MANIPALCIGNA ACCIDENT SHIELD

Policy Contract

B. Preamble

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

If any claim arising as a result of an Injury solely and directly due to an Accident anywhere in the world, that occurred during the Policy Period becomes payable, then We shall pay the Benefits in accordance with terms, conditions and exclusions of the Policy

C. Definitions

C.I. Standard Definitions

1. **Accident** means a sudden, unforeseen and involuntary event cause by external, visible and violent means.
2. **AYUSH Hospital** is a healthcare facility wherein medical/ surgical/ para-surgical treatment procedures and interventions are carried outby AYUSH Medical Practitioner(s) comprising any of the following:
   a. Central or State Government AYUSH Hospital;or
   b. Teaching hospitals attached to AYUSH College recognized by the Central Government/ Central Council of Indian Medicine/Central Council for Homeopathy;or
   c. AYUSH Hospital, standalone or co-located with In-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
      i) Having at least five In-patient beds;
      ii) Having qualified AYUSH Medical Practitioner in charge round the clock;
      iii)Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
      iv)Maintaining daily record of the patients and making them accessible to the insurance company's authorized representative.
3. **AYUSH Treatment** refers to the medical and/or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
4. **Break In Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
5. **Cashless Facility** means a facility extended by the insurer to the insured 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 approved.
6. **Condition Precedent** means a Policy term or condition upon which Our liability under the Policy is conditional upon.
7. **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
8. **Day Care Centre** - A day care centre means any institution established for day care treatment of illness and/or injuries or a medical set-up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:-
   a) has qualified nursing staff under its employment
   b) has qualified medical practitioner (s) in charge
   c) has a fully equipped operation theatre of its own where surgical procedures are carried out
   d) maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

10.Dental Treatment - Dental treatment means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

11.Disclosure to Information Norm - The Policy shall be void and all premium paid thereon shall be forfeited to Us, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

12.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

13.Grace Period means the specified period of time, immediately following the premium due date during which premium payment can be made to renew or continue a policy in force without loss of continuity benefits pertaining to waiting periods and coverage of pre-existing diseases. Coverage need not be available during the period for which no premium is received. The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases.

14.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 qualified nursing staff under its employment round the clock;

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

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

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

16.Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery

(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check ups, an/ortests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

17.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.

18.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.

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

20.Medical Advice means any consultation or advise from a Medical Practitioner including the issue of any prescription or follow-up prescription.

21.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.

22.Medically Necessary Treatment 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.

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

23.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.

24.Network Provider means hospitals or health care provider enlisted by an insurer, TPA or jointly by an insurer and TPA to provide medicalservices to an insured by a cashless facility.

25.Non-Network Provider Any hospital, day care centre or other provider that is not part of the network

26.Notification of Claim means the process of intimating a claim to the insurer or TPA through any of the recognised modes of communication.

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

28.Pre-Existing disease (PED) means any condition, ailment, injury or disease:

a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

29.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.

30.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 In-patient Hospitalization claim for such Hospitalization is admissible by the insurance company.

31.Qualified Nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

32.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.

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

34. **Room Rent -** Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

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

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

C.II. Specific Definitions

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

2. **Ambulance means** a road vehicle operated by a licensed/authorized service provider and equipped for the transport and paramedicaltreatment of the person requiring medical attention.

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

4. **Associated Medical Expenses.** shall include nursing charges, operation theatre charges, fees of Medical Practitioner/surgeon/anesthetist/ Specialist, excluding cost of pharmacy and consumables, cost of implants and medical devices, cost of diagnostics conducted within the same Hospital where the Insured Person has been admitted. It shall not be applicable for Hospitalization in ICU.

   Associated Medical Expenses shall be applicable for covered expenses, incurred in Hospitals which follow differential billing based on the room category.

5. **Common Carrier** means any land, sea or air conveyance operated under a licence issued by a government authority having jurisdiction for the transportation of fare paying passengers and which has fixed established routes only.

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

7. **Dependents** means only the family members listed below
   i) Your legally married spouse as long as he/she continues to be married to You
   ii) Your children Aged between 5 Years and 25 years if they are unmarried
   iii) Your natural parents or parents that have legally adopted You and/or your parents-in-law

8. **Dependent Child** means a child up to the age of 25 years (naturally or legally adopted), who is financially dependent on You and does not have his/her independent source of income.

9. **Emergency** shall mean a serious medical condition or symptom resulting from injury 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 stabilization at which time this medical condition or symptom is not considered an emergency anymore.

10. **Expiry Date** is the date on which this Policy expires as specified in the Policy Schedule.

11. **Fracture** is a break in continuity of the bone evidenced by an X-Ray and certified by the attending Medical Practitioner.

12. **Family** for the purpose of Section EII.4 means immediate family member or blood relative.

13. **Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained or not. Such sport/ activity includes 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 limbing/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 labor, 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, ski jumping, ski racing, sky diving, small bore target shooting, speed trials/time trials, triathlon,water ski jumping, weight lifting or wrestling any type.

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

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

16.**Insured Person** means the person(s) named in the Policy Schedule, who is/are covered under this Policy, for whom the insurance is proposed and the appropriate premium paid.

17.**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.

18.**Nominee** means the person named in the Policy Schedule who is nominated to receive the benefits under the Policy in accordance withthe terms and conditions of the Policy, if You are deceased.

19.**Policy** means this Terms & Conditions document, the Proposal Form, Policy Schedule, Add-On Benefit Details (if applicable) and Annexures which form part of the Policy contract including endorsements, as amended from time to time which form part of the Policy Contract and shall be read together.

20.**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.

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

22.**Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Policy Holder, Insured Persons, the Sum Insured, the period and the limits to which benefits under the Policy are subject to, Premium Paid (including taxes), 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.

23.**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.

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

25.**We/ Our/ Us** means ManipalCigna Health Insurance Company Limited.

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

D. Benefits covered under the policy

D.I Base Covers

If an Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such Injury solely and directly results in the Insured Person's death or disablement which is of the nature specified below within 365 days of the Accident, then We shall pay the corresponding benefits specified below to You, the Insured Person or the Nominee, as the case may be.

D.I.1. Accidental Death

If the Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such Injury solely and directly results in the death of the Insured Person within 365 days from the date of the Accident, We will pay 100% of opted Sum Insured as specified in the Policy Schedule. Where such Death occurs while the Insured Person is a fare paying passenger on a common carrier, We will pay 200% of opted Sum Insured as specified in the Policy Schedule.

Table of Benefits	Percentage of the Sum Insured payable
a. Accidental Death	100%
b. Accidental Death (Common Carrier)	200%

Once a claim has been accepted and paid under this Benefit then this Policy will automatically terminate in respect of that Insured Person.

D.I.2. Permanent Total Disablement

If the Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such 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 in the table below. Where such Permanent Total Disablement occurs while the Insured Person is a fare paying passenger on a common carrier, We will pay 200% of opted Sum Insured as specified in the table below.

Table of Benefits	Percentage of the Sum Insured payable
a. Type of Permanent Total Disablement	
i) Total and irrecoverable loss of sight of both eyes	100%
ii) Loss by physical separation or total and permanent loss of use of both hands or both feet	100%
iii) Loss by physical separation or total and permanent loss of use of one hand and one foot	100%
iv) Total and irrecoverable loss of sight of one eye and loss of a Limb	100%
v) Total and irrecoverable loss of hearing of both ears and loss of one Limb/loss of sight of one eye	100%
vi) Total and irrecoverable loss of hearing of both ears and loss of speech	100%
vii) Total and irrecoverable loss of speech and loss of one Limb/ loss of sight of one eye	100%
viii) Permanent total and absolute disablement (not falling under the above) disabling the Insured Person from engaging in any employment or occupation or business for remuneration or profit, of any description whatsoever which results in "Loss of Independent Living"	100%
b. Permanent Total Disablement (of the nature listed under D.I.2.b which occurs due to an Accident while the Insured Person is a fare paying passenger on a common carrier)	200%

For the purpose of this benefit,

- **Limb** means a hand at or abov 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 benefits 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; and

b. The Permanent Total Disablement continues for a period of at least 180 days from the commencement of the Permanent Total Disablement; provided that We must be satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement.

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 it will be payable under Accidental Death Benefit under D.I.1 above provided it is payable as per the coverage under Section D.I.1 and such intimation of death has been made to Us.

d. If We have admitted a claim for Permanent Total Disablement in accordance with this Benefit, then We shall not be liable to make any payment under the Policy on the death of the Insured Person, if the Insured Person subsequently dies.

e. Once a claim has been accepted and paid under this Benefit then cover under this Policy shall immediately and automatically cease in respect of that Insured Person.Claims in respect of Common Carrier benefit are limited to Accidental Death D.I.1 & Permanent Total Disability D.I.2 only.

D.I.3. Permanent Partial Disablement

If the Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such 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.

