involved in such above situations, the complete Policy will be terminated.

Revival Period:

For instalment premium policies, the revival period shall be 15 days. Wherever premiums are not received within the revival period the policy will be terminated and all claims that fall beyond such instalment due date shall not be covered as part of the policy. However, We will be liable to pay in respect of all claims where the treatment/admission/accident has commenced/occurred before date of termination of such policies.

Renewal Terms

Alterations like increase/ decrease in Sum Insured or Change in Plan or Optional Covers can be requested at the time of renewal of the Group Plan. We reserve our right to carry out underwriting assessment of the group and provide the renewal quote in respect of the revised plan opted.

Where We have discontinued or withdrawn this product/plan or where You will not be eligible to renew as You have moved out of the Group, You will have the option to renewal under the nearest substitute Group/Retail Policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy which has been approved by IRDA.

We may in Our sole discretion, revise the premiums payable under the Policy or the terms of cover, provided that all such changes are approved by IRDA and in accordance with the IRDA rules and regulations as applicable from time to time. We will intimate You of any such changes at least 3 months prior to date of such revision, withdrawal or modification.

IV.20. Cancellation/Termination

Cancellation by You

Request for cancellation shall be intimated to Us from Your side by giving 15 days' notice in which case We shall refund the percentage of premium for the unexpired Policy Period as per the short period scale mentioned below.

Premium shall be refunded only if no claim has been made under the Policy.

The grid is applicable for single premium Policy.

(Term more than 1 Year is available only for Credit Linked Policy)

In force up to	Policy Period and refund as a % of the premium				
	1	2	3	4	5
15 days-3 Months	50	75	83	88	90
3-6 Months	25	63	75	81	85
6-9 Months	15	58	72	75	83
9-12 Months	0	50	67	75	80
12-15 Months		25	50	63	70
15-18 Months		13	42	56	65
18-21 Months		8	38	54	63
21-24 Months		0	33	50	60
24-27 Months			17	38	50
27-30 Months			8	31	45
30-33 Months			5	29	43
33-36 Months			0	25	40
36-39 Months				13	30
39-42 Months				6	25
42-45 Months				4	23
45-48 Months				0	20
48-51 Months					10
51-54 Months					5
54-56 Months					3
56-60 Months					0

For installment premium, We will refund premium on pro rata basis after deducting Our expenses.

The short period scale is not applicable for Short Term Group Personal Accident Polices.

You further understand and agree that We may cancel the Policy by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address on grounds of misrepresentation, fraud, non-disclosure of material fact or for non-co-operation by You / Insured person without any refund of premium.Termination of Policy:

Prior to the termination of the Policy, at the expiry of the period shown in the Policy Schedule/ Certificate Of Insurance, cover will end immediately for all Insured Persons, if:

- there is misrepresentation, fraud, non-disclosure of material fact by You / Insured Person without any refund of premium, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- there is non-cooperation by You/ Insured person, with refund of premium on pro rata basis after deducting Our expenses, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to Your last known address.
- the Policyholder does not pay the premiums owed under the Policy within the Grace Period.

Upon termination, cover and services under the Policy shall end immediately.

Cover will end for a Member or dependent:

- If the Policyholder stops paying premiums for the Insured Person(s) and their Dependants (if any);
- When this Policy terminates at the expiry of the period shown in the Policy Schedule/ Certificate Of Insurance.
- If he or she dies;
- When he or she ceases to be a Dependant;
- If the Insured Person ceases to be a member of the group.

IV.21. Changes to the terms and conditions of the Policy

We can end the Policy or change any of the terms and conditions relating to the Policy subject to IRDAI approval. If the Policy changes because of new laws, We will inform the Policyholder in writing. In all circumstances, We will give the following notice:

- for changes to the list of Benefits, at least 90 days' notice in writing if allowed as per IRDAI;
- for changes to the Policy terms and conditions, or ending the Policy, at least 90 days' notice in writing. The change will take place, failing which, the Policy will end on the next Annual Renewal Date.

IV.22. Special Provisions

Any special provisions subject to which this Policy has been entered into or endorsed on the Policy or in any separate instrument shall be deemed to be part of this Policy and shall have effect accordingly.

It is further clarified that if any special condition is stipulated in the Policy Schedule and/ or Certificate of Insurance, then such special condition shall have effect accordingly.

IV.23. Records to be maintained

You or the Insured Person, as the case may be, shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person, as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Year and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

IV.24. Fraudulent Claims

If any claim is found to be fraudulent, or if any false declaration is made, or if any fraudulent devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy then this Policy shall be void in respect of such Insured Person and all claims in respect of such Insured Person shall be forfeited. All sums paid under this Policy shall be repaid to Us by You on behalf of such Insured Person who shall be jointly liable for such repayment.

