Digit Life Healthy Group Policy

(Health Plus Life Combi Product from Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd)

UIN: GODHLGP24094V012324

Policy Wordings

Let's get started!

You're already awesome because you decided to protect your most important asset, your health. Think of Digit as your running or gym buddy, keeping pace with you all the way.

This is a Group Combi Product, combination of health insurance product (ie. I. Digit Health Plus Policy (Revision)) and life insurance product (ie. II. Digit Life Group Term Life Insurance). Digit Health Plus Policy (Revision) is being offered by Digit General Insurance Limited and Digit Life Group Term Life Insurance is being offered by Digit Life Insurance Limited.

While you're reading this policy, you get confused or have a query, or you are referring to this policy because you have a claim to make, please call us at:
For Health: 1800-258-4242 or mail us at healthclaims@godigit.com.
For Life: 9960126126 or mail us at lifeclaims@godigit.com.

I. Digit Health Plus Policy (Revision)

A. PREAMBLE

Based on the declaration provided by You to us, Go Digit General Insurance Limited (hereinafter called 'the Company/DIGIT') which forms the basis of this health policy contract, and having received your premium, we take pleasure in issuing this policy to you.

Go Digit General Insurance Limited will cover You under this Policy up to the Sum Insured, during the policy period mentioned in your Policy Schedule / Certificate of Insurance. Of course, like any insurance cover, it is governed by, and subject to certain terms, conditions and exclusions mentioned in this Policy.

Note: This Policy Wording provides detailed terms, conditions and exclusions for all Sections available under this Product. Kindly refer to the Policy Schedule / Certificate of Insurance to know exact details of Sections opted by You. Only Wordings related to Sections mentioned in your Policy Schedule/Certificate of Insurance are applicable.

B. DEFINITIONS

Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them.

I. STANDARD DEFINITIONS:

1. **Accident, Accidental** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
3. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
   a. Central or State Government AYUSH Hospital or
   b. Teaching hospital 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 5 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 records of the patients and making them accessible to the insurance company's authorized representative.
4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without inpatient services and must comply with all the following criterion:
   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
   ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
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 is approved.
6. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
7. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
   a. Internal Congenital Anomaly means a Congenital anomaly which is not in the visible and accessible parts of the body.
   b. External Congenital Anomaly means a Congenital anomaly which is in the visible and accessible parts of the body
8. **Co-Payment** means a cost sharing requirement under a Health Insurance Policy that provides that the Policyholder/Insured will bear a specified percentage of the admissible claims amount. A co-payment does not reduce the Sum Insured. Co-Payment will not be applicable to benefit Policies - Daily Hospital Cash Cover & Critical Illness Benefit, Cancer Benefit.

9. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
10. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
    i. has qualified nursing staff under its employment;
    ii. has qualified medical practitioner/s in charge;
    iii. has fully equipped operation theatre of its own where surgical procedures are carried out;
    iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
11. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    i. undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    ii. which would have otherwise required hospitalization of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
12. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Hospital Cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
13. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
14. **Disclosure to information norm:** The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact.
15. **Domiciliary Hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:
    i) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    ii) the patient takes treatment at home on account of non-availability of room in a hospital.
16. **Emergency / Emergency Care** means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the insured person's health.
17. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.
18. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 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 inpatient 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 these accessible to the insurance company's authorized personnel;
19. **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.
20. **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, and /or tests
        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
21. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
22. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
23. **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.

24. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
25. **Maternity expenses** means;
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b) expenses towards lawful medical termination of pregnancy during the policy period.
26. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
27. **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.
28. **Medical Practitioner/Dentist** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The registered practitioner should not be the insured or close member of the family.
29. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i)is required for the medical management of the illness or injury suffered by the insured;
    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.
30. **Migration** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer
31. **Network Provider** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
32. **New Born Baby** means baby born during the Policy Period and is aged upto 90 days.
33. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.
34. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
35. **OPD treatment** means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
36. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement **or**
    b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
37. **Pre-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    i. Such Medical Expenses are incurred 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.
38. **Post-hospitalization Medical Expenses** means medical expenses incurred during pre- defined number of days immediately after the insured person is discharged from the hospital provided that:
    i. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
39. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer
40. **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.
41. **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.
42. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

43. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
44. **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 from suffering and prolongation of life, performed in a hospital or day care centre by a medical practitioner.
45. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