Table of Benefits	Percentage of the Sum Insured payable
a. Permanent Partial Disablement	
i) Total and irrecoverable loss of sight of 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 - two phalanges - one phalanx	10% 8% 4%
xiv) Loss of middle/ring/little finger-three phalanges - two phalanges - one phalanx	6% 4% 2%

The benefits 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;

b. The Permanent Partial Disablement continues for a period of at least 180 days from the commencement of the Permanent Partial Disablement; provided that We must be satisfied at the expiry of the 180 days that there is no reasonable medical hope of improvement.

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 it will be payable under Accidental Death Benefit under D.I.1 above, provided it is payable as per the coverage under Section D.I.1 and such intimation of death has been made to Us.

d. In case the Insured Person suffers a loss not mentioned in the table above, then Our medical advisors will determine the degree of disablement and the amount payable, if any.

e. We will not make any payment under Permanent Partial Disability if we have already paid or accepted any claims under Permanent Total Disability, Permanent Partial Disability or Temporary Total Disability in respect of the Insured Person and the total amount paid or payable under those claims is cumulatively greater than or equal to the opted Sum Insured for that Insured Person.

f. Once a claim has been accepted and paid under

this Benefit then cover under this Policy shall be reduced to the extent of payment made under Permanent Partial Disability in respect of that Insured Person.

D.I.4. Funeral Expenses

If We have accepted a claim under Section D.I.1 in respect of an Insured Person, then in addition to any amount payable under Section D.I.1, We will make a onetime payment as per the amount specified in the table below, towards the funeral cremation expenses of that Insured Person.

Sum Insured Opted (In ₹)	Funeral Expenses (in ₹)
Up to 50 Lac	₹50,000
Above 50 Lacs	₹1,00,000

D.I.5. Repatriation of Mortal Remains

If We have accepted a claim under Section D.I.1, in respect of an Insured Person, We will reimburse the Reasonable and Customary expenses up to the limit specified against this benefit in the Policy Schedule/Product Benefit Table towards the costs associated with the transportation of mortal remains from the place of death to the home location as mentioned in the Policy Schedule

Any claim under this Benefit shall be payable if the death of the insured person occurs outside the city of residence as mentioned in the Policy Schedule.

D.II Optional Covers

The Policy provides the following optional covers The Policy Schedule will specify the Optional Covers that are in force for the Insured Person. Wherever opted, such Optional Covers shall apply to all Insured Persons under a single policy without any individual selection, except for the following covers: 1. Temporary Total Disablement, 2. Child Welfare Benefit, 3. Loss of employment, 4. EMI Shield and 5. Loan Shield. All covers available under optional benefits, except Adventure Sports Cover, are in addition to the Base Covers opted under the respective Plan. 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

D.II.1. Temporary Total Disablement

If the Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such Injury solely and directly results in the Temporary Total Disablement of the Insured Person immediately after an Accident, We will pay an amount equal to 2% of the Sum Insured or ₹1,00,000 or the actual base weekly income whichever is lesser, per week in case of an earning member, and 1% of the Sum Insured or ₹50,000 or 50% of the weekly compensation payable for the earning member (at the time of claim) covered in the same Policy, whichever is lesser, per week in case of a non-earning member, 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 the availability of the Sum Insured. Minimum absence from work and unable to perform his/her duties must be for 7 consecutive days, 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.

In case of salaried persons this weekly benefit shall in no case exceed the Insured Persons base weekly income excluding overtime, bonuses, tips, commissions or any other special compensation. In case of self-employed persons this weekly benefit shall in no case exceed the Insured Persons base weekly income derived from the income tax returns filed for the previous financial year.This cover can be opted by the non-earning members only when an earning member has opted for the Temporary Total Disablement cover.

This cover is not applicable for Dependent Children. 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 or unable to perform his/her duties, of any description whatsoever on a temporary basis and a disability certificate is issued by the treating Doctor or Civil Surgeon or the equivalent appointed by the District/ State or Government Board.

D.II.2. Burns Benefit

If the Insured Person suffers from Burns due to an Injury 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 subject to the following:

- 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 surface area in writing.

- If the Injury results in more than one of the descriptions in the table mentioned below, then We will pay cumulatively maximum up to the Sum Insured.

For the purpose of this benefit, Burns means any burns suffered by the Insured Person as specifically defined in the table below.

Table of Benefits 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%

Where a claim for 100% Sum Insured has been paid under this coverage under this benefit shall lapse and the policy will continue for the balance period for the other covers, however no further renewals will be permitted.

D.II.3. Broken Bones Benefit

If the Insured Person suffers from Broken Bones due to an Injury 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 subject to the following:

- The breakage of bones is not self-inflicted by the Insured Person in any way; and

For the purpose of this benefit, Broken Bones means the breakage of such bones of the Insured Person, evidenced by a Fracture and are specifically defined in the table below excluding any form of hair line or simple fracture.

If the Injury results in more than one of the descriptions mentioned in the table below, then We will pay for the highest one up to the limits as mentioned against that particular description.

Table of Benefits	Payable Percentage of Sum Insured for Broken Bones Benefit
Injury to vertebral body resulting in spinal cord damage	100% of SI or ₹20 Lacs whichever is lower
Pelvis	50% of SI or ₹10 Lacs whichever is lower
Skull (excluding nose and teeth)	1. Compound fracture with damage to the brain tissue- 100% of SI or ₹20 Lacs whichever is lower 2. Compound fracture without damage to the brain tissue- 50% of SI or ₹10 Lacs whichever is lower 3. All other fractures- 30% of SI or ₹3 Lacs whichever is lower

Chest (all ribs and breast bone)	1. Open Fracture - 50% of SI or ₹5 Lacs whichever is lower 2. Closed Fracture - 25% of SI or ₹3 Lacs whichever is lower
Shoulder (collar bone and shoulder blade)	1. Open Fracture - 30% of SI or ₹3 Lacs whichever is lower 2. Closed Fracture- 15% of SI or ₹2 Lacs whichever is lower
Arm	25% of SI or ₹5 Lacs whichever is lower
Leg	
Vertebra-vertebral arch (excluding coccyx)	30% of SI or ₹5 Lacs whichever is lower
Wrist (collies or similar fractures)	1. Open Fracture - 30% of SI or ₹3 Lacs whichever is lower 2. Closed Fracture- 15% of SI or ₹2 Lacs whichever is lower
Ankle (Potts or similar fracture)	1. Open Fracture - 10% of SI or ₹2 Lac whichever is lower 2. Closed Fracture- 5% of SI or ₹1 Lac whichever is lower
Coccyx	5% of SI or ₹1 Lacs whichever is lower
Hand	3% of SI or ₹1 Lac whichever is lower
Finger	
Foot	
Toe	
Nasal bone	

For the Purpose of this benefit;

- 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.
- Any Fracture caused as a result of Sickness or disease (including malignancy), or due to osteoporosis will not be payable under this benefit.
- If an Insured Person suffers a fracture not mentioned in the table above, then We will assess the fracture with Our medical advisors and determine the amount of payment to be made.
- Our maximum liability under this benefit is limited to the opted Sum Insured, irrespective of the number of fractures that the Insured Person suffers caused by the same Accident. Where a claim for 100% Sum Insured has been paid under this coverage under this benefit shall lapse and the policy will continue for the balance period for the other covers, however no further renewals will be permitted.
- If a claim in respect of any fracture of a whole bone alsoencompasses some or all of its parts, Our liability to make payment will be limited to the whole bone only and not any of its parts.

D.II.4. Coma Benefit

If the Insured Person suffers from a Coma due to an Injury solely and directly due to an Accident that occurs during the Policy Period, We will pay an amount equal to the limit applicable for this benefit and as specified in the Policy Schedule/Product Benefit Table in respect of that Insured Person, subject to the terms below.

For the purpose of this benefit, Coma means a state of unconsciousness with no reaction or response to external stimuli or internal needs. The Insured Person suffers from a Coma within 30 days from the date of Accident.

This diagnosis of Coma 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 of Coma has to be confirmed by a specialist Medical Practitioner in writing. Coma resulting directly from alcohol/drug abuse or due to sickness or disease is excluded under this Policy.

D.II.5. Child Welfare Benefit

i) Education Fund

If an Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such injury solely and directly results in Accidental Death (AD), in respect of an Insured Person, We will make an one-time payment equal to the limit applicable for this benefit and as specified in the Policy Schedule/Product Benefit Table of this Policy towards the Dependent Child/ Children irrespective of whether the Dependent Child/Children is also an insured.

This benefit shall be payable subject to the Dependent Child / Children 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.

Our maximum and cumulative liability under this benefit shall be equal to the limit applicable for this benefit and as specified in the Policy Schedule/ Product Benefit Table of this Policy, irrespective of the number of Dependent Child / Children.

ii) Orphan Benefit

If an Insured Person suffers an Injury solely and directly due to an Accident that occurs during the policy period and such injury solely and directly results in Accidental Death (AD) in respect of an Insured person who is a Parent, We will make an one-time payment equal to the limit applicable for this benefit and as specified in the Policy Schedule/ Product Benefit Table of the policy towards the Dependent Child/Children irrespective of whether the Dependent Child/Children is also an insured. The pay-out under orphan benefit will be in addition to the Education Benefit.