IV.25. Limitation of Liability

If a claim is rejected or partially settled and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within thirty six months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability shall be extinguished and shall not be recoverable thereafter.

Any claim for which the notification of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless it is proved to Our satisfaction that the delay in reporting of the Claim was for reasons beyond Your or the Insured Persons control.

IV.26. Portability

All health insurance policies are portable. An Insured Person under this Policy can port to an approved Retail Health Policy available with Us at the time of such portability, provided that:

a) The Insured Person has been covered under this Policy.

b) Continuity of Benefits will be provided for the period based on the number of years of continuous coverage under this Policy with Us.

c) We should have received the application for Portability with complete documentation at least 45 days before the expiry of the present period of Insurance

d) We may subject such proposal to Our medical underwriting, restrict the terms upon which We may offer cover, the decision as to which shall be in line with our Board approved underwriting policy.

e) There is no obligation on Us to insure all Insured Persons on the proposed terms, even if we have received all the documentation

After maintaining the retail policy with Us for a period of one year an Insured Person may port the Policy to any other retail product offered by Us or other insurers that is available in the market.

IV.27. Underwriting Loadings & Discounts

a. We may apply a risk loading on the premium payable (excluding statutory levies and taxes) or Special Conditions on the Policy based upon the health status of the persons proposed to be insured and declarations made at the time of enrolment. These loadings will be applied from the Inception Date of the first Policy including subsequent Renewal(s) with Us. There will be no loadings based on individual claims experience.

b. We may apply a specific Sub Limit on a medical condition/ailment depending on the past history and declarations or additional Waiting Periods on Pre-Existing Diseases as part of the Special Conditions on the Policy.

c. We shall inform You about the applicable risk loading or Special Condition through a counter offer letter and You would be required to respond with Your consent and additional premium (if any) within 7 working days of the issuance of such counter offer letter.

d. In case, You neither accept the counter offer nor respond to Us within 7 working days, We shall cancel Your application and refund the premium paid. Your Policy will not be issued unless We receive Your consent.

IV.28. Operation of Master Policy & Certificate of Insurance

Master Policies shall be issued for the duration as specified in the Schedule. The Certificate of Insurance takes effect on the Effective Date stated on the Certificate of Insurance and ends on the date of expiry of Master Policy. For specific groups upon request, all additions thereto by way of certificate/s of insurance shall be valid for a period of one year commencing from the actual date of addition to the Master Policy, it being agreed and understood that We shall continue to extend the benefit of coverage of insurance to the Insured Person(s) in the same manner on renewal of the Master Policy or until expiry of the Certificate of Insurance whichever is later.

IV.29. Electronic Transactions

The Policyholder/ Insured agrees to comply with all the terms, conditions as We shall prescribe from time to time, and confirms that all transactions effected facilities for conducting remote transactions such as the internet, World Wide Web, electronic data interchange, call centres, 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, in respect of this Policy, or Our other products and services, shall constitute legally binding when done in compliance with Our terms for such facilities.

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 Policyholder/ Insured Person. 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 Policyholder/ Insured Person.

IV.30. Communications & Notices

Any communication or notice or instruction under this Policy shall be in writing and will be sent to:

a) The policyholder, at the address as specified in Schedule

b) To Us, at the address specified in the Schedule.

c) No insurance agents, brokers, other person or entity is authorised to receive any notice on the behalf of Us unless explicitly stated in writing by Us.

d) Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

IV.31. Complete Discharge

We will not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy except in case of assignment of the Benefit under Accidental Death in respect of an Insured Person where the Policyholder is a creditor of the Insured Person. The payment made by Us to the Insured Person or to their Nominee/ legal representative or to the valid assignee, as the case may be, of the compensation or Benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

IV.32. Grievances Redressal Procedure

If You/Insured Person may have a grievance that requires to be redressed, You/ Insured Person may contact Us with the details of the grievance through:

Our website: <<www.cignattkinsurance.in>>

Email: <<customercare@cignattk.in>>

Toll Free : <<1-800-10-24462>>

Fax: <<022 40825222>>

Courier: Any of Our Branch office or corporate office during business hours.

You/ Insured Person may also approach the grievance cell at any of Our branches with the details of the grievance during Our working hours from Monday to Friday.