II. SPECIFIC DEFINITIONS

46. **Alternative/Ayush Treatment** means forms of treatments other than treatment "Allopathy" or "modem medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
47. **Contribution**
    Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any benefit offered on a fixed benefit basis
48. **Hazardous Sports** means any sport, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. Such sport includes but not limited to Insured Persons whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/spelunking/pot holing, cave tubing, climbing/ trekking/ walking over 4,000 meters, cycle racing, cyclo-cross, drag racing, endurance testing, hang gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river- boarding, river bugging, 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, wrestling snow and ice sports or involving a naval military or air force operation. Insured Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular schedule airline or air charter company.
49. **Policy** means the Proposal, the Schedule / Certificate of Insurance (and any endorsement attaching to or forming part thereof) and the Policy Wordings.
50. **Policy Period** means the period between the commencement date and the expiry date specified in the Schedule /Certificate of Insurance and includes both the commencement date as well as the expiry date.
51. **Room** means a Single Room without wall/permanent partition, dining or waiting room and with or without following amenities: an attendant cot, one television, one sofa, a telephone, refrigerator, wardrobe, computer with internet connection and microwave oven.
52. **Sum Insured** means the amount as opted by You and stated in the Policy Schedule / Certificate of Insurance against the Section/Cover for each insured person including cumulative bonus (if any) for Individual Sum Insured Policy and aggregately for all insured members for a Floater Policy**.**
53. **Tertiary Care** constitutes of Specialized Advanced Care Unit designed to care to complex medical condition involving super specialist consultant like Neuro Surgeon, Neurologist, Spine Surgeons and Reconstructive Surgeons.
54. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited
55. **You, Your, Yours, Yourself, Policyholder, Insured Person(s) means** the Individual Group Members who will be treated as Insured beneficiary.

C. BENEFITS COVERED UNDER THE POLICY

I. COVERAGE

SECTION 1. HOSPITALIZATION COVER

A. Accidental Hospitalization Cover

If You have opted for this Cover and You suffer an Accidental Injury during the Policy Period that requires Hospitalization as an inpatient, we'll be there for you. We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible claim. The claim can be made under the following benefits and up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule/ Certificate of Insurance against this Cover.

	Note: If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off by Us and mentioned in Your Policy Schedule/Certificate of Insurance. ***Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.***
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

A1. Day Care Procedures

If You suffer an Accidental Injury during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for a stay less than 24 hour because of technological advancement, We will pay the Medical Expenses Incurred for such Day Care Procedures.

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

A2. Pre-Hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover, prior to the date of Your admission in a hospital, provided that:

a) Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which Your Subsequent Hospitalization was required.
b) We have accepted an Inpatient Accidental Hospitalization Claim under **Section 1.A. Accidental Hospitalization Cover** of this Policy.

A3. Post-Hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover, from the date of Your Discharge from the hospital, provided that:

a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
b) We have accepted an Inpatient Accidental Hospitalization Claim under **Section1. A. Accidental Hospitalization Cover** of this Policy.

Instead, You may also choose to opt for a onetime lumpsum benefit, which shall be a percentage of the claim amount approved under **Section 1.A. Accidental Hospitalization Cover** towards Post Hospitalization Expenses, after Your discharge from the Hospital. This percentage is mentioned in Your Policy Schedule/Certificate of Insurance.

If we have paid a lump sum amount, then You won't be eligible for any other payment under this benefit for that particular Hospitalization.

A4. Dental Treatment

We will pay for the medical expenses incurred by You for any necessary Dental Treatment needed after an accident. A claim here is valid if the accident resulted in an admissible inpatient Hospitalization Claim under **Section 1. A. Accidental Hospitalization Cover.**

A5. Road Ambulance

We will pay for the expenses incurred on Your road transportation by a Healthcare or an Ambulance Service Provider to a Hospital for treatment following an Emergency arising out of an Accident, provided that:

a) We have accepted a claim under **Section 1. A. Accidental Hospitalization Cover.**

b) The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

c) The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

A6. Second Medical Opinion

We shall arrange and bear the cost for Second Opinion from our panel of Medical Practitioners. This is for times when there has been a major accidental injury that requires your hospitalisation in a tertiary care facility during the Policy Period, provided that:

1. We have received Your request to arrange for a Second Opinion.
2. You have the option to choose any One of Our Panel Medical Practitioners.
3. We will not provide more than one Opinion for the same Medical Condition within a Policy Period.

All the above Covers are Subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

B. Accidental & Illness Hospitalization Cover

If You have opted for this Cover and You suffer an Accidental Injury or Illness during the Policy Period that requires Hospitalization as an inpatient, We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible claim. The claim can be made under the following benefits and up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover. Note: If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off and mentioned in Your Policy Schedule/Certificate of Insurance. ***Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.***
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

B1. Day Care Procedures

If You suffer an Accidental Injury or Illness during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for stay less than 24 hrs because of technological advancement, We will pay the Medial Expenses Incurred for such Day Care Procedure.
Treatment normally taken on an out-patient basis is not included in the scope of this Cover.

B2. Pre-Hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover, prior to the date of Your admission in a hospital, provided that:

a) Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which Your Subsequent Hospitalization was required.
b) We have accepted an Inpatient Hospitalization Claim under **Section 1.B. Accidental & Illness Hospitalization Cover** of this Policy.

B3. Post-Hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover, from the date of Your Discharge from the hospital, provided that:

a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
b) We have accepted an Inpatient Hospitalization Claim under **Section 1.B. Accidental & Illness Hospitalization Cover** of this Policy.

Instead, You may also choose to opt for a onetime lumpsum which shall be a percentage of the claim amount approved under **Section 1.B. Accidental & Illness Hospitalization Cover** towards Post Hospitalization Expenses, after Your discharge from the Hospital. This percentage is mentioned in Your Policy Schedule/Certificate of Insurance.

If we have paid a lump sum amount, then You won't be eligible for any other payment under this benefit for that particular Hospitalization.