Our maximum and cumulative liability under this benefit shall be equal to the limit applicable for this benefit and as specified in the Policy Schedule/ Product Benefit Table of this Policy, irrespective of the number of Dependent Child / Children.

This benefit shall be payable subject to the Dependent Child/ Children being up to 25 years of age as on date of occurrence of the event. Incase of any surviving parent, Orphan Benefit is not payable.

D.II.6. Loss of Employment

If an Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such injury solely and directly results in Permanent Total Disablement (PTD), Permanent Partial Disablement (PPD) in respect of an Insured Person, due to which the Insured Person is totally disabled from engaging in his/her employment and loses his/her source of income generation through engaging in his/her primary occupation, We will make an one-time payment equal to the limit applicable for this benefit and as specified in the Policy Schedule/Product Benefit Table of this Policy.

The pay-out under this benefit is limited to the least of base monthly net income excluding overtime, bonuses, tips, commissions, any other special compensation or the Sum Insured opted under this cover.

This benefit is applicable only for the salaried employees and available once in a lifetime in respect of that Insured Person.

D.II.7. Air Ambulance

If an Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such injury solely and directly results in requirement of an Air Ambulance, We will reimburse the Reasonable and Customary expenses incurred towards transportation of an Insured Person, to the Hospital or to move the Insured Person to and from healthcare facilities, by an Air Ambulance, provided that:

i. Air Ambulance is used in case of an Emergency life threatening health condition of the Insured Person which requires immediate and rapid ambulance transportation to the hospital or a medical centre which ground transportation cannot provide;

ii. The transportation should be provided by medically equipped aircraft which can provide medical care in flight and should have medical equipment to monitor vitals and treat the Insured Person suffering from an Illness/Injury such as but not limited to ventilators, ECG's, monitoring units, CPR equipment and stretchers;

iii. Air Ambulance service is offered by a Registered Ambulance service provider;

iv. The treating Medical Practitioner certifies in writing that the severity and nature of the Insured Person's Injury warrants the Insured Person's requirement for Air Ambulance;

Benefit under this cover is payable up to the limits as specified in the Policy Schedule / Product Benefit Table of this Policy. This coverage is available only on reimbursement basis.

What is not covered: Expenses incurred in return transportation to Insured Person's home by air ambulance is excluded.

D.II.8. Accidental Hospitalization

If an Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such injury solely and directly results in requirement of Hospitalization, We will indemnify the Reasonable and Customary expenses incurred towards the Hospitalization Expenses of an Insured Person, as per the limitsspecified in the Policy Schedule/Product Benefit Table of this Policy.

This cover is applicable only within India.

The Accidental Hospitalization expenses shall cover the following:

1. In-Patient Hospitalization and Day Care treatment Expenses:We will pay Medical Expenses up to

the limits as specified in the Policy Schedule for:

a. Reasonable and Customary Charges for Room Rent for accommodation in Hospital room up to any room Category,
b. Intensive Care Unit charges for accommodation in ICU,
c. Operation theatre charges,
d. Fees of Medical Practitioner/ Surgeon,
e. Anesthetist,
f. Qualified Nurses,
g. Specialists,
h. Cost of diagnostic tests,
i. Medicines,
j. Drugs and consumables, blood, oxygen, surgical appliances and prosthetic devices recommended by the attending Medical Practitioner and that are used intra operatively during a Surgical Procedure.

2. Ayush In-Patient Treatment: Expenses incurred on hospitalization due to accident, under AYUSH systems of medicine shall be covered.
3. Pre-hospitalization and Post-hospitalization Medical Expenses up to 30 days each on reimbursement basis.
4. Reasonable and Customary expenses incurred on road Ambulance subject to a maximum of ₹10,000/- per hospitalization on reimbursement basis, within the Accidental Hospitalization Sum Insured.
5. Medically necessary Dental treatment and Plastic Surgery
6. Accidental OPD Expenses: Covered up to 1% of the Accidental Hospitalization Sum Insured, subject to a maximum of ₹25,000/-, within the Accidental Hospitalization Sum Insured, towards the Reasonable and Customary expenses for Doctor consultation & prescribes Diagnostic tests.

We will indemnify the Reasonable and Customary expenses of the following Medical expenses incurred by the Insured Person, for an Injury solely and directly due to an Accident that occurs during the Policy Period and such injury solely and directly results in requirement of an Out-patient treatment.

- Consultations with Medical Practitioners and Specialists;
- Diagnostic tests as recommended by the treating Medical Practitioner and Specialists

Exclusion E.II.1.i is not applicable towards Accidental OPD Expenses.

7. Cost of Crutches, Wheel chairs, Prosthetics & Artificial limbs will be covered maximum up to ₹1 Lac, within the Accidental Hospitalization Sum Insured, and will be payable as per actuals for purchasing or renting of the necessary Crutches, Wheel chairs, Prosthetics & Artificial Limbs provided that:
   i. The necessity of the Medical equipment and/ or artificial limbs to be recommended by the treating Doctor.
   ii. Purchase or Renting to be initiated during hospitalization or within 30 days from the time of discharge from the hospital.

For the benefit of this cover,

Medical Equipment and Artificial limbs shall include artificial devices replacing body parts such as artificial limbs or eyes, orthopectic braces and durable medical equipment such as wheelchair, crutches, hospital beds, traction equipment, Walkers.

D.II.9. EMI Shield

If an Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such injury solely and directly results in Accidental Death (AD), Permanent Total Disablement (PTD), Permanent Partial Disablement (PPD) in respect of an Insured Person, We will make an one-time payment to You, equal to the limit applicable for this benefit and as specified in the Policy Schedule/Product Benefit Table of this Policy towards the payment of EMIs (Equated Monthly Instalments)

EMI amount under this benefit would not include any arrears due to any reasons whatsoever.

The pay-out under this benefit is limited to the least of sum total of 3 EMIs due or the Sum Insured opted under this cover.

During the subsequent renewal, the Sum Insured under this cover can be modified basis the EMIs due or this cover can be removed if the loan is closed.

D.II.10. Loan Shield

If an Insured Person suffers an Injury solely and directly due to an Accident that occurs during the Policy Period and such injury solely and directly results in Accidental Death (AD), Permanent Total Disablement (PTD) in respect of an Insured Person, We will make an one-time payment to You, equal to the outstanding loan amount (excluding any arrears, penalties and penal interest) as on date of

the accident, or the limit applicable for this benefit and as specified in the Policy Schedule/Product Benefit Table of this Policy, whichever is lower.

During the subsequent renewal, the Sum Insured under this cover can be modified basis the actual outstanding of loan or this cover can be removed if the loan is closed.

For the purpose of this benefit:

a. The loan has to be in the name of the insured and from a bank or a housing finance company licensed by the appropriate authority.

b. Loans from Credit Societies, Moneylenders or similar unorganized lending institutions are excluded.

c. If the member has more than one loan outstanding, the cumulative amount of all the loans together would be considered.

d. Claim will be payable only to You or the nominee and not to any financial institution.

D.II.11. Adventure Sports Cover

If an Insured Person suffers an Injury solely and directly due to an Accident, whilst engaging in an Adventure Sports, that occurs during the Policy Period and such injury solely and directly results in Accidental Death (AD), Permanent Total Disablement (PTD) in respect of an Insured Person We will pay as per the limits specified in the Policy Schedule/Product Benefit Table of this Policy.

This cover can be opted only at the time of new Policy purchase and shall not be permitted to opt in during the renewals (wherever not opted at the time of Policy purchase).

This cover shall cease to exist from the Policy once any Insured person attains the Age of 60 years either during the Policy purchase or during subsequent renewals.

Exclusions E.I.9, E.II.17, E.II.19 shall not be applicable for this cover, only to the extent of the Adventure Sports that are defined as below.

For the benefit of this cover, Adventure Sports means:

The Adventure Sports must be performed in a non-professional capacity and are organized and supervised by a trained professional.

a. Sky Sports: Sky Diving, Hang Gliding, Ballooning, Parasailing, Paragliding, Bungee Jumping, Bridge Swinging, Zip Lining, Zip Trekking.

b. Mountain Sports (with equipment): Skiing, Snowboarding, Rock Climbing, Rock Scrambling, Rappelling, Via Ferrata, Fell Running, Fell Walking, Gorge Walking, Indoor Rock Climbing, Mountain Biking,Cannoning, Mountaineering, caving or pot-holing.

c. Water Sports: Fishing, Deep Sea Fishing, Kite Surfing, Body Boarding, Paddle Boarding, Kayaking, Canoeing, Scuba Diving, Shark Diving, Swimming with Dolphins, Diving with Whales, Wakeboarding, Surfing, white water rafting, Snorkelling, Water-sskiing, Whale Watching, skin diving or other underwater activity.

d. Earth Sport: Land Windsurfing, Zorbing, Sand Boarding

D.II.12. Medical Repatriation

If an Insured Person suffers an Injury and hospitalized outside his/her city of residence, solely and directly due to an Accident that occurs during the Policy Period and such injury solely and directly results in requirement of medical repatriation, We will reimburse the Reasonable and Customary expenses incurred towards the medical repatriation of an Insured Person, as per the limits specified in the Policy Schedule/Product Benefit Table of this Policy, provided that:

The repatriation of the Insured Person from outside his/her city of residence as specified in the Policy Schedule to,

i. his/her residence in India; or

ii. a Hospital near his/her residence, in India.

The benefit is payable subject to the below conditions:

i. The medical repatriation must be determined by the attending Medical Practitioner, to be Medically Necessary;

ii. Transportation to be provided by medically equipped specialty aircraft, commercial airline, train or Ambulance depending upon the medical needs and available transportation specific to each case;

iii. These cover shall be available only on the reimbursement basis

E. Exclusions

E.I Standard Exclusions

We shall not be liable to make any payment for any claim 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 unless otherwise stated in the Policy:

Exclusions specific to section D.II.8 “Accidental Hospitalization”

E.I.1 Investigation & Evaluation- Code- Excl 04

a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

E.I.2 Rest Cure, rehabilitation and respite care- Code- Excl 05

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

E.I.3 Cosmetic or Plastic Surgery: Code- Excl 08

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

E.I.4 Excluded Providers: Code- Excl 11

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the Policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

E.I.5 Treatment for Alcoholism,drug or substance abuse or any addictive condition and consequences thereof. **Code- Excl 12**

E.I.6 Treatments received in heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code- Excl13**

E.I.7 Dietary supplements andsubstances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of hospitalization claim or day care procedure. **Code- Excl 14**

E.I.8 Unproven Treatments: Code- Excl 16

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

Exclusions (applicable to all sections of the policy)

E.I.9 Hazardous or Adventure sports: Code- Exc09

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

E.I.10 Breach of law: Code- Excl 10

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

E.II. Specific Exclusions

We shall not be liable to make any payment for any claim 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 unless otherwise stated in the Policy:

1. Exclusions specific to section D.II.8 "Accidental Hospitalization"

   i. Expenses incurred for treatment of accidental injuries which does not warrant hospitalization.

   ii. Costs of donor screening or costs incurred in an organ transplant surgery involving organs not harvested from a human body.

   iii. Any form of Non-Allopathic treatment (except AYUSH Treatment (In-patient Treatment)), Hydrotherapy, Acupuncture, Reflexology, Chiropractic treatment or any other form of indigenous system of medicine.

   iv. Any expenses incurred on Domiciliary Hospitalization.

v. Treatment taken outside the geographical limits of India.

vi. All expenses listed in Annexure-3 (List I) of the Policy.

Exclusions (applicable to all sections of the policy)

2. Any Pre-existing Disease or Disability arising out of a Pre-existing Diseases or any complication arising therefrom.
3. Suicide or attempted Suicide, intentional self-inflicted injury, acts of self-destruction whether the Insured Person is medically sane or insane.
4. Certification by a Medical Practitionerwho shares the same residence as the Insured Person or who is a member of the Insured Person's Family.
5. 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.
6. Death or disablement directly or indirectly caused by or associated with any venereal disease, sexually transmitted disease
7. Congenital internal or external diseases, defects or anomalies or in consequence thereof.
8. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement arising from Bacterial infections (except pyogenic infection which occurs through an cut or wound due to Accident).
9. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement arising from Medical or surgical treatment except as necessary solely and directly as a result of an Accident.
10. Benefit under Accidental Death, Permanent Total Disablement, Permanent Partial Disablement arising from Hernia.
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, misdemeanor 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 includingectopic 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, tunneling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel.
19. Engaged or while engaging in Hazardous Activities.
20. 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.
    - 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.
21. 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.

E.III. Exclusion which can be opted for cover by payment of additional premium

1. Expenses incurred for treatment of accidental injuries which does not warrant hospitalization. (Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.II.8 of the Policy and limits as specified in the Policy Schedule)
2. Hazardous or Adventure sports: Code-Excl 09

   Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

   (Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.II.11 of the Policy and limits as specified in the Policy Schedule)
3. 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. (Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.II.11 of the Policy and limits as specified in the Policy Schedule)
4. Engaged or while engaging in Hazardous Activities.

   (Benefits covered upon payment of additional premium under the said exclusion shall be limited upto the extent specified under the corresponding section defined under section D.III.4 of the Policy and limits as specified in the Policy Schedule

F. General Terms and Clauses

F.I. Standard General Terms and Clauses

F.I.1. Disclosure of Information

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

b. The Policy shall be null and void, and all premium paid thereon shall be forfeited to the Company in the event of non-disclosure of any material fact by the policyholder.

("Material facts" for the purpose of this Policy shall mean all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

F.I.2 Condition Precedent to Admission of Liability

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

F.I.3 Claim Settlement (provision for Penal Interest)

i. The Company shall settle or reject the claim, as the case may be, within 15 days (other than cashless) from date of submission of necessary claim documents.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest tothe policyholder from date of submission of necessary claim documents to the date of payment of claim at a rate 2% above the bank rate.

F.I.4 Complete Discharge

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

F.I.5 Multiple policies (Applicable for Section D.II.8- Accidental Hospitalization)

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

In case of multiple indemnity policies taken by an

Insured Person during a period from one or more Insurers, the Insured Person shall have the right to require settlement of his/her claim under any of his/her policies, subject to proper disclosure of information about their multiple indemnity policies to chosen Insurer, either at policy inception,at renewal, or at the time of claim intimation.

Upon a claim, the Insurer chosen by the Insured for claim settlement shall be treated as the Primary Insurer and shall be obligated to settle the claim within the limits and terms of the chosen policy. If the available coverage under the chosen policy is less than the admissible claim amount, the Primary Insurer shall co-ordinate with other Insurer to ensure settlement of the balance amount as per the policy contract.

F.I.6 Fraud

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

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression “fraud” means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a insurance Policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The company shall not repudiate the policy on the ground of fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

F.I.7. Cancellation

i. The Insured may cancel this Policy by giving 15 days’ written notice, and in such an event, the Company shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

<table>
<tr><th colspan="4">Refund Grid as % of Premium</th></tr>
<tr><th>Policy Cancelation Within (Days)</th><th>Policy Year-1</th><th>Policy Year-2</th><th>Policy Year-3</th></tr>
<tr><td>0 - 30 Days</td><td>85.00%</td><td>87.50%</td><td>89.00%</td></tr>
<tr><td>31 - 90 Days</td><td>75.00%</td><td>80.00%</td><td>82.50%</td></tr>
<tr><td>91 - 181 Days</td><td>50.00%</td><td>70.00%</td><td>75.00%</td></tr>
<tr><td>182 - 272 Days</td><td>30.00%</td><td>60.00%</td><td>70.00%</td></tr>
<tr><td>273 - 365 Days</td><td>0.00%</td><td>50.00%</td><td>60.00%</td></tr>
<tr><td>366 - 456 Days</td><td rowspan="4">NIL</td><td>35.00%</td><td>55.00%</td></tr>
<tr><td>457 - 547 Days</td><td>25.00%</td><td>45.00%</td></tr>
<tr><td>548 - 638 Days</td><td>15.00%</td><td>40.00%</td></tr>
<tr><td>639 - 730 Days</td><td>0.00%</td><td>30.00%</td></tr>
<tr><td>731 - 821 Days</td><td rowspan="4"></td><td rowspan="4">NIL</td><td>25.00%</td></tr>
<tr><td>822 - 912 Days</td><td>15.00%</td></tr>
<tr><td>913 - 1003 Days</td><td>5.00%</td></tr>
<tr><td>1004 and more Days</td><td>0.00%</td></tr>
</table>

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured person under the Policy.

ii. The Company may cancel the Policy at any time on grounds of misrepresentation, nondisclosure of material facts, fraud by the Insured Person, by giving 15 days’ written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

iii. No refund will be processed for cancellation of policies with Premium Payment Mode as Half yearly, Quarterly or Monthly.

F.I.8 Nomination:

The insured person is required at the inception of the policy, to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an

endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/ Policy Certificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

F.I.9 Renewal of the Policy:

The policy shall ordinarily be renewable except on grounds of established fraud, misrepresentation, non-disclosure of material facts by the insured person.

i. The Company shall give notice for renewal at least 30 days in advance from the Policy due date.

ii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iii. At the end of the policy period, the policy shall terminate and can be renewed within the Grace period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

iv. No loading shall apply on renewals based on individual claims experience.

v. The cover for the Insured shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under Coverage Death or Permanent Total Disability and no Renewal of contract will be permissible.

vi. The insured may also avail an optional cover or opt out of the optional cover (as applicable) at the time of renewal.

F.I.10 Possibility of Revision of Terms of the Policy Including the Premium Rates:

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

F.I.11 Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

i. Grace Period of 30 days would be given for Half-yearly and Quarterly mode of payment and grace period of 15 days for monthly mode of payment would be given to pay the instalment premium due for the Policy.

ii. If the premium is paid in instalments during the Policy Period, coverage will be available during such Grace Period.

iii. Instalment facility shall not be available for the Policy Tenure more than 1 year.