If You/ Insured Person are not satisfied with Our redressal of Your grievance through one of the above methods, You/Insured Person may contact Our Head of Customer Service at The Grievance Cell, CignaTTK Health Insurance Company Limited, << CignaTTK Health Insurance Company Limited, 401/402, Raheja Titanium, Western Express Highway, Goregaon (East), Mumbai – 400063 >> or email << **headcustomercare@cignattk.in** >>.

If You/ Insured Person are not satisfied with Our redressal of grievance through one of the above methods, You/ Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices attached as Annexure I to this Policy document.

PART IV. DEFINITIONS

1. **Accident or Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2. **Alternative Treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

3. **Acute condition** means 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.

4. **Age or Aged** means the completed age (in years) of the Insured Person as on his/ her last birthday.

5. **Annexure** means a document attached and marked as Annexure to this Policy.

6. **Annual Renewal Date** means the anniversary of the Inception date each year or any other date which We agree and the Policyholder may agree in writing.

7. **Ambulance** means a road vehicle operated by a licenced/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention

8. **Benefit** means any benefit shown in the list of benefits

9. **Capital Sum Insured** means the maximum amount of Basic Personal Accident Benefit to which an Insured Person is eligible, as specified in the Policy Schedule.

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

    a. **Internal Congenital Anomaly -** Congenital anomaly which is not in the visible and accessible parts of the body

    b. **External Congenital Anomaly -** Congenital anomaly which is in the visible and accessible parts of the body

11. **Cashless Facility** means a facility extended by the Insurer to the Insured Person where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization is approved.

12. **Chronic Condition -** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

    - it needs on going or long-term monitoring through consultations, examinations, check-ups, and / or tests
    - t needs on going or long-term control or relief of symptoms
    - it requires the Insured person's rehabilitation or for them to be specially trained to cope with it
    - it continues indefinitely
    - it comes back or is likely to come back.

13. **Common Carrier** means transportation which is available as a public service and operated by an entity in the business of transporting goods or people for hire, as a public service.

14. **Condition Precedent** means a Policy term or condition upon which Our liability under the Policy is conditional upon.

15. **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured.

    This clause shall not apply to any Be~~nefit offered on fixed benefit basis.~~

16. **Cosmetic Surgery** means Surgery or Medical Treatment that modifies, improves, restores or maintains normal appearance of a physical feature, irregularity, or defect

17. **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 the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under –

    – has qualified nursing staff under its employment;

    – has qualified Medical Practitioner(s) in charge;

    – has a fully equipped operation theatre of its own where surgical procedures are carried out;

    – maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

18. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:

    i. undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and

    ii. which would have otherwise required a hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.

19. **Dependent** means the insured's spouse or Parent or Parent- in- law or child who has been enrolled in the Group Policy.

20. **Dependent Child** A dependent child refers to a child (natural or legally adopted), who is financially dependent on the Policy Holder, does not have his / her independent source of income, is up to the age of 25 years and unmarried. For the purpose of coverage under this Policy, the age limit for a dependent child shall be 25 years, however with respect to coverage under specific sections separate age limits shall be defined under the each benefit.

21. **Disclosure to Information Norm** means that the Policy shall be void and all premiums paid hereon shall be forfeited to Us, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

22. **Emergency Care** means management for a severe 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.

23. **Emergency** means a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.

24. **Exclusions** mean specified coverage, hazards, services, conditions, and the like that are not provided for (covered) under a particular health insurance contract

25. **Expiry Date** means the date on which this Policy expires as specified in the Policy Schedule.

26. **Employee** means any member of Policyholder's staff under full time employment and who is nominated and sponsored by the Policyholder who becomes an Insured Person.

27. **Fracture** means a break in continuity of the bone which is evidenced by an X-ray and certified by the attending Medical Practitioner.

28. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

29. **Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained in such sport or activity or not. Such sport/activity includes without limitation stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/obstacle riding, bobsleighing/using skeletons, bouldering, boxing, canyoning, cavin/pot holing, cave tubing, rock climbing/trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labour, marathon running, martial arts, micro-lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo riding, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting or wrestling any type.

30. **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 the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section of 56(1) of the said Act OR complies with all minimum criteria as under:

    i. Has a fully equipped operation theatre of its own where Surgical Procedures are carried out;

    ii. Has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

    iii. Has qualified Medical Practitioner(s) in charge round the clock;

    iv. Has qualified nursing staff under its employment round the clock;

    v. Maintains daily records of patients and makes this accessible to the insurance company's authorized personnel.

31. **Hospitalization or Hospitalised** means admission in a Hospital for a minimum period of 24 In-patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

32. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

33. **Immediate Family Member** means legally wedded spouse, children (natural or legally adopted) and parents of the Insured Person.

34. **Inception Date** means the inception date of this Policy as specified in the Policy Schedule

35. **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.

36. **In-patient** means an Insured Person who is admitted to a Hospital and stays for at least 24 hours for the sole purpose of receiving treatment.

37. **In patient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

38. **Insured Person** means the Member or Dependants named in the Policy Schedule, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium received.

39. **Intensive Care Unit** means an identified section, ward or wing o f a hospital which is under the constant supervision o f a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

40. **Loss of Independent Living** means that the Insured Person is permanently unable to perform independently three or more of the following six activities of daily living:

    i. Washing: the ability to maintain an adequate level of cleanliness and personal hygiene;

    ii. Dressing: the ability to put on and take off all necessary garments, artificial limbs or other surgical appliances that are medically necessary;

    iii. Feeding: the ability to transfer food from a plate or bowl to the mouth once food has been prepared and made available;

    iv. Toileting: the ability to manage bowel and bladder function, maintaining an adequate and socially acceptable level of hygiene;

    v. Mobility: the ability to move indoors from room to room on level surfaces at the normal place of residence;

    vi. Transferring: the ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa.

41. **Maternity Expense** shall include the following:

    - Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation);
    - Expenses towards lawful medical termination of pregnancy during the Policy Period

42. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

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

44. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which

    i. Is required for the medical management of the Illness or Injury suffered by the Insured Person;

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

    iii. Must have been prescribed by a Medical Practitioner; and

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

45. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license.

46. **Network Provider** means hospitals or health care providers enlisted by an Insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

47. **Neurological Deficit** means Symptoms of dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person's life. Symptoms that are covered include numbness, increased sensitivity, paralysis, localized weakness,

48. **New Born Baby** means those babies born to the Insured Member and their spouse during the Policy Period aged between 1 day and 90 days, both days inclusive.

49. **Nominee** means the person named in the Policy Schedule who is nominated to receive the benefits in respect of an Insured Person under the Policy in accordance with the terms and conditions of the Policy, if the Insured Person is deceased.

50. **Non-Network** means any hospital, day care centre or other provider that is not part of the network.

51. **Notification of Claim** means the process of notifying a claim to the insurer or TPA (if applicable) by specifying the timelines as well as the address/telephone number to which it should be notified.

52. **OPD treatment** means a treatment in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

53. **Policy** means this Policy document, the Group Proposal Form, the Certificates of Insurance issued to Insured Persons and the Policy Schedule which form part of the Policy including endorsements, as amended from time to time which form part of the Policy and shall be read together.

54. **Policy Period** means the period between the Inception Date and the Expiry Date of the Policy as specified in the Policy Schedule or the date of cancellation of this Policy, whichever is earlier.

55. **Policy Schedule** means the schedule attached to and forming part of this Policy mentioning the details of the Insured Persons, the Sum Insured, the period and the limits to which Benefits under the Policy are subject to, including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

56. **Policy Year** means a period of 12 consecutive months commencing from the Inception Date.

57. **Portability** means the right accorded to an individual health insurance policyholder (including family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another or from one plan to another plan of the same insurer.

58. **Post-hospitalization Medical Expenses**

Post-hospitalization Medical Expenses means medical expenses incurred during predefined number of days immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and

ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

59. **Pre-hospitalization Medical Expenses**

Pre-hospitalization Medical Expenses means medical expenses incurred during predefined number of days preceding the hospitalization of the Insured Person, provided that:

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

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

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

61. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/Injury involved.

62. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

63. **Service Partner** is an assistance company utilised by Us to support You for facilitation of access to Network Providers and for providing Medical Assistance Services

64. **Spouse** means the insured members' legal husband or wife

65. **Sum Insured** means, subject to terms, conditions and exclusions of this Policy, the amount representing Our maximum, total liability for any or all claims arising under this Policy in respect of an Insured Person and is as specified in the Policy Schedule against the particular benefit opted.

66. **Surgery/Surgical Procedure** means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or day care centre by a Medical Practitioner.

67. **Survival Period** means a period of 30 days calculated from the date of first confirmed diagnosis or actual performance of a surgical procedure whichever is earlier as defined under the list of Critical Illnesses covered under this Policy.

68. **TPA** Third Party Administrator (TPA)", means a company registered with the Authority, and engaged by Us, for a fee or remuneration, by whatever name called and as may be mentioned in the agreement, for providing health services as mentioned under TPA Regulations.

69. **Unproven/Experimental Treatment** means treatment, including drug experimental therapy, which is not based on established medical practice in India.

70. **We/ Our/ Us** means CignaTTK Health Insurance Company Limited.