B4. Dental Treatment

We will pay for the Medical Expenses incurred in respect of any necessary Dental Treatment from a dentist provided the Dental Treatment is required as a result of an Accident that results in an admissible inpatient Hospitalization Claim under **Section 1. B. Accidental & Illness Hospitalization Cover.**

B5. Road Ambulance

We will pay for the expenses incurred on Your road transportation by a Healthcare or an Ambulance Service Provider to a Hospital for treatment following an Emergency, provided that:

a) We have accepted a claim under **Section 1. B. Accidental & Illness Hospitalization Cover.**
b) The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.
c) The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

B6. Bariatric Surgery Cover

Therefore, if You are hospitalized for a Bariatric Surgery which is medically necessary, on the advice of a Medical Practitioner, we cover the related Medical Expenses subject to the following conditions:

a) The Insured Person undergoing the surgery is minimum 18 Years old.
b) The Medical Practitioner / Bariatric Surgeon confirms that Your Existing Body Mass Index (BMI) and health conditions fall within the below qualification requirements for Bariatric Surgery:
    - Class III Obesity (extreme obesity)- [Body Mass Index (BMI) ≥ 40 kg/m2)];
    - Class II Obesity- (Body Mass Index (BMI) 35-39.9 kg/m2) along with any of the following co-morbidities:
        - Uncontrolled Diabetes Mellitus
        - Cardiovascular Disease [***Example: Stroke, Myocardial Infarction, Poorly Controlled Hypertension***]
        - History of Coronary Artery Disease with a surgical intervention such as Cardiopulmonary Bypass or Percutaneous Transluminal Coronary Angioplasty;
        - Cardiopulmonary Problems as a result of another disease process, including, though not limited to, a documented severe obstructive sleep apnea (OSA), confirmed on polysomnography.
c) A claim under this cover is acceptable *only* if it is under any of the below procedures:
    - Gastric Bypass-
        - The Roux-en-Y Gastric Bypass
        - Biliopancreatic Diversion with or without Duodenal Switch (BPD/DS) Gastric Bypass
    - Sleeve Gastrectomy
    - Laparoscopic Gastric Banding
d) This particular cover has a waiting period. Waiting period shall be as per the "**Specific Waiting Period**" Section stated in Your Schedule / Certificate of Insurance against this Section which shall apply from the date of inception of the first policy

with Us, provided that the Policy has been renewed continuously with Us without break with Bariatric Surgery Cover as a benefit since inception of the first policy.

e) If you are porting an existing policy under Portability Guidelines, from some other General or Health Insurance Company or if you are adding this cover while renewing our health policy, a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance will be applied.
f) Confirmation from Medical Practitioner / Bariatric Surgeon that the Bariatric Surgery is not for a specific correctable cause for treating obesity. ***Example: Endocrine disorder***.
g) And we would need a documented detailed history of your obesity-related health problems, difficulties, and treatment attempts demonstrating that a multidisciplinary approach with dietary, other lifestyle modifications (such as exercise and behavioural modification), and pharmacological therapy, if appropriate, have been unsuccessful, at least for past 6 months.
h) A prior approval should be taken from us before the Bariatric Surgery is performed.
i) Our maximum liability under this benefit is restricted to the Limit as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

Bariatric surgery for the following reasons is not covered:

a) For Cosmetic/Aesthetic reasons.
b) For treating Drug-Induced Obesity, for Severe Untreated Hormonal Imbalance, Psychiatric and Eating Disorders-Induced Obesity.

B7. Psychiatric illness Cover

We will pay up to the Limit mentioned in Your Policy Schedule / Certificate of Insurance against this Cover for the Medical Expenses, related to Psychiatric Illness which includes, though not limited to, dementia, depression, bipolar disorder, schizophrenia, Anxiety disorders and obsessive-compulsive disorders, provided that:

a) The first diagnosis and Hospitalization, as an inpatient, was during the Policy Period.
b) This also has a waiting period. Waiting period shall be as per the '"**Specific Waiting Period**'" Section stated in Your Schedule / Certificate of Insurance against this Cover which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with Psychiatric as a benefit since inception of the first policy.
c) Hospitalization under this benefit shall be subject to prior approval from Us, except in cases of emergencies.

B8. Complimentary Health Check Up

If You Renew Your Policy with Us without a break, then at every Policy Renewal We will pay the expenses incurred towards cost of health check-up up to the Limits Per Policy (excluding any cumulative bonus) mentioned in Your Policy Schedule/Certificate of Insurance . This shall be paid, provided that:

a. You are above 18 Years of age at the time of Health Check Up.
b. You submit a duly filled and signed claim form along with original bills and copy of medical reports.

Please Note- Payment under this benefit won't be deducted from Your Sum Insured. It is additional.

B9. Second Medical Opinion

When it comes to Cancer or any major Illness and You are required to get hospitalized in a tertiary care facility during the Policy Period, We will arrange and bear the cost for a Second Opinion provided that:

1. We have received Your request to arrange for Second Opinion.
2. You have option to choose any one of Our Panel Medical Practitioners.
3. We will not provide more than one Opinion for the same Medical Condition within a Policy Period.