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

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

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

vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

F.I.12 Free look period

The Free Look Period will be applicable on the new policy and not on renewals.

1. The insured will be allowed a period of 30 days from date of receipt of the Policy to review the terms and conditions of the Policy, and to return the same if not acceptable.
2. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.
3. Free look cancellation & refund will be made within 7 days from the date of receipt of request.
4. In case of any delay in refund, the insurer shall refund such amounts along with interest at the bank rate plus 2 percent on the refundable amount, from the date of receipt of the request for free look cancellation till the date of refund

F.I.13 Redressal of Grievances

If you have a grievance that you wish us to redress, you may contact us with the details of the grievance through Our website:www.manipalcigna.com

Email: customercare@manipalcigna.com,

Senior Citizens may write to us at - seniorcitizensupport@manipalcigna. com

Toll Free: 1800-102-4462

Contact No.: + 91 22 71781300

Courier: Any of Our Branch office or corporate office during business hours. Insured Person may also approach the grievance cell at any of company's branches with the details of the grievance.

If Insured Person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at,

'The Grievance Cell,

ManipalCigna Health Insurance Company Limited,

Techweb center 2nd Floor New Link Rd,

Anand Nagar, Jogeshwari West, Mumbai, Maharashtra 400102, India or

Email - headcustomercare@manipalcigna.com.

For updated details of grievance officer, kindly refer link -https://www.manipalcigna.com/grievance redressal

If Insured person is not satisfied with the redressal of grievance through above methods, the Insured Person may also approach the office of Insurance Ombudsman of the respective area/ region for redressal of grievance as per Insurance Ombudsman Rules 2017. The contact details of Ombudsman offices attached as Annexure I to this Policy document.

Grievance may also be lodged at IRDAI complaints management system - https://bimabharosa.irdai.gov.in/

You may also approach the Insurance Ombudsman if your complaint is open for more than 30 days from the date of filing the complaint.

The office Name and address details applicable for your state can be obtained from - https://www.cioins.co.in/Ombudsman

F.II Specific terms and clauses

F.II.1 Duty of Disclosure

The Policy shall be null and void and We shall have no liability to make any payment of claims and the premium paid shall be forfeited to Us in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the Proposal Form, Personal Statement, Declaration, Claim Form Declaration, Medical History on the Claim Form and connected documents, or any material information having been withheld by You/Insured Person or any one acting on their behalf or non-cooperation by You/Insured Person, under this Policy.

F.II.2 Material Change

Material information to be disclosed includes every matter that You are 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 Company may in its discretion adjust the scope of cover and/or the premium paid or payable, accordingly. You must exercise the same duty to disclose those matters to Us before the Renewal, extension, variation, endorsement or reinstatement of the Policy.

F.II.3 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 You/ Insured Person, shall be a Condition Precedent to Our liability under this Policy.

F.II.4 Reasonable Care

You/Insured Person understand and agree to take all reasonable steps in order to safeguard against any Accident or Injuries that may give rise to any claim under this Policy.

F.II.5 Alterations in the Policy

This Policy constitutes the complete contract of insurance between You 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.

F.II.6 Change of Policyholder

The policyholder may be changed only at the time of Renewal of the Policy. The new policyholder must be a member of the Insured Person's immediate family. Such change would be solely subject to Our discretion and payment of premium by You. The renewed Policy shall be treated as having been renewed without a break.

The policyholder may be changed upon request in case of his demise, his moving out of India or in case of divorce during the Policy Period.

F.II.7 No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to You/Insured Person which is in Our possession and not specifically informed by You/Insured Person shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

F.II.8 Geography

This Policy applies to events or occurrences taking place anywhere in the world (except for coverage under section D.II.8 - Accidental Hospitalization) unless limited under this Policy in a particular benefit or definition or by Us through an endorsement. However, all admitted or payable claims shall be settled in India in Indian rupees.

F.II.9 Special Provisions

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

F.II.10 Records to be Maintained

You or the Insured Person, as the case may be shall keep an accurate record containing all relevant medical records relevant to the Injury in respect of which a claim has been made under this Policy and shall allow Us or our representative(s) to inspect such records. Such information shall be furnished to Us as may be required by Us under this Policy at any time during the Policy Period and up to the later of three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

F.II.11 Loadings and Underwriting

There is no defined pre-medical examination grid. Medical examination may be called for in case of disclosure in the Proposal Form / Tele/Video MER, We may ask such member to undergo specific tests, as We may deem fit to evaluate such member, irrespective of Age/ Sum Insured/Plan opted. 100% of the pre-policy medical check-up cost will be borne by the company.

Underwriting Loadings will be applicable at the time of acceptance of fresh business on a case to case basis depending on the relevance of each of the below mentioned criteria.

- Medical History & Declarations on the Proposal Form/medical documents
- Overall Health Risk Scoring Generated in the UW Tool Maximum loading applicable on a policy shall be 100% per Insured Person. There will be no loadings based on individual claims experience

F.II.12 Cancellation

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 without any refund of premium.

An individual Policy with a single Insured Person shall automatically terminate in case of Your death or upon the payment of all eligible Sum Insured's in accordance with the payment of benefits under the applicable sections. In case of a Policy with multiple Insured Persons, the Policy shall continue to be in force for the remaining Insured Persons up to the expiry of current Policy Period until the death of such Insured Persons or upon the payment of the Sum Insured in accordance with Section D. The Policy may be Renewed on an application by another adult Insured Person under the Policy or any other Member who satisfies the criteria to be a Policyholder whenever such is due for Renewal. All relevant particulars in respect of such person (including his/her relationship with You) must be given to Us along with the application.

F.II.13 Grace Period, Revival, Renewal and DiscountsGrace Period:

The Policy may be Renewed by mutual consent for life subject to application of renewal and realization of renewal premium 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 fifteen days where premium payment mode is monthly and 30 days (for Single premium payment mode) from the date of expiry of the Policy. We will not be liable to pay for any claim arising out of an Injury /Accident/condition that occurred during the Grace Period and the period between the date of expiry of previous policy and date of inception of subsequent policy. The provisions of Section 64VB of the Insurance Act shall be applicable. All policies Renewed within the Grace Period shall be eligible for continuity of cover.

Revival Period:

For instalment (Half-yearly and Quarterly) premium policies, the revival period shall be 30 days and for Monthly premium payment mode the revival

period shall be 15 days from the due date of next instalment.

You may pay the premium through National Automated Clearing House (NACH)/ Standing Instruction (SI) provided that:

i. NACH/Standing Instruction Mandate form is completely filled & signed by You.

ii. The Premium amount which would be auto debited & frequency of instalment is duly filled in the mandate form.

iii. New Mandate Form is required to be filled in case of any change in the Policy Terms and Conditions whether or not leading to change in Premium.

iv. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the NACH/ Standing Instruction facility.

v. Non-payment of premium on due date as opted by You in the mandate form subject to an additional renewal/ revival period will lead to termination of the policy.

Renewal Terms:

a. The Policy will automatically terminate at the end of the Policy Period.

b. The Policy would be considered as a fresh policy if there would be break of more than 30 days for Single, Annual, Half-yearly and Quarterly payment mode and 15 days for Monthly payment mode, between the previous policy expiry date and current Policy start date.

c. Renewals will not be denied except on grounds of misrepresentation, established fraud, non-disclosure by You

d. Where We have discontinued or withdrawn this product/plan You will have the option to Renew under the nearest substitute policy being issued by Us, provided however benefits payable shall be subject to the terms contained in such other policy. We will notify You regarding withdrawal of this product and the options available at the time of Renewal of this Policy.

e. Insured Persons shall disclose to Us in writing of any material change in his/her health condition or Occupation at the time of seeking Renewal of this Policy, irrespective of any claim arising or made. The terms and condition of the existing policy will not be altered.

f. We may in Our sole discretion, revise the Renewal premium payable under the Policy or the terms of cover, provided that the Renewal premiums are in accordance with the IRDA guidelines and regulations as applicable from time to time. Renewal premiums will not alter based on individual claims experience. We will intimate You of any such changes at least 3 months prior to date of such revision or modification coming into effect.

g. Alterations like increase/decrease in Sum Insured or change in plan, addition/deletion of Insured Persons, addition/deletion of optional covers/ riders will be allowed at the time of Renewal of the Policy. You can submit a request for the changes by filling the proposal form before the expiry of the Policy. We reserve Our right to carry out underwriting in relation to acceptance or rejection of the request for changes on Renewal. The terms and conditions of the existing Policy will not be altered.

Discounts under the Policy

You can avail of the following discounts on the applicable premium on your policy.

Long Term policy discount: You can avail of a long term discount of 7.5% and 10% on selecting a 2 and 3 years policy term respectively.

Worksite Marketing Discount (Only at inception – One time): A discount of 10% will be available on polices which are sourced through worksitemarketing channel.

Corporate Discount (Only at inception – One time): 5% of one-time discount for an employee who is working in any Public or Private Limited Companies

Online Renewal Discount: 3% discount on the renewal premium, if the renewal premium is received through NACH or standing instruction (where payment is made either by direct debit of bank account or credit card)

Employee Discount: 10% discount on the premium.

Only one of the following discounts can be opted – Worksite Marketing discount / Employee discount / Corporate discount

Maximum Discount in any policy year cannot exceed 25%

F.II.14 Premium calculation

The Premium charged on the Policy will depend on the Plan, Sum Insured, Optional Covers and Policy Period. Premium can be paid on Single, Half yearly, Quarterly or Monthly basis. Premium payment mode can only be selected at the inception of the Policy or at the renewal of the Policy.

In case of premium payment modes other than Single, a loading will be applied on the premium.

Loading grid applicable for Half-yearly, Quarterly

and Monthly payment mode.

Premium payment mode	% Loading on premium
Monthly	5.5%
Quarterly	3.5%
Half yearly	2.5%

The premium payment mode can be changed only on a policy anniversary by sending a request at least one month in advance. Change in premium payment mode is subject to:

1. Payment of premium and loading, if any.
2. Minimum premium requirement for the requested premium payment mode, if any.
3. Availability of the requested premium payment mode on the day of implementation of request.
4. Premium rates/ tables applicable for the changed premium payment mode will be the same as the premium rates/ tables applicable on the date of commencement of policy.

F.II.15 Communications & Notices

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

a. Your address as specified in Policy Schedule;

b. To Us, at the address specified in the Policy Schedule;

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

c. 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.

F.II.16 Electronic Transactions

You agree to comply with all the terms, conditions as We shall prescribe from time to time, and confirm 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 be 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 You. 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 You.

All terms and conditions in respect of Electronic Transactions shall be within the approved Terms and Conditions of the Policy.

F.II.17 Limitation of Liability

If a claim is rejected and is not the subject of any pending suit or other proceeding or arbitration, as the case may be, within twelve 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.

F.II.18 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. The payment made by Us to You/Insured Person or to Your Nominee/legal representative, as the case may be, of the Sum Insured under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

F.II.19 Dispute Resolution

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.

G. Other terms and conditions

G.I. Claim Procedure

G.I.1. Conditions Preceding

The fulfilment 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 admissibilityof 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 We are satisfied 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 the claims process under this Section, shall be essential failing which We shall not be bound to accept a claim.

G.I.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 claim procedure set out under Section G.I.3. and G.I.6. 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.

G.I.3. Notification of Claim

Upon the discovery or occurrence of any Illness / Injury that may give rise to a Claim under this Policy, You / Insured Person or the nominee as the case may be shall undertake the following:

In the event of any Illness or Injury or occurrence of any other contingency which has resulted in a Claim or may result in a claim covered under the Policy, You/the Insured Person, must notify Us either at the call center or in writing within 10 days from the date of such Accident (In case of claims other than for the benefit under Accidental Hospitalization), in the event of:

- Planned Hospitalization, You/the Insured Person will intimate such admission at least 48 hours prior to the planned date of admission
- Emergency Hospitalization (under benefit - Accidental Hospitalization), You /the Insured Person will intimate such admission within 24 hours of such admission.

The following details are to be provided to Us at the time of intimation of Claim in case of an Injury / Illness:

- Policy Number
- Name of the Policyholder
- Name of the Insured Person in whose relation the Claim is being lodged
- Nature of Illness / Injury
- Name and address of the attending Medical Practitioner and Hospital (if admission has taken place)
- Date of Admission if applicable
- Any other information as requested by Us

G.I.4.Cashless Facility (Applicable for the Benefit- Accidental Hospitalization)

Cashless facility is available only at our Network Hospital or Common empanelment of hospital/ healthcare providers as specified by Insurance Council. The Insured Person can avail Cashless facility at the time of admission into any Network Hospital or Common empanelment of hospital/ healthcare providers as specified by Insurance Council, by presenting the health card as provided by Us with this Policy, along with a valid photo identification proof (Voter ID card / Driving License/ Passport/PAN Card/any other identity proof as approved by Us).

(a) For Planned Hospitalization:

i. The Insured Person should at least 48 hours prior to admission to the Hospital approach the Network Provider for Hospitalization for medical treatment.

ii. The Network Provider or common empanelment of hospital/healthcare providers will issue the request for authorization letter for Hospitalization in the pre-authorization form prescribed by the IRDA.

iii. The Network Provider or common empanelment of hospital/healthcare providers shall electronically send the pre-authorization form along with all the relevant details to the 24 (twenty four) hour authorization/cashless department along with contact details of the treating Medical Practitioner and the Insured Person.

iv. Upon receiving the pre-authorization form and all related medical information from the Network Provider or common empanelment of hospital/ healthcare providers, We will verify the eligibility of cover under the Policy.

v. Wherever the information provided in the request is sufficient to ascertain the authorization We shall issue the authorization Letter to the Network Provider or common empanelment of hospital/ healthcare providers. Wherever additional information or documents are required We will call for the same from the Network provider or common empanelment of hospital/healthcare providers and upon satisfactory receipt of last necessary documents the authorization will be issued. All authorizations will be issued within a period of 1 hour from the receipt of last complete documents.

vi. The Authorization letter will include details of sanctioned amount, any specific limitation on the claim, any co-pays or deductibles and non-payable items if applicable.

vii. The authorization letter shall be valid only for a period of 15 days from the date of issuance of authorization.

In the event that the cost of Hospitalization exceeds the authorized limit as mentioned in the authorization letter:

i. The Network Provider shall request Us for an enhancement of authorization limit as described under Section G.I.4 (a) including details of the specific circumstances which have led to the need for increase in the previously authorized limit.

ii. We will verify the eligibility and evaluate the request for enhancement on the availability of further limits.

iii. We shall accept or decline such additional expenses within 1 (one) hour of receiving the request for enhancement from You.In the event of a change in the treatment during Hospitalization to the Insured Person, the Network Provider shall obtain a fresh authorization letter from Us in accordance with the process described under G.I.4 (a) above.

At the time of discharge:

i. the Network Provider or common empanelment of hospital/healthcare providers may forward a final request for authorization for any residual amount to us along with the discharge summary and the billing format in accordance with the process described at G.I.4.(a) above.

ii. We shall accept or decline such additional expenses within 3 (Three) hours of receiving the complete documents for final discharge from Network provider or Common empanelment of hospital/healthcare providers.

iii. Upon receipt of the final authorization letter from us, You may be discharged by the Network Provider.

(b) In case of Emergency Hospitalization

i. The Insured Person may approach the Network Provider or common empanelment of hospital/ healthcare providers for Hospitalization for medical treatment.

ii. The Network Provider or common empanelment of hospital/healthcare providers shall forward the request for authorization within 24 hours of admission to the Hospital as per the processunder Section G.I.4 (a).

iii. It is agreed and understood that we may continue to discuss the Insured Person's condition with the treating Medical Practitioner till Our recommendations on eligibility of coverage for the Insured Person are finalized.

iv. In the interim, the Network Provider or common empanelment of hospital/healthcare providers may either consider treating the Insured Person by taking a token deposit or treating him as per their norms in the event of any lifesaving, limb saving, sight saving, Emergency medical attention requiring situation.

v. The Network Provider or common empanelment of hospital/healthcare providers shall refund the deposit amount to You barring a token amount to take care of non-covered expenses once the pre-authorization is issued.

The Network Provider or common empanelment of hospital/healthcare providers will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to us. The following claim documents should be submitted to Us within 15 days from the date of discharge from Hospital -

- Claim Form Duly Filled and Signed
- Original pre-authorization request
- Copy of pre-authorization approval letter (s)
- Copy of Photo ID of Patient Verified by the Hospital
- Original Discharge/Death Summary
- Operation Theatre Notes(if any)
- Original Hospital Main Bill and break up Bill
- Original Investigation Reports, X Ray, MRI, CT Films, HPE

- Doctors Reference Slips for Investigations/ Pharmacy
- Original Pharmacy Bills
- MLC/FIR Report/Post Mortem Report (if applicable and conducted)

We may call for any additional documents as required based on the circumstances of the claim There can be instances where We may deny Cashless facility for Hospitalization due to insufficient Sum Insured or insufficient information to determine admissibility in which case You/Insured Person may be required to pay for the treatment and submit the claim for reimbursement to Us which will be considered subject to the Policy Terms &Conditions.

We in our sole discretion, reserves the right to modify, add or restrict any Network Hospital for Cashless services available under the Policy. Before availing the Cashless service, the Policyholder / Insured Person is required to check the applicable/latest list of Network Hospital on the Company's website or by calling our call centre

G.I.5 Claim Reimbursement Process

(a) Collection of Claim Documents

i. Wherever You have opted for a reimbursement of expenses, You may submit the following documents for reimbursement of the claim to Our branch or head office at your own expense not later than 15 days from the date of discharge from the Hospital. You can obtain a Claim Form from any of our Branch Offices or download a copy from our website: https://www.manipalcigna.com/downloads/claims

ii. List of necessary claim documents to be submitted for reimbursement are as following:

Claim form duly signed
Copy of photo ID of patient
Hospital Discharge summary
Operation Theatre notes
Hospital Main Bill
Hospital Break up bill
Investigation reports
Original investigation reports, X Ray, MRI, CT films, HPE, ECG
Doctors reference slip for investigation
Pharmacy Bills
MLC/ FIR report, Post Mortem Report if applicable and conducted
KYC documents (Photo ID proof, address proof, recent passport size photograph)
Cancelled cheque for NEFT payment
Payment receipt.

We may call for any additional documents information as required based on the circumstances of the claim.

iii. Our branch offices shall give due acknowledgement of collected documents to You.

In case You/ Insured Person delay submission of claim documents as specified in G.I.5.(a) above, then in addition to the documents mentioned in G.I.5.(a) above, You are also required to provide Us the reason for such delay in writing. In case You delay submission of claim documents, then in addition to the documents mentioned above, You are also required to provide Us the reason for such delay in writing. We will accept such requests for delay up to an additional period of 30 days from the stipulated time for such submission. We will condone delay on merit for delayed Claims where the delay has been proved to be for reasons beyond Your/Insured Persons control.

G.I.6 Claim Documents & Submission

The following documents are required to be submitted to Us within 30 days of the date of occurrence of the Accident to Our branch or Head Office.

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,
- Income Proof
  - Last 3 months Salary Slip/Form 16 for salaried persons
  - Last financial years ITR for self-employed persons

<u>Section D.I.1 Accidental Death:</u>

- Original Death certificate issued by the office of Registrar of Birth & Deaths;
- Death summary issued by a Hospital;
- Post Mortem Report (if conducted);

- 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.

Claim under Sections D.I.2 Permanent Total Disablement & D.I.3. Permanent Partial Disablement as well as optional benefit under Section D.II. 1 Temporary Total Disablement

- Original treating Medical Practitioner's certificate describing the disablement;
- Original Discharge summary from the Hospital;
- Photograph of the Insured Person reflecting the disablement;
- Prescriptions and consultation papers of the treatment;
- Disability certificate issued by treating Medical Practitioner (in case of TTD), civil surgeon or equivalent appointed by the District/State or Government Board.
- Any other medical, investigation reports, inpatient or consultation treatment papers, as applicable;
- In case of TTD, We may ask for Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board on case to case basis.

The submitted medical documents may be re-validated by Our Doctors.

Additional documents required under Section D.II.1 Temporary Total Disablement

- Leave/Absence Certificate from Employer (If Employed)
- Latest salary slip or certificate from employer specifying remuneration (in case of salaried Person).
- Income Tax Returns of the previous financial year (in case of self-employed person)

Additional documents required under Section D.I.1 & D.I.2 Accidental Death & Permanent Total Disablement (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.

Additional documents for Benefits (as applicable):

Air Ambulance :

a. Original Bill from a certified Ambulance Service Provider or Hospital.

Child Welfare Benefit:

Education Fund:

a. Proof to establish relationship - Passport/ Education certificate establishing proof of relationship of child with parents/Birth Certificate or Adoption Papers (if adopted).
b. Photo Identity Proof of Child (Children)
c. Age proof of Child (Children)
d. Certificate from Educational Institution describing course details
e. Death certificate of the parent(s)

Orphan Benefit:

a. Birth Certificate of child or adoption papers (if adopted)
b. Photo Identity Proof of Child (Children)
c. Age proof of Child (Children)
d. Any other proof to establish relationship – Passport/Education certificate establishing proof of relationship of child with parents.
e. Legal Guardian Certificate if the Child is a minor
f. Death certificate of parent(s)

Loss of Employment:

a. Loss of Employment/Termination Letter/Relieving letter indicating the reason for termination.
b. Salary Slip of last 3 months
c. Last year's Form 16 issued by the employer
d. Income Tax Return attested copy
e. Disability certificate issued by civil surgeon or equivalent appointed by the District/State or Government Board

Broken Bones Benefits:

a. Original X-Ray/MRI/CT-Scan/Radiology Films/ Reports confirming the extent of fracture.

Coma benefit:

a. Original Specialist Medical practitioner certificate confirming condition with permanent neurological deficit, and the reason for the same and the duration of comatose stage
b. Other documents as specified under Section

D.II.4 for Coma Benefit

Burns Benefit:

a. Original Specialist Medical practitioner certificate confirming degree of burns and total area involved

Adventure Sports cover:

a. Same list of documents as per Accidental Death or Permanent Total Disablement (as applicable)
b. Age proof of Insured person.
c. Certificate of participation from Sports event organizer/service provider
d. Pre participation fitness certificate
e. Certificate from the treating doctor mentioning the nature of the Injury
f. All Investigation reports
g. Discharge summary (If hospitalized)

EMI Shield:

a. Latest Loan account statement(s) with NEFT of Financial institution
b. Same list of documents as per Accidental Death, Permanent Total Disablement, Permanent Partial Disablement (as applicable)
c. Current outstanding Loan certificate(s) from financer, along with the documents submitted
d. Loan disbursement letter(s) along with the payment record till the date of Accident
e. Repayment schedule showing the EMI details

Loan Shield:

a. Latest Loan account statement(s) with NEFT of Financial institution
b. Same list of documents as per Accidental Death, Permanent Total Disablement, Permanent Partial Disablement (as applicable)
c. Current outstanding Loan certificate(s) from financer, along with the documents submitted
d. Repayment schedule showing the EMI details
e. Loan disbursement letter(s) along with the payment record till the date of Accident

Repatriation of Mortal Remains:

a. Original Invoice of expenses.
b. Same list of documents as per Accidental Death

Medical Repatriation:

a. Original Specialist Medica practitioner certificate confirming the requirement of Medical repatriation
b. Original Invoice of expenses.

Cost of Crutches, Wheel chairs, Prosthetics & Artificial limbs:

a. Original Invoice of expenses.
b. Original Specialist Medical practitioner prescription advising the same.

Accidental OPD:

a. Completed claim form.
b. Photo Identity proof of the patient.
c. Medical practitioner's prescription
d. Original bills with itemized break-up
e. Payment receipts
f. Investigation/Diagnostic test reports etc supported by the prescription from attending medical practitioner
g. NEFT details (to enable direct credit of amount in bank account) and cancelled cheque
h. KYC (Identity proof with Address) of the proposer

The above list provided under G.I.6 is indicative and We may ask for any other evidence as specified under the relevant Section of thePolicy.

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 reason 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 Policyholderor Insured Person.

G.I.7 Scrutiny of Claim Documents

a. We shall scrutinize the claim and accompanying documents, and notify the relevant stakeholders (such as Network Provider or Common empanelment of hospital/healthcare providers) of any document deficiencies. We will contact the relevant stakeholders on your behalf to collect the required documents.
b. We shall settle the claim payable amount after scrutinizing the claim documents.
c. In case a reimbursement claim is received when a Pre-Authorization letter has been issued, before approving such claim a check will be made with the provider whether the Pre-authorization has

been utilized as well as whether the Policyholder has settled all the dues with the provider. Once such check and declaration is received from the Provider, the case will be processed.

G.I.8 Claim Assessment

a. We will pay fixed benefit amounts as specified in the applicable benefits in accordance with the terms of this Policy. We are not liable to make any reimbursements of medical expenses or pay any other amounts not specified in the Policy.

b. Claim payment for policies with Monthly, Quarterly and Half-Yearly Premium Payment Mode:

   i. In case of a claim, an amount equivalent to the balance of the instalment premiums payable, in that policy year would be recoverable from the claim amount payable in respect of the Insured person.

G.I.9 Claims Investigation

We may, at Our discretion, depending upon the facts of the case, investigate and determine the validity of claims. Such investigation shall be conducted on case to case basis and will be concluded accordingly. Any verification or investigation will be carried out by individuals or entities authorized by Us, and the cost of such verification/ investigation will be borne by Us.

G.I.10 Settlement & Repudiation of a claim

We shall settle the claim within 15 days from the date of submission of necessary claim documents.

In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from date of submission of necessary claim documents to the date of payment of claim at a rate 2% above the bank rate.

G.I.11 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.

G.I.12 Re-opening of Claim

We may allow a closed claim to be reopened depending on the validity and the circumstances of the claim.

G.I.13 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, the Policy will terminate and no further renewals will be available under this Policy.

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. We will not be liable for any claims which are incurred from the due date of instalment till the date and time of revival of the Policy.

f. Additionally, in the event of any claim being lodged under the Policy for any cause whatsoever, 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

g. 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.

G.II . Annexure – I:
Ombudsman

Name of the Office of Insurance Ombudsman	State-wise Area of Jurisdiction
AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email:- bimalokpal.ahmedabad@cioins.co.in	State of Gujarat and Union Territories of Dadra and Nagar Haveli and Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	State of Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Email:- bimalokpal.bhopal@cioins.co.in	States of Madhya Pradesh and Chhattisgarh.
BHUBANESWAR Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.:- 0674-2596461/2596455 Email:- bimalokpal.bhubaneswar@cioins.co.in	State of Orissa.
CHANDIGARH Office of the Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017 Tel.:- 0172 - 4646394 / 2706468 Email:- bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana, (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh 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 / 24333678 Email:- bimalokpal.chennai@cioins.co.in	State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).
DELHI Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.:- 011 - 23237539 Email:- bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahadurgarh

ManipalCigna Health Insurance

GUWAHATI Office of the Insurance Ombudsman, 'Jeevan Nivesh', 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.:- 0361-2132204/2132205 Email:- bimalokpal.guwahati@cioins.co.in	States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court" Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.:- 040 - 23312122 Email:- bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email:- bimalokpal.jaipur@cioins.co.in	State of Rajasthan.
KOCHI Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email:- bimalokpal.ernakulam@cioins.co.in	States of Kerala and Union Territory of (a) Lakshadweep (b) Mahe-a part of Union Territory of Puducherry.
KOLKATA Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. TEL : 033 - 22124339 / 22124341 Email:- bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim, and Union Territories of 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 - 4002082 / 3500613 Email:- bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorakhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharthnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.:- 022 - 69038800/27/29/31/32/33 Email:- bimalokpal.mumbai@cioins.co.in	State of Goa and Mumbai Metropolitan Region excluding Areas of Navi Mumbai and 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.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farukkabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	States of Bihar and Jharkhand.
PUNE Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	States of Maharashtra, Areas of Navi Mumbai and Thane but excluding Mumbai Metropolitan.

G.III. Annexure-II:

Product Benefit Table

Title	Description Please refer to the Plan and Sum Insured you have opted to understand the available benefits under your plan in brief			
Your Coverage Details:	Identify your Plan	**CLASSIC**	**PLUS**	**PRO**
Basic Covers This section lists the Basic benefits available on your plan	Identify your Opted Sum Insured (SI) (in ₹)	₹5 Lac to ₹25 Cr (in multiples of 10,000)	₹5 Lac to ₹25 Cr (in multiples of ₹10,000)	₹5 Lac to ₹25 Cr (in multiples of ₹10,000)
	Accidental Death (AD)	100% of SI 200% of SI (If death occurs due to an Accident while travelling as a fare paying passenger on a common carrier)		
	Permanent Total Disablement (PTD)	Not Applicable	100% of SI 200% of SI (If PTD occurs due to an Accident while travelling as a fare paying passenger on a common carrier)	
	Permanent Partial Disablement	Not Applicable		Up to percentage as specified in the policy wordings
	Funeral expenses	SI Up to ₹50 Lacs - ₹50,000 SI Above ₹50 Lacs - ₹1,00,000		
	Repatriation of Mortal Remains	Up to 2% of SI, subject to a maximum of ₹5 Lac Payable on Reimbursement basis. Any claim under this Benefit shall be payable if the death of the insured person occurs outside his city of residence..		
Optional Covers This section lists the available optional covers under your plan and the limits under each of these options	Temporary Total Disablement (TTD)	Limit (Applicable for Adult Insured members): For earning member - 2% of SI or ₹1,00,000 per week or Insured Persons base weekly income at the time of claim, whichever is lower (for a maximum of 100 weeks) for the duration of the Temporary Total Disablement of the Insured Person. Minimum absence from work shall be for 7 consecutive days. For Non-earning member (Can be opted only if the earning member is part of the TTD cover) - 1% of SI or ₹50,000 per week or 50% of the weekly compensation payable for the earning member (at the time of claim) covered in the same Policy, whichever is lower (for a maximum of 100 weeks) for the duration of the Temporary Total Disablement of the Insured Person.		
	Burns benefit	Injury due to accidents leading to Burns is payable as a % of SI If the Injury results in more than one of the Descriptions of policy wordings, then the Company will pay cumulatively maximum up to the Sum Insured		
	Broken Bones Benefit	Not Applicable	Not Applicable	Injury due to accidents leading to Broken Bones is payable as a % of SI If the Injury results in more than one of the Descriptions of policy wordings, then the Company will pay for the highest one up to the limits as mentioned against that particular description
	Coma Benefit	25% of SI subject to a maximum of ₹25 Lac. Should be in comatose state for at least 96 hours Coma resulting directly from alcohol / drug abuse or due to sickness or disease is excluded.		

	Child Welfare Benefit	In case of Accidental Death of an Insured Person Education Benefit: 10% of the SI, subject to a maximum of ₹20 Lac (Irrespective of number of dependent chid(ren)) Available for dependent children up to age 25 years, even if not insured in the policy. Orphan Benefit: (In addition to Education Benefit) 20% of the SI, subject a maximum of ₹40 Lac (Irrespective of number of dependent chid(ren)) Available for dependent children up to age 25 years, even if not insured in the policy. In case of any surviving parent, Orphan benefit shall not be payable.
	Loss of employment	Payable in case of PTD / PPD Options: 3 months salary totalling up to the following options: ₹50000 to ₹500000 (in multiples of ₹10,000) This benefit is applicable only for the salaried employees and not applicable for self employed. Customer can select the nearest SI option(s) as per the Salary. The pay-out under this benefit is limited to the least of base monthly net income excluding overtime, bonuses, tips, commissions, any other special compensation or the Sum Insured opted under this cover We will pay for this benefit on Lump sum basis once upon occurrence of PTD / PPD that results in loss of employment. Would be available once in a lifetime of the insured person.
	Air Ambulance	Up to ₹10 Lacs Payable on Reimbursement basis Applicable across the World, from the point of incidence to the hospital. We will not pay for return transportation to the Insured Person's home by air ambulance
	Accidental Hospitalization	SI options(₹) - 5 Lac, 10 Lac, 15 Lac, 20 Lac, 25 Lac, 50 Lac Applicable only within India. Room type - Any Room ICU- Up to SI 1) Inpatient treatment 2) Ayush Expenses 3) Medically necessary Dental Treatment 4) Medically necessary Plastic surgery 5) Day care Treatment 6) Pre & Post Hospitalization (up to 30 days each) 7) Road Ambulance - Covered Up to ₹10,000 per hospitalization (Covered within the accidental hospitalization SI) 8) Accidental OPD (For procedures that require less than 24 hours of hospitalization, Doctor consultation & Diagnostic Tests) (Covered within the accidental hospitalization SI) - Upto 1% of SI, subject to a maximum of ₹25,000. (Available on Reimbursement basis) 9) Cost of Crutches, Wheel chairs, Prosthetics & Artificial limbs - Maximum up to ₹1 Lac (Covered within the accidental Hospitalization SI) Payable as per actuals for purchase or renting of necessary Crutches, Wheel chairs, Prosthetics & Artificial limbs as recommended by the treating Doctor. Purchase or Renting to be initiated within 30 days from the time of discharge from the hospital.

	EMI Shield	Payable in case of AD /PTD / PPD 3 EMIs totaling up to the following SI options (Rs): 50000 to 5 Lac (in multiples of ₹10,000) Customer can select the nearest SI options as per the EMI at the time of policy purchase and at the time of Renewal. EMI amount under this benefit would not include any arrears due to any reasons whatsoever. The pay-out under this benefit is limited to the least of sum total of 3 EMIs due or the Sum Insured opted under this cover. We will pay for this benefit on Lump sum basis once upon the occurrence of AD/PTD/ PPD		
	Loan Shield	Payable in case of AD / PTD SI Options(₹) - 1 Lac to ₹1 Cr (in multiples of ₹10,000) SI option(s) under this benefit can be chosen only up to the Accidental Death SI amount, subject to a maximum SI limit available under Loan Shield cover. Customers can select the nearest SI option(s) as per the outstanding loan amount at the time of policy purchase and at the time of Renewal. We will pay the only the lowest of outstanding loan amount or the SI chosen under this benefit, upon occurrence of AD / PTD.		
	Adventure Sports Cover (Cover can be opted only at the time of policy purchase and shall not be permitted to opt in during the renewals (wherever not opted at the time of policy purchase)	Not Applicable	Not Applicable	Payable in case of AD / PTD 50% of SI, subject to a maximum of ₹50 Lac Covered as per the list of specified adventure sports in Policy Wordings. This cover is available only up to 60 years of age (at New Business / Renewal)
	Medical Repatriation	Up to 25% of SI, subject to a maximum of ₹25 Lac Applicable across the world on reimbursement basis		

You are advised to refer to the attached Customer Information Sheet (CIS) for summary of benefits available in the Policy Wordings.

G.IV. Annexure-III:

Applicable for Accidental Hospitalization Cover under section D.II.8

List I – Items for which Coverage is not available in the Policy

Sl No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL I INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

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

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/ INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE I ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES I ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS I VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES I MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND I NAME TAG
37	PULSEOXYMETER CHARGES

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

Sl No.	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

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

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