71. **You/Your/Policyholder** means the person named in the Policy Schedule as the policyholder and who has concluded this Policy with Us.

ANNEXURE 1: LIST OF OMBUDSMEN OFFICES

Ombudsmen Centres

Contact Details
Office of The Governing Body of Insurance Council (Monitoring Body for Offices of Insurance Ombudsman) **3rd Floor, Jeevan Seva Annexe, Santacruz (West), Mumbai - 400054. Tel.: 26106671/6889. Email ID: inscoun@gbic.co.in Web: www.gbic.co.in** If you have a grievance, approach the grievance cell of Insurance Company first. If complaint is not resolved/ not satisfied/ not responded for 30 days then you can approach The Office of the Insurance Ombudsman (Bimalokpal). Please visit our website for details to lodge complaint with Ombudsman.

CONTACT DETAILS	JURISDICTION
AHMEDABAD Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad – 380 014 Tel.:- 079-27546150/139 Fax:- 079-27546142 Email:- bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Mangal Bldg., 2nd Floor, Behind Canara Mutual Bldgs., No.4, Residency Road, Bengaluru – 560 025. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Bhopal – 462 011. Tel.:- 0755-2769201/202 Fax:- 0755-2769203 Email:- bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh and Chattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.:- 0674-2596461/2596455 Fax:- 0674-2596429 Email:- bimalokpal.bhubaneswar@ecoi.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.:- 0172-2706196/6468 Fax:- 0172-2708274 Email:-bimalokpal.chandigarh@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI – 600 018. Tel.:- 044-24333668/24335284 Fax:- 044-24333664 Email:- bimalokpal.chennai@ecoi.co.in	Tamil Nadu and Pondicherry Town and Karaikal (which are part of Union Territory of Pondicherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011-23239633/23237539 Fax:- 011-23230858 Email:- bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205 Fax:- 0361-2732937 Email:- bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040-65504123/23312122 Fax:- 040-23376599 Email:- bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of the Territory of Pondicherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 -2740363 Fax: 0141 -Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM Office of the Insurance Ombudsman, 2nd Floor, CC 27 / 2603, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.:- 0484-2358759/9338 Fax:- 0484-2359336 Email:- bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4, C.R. Avenue, 4th Floor, KOLKATA - 700 072. TEL : 033-22124340/22124339 Fax : 033-22124341 Email:- bimalokpal.kolkata@ecoi.co.in	West Bengal, Bihar, Sikkim, and Andaman and Nicobar Islands.

LUCKNOW Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.:- 0522-2231330/1 Fax:- 0522-2231310 Email:- bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022-26106552/6960 Fax:- 022-26106052 Email:- bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman,1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No's. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020 -32341320 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

The updated details of Insurance Ombudsman are available on the IRDA website: www.irda.gov.in and on the website of General Insurance Council: www.gicouncil.in

ANNEXURE II: LIST OF NON-MEDICAL EXPENSES

SNO	Item
I	**TOILETRIES/COSMETICS/PERSONAL COMFORT OR CONVENIENCE ITEMS/SIMILAR EXPENSES**
1	HAIR REMOVAL CREAM
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
3	BABY FOOD
4	BABY UTILITES CHARGES
5	BABY SET
6	BABY BOTTLES
7	BRUSH
8	COSY TOWEL
9	HAND WASH
10	M01STUR1SER PASTE BRUSH
11	POWDER
12	RAZOR
13	SHOE COVER
14	BEAUTY SERVICES
15	BELTS/ BRACES
16	BUDS
17	BARBER CHARGES
18	CAPS
19	COLD PACK/HOT PACK
20	CARRY BAGS
21	CRADLE CHARGES
22	COMB
23	DISPOSABLES RAZORS CHARGES (for site preparations)
24	EAU-DE-COLOGNE / ROOM FRESHNERS
25	EYE PAD
26	EYE SHEILD
27	EMAIL / INTERNET CHARGES
28	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)

29	FOOT COVER
30	GOWN
31	LEGGINGS
32	LAUNDRY CHARGES
33	MINERAL WATER
34	OIL CHARGES
35	SANITARY PAD
36	SLIPPERS
37	TELEPHONE CHARGES
38	TISSUE PAPER
39	TOOTH PASTE
40	TOOTH BRUSH
41	GUEST SERVICES
42	BED PAN
43	BED UNDER PAD CHARGES
44	CAMERA COVER
45	CLINIPLAST
46	CREPE BANDAGE
47	CURAPORE
48	DIAPER OF ANY TYPE
49	DVD, CD CHARGES
50	EYELET COLLAR
51	FACE MASK
52	FLEXI MASK
53	GAUSE SOFT
54	GAUZE
55	HAND HOLDER
56	HANSAPLAST/ADHESIVE BANDAGES
57	INFANT FOOD
58	SLINGS
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
62	HORMONE REPLACEMENT THERAPY
63	HOME VISIT CHARGES
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES
69	DONOR SCREENING CHARGES
70	ADMISSION/REGISTRATION CHARGES
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY
74	STEM CELL IMPLANTATION/ SURGERY and STORAGE
75	WARD AND THEATRE BOOKING CHARGES
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS
77	MICROSCOPE COVER
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER
79	SURGICAL DRILL

80	EYE KIT
81	EYE DRAPE
82	X-RAY FILM
83	SPUTUM CUP
84	BOYLES APPARATUS CHARGES
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
86	ANTISEPTIC or DISINFECTANT LOTIONS
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES
88	COTTON
89	COTTON BANDAGE
90	MICROPORE/ SURGICAL TAPE
91	BLADE
92	APRON
93	TORNIQUET
94	ORTHOBUNDLE, GYNAEC BUNDLE
95	URINE CONTAINER
II	**ELEMENTS OF ROOM CHARGE**
96	LUXURY TAX
97	HVAC
98	HOUSE KEEPING CHARGES
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
100	TELEVISION & AIR CONDITIONER CHARGES
101	SURCHARGES
102	ATTENDANT CHARGES
103	IM IV INJECTION CHARGES
104	CLEAN SHEET
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
106	BLANKET/WARMER BLANKET
III	***ADMINISTRATIVE OR NON-MEDICAL CHARGES***
107	ADMISSION KIT
108	BIRTH CERTIFICATE
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
110	CERTIFICATE CHARGES
111	COURIER CHARGES
112	CONVENYANCE CHARGES
113	DIABETIC CHART CHARGES
114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
115	DISCHARGE PROCEDURE CHARGES
116	DAILY CHART CHARGES
117	ENTRANCE PASS / VISITORS PASS CHARGES
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
119	FILE OPENING CHARGES
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
121	MEDICAL CERTIFICATE
122	MAINTENANCE CHARGES
123	MEDICAL RECORDS
124	PREPARATION CHARGES
125	PHOTOCOPIES CHARGES
126	PATIENT IDENTIFICATION BAND / NAME TAG
127	WASHING CHARGES
128	MEDICINE BOX

129	MORTUARY CHARGES
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)
IV	**EXTERNAL DURABLE DEVICES**
131	WALKING AIDS CHARGES
132	BIPAP MACHINE
133	COMMODE
134	CPAP/ CAPD EQUIPMENTS
135	INFUSION PUMP - COST
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
137	PULSEOXYMETER CHARGES
138	SPACER
139	SPIROMETRE
140	SP 02 PROBE
141	NEBULIZER KIT
142	STEAM INHALER
143	ARMSLING
144	THERMOMETER
145	CERVICAL COLLAR
146	SPLINT
147	DIABETIC FOOT WEAR
148	KNEE BRACES (LONG/ SHORT/ HINGED)
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
150	LUMBOSACRAL BELT
151	NIMBUS BED OR WATER OR AIR BED CHARGES
152	AMBULANCE COLLAR
153	AMBULANCE EQUIPMENT
154	MICROSHEILD
155	ABDOMINAL BINDER
V	**ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION**
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\ DSINFECTANTS ETC
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES - DIET CHARGES
159	SUGAR FREE Tablets
160	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
161	Digestion gels
162	ECG ELECTRODES
163	GLOVES
164	HIV KIT
165	LISTERINE/ ANTISEPTIC MOUTHWASH
166	LOZENGES
167	MOUTH PAINT
168	NEBULISATION KIT
169	NOVARAPID
170	VOLINI GEL/ ANALGESIC GEL
171	ZYTEE GEL
172	VACCINATION CHARGES
VI	**PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE**
173	AHD
174	ALCOHOL SWABES
175	SCRUB SOLUTION/STERILLIUM
VII	**OTHERS**

176	VACCINE CHARGES FOR BABY
177	AESTHETIC TREATMENT / SURGERY
178	TPA CHARGES
179	VISCO BELT CHARGES
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
181	EXAMINATION GLOVES
182	KIDNEY TRAY
183	MASK
184	OUNCE GLASS
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
186	OXYGEN MASK
187	PAPER GLOVES
188	PELVIC TRACTION BELT
189	REFERAL DOCTOR'S FEES
190	ACCU CHECK (Glucometery/ Strips)
191	PAN CAN
192	SOFNET
193	TROLLY COVER
194	UROMETER, URINE JUG
195	AMBULANCE
196	TEGADERM / VASOFIX SAFETY
197	URINE BAG
198	SOFTOVAC
199	STOCKINGS

ANNEXURE III: LIST OF DAY CARE TREATMENTS/SURGERIES/PROCEDURES INCLUDING BUT NOT LIMITED TO THE FOLLOWING:

Microsurgical Operations on the middle ear

1. Stapedotomy to treat various lesions in the middle ear
2. Revision of Stapedotomy
3. Othe roperations of the auditory ossicles
4. Myringoplasty (post-aura/ endural approach as well as simple Type – I Tympanoplasty)
5. Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicle)
6. Revision of a Tympanoplasty
7. Other microsurgical operations on the middle ear

Other operations on the middle & internal ear

8. Myringotomy
9. Removal of a tympanic drain
10. Incision of the mastoid process and middle ear
11. Mastoidectomy
12. Reconstruction of the middle ear
13. Other excisions of the middle and inner ear
14. Fenestration of the inner ear
15. Revision of a fenestration of the inner ear
16. Incision (opening) and destruction (elimination) of the inner ear
17. Other operations on the middle ear
18. Removal of Keratosis Obturans

Operations on the nose & the nasal sinuses

19. Excision and destruction of diseased tissue of the nose
20. Operations on the turbinates (nasal concha)
21. Other operations on the nose
22. Nasal sinus aspiration
23. Foreign body removal from nose

Operations on the eyes

24. Incision of tear glands
25. Other operations on the tear ducts
26. Incision of diseased eyelids
27. Correction of Eyelids Ptosis by Levator Palpebrae Superioris Resection (bilateral)
28. Correction of Eyelids Ptosis by Fascia Lata Graft (bilateral)
29. Excision and destruction of diseased tissue of the eyelid
30. Operations on the canthus and epicanthus
31. Corrective surgery for entropion and ectropion
32. Corrective surgery for blepharoptosis
33. Removal of a foreign body from the conjunctiva
34. Removal of a foreign body from the cornea
35. Incision of the cornea
36. Operations for pterygium
37. Other operations on the cornea
38. Removal of a foreign body from the lens of the eye
39. Removal of a foreign body from the posterior chamber of the eye
40. Removal of a foreign body from the orbit and eyeball
41. Operation of cataract
42. Diathermy/ Cryotherapy to treat retinal tear
43. Anterior chamber Pancentesis/ Cyclodiathermy/ Cyclocryotherapy/ goniotomy/ Trabeculotomy and Filtering and Allied operations to treat glaucoma
44. Enucleation of the eye without implant
45. Dacryocystorhinostomy for various lesions of Lacrimal Gland
46. Laser photocoagulation to treat ratinal Tear

Operations on the skin & subcutaneous tissues

47. Incision of a pilonidal sinus
48. Other incisions of the skin and subcutaneous tissues
49. Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
50. Local excision of diseased tissue of the skin and subcutaneous tissues
51. Other excisions of the skin and subcutaneous tissues
52. Simple restoration of surface continuity of the skin and subcutaneous tissues
53. Free skin transplantation, donor site
54. Free skin transplantation, recipient site
55. Revision of skin plasty
56. Other restoration and reconstruction of the skin and subcutaneous tissues
57. Chemosurgery to the skin
58. Destruction of diseased tissue in the skin and subcutaneous tissues
59. Recontruction of deformity/ defect in NailBed

Operations on the tongue

60. Incision, excision and destruction of diseased tissue of the tongue
61. Partial glossectomy
62. Glossectomy
63. Reconstruction of the tongue
64. Other operations on the tongue

Operations on the salivary glands & salivary ducts

65. Incision and lancing of a salivary gland and a salivary duct
66. Excision of diseased tissue of a salivary gland and a salivary duct
67. Resection of a salivary gland
68. Reconstruction of a salivary gland and a salivary duct
69. Other operations on the salivary glands and salivary ducts

Other operations on the mouth & face

70. External incision and drainage in the region of the mouth, jaw and face
71. Incision of the hard and soft palate
72. Excision and destruction of diseased hard and soft palate
73. Incision, excision and destruction in the mouth
74. Palatoplasty
75. Other operations in the mouth

Operations on tonsils and adenoids

76. Transoral incision and drainage of pharyngeal abscess
77. Tonsillectomy without adenoidectomy
78. Tonsillectomy with adenoidectomy
79. Excision and destruction of a lingual tonsil
80. Other operations on the tonsil and adenoids
81. Traumasurgery and orthopaedics
82. Incision on bone, septic and aseptic
83. Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
84. Suture and other operations on tendons and tendon sheath
85. Reduction of dislocation under GA
86. Adnoidectomy

Operations on the breast

87. Incision of the breast
88. Operations on the nipple
89. Excision of single breast lump

Operations on the digestive tract, Kidney and bladder

90. Incision and excision of tissue in the perianal region
91. Surgical treatment of anal fistulas
92. Surgical treatment of haemorrhoids

93. Division of the anal sphincter (sphincterotomy)
94. Other operations on the anus
95. Ultrasound guided aspirations
96. Sclerotherapy etc.
97. Laprotomy for grading Lymphoma with Splenectomy/ Liver/ Lymph Node Biopsy
98. Therapeutic laproscopy with Laser
99. Cholecystectomy and choledocho – jejunostomy/ Duodenostomy/ Gastrostomy/ Exploration Common Bile Duct
100. Esophagoscopy, gastroscopy, dudenoscopy with polypectomy/ removal of foreign body/ diathermy of bleeding lesions
101. Lithotripsy/ Nephrolithotomy for renal calculus
102. Excision of renal cyst
103. Drainage of Pyonephrosis/ Perinephric Abscess
104. Appendicectomy with/ without Drainage

Operations on the female sexual organs

105. Incision of the ovary
106. Insufflation of the Fallopian tubes
107. Other operations on the Fallopian tube
108. Dilatation of the cervical canal
109. Conisation of the uterine cervix
110. Theraputic curettage with Colposcopy/ Biopsy/ Diathermy/ Cryosurgery
111. Laser therapy of cervix for various lesions of Uterus
112. Other operations of the Uterine cervix
113. Incesion of the uterus (hysterectomy)
114. Local incision and destruction of diseased tissue of the vagina and the pouch of Douglas
115. Incision of the vagina
116. Incision of vulva
117. Culdotomy
118. Operations on Bartholin's glands (cyst)
119. Salpino-Oophorectomy via Laproscopy

Operations on the prostate & seminal vesicles

120. Incision of the prostate
121. Transurethral excision and destruction of prostate tissue
122. Transurethral and percutaneous destruction of prostate tissue
123. Open surgical excision and destruction of prostate tissue
124. Radical prostatovesiculectomy
125. Other excision and destruction of prostate tissue
126. Operations on the seminal vesicles
127. Incision and excision of periprostatic tissue
128. Other operations on the prostate

Operations on the scrotum & tunica vaginalis testis

129. Incision of the scrotum and tunica vaginalis testis
130. Operation on a testicular hydrocele
131. Excision and destruction of diseased scrotal tissue
132. Other operations on the scrotum and tunica vaginalis testis

Operations on the testes

133. Incision of the testes
134. Excision and destruction of diseased tissue of the testes
135. Unilateral orchidectomy
136. Bilateral orchidectomy
137. Orchidopexy
138. Abdominal exploration in cryptorchidism
139. Surgical repositioning of an abdominal testis
140. Reconstruction of the testis
141. Implantation, exchange and removal of a testicular prosthesis
142. Other operations on the testis

Operations on the spermatic cord, epididymis and ductus deferens

143. Surgical treatment of a varicocele and a hydrocele of the spermatic cord
144. Excision in the area of the epididymis
145. Epididymectomy

Operations on the penis

146. Operations on the foreskin
147. Local excision and destruction of diseased tissue of the penis
148. Amputation of the penis
149. Other operations on the penis

Operations on the urinary system

150. Cystoscopical removal of stones
151. Catheterisation of baldder

Other Operations

152. Lithotripsy
153. Coronary angiography
154. Biopsy of Temporal Artery for Various leisons
155. External Arterio-venus shunt
156. Haemodialysis
157. Radiotherapy for Cancer
158. Cancer Chemotherapy
159. Endoscopic polypectomy

Operation of bone and joints

160. Surgery for ligament tear
161. Surgery for meniscus tear
162. Surgery for hemoarthrosis/ pyoarthrosis
163. Removal of fracture pins/ nails
164. Removal of metal wire
165. Closed reduction on fracture, luxation
166. Reduction of dislocation under GA
167. Epiphyseolysis with osterosynthesis
168. Excision of Bursirtis
169. Tennis elbow release
170. Excision of various lesions in Coccyx
171. Arthroscopic knee aspiration

For any assistance contact: 1800-10-24462 servicesupport@cignattk.in www.cignattkinsurance.in

Corporate Office: **Corporate Office**: 401/402 Raheja Titanium Western Express Highway Goregaon (East) Mumbai – 400063 IRDA Registration No 151