SECTION 2. INFERTILITY TREATMENT COVER

If You have opted for this Cover, We will pay the Medical Expenses if You are hospitalized on the advice of the Medical Practitioner for Infertility/ Subfertility Treatments. This includes, though not limited to, IVF, IUI, ZIFT, ICSI. Make sure the following conditions are met:

a) A waiting period of 48 months will apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with this cover, without a break, with 'Infertility Treatment Cover' as a benefit since inception of the first policy.
b) Our maximum liability per Hospitalization shall be restricted to the amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
c) The benefit is payable only once to an Insured Person during the Policy Tenure.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 3. ORGAN DONOR

If You have opted for this Cover, We will pay You for the following incurred Medical Expenses in respect of organ transplantation:

a) For the harvesting of the donated organ subject to availability of the Sum Insured under **Section 1. B. Accidental & Illness Hospitalization Cover.**
b) There are strict guidelines when it comes to organ transplantation, therefore the organ donor whose organ has been made available should be in accordance and in compliance with the Transplantation of Human Organs Act 1994 (as amended) and the organ is donated for Your use only.
c) We will pay the donor's Pre and Post Hospitalization expenses. This is up to 5% of the claim amount approved in respect of harvesting expenses.
d) We will not pay any other medical treatment for the donor consequent on the harvesting.
e) This also has a waiting period. Waiting period shall be as per the "**Specific Waiting Period**" Section stated in Your Schedule / Certificate of Insurance against this Section which shall apply from the date of inception of the first policy with Us, provided that the Policy has been renewed continuously with Us without break, with ORGAN DONOR Cover as a benefit since inception of the first policy.

Provided that, We have accepted a claim under **Section 1. B. Accidental & Illness Hospitalization Cover.**

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER

If You have opted for this Cover, we will pay the Medical Expenses for Your In-patient Treatment, taken under Ayurveda, Unani, Siddha or Homeopathy. This is up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against **Section 1. B. Accidental & Illness Hospitalization Cover.** This is paid provided that treatment has been undergone in Ayush Hospital

You should also be aware what We won't pay for:

a) Outpatient Medical Expenses.
b) All Preventive and Rejuvenation Treatments (non-curative in nature) including, without limitation, treatments that are not Medically Necessary.

Specific Conditions applicable to this cover:

Claim will be payable under this section only if AYUSH Hospitals and AYUSH Day Care Centres have obtained pre-entry level certificate (or higher level of certificate) issued by National Accreditation Board for Hospitals and Healthcare Providers (NABH) or State Level Certificate (or higher level of certificate) under National Quality Assurance Standards (NQAS), issued by National Health Systems Resources Centre (NHSRC).

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 5. EMERGENCY AIR AMBULANCE

If You have opted for this Cover, We will pay You the expenses incurred for Your transportation in an airplane or helicopter for emergency life threatening health conditions which requires immediate and rapid ambulance transportation to the nearest hospital.

This transportation will be from the location where the illness /accident happened the first time and subject to availability of Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** and provided that such Transportation in an airplane or helicopter has been prescribed by a Medical Practitioner and/or is Medically Necessary**.**

Provided that, We have accepted a claim under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover.**

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 6. LONG HOSPITALIZATION CASH BENEFIT

If You are Hospitalized for a minimum number of consecutive days as Opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this Section, We will give you a lump sum amount as mentioned in the Policy Schedule / Certificate of Insurance. Provided that:

a) We have accepted a claim under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover,** and
b) The benefit is payable only once to an Insured Person during the Policy Period.

For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 7. MATERNITY BENEFIT & NEWBORN BABY COVER

A. Maternity Benefit

If You have opted for this Cover, We will pay the Maternity Expenses incurred towards the delivery of a baby and/or treatment related to any complication of pregnancy or medically necessary termination. This is up to the Sum Insured opted by You and as mentioned in Your Policy Schedule / Certificate of Insurance against this Section, during the Policy Period provided that:

a) Female Insured Person's legally married spouse is also covered under this Policy, unless specifically waived by Us (***Example, if You are a single parent, this clause will not apply***). This also has a waiting period. Waiting period as opted by you and mentioned in your Policy Schedule / Certificate of Insurance shall apply from the date of inception of the first policy with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.
b) If you are porting an existing policy under Portability Guidelines, from some other General or Health insurance company or if you are adding this cover while renewing our health policy, a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance will be applied.
c) The maternity benefit is limited to cover up to two living children. However, there is no restriction on the number of medically necessary and lawful termination of pregnancies.
d) If on renewal without any break in coverage, the sum insured is increased, there is a fresh waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance applied to the increased part of the Sum Insured.
e) Any complications arising out of or as a consequence of maternity/childbirth will also be covered within the limit of Sum Insured, available under this benefit.

If we had already accepted a claim for Maternity Expenses for your first living child under this benefit, then for the subsequent Maternity Expenses i.e. for the delivery of Your Second child, we shall pay up to the percentage of the Sum Insured opted under this Section and mentioned in Your Policy Schedule / Certificate of Insurance provided the Policy is renewed with Us continuously without break with Maternity Benefit & New Born Baby Cover benefit.

We shall not pay for the following under this Section:

a) Expenses for the harvesting and storage of stem cells when carried out as a preventive measure against possible future illness.
b) Medical Expenses for Ectopic Pregnancy will be covered under **Section 1. B. In-patient Accidental & Medical Treatment** and not under the Maternity Benefit.
c) Pre-natal and Post-natal Medical Expenses are not covered unless leading to Your Hospitalization.

B. Newborn Baby Benefit

Under this cover, we will also pay the Medical Expenses, within the limit of the Sum Insured available under the **Section 7. A Maternity Benefit Section** of the Policy, provided that We have accepted a claim under **Section 7. A. Maternity Benefit**, incurred towards:

a) The medical treatment of the Insured Person's New Born Baby while the Insured Person is hospitalised as an inpatient for delivery.
b) The New Born Baby's hospitalisation charges as a result of any medical complications, up to 90 Days from the date of delivery.
c) Reasonable and Customary Charges for the Vaccinations of the New Born Baby as per National Immunization Schedule as defined by Government of India, up to 90 Days from the date of delivery. However, once the New Born Baby is added as an Insured Person under the Policy, We will pay the Reasonable and Customary Charges for the Vaccinations of the New Born Baby as per National Immunization Schedule as defined by Government of India until the New Born Baby attains 5 Years of age, provided that the Policy is continuously renewed with Us without break and with **Maternity Benefit and New Born Baby Cover** as a benefit since inception of the first policy.
d) If the Policy Expires before 90 days from the date of delivery, the New Born Baby will be covered only if the Policy is Renewed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of any additional premium.
e) After 90 Days from the date of delivery, the New Born Baby will be covered under the existing Policy only if it is Endorsed with the New Born Baby as an Insured Person. This is subject to our underwriting policy and payment of the Pro-Rata Additional Premium, for the balance period.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 8. OUT-PATIENT (OPD) BENEFIT

If You have opted for this Cover, We will pay the Reasonable and Customary Charges for below mentioned expenses incurred by You as an Allopathic Out-patient when treatment is taken from a Network Medical Practitioner to the extent of the Sum Insured opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section and subject to the Co-Payment Basis Opted by You.

Basis 1: Co-payment of 25% in the First Year of this Section being Opted, 10% on First Renewal. From the Second Renewal, there will be no Co-payment, provided the Policy is renewed with Us continuously without a break with this benefit.

Basis 2: Nil Co-payment

What all is covered under this:

Professional Fees	Fees for Medically Necessary Consultation and Examination by Medical Practitioners to assess Your Health for any Illness.
Diagnostic	Medically Necessary Out-patient diagnostic Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment from a diagnostic centre.
Surgical Treatment	Minor Surgical Procedure such as POP, Suturing, Dressings for Accidents and Animal Bite Related Outpatient Procedures Etc. Carried out by a Medical Practitioner
Medication	Drugs & Medicines prescribed by a Medical Practitioner
Out-Patient Dental Treatment	Out-patient dental treatment for the immediate relief of dental Pain; taken by You from a dentist, provided that We will pay only for X-rays, Extractions, Amalgam or composite fillings, root canal treatments and prescribed drugs for the same, teeth alignment for adolescents. We will not pay for any dental treatment that comprises cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for temporomandibular (jaw), or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury or cancer.
Hearing Aids	One pair of hearing aids (Excluding Batteries), provided that: ▪ These have been prescribed by an ENT specialist or Network Medical Practitioner. ▪ You have continuously renewed the Policy with Us without break for a period of 36 months with **Out-Patient (OPD) Benefit** as a benefit, since inception of the first policy.
Psychiatric Illness	Specialist Consultation, assessment, treatment and medication for Psychiatric Disorders.

This cover excludes expenses incurred towards Spectacles, Contact Lenses and Physiotherapy, Cosmetic Procedures, Ambulatory Devices like Walkers, BP Monitors, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION

If You have opted for this Cover, We will pay the Medial Expenses incurred by You for any illness or Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization, provided that:

a) The condition of the patient is such that s/he is not in a condition to be moved to a Hospital or
b) The patient takes treatment at home on account of non-availability of room in a Hospital, and
c) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period
d) No Payment will be made if the condition for which You require medical treatment is due to:
Asthma, Bronchitis, Tonsillitis, Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, Cough and Cold, Influenza, Arthritis, Gout and Rheumatism, Chronic Nephritis and Nephritic Syndrome, Diarrhoea and all types of Dysenteries including Gastroenteritis, Diabetes Mellitus and Insipidus, Epilepsy, Hypertension, Psychiatric or Psychosomatic Disorders of all kinds, Pyrexia of unknown Origin.
e) Subject to availability of the sum insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover.**

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 10. SUM INSURED REFILL BENEFIT

If you have opted for this Cover, We will refill 100% of the Sum Insured specified and utilized under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** for that particular Policy Period, provided that:

a) The refilled Sum Insured would be triggered only if the cause of the Hospitalization is not related to /arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during the same policy period for the same Insured Person, unless this condition is specifically waived by us and mentioned in Your Policy Schedule / Certificate of Insurance
b) If the first claim amount exceeds the Sum Insured under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**, the refilled Sum Insured will not be applicable for the same hospitalisation.
c) After the refill, the maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover.**
d) The number of times this benefit may be availed shall be as per the limit mentioned in Your Policy Schedule / Certificate of Insurance against this Section during each Policy Period.
e) In case of Floater Policy, the refilled Sum Insured will be applicable on family floater basis.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 11. DAILY HOSPITAL CASH COVER

A) Accidental Hospitalization Cover

If You have opted for this Cover, We agree to pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accident for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay twice the Daily Cash Allowance amount mentioned in the Policy Schedule / Certificate of Insurance against this Section.

Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

B) Accidental & Illness Hospitalization Cover

If You have opted for this Cover, We agree to pay a Daily Cash Allowance, amount for this will be mentioned in your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accident or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay twice the Daily Cash Allowance amount mentioned in the Policy Schedule / Certificate of Insurance against this Section.

Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

SECTION 12. CRITICAL ILLNESS BENEFIT COVER

If You have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule / Certificate of Insurance against this Section, in case You are diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures as specified below Provided that,

a) This Critical illness or covered surgical procedure has happened to you for the first time in your life.
b) We will not make any payment if You are diagnosed as suffering from Critical Illness within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us..
c) You survive for a minimum period of at least 30 days from the date of diagnosis of such Critical Illness, unless this condition is specifically waived by Us
d) The Critical Illness or the Surgical Procedure Claim is not a consequence of or arising out of any pre-existing condition/disease
e) Once a claim has been Paid under Critical Illness and / or Surgical Procedure, Cover under this Section shall cease and no further payment will be made for any consequent disease or any dependent disease.

Critical Illness means the following major disease, which You have been diagnosed during the Policy Period to have suffered from and which requires Hospitalisation and are specifically defined as below:

Sr. No.	Category	Critical Illness
1	**Malignancy**	Cancer of Specified Severity
2	**Cardiovascular system**	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7	**Major Organ Transplant**	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	**Nervous System**	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	**Others**	Loss of Independent Existence
20		Aplastic Anaemia

SECTION 13. CRITICAL ILLNESS HOSPITALIZATION COVER

If You have opted for this Cover and You are diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures as specified below, during the Policy Period, We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible hospitalization claim, up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Provided that,

a) This Critical illness or covered surgical procedure has happened to you for the first time in your life
b) We will not make any payment if You are diagnosed as suffering from Critical Illness and hospitalized within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us.
c) No Claim under this option shall be admissible if the Critical Illness or the Surgical Procedure is a consequence of or arising out of any pre-existing condition/disease.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section. Note: If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables. ***Example, if You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.***
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.

Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

Critical Illness means the following major disease, which You have been diagnosed during the Policy Period to have suffered from and which requires Hospitalisation and are specifically defined as below:

Sr. No.	Category	Critical Illness
1	**Malignancy**	Cancer of Specified Severity
2	**Cardiovascular system**	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7	**Major Organ Transplant**	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	**Nervous System**	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms
18		Multiple Sclerosis with Persisting Symptoms
19	**Others**	Loss of Independent Existence
20		Aplastic Anaemia

Critical Illness Definitions Applicable to Section 12 & Section 13 Above:

I. Standard Definitions:

1. CANCER OF SPECIFIED SEVERITY

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

II. The following are excluded –

i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. MYOCARDIAL INFARCTION

(First Heart Attack of specific severity)

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

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes
ii. Any type of angina pectoris
iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

4. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

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

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

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

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

5. OPEN CHEST CABG

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

II. The following are excluded:

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

6. END STAGE LUNG FAILURE

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

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
iv. Dyspnoea at rest.

7. END STAGE LIVER FAILURE

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

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.

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

8. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

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

9. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

II. **The following are excluded:**

i. Other stem-cell transplants
ii. Where only Islets of Langerhans are transplanted

10. BENIGN BRAIN TUMOR

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
    i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
    ii. Undergone surgical resection or radiation therapy to treat the brain tumor.
III. The following conditions are **excluded:**
    i. Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

11. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
    i. no response to external stimuli continuously for at least 96 hours;
    ii. life support measures are necessary to sustain life; and
    iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

12. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit is to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means, and independently of all other causes.
II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.
III. The Activities of Daily Living are:
    i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
    ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
    iv. Mobility: the ability to move indoors from room to room on level surfaces;
    v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    vi. Feeding: the ability to feed oneself once food has been prepared and made available.
IV. The following are excluded:
    i. Spinal cord injury;

13. PERMANENT PARALYSIS OF LIMBS

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

14. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
II. The following are excluded:
    i. Transient ischemic attacks (TIA)
    ii. Traumatic injury of the brain
    iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

15. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

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

16. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

II. Neurological damage due to SLE is excluded.

II. Specific Definitions:

17. SURGERY TO AORTA

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

18. APALLIC SYNDROME

I. Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

19. LOSS OF INDEPENDENT EXISTENCE

I. Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of the following Activities of Daily Living Activities of Daily Living:
   i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   iv. Mobility: the ability to move indoors from room to room on level surfaces;
   v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   vi. Feeding: the ability to feed oneself once food has been prepared and made available.

20. APLASTIC ANAEMIA

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

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

Subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 14. CANCER BENEFIT COVER

If You have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule / Certificate of Insurance against this Section, in case You are diagnosed as suffering from Cancer for Specified Severity for the first time in Your life. Provided that,

a) We will not make any payment if You are diagnosed as suffering from Cancer for Specified Severity within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us..
b) You survive for a minimum period of at least 30 days from the date of diagnosis of such Cancer for Specified Severity, unless this condition is specifically waived by Us
c) No Claim under this option shall be admissible if the Cancer is a consequence of or arising out of any pre-existing condition/disease except for pre-existing condition/disease which were disclosed by the Insured and accepted by Us at the time of buying the Policy with Us, where this benefit is opted.
d) Cover under this Section shall cease upon payment of the compensation on the happening of a Cancer for Specified Severity and no further payment will be made for any consequent disease or any dependent disease.

For this Cover, "CANCER OF SPECIFIED SEVERITY" means:

I. A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
II. The following are excluded –
   i. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
   ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
   iii. Malignant melanoma that has not caused invasion beyond the epidermis;
   iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
   v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
   vi. Chronic lymphocytic leukaemia less than RAI stage 3
   vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
   viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

SECTION 15. CANCER HOSPITALIZATION COVER

If You have opted for this Cover and You are diagnosed as suffering from Cancer for Specified Severity for the first time in Your life during the Policy Period , We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible hospitalization claim for Cancer for Specified Severity up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Provided that,

a) We will not make any payment if You are diagnosed as suffering from Cancer for Specified Severity and hospitalized within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first policy with us..
b) No Claim under this option shall be admissible if Cancer is a consequence of or arising out of any pre-existing condition/disease except for pre-existing condition/disease which were disclosed by the Insured and accepted by Us at the time of buying the Policy with Us, where this benefit is opted.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room subject to a Limit Per Day as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section. Note: If You have opted for a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization our liability will be restricted to the same proportion Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables. ***Example, If You have opted a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.***
ICU	Intensive Care Unit

Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

For this Cover, "CANCER OF SPECIFIED SEVERITY" means:

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

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

SECTION 16. WELLNESS BENEFIT PROGRAM

Our Wellness Benefit Program provides the benefits listed below and shall be available to the Insured Person as mentioned in the Policy Schedule/Certificate of Insurance. Through this Program, We intend to incentivize the Insured Person(s) for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services.

There are total 12 services under Wellness Benefit Program. Services applicable for Your Policy are as shown in Your Policy Schedule / Certificate of Insurance. Only services mentioned in your Policy Schedule/Certificate of Insurance are available for You.

1. **Doctor on Call**
   Upon Your request, We will facilitate an appointment, through Our empanelled Service Provider, with a Medical Practitioner who can help You by providing round-the-clock medical helpline services through an online portal as a chat service, a call back service or a voice call service.
2. **Wellness Coach**
   In order to educate, empower and engage You to become more aware of Your health and proactively manage it, We will, through periodic communications like e-mailers, blogs and online platform provide You information on wellness coaching in areas such as:
   a) Weight Management
   b) Activity and Fitness
   c) Nutrition
   d) Tobacco Cessation
   e) Alcohol Abuse de-addiction Program
   f) Information on various diseases
   g) Dietary Plans
3. **Lab Services (Home Collection)**
   Upon Your request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc from Your home address for further testing and analysis.
   The cost of these tests and reports will have to be borne by You.
4. **Pharmacy (Home Delivery)**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner from the nearby Network Pharmacy, subject to copy of prescription being shared (where ever required) and availability of the medication with the Pharmacy.
   The cost of the medication will have to be borne by You.
5. **Vital/Physical Activity Monitoring Services**

Upon Your request, We will facilitate, through Our Empanelled Service Provider, the integration of Your Health Device(s) such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, Smart Watches etc. to an online database that will track and asses Your vitals as reported by the device.
It can provide periodic updates and reports of your health status. The cost of the device will have to be borne by You.

6. **Reminder Notifications**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to You as a reminder to schedule Your medical appointments and/or take daily dosage of Your medicine as per the information shared by You.
7. **Medical Wallet**
   Upon Your request, We will arrange, through Our Empanelled Service Provider, for a medical wallet. This will be a digital cloud service which will allow You to store all Your medical reports online. It will provide easy access of Medical history and reports to the treating Medical Practitioners and to any other person with whom You may share the login and access codes, easing Your need to physically carry documents with You.
8. **Report Aggregation**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of Your health status as per the medical records/reports shared by You. It will highlight your wellbeing or any areas of concern or deterioration in Your health, allowing You to take necessary calls about your health.
9. **Home Care Services**
   Upon Your request, We will facilitate, through Our Empanelled Service Provider, Home Care Services for You in case You are in need of any of the following:
   a. Home Care Nursing
   b. Patient Assistant
   c. Physiotherapy
   d. Yoga Trainer
   e. Psychologist
   f. Palliative Care
   g. Renting Medical equipment. For Example - Wheel-Chair, Patient Bed, Oxygen Cylinder etc.

   The cost of the Services/Equipment will have to be borne by You.
10. **Ambulance Arrangement Services**
    Upon request, We will facilitate, through Our Empanelled Service Provider, ambulance services for Your transportation subject to availability of ambulance in the area where such service needs to be arranged.
    The cost of the transportation will have to be borne by You.
11. **Pick-up and Drop Services for Consultation**
    Upon Your request, We will facilitate, through Our Empanelled Service Provider, Pick-up and Drop Service, for Your transportation to the Health Care Facility for treatment/Diagnostics subject to availability of vehicle/taxi in the area where such service needs to be arranged.
    The cost of the transportation will have to be borne by You.
12. **Prioritizing Appointments**
    Upon Your request, We will facilitate, through Our Empanelled Service Provider, prioritization of Your appointment, based on the urgency, with the Network Providers offering the necessary treatment/diagnostics subject to availability of the service(s).
    The cost of the Consultancy/Diagnostic will have to be borne by You.

Terms and Conditions applicable to Wellness Benefit Program

1. Any Information provided by You shall be kept confidential.
2. For services which are provided through Our Empanelled Service Provider/Medical Experts/Centres, We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services.
3. All medical services are being provided by Empanelled Service Provider/Medical Experts/Centres who are empanelled after full due diligence. Insured Person may however consult their Personal/Family Doctor before availing the medical services. The decisions to utilise the services will solely be at the discretion of the Insured Person.
4. We/Company/Us or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured Person/You may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.
5. This shall not be deemed to substitute the Insured Person's visit or consultation to an Independent Medical Practitioner. The Insured Person is free to choose whether or not to undergo the same and if done whether or not to act on it.
6. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, advice, prescription, actual or alleged errors, omissions and representations made by the Medical Practitioner.

II. Cumulative Bonus

If You've been safe and healthy and have had No Claims made under the **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness Hospitalization Cover** and/or **Section 15. Cancer Hospitalization Cover** in the expiring Policy Period, You would be eligible for Cumulative Bonus at the time of renewal as mentioned in Your Policy Schedule / Certificate of Insurance, provided that:

1. There is an upper limit to the Cumulative Bonus You can earn. In any Policy period, the accrued Cumulative Bonus (including any carried forward Cumulative Bonuses from the previous policy) shall not exceed the limit mentioned in Your Policy Schedule / Certificate of Insurance.
2. For a Floater Policy, the Cumulative Bonus shall be available only on Floater Basis. It shall accrue only if no claim has been made for any of the Insured Members during the expiring Policy Period.
3. In the event of a claim in the expiring policy period, the Cumulative Bonus will reduce in the same way as it was accrued in the policy at the time of renewal.
4. If You discontinue the Policy or fail to renew the Policy within the Grace Period of 30 days from the due date of renewal, the entire Cumulative Bonus will be lost.
5. The Cumulative Bonus shall be applicable on an annual basis subject to continuation of the Policy with Us.
6. The Cumulative Bonus will be Calculated on the Sum Insured as opted by You under **Section 1. A. Accidental Hospitalization Cover** and/or **Section 1. B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness Hospitalization Cover** and/or **Section 15. Cancer Hospitalization Cover**.

OR

No Claim Discount

If You've been safe and healthy and have had No Claims made under the **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover** and/or **Section 13. Critical Illness Hospitalization Cover** and/or **Section 15. Cancer Hospitalization Cover** in the expiring Policy Period, You would be eligible for a 5% No Claim Discount in the premium against these sections (if opted by you) at the time of renewal.

Note: *Cumulative bonus or No claim discount opted at the inception of the first policy with us can't be changed during the policy period and subsequent renewals.*

D. EXCLUSIONS

We shall not be liable to make any claim payment under this Policy directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following unless specifically agreed and mentioned elsewhere in the Policy Schedule / Certificate of Insurance:

I. STANDARD EXCLUSIONS

1. **Pre-Existing Diseases - Code- Excl01**
   a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of number of months, as opted by You and specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with insurer.
   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 number of months, as specified in the Policy Schedule, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

2. **Specified disease/procedure waiting period- Code- Excl02**
   a. Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of number of months, as opted by You and specified in the Policy Schedule, of continuous coverage after the date of inception of the first policy with us. 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
   f. List of specific diseases/procedures
      i. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident)
      ii. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.
      iii. Cataract, Glaucoma and Disorder of retina
      iv. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele
      v. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease
      vi. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.
      vii. Hernia of all sites,
      viii. Chronic Kidney disease and failure,
      ix. Varicose veins of lower extremities,
      x. Disease of middle ear and mastoid including otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Sinusitis, Tonsillitis, Adenoid hypertrophy, Nasal septum deviation, Turbinate hypertrophy, Nasal polyp, Mastoiditis, Nasal concha bullosa,
      xi. All internal and external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump including breast lumps (each of any kind unless malignant),
      xii. Internal Congenital Anomaly. This specific waiting period will not be applicable to New Born Baby/infants.
      xiii. Psychiatric illness
      xiv. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease.
      xv. **Joint Replacement, Bariatric Surgery and Organ Transplant**
      Any Medical Expenses incurred as a result of Joint Replacement, Bariatric Surