CUSTOMER INFORMATION SHEET/KNOW YOUR POLICY

This document provides key information about your policy. You are also advised to go through your policy document.
Please Note: *This Customer Information Sheet provides information available under this Product. Kindly refer to the Policy Schedule to know exact details of coverage opted by You.*

Sl No	Title	Description	Policy Clause Number
1	Name of Insurance Product/ Policy	**Arogya Sanjeevani Policy, Go Digit** **(UIN: GODHLIP20168V011920)**	
2	Policy number	Please refer Your Policy Schedule	
3	Type of Insurance Product/ Policy	**The Product is on Indemnity Basis**	**C.Benefit Covered under the Policy**
4	Sum Insured (Basis) (Along with amount)	This product can be on "Individual Sum Insured" as well as on "Floater Sum Insured" basis. Please refer Your Policy Schedule to know the Sum Insured basis applicable to Your Policy. • Individual Sum Insured -Where each member has a separate sum insured under the policy), • Floater Sum Insured-Where all members under the policy have a single sum insured limit which may be utilised by any or all members. Sum Insured Amount available under Your policy will be as per amount mentioned in Your Policy Schedule.	NA
5	Policy Coverage (What am I covered for?) (Policy Clause Number/s)	**I. Coverage** The covers listed below are inbuilt Policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in this Policy. **1. Hospitalization** The Company shall indemnify medical expenses incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the policy schedule, for,	**C.I. Coverage**

		i. Room Rent, Boarding, Nursing Expenses as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000 /-, per day. ii. Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses up to 5% of sum insured subject to maximum of Rs. 10,000/- per day. iii. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees whether paid directly to the treating doctor/ surgeon or to the hospital iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses. **1.1 Other expenses** i. Expenses incurred on treatment of cataract subject to the sub limits ii. Dental treatment, necessitated due to disease or injury iii. Plastic surgery necessitated due to disease or injury iv. All day care treatments v. Expenses incurred on road Ambulance subject to a maximum of Rs.2000/- per hospitalisation. **Note:** 1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment 2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of (a) cost of pharmacy and consumables, (b) cost of implants and medical devices, (c) cost of diagnostics, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges. 3. Proportionate deductions will not apply in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category. **2. AYUSH Treatment**	

The Company shall indemnify medical expenses incurred for inpatient care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum insured as specified in the policy schedule in any AYUSH Hospital.

3. Cataract Treatment

The Company shall indemnify medical expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per each eye in one policy year.

4. Pre-Hospitalization

The company shall indemnify pre-hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalization covered under the policy.

5. Post Hospitalisation

The company shall indemnify post hospitalization medical expenses incurred, related to an admissible hospitalization requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalization covered under the policy.

6. The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to 50% of Sum Insured, specified in the policy schedule, during the policy period:

A. Uterine Artery Embolization and HIFU (High intensity focused ultrasound)

B. Balloon Sinuplasty

C. Deep Brain stimulation

D. Oral chemotherapy

E. Immunotherapy - Monoclonal Antibody to be given as injection

F. Intra vitreal injections

G. Robotic surgeries

H. Stereotactic radio surgeries

		I. Bronchial Thermoplasty J. Vaporisation of the prostrate (Green laser treatment or holmium laser treatment) K. IONM - (Intra Operative Neuro Monitoring) L. Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered. **7.** The expenses that are not covered in this policy are placed under List-I of Annexure-A. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-A respectively. **II. <u>CUMULATIVE BONUS (CB)</u>** Cumulative Bonus will be increased by 5% in respect of each claim free policy year (where no claims are reported), provided the policy is renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year. **Notes:** i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported. CB shall reduce only in case of claim from the same Insured Person. ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case of claim from any of the Insured Persons. iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period. iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is applicable to the lowest among all the Insured Persons v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the	**C.II. Cumulative Bonus**

		Sum Insured into two or more floater policies / individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed Policy vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy. vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year. If a claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn	
6	Exclusions (what the policy does not cover)	**<u>There are 3 types of exclusions:</u>** **I. <u>STANDARD EXCLUSIONS (Please refer below for brief headers, for detail exclusions, please refer to the policy wordings)</u>** **1. Pre-Existing Diseases - Code- Excl01** **2. Specified disease/procedure waiting period- Code- Excl02** **3. First Thirty Days Waiting Period Code- Excl03** **4. Investigation & Evaluation- Code- Excl04** **5. Rest Cure, rehabilitation and respite care- Code- Excl05** **6. Obesity/ Weight Control: Code- Excl06** **7. Change-of-Gender treatments: Code- Excl07** **8. Cosmetic or plastic Surgery: Code- Excl08** **9. Hazardous or Adventure sports: Code- Excl09** **10. Breach of law: Code- Excl10** **11. Excluded Providers: Code- Excl11** **12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof– Code- Excl12** **13. 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** **14. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure – Code- Excl14**	D.I Standard Exclusion

		15. Refractive Error: Code- Excl15 **16. Unproven Treatments: Code- Excl16** **17. Sterility and Infertility: Code- Excl17** **18. Maternity: Code Excl18** **II.<u>SPECIFIC EXCLUSIONS</u>** **19. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.** **20. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:** a) **Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.** b) **Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.** c) **Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.** **21. Any expenses incurred on Domiciliary Hospitalization and OPD treatment** **22. Treatment taken outside the geographical limits of India.** **23. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent), policyholder is not entitled to get the coverage for specified ICD codes.** **<u>III. Any other specific exclusions mentioned in the policy schedule.</u>**	D.II Specific Exclusion
7	Waiting period	**<u>First Thirty Days Waiting Period (Code- Excl03)</u>** i. Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.	**D.I.**

	• Time period during which specified diseases/ treatments are not covered. • It is counted from the beginning of the policy coverage .	ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently. **Specific Waiting Periods** a) Expenses related to the treatment of the following listed conditions, surgeries/treatments shall be excluded until the expiry of 24/48 months of continuous coverage, as may be the case after the date of inception of the first policy with the insurer. This exclusion shall not be applicable for claims arising due to an accident. b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase. c) If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply. d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion. e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage. **i. 24 Months waiting period** 1. Benign ENT disorders 2. Tonsillectomy 3. Adenoidectomy 4. Mastoidectomy 5. Tympanoplasty 6. Hysterectomy 7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps 8. Benign prostate hypertrophy 9. Cataract and age-related eye ailments 10. Gastric/ Duodenal Ulcer 11. Gout and Rheumatism 12. Hernia of all types 13. Hydrocele 14. Non-Infective Arthritis	2. First Thirty Days Waiting Period Code- Excl03 **D.I.** 3. Specific waiting period- Code- Excl02

		15. Piles, Fissures and Fistula in anus 16. Pilonidal sinus, Sinusitis and related disorders 17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident 18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy. 19. Varicose Veins and Varicose Ulcers **ii. 48 Months waiting period** 1. Treatment for joint replacement unless arising from accident 2. Age-related Osteoarthritis & Osteoporosis **Pre-Existing Diseases** a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us. b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase. c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage. d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us. **Following are the waiting period options available under this product. Waiting Period applicable to Your policy will be as mentioned in Your Policy Schedule.** **Following are the waiting period options available under this product. Waiting Period applicable to Your policy will be as mentioned in Your Policy Schedule.** a) Pre-Existing Diseases will be covered after a waiting period of forty-eight (48) months of continuous coverage. b) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident. c) Specified surgeries/treatments/diseases are covered after specific waiting period of 24 months d) Specified surgeries/treatments/diseases are covered after specific waiting period of 48 months	**D.I.** 1. Pre-Existing Diseases - Code- Excl01
8	Financial limits of coverage	**Sub – Limit, Co-payment and Deductible as applicable to Your policy will be mentioned in your policy schedule.**	

I. Sub-limit (It is a pre-defined limit and the insurance company will not pay any amount in excess of this limit).

II. Co-payment (It is a specified amount /percentage of the admissible claim amount to be paid by policyholder/insured).

III. Deductible (It is a specified amount:

Details of Section Wise Sub-Limits available under the product are mentioned below:

Section Details	Sub Limits (Options)
1. HOSPITALIZATION COVER	
1.1 Room Rent, Boarding, Nursing Expenses	2% of the sum insured subject to maximum of Rs.5000 /- per day
1.2 Intensive Care Unit (ICU)/ Intensive Cardiac Care Unit (ICCU) expenses	5% of sum insured subject to maximum of Rs. 10,000/- per day
1.3 Day Care Treatment	Inbuilt Sum Insured under section 1
1.5 Road Ambulance	upto Rs.2000/- per hospitalisation under Section 1
2. AYUSH Treatment	Inbuilt Sum Insured under section 1
3. Cataract Treatment	Limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per each eye in one policy year
4. Pre-Hospitalization	Inbuilt Sum Insured under section 1
5. Post Hospitalization	Inbuilt Sum Insured under section 1

Details of Section Wise Deductible and Co-payment available under the product are mentioned below:

Name of the Benefit	Deductible allowed	If Yes, Amount or days	Co-Pay allowed	If Yes, Percentage
1. HOSPITALIZATION COVER	NA		Yes	5%
2. AYUSH Treatment	NA		Yes	5%
3. Cataract Treatment	NA		Yes	5%
4. Pre-Hospitalization	NA		Yes	5%
5. Post Hospitalization	NA		Yes	5%

	- upto which an insurance company will not pay any claim, and - which will be deducted from total claim amount (if claim amount is more than the specified amount) IV. Any other limit (as applicable)		
9	Claims/Claims Procedure	**1. Procedure for Cashless claims:** i. Treatment may be taken in a network provider and is subject to preauthorization by the Company or its authorized TPA. ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization. iii. The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification. iv. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.	E.II.28

v. The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.

vi. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/ TPA for reimbursement.

2. Procedure for reimbursement of claims:

For reimbursement of claims the insured person may submit the necessary documents to TPA (if applicable)/Company within the prescribed time limit as specified hereunder.

Sl No	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and prehospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

a. Notification of Claim

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

i. Within 24 hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.

ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

b. Documents to be submitted:

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

i. Duly Completed claim form

ii. Photo Identity proof of the patient

iii. Medical practitioner's prescription advising admission

iv. Original bills with itemized break-up

v. Payment receipts

vi. Discharge summary including complete medical history of the patient along with other details.

vii. Investigation/Diagnostic test reports etc. supported by the prescription from attending medical practitioner

viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).

ix. Sticker/Invoice of the Implants, wherever applicable.

x. MLR (Medico Legal Report copy if carried out and FIR (First information report) if registered, wherever applicable.

xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque

xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines

xiii. Legal heir/succession certificate, wherever applicable

xiv. Any other relevant document required by Company/TPA for assessment of the claim.

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

c. Co-payment

Each and every claim under the Policy shall be subject to a Co-payment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the co-payment.

d. Claim Settlement (provision for Penal Interest)

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

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

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

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

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

e. Services Offered by TPA (To be stated where TPA is involved)

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;

ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

f. Payment of Claim

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

No loading shall apply on renewals based on individual claims experience. Insurance is the subject matter of solicitation.

Network Hospitals details: https://www.godigit.com/health-insurance/digit-cashless-network-hospitals-list

Helpline no. - 1800-258- 4242

		Hospitals which are blacklisted or from where no claims will be accepted by insurer: List of Non-Preferred Hospital https://www.godigit.com/health-insurance/digit-cashless-network-hospitals-list/non-preferred-hospitals **Downloading/getting claim form:** https://www.godigit.com/health-insurance/file-a-claim	
10	Policy Servicing	**Call Centre Details of the Insurer** Toll Free: 1800-258- 4242 Email: healthclaims@godigit.com Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.com Website: https://www.godigit.com **Details of Company Officials:** NA With intent to provide better and fast service to our customers, our claims process is paperless. You may get in touch with the above email id and call centre number we assist you in case of any Policy Servicing issues.	E.I.17
11	Grievances/Complaints	**Customer Grievance Redressal Policy** In case of any grievance the insured person may contact the company through Website: https://www.godigit.com Toll Free: 1-800-258- 4242 Email: hello@godigit.com Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.com Insured person may also approach the grievance cell at any of the company's branches with the details of grievance If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at grievance@godigit.com For updated details of grievance officer, kindly refer the link: Click Here https://d2h44aw7l5xdvz.cloudfront.net/claims/GRO-list.pdf 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 Grievance may also be lodged at IRDAI Integrated Grievance Management System- https://igms.irda.gov.in/	E.I.17

		The contact details of the Insurance Ombudsman Centers are mentioned in the Policy Wordings.	
11	Things you need to know	**<u>Free Look Period</u>** You may cancel the insurance policy if you do not want it, within 15 days from the beginning of the policy. This period is for 30 days in case of policy online. The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy. The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable. If the insured has not made any claim during the Free Look Period, the insured shall be entitled to i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period; Please note KYC documents (Photo ID card) shall be required at the premium refund to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per premium refund **<u>Policy Renewal</u>** Except on grounds of fraud, moral hazard or misrepresentation or non-cooperation, renewal of your policy shall not be denied, provided the policy is not withdrawn. **<u>Migration and Portability:</u>** When your policy is due for renewal, you may migrate to another policy with us or port your policy to another insurer**<u>.</u>** **<u>Portability</u>** The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance	E.I.12 E.I.8

		policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability. For Detailed Guidelines on portability, kindly refer the link Click Here https://d2h44aw7l5xdvz.cloudfront.net/policyDocuments/Guidelines%20on%20Migration%20and%20Portability%20of%20health%20insurance%20policies.pdf **Migration** The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration. For Detailed Guidelines on migration, kindly refer the link Click Here https://d2h44aw7l5xdvz.cloudfront.net/policyDocuments/Guidelines%20on%20Migration%20and%20Portability%20of%20health%20insurance%20policies.pdf **Change in Sum Insured:** Sum Insured can be changed (increased/decreased) only at the time of renewal or at any time, subject to underwriting by the company. For increase in SI, the waiting period if any shall start afresh only for the enhanced portion of the sum insured. **Moratorium Period** After completion of eight continuous years under the policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.	E.I.7 E.I.14
12	Your Obligations	Please disclose all pre-existing disease/s or condition/s before buying a policy. Non-disclosure may affect the claim settlement. Please Disclose any change in Material Information during the policy period.	

		Material Information 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 tale informed decision in the context of underwriting the risk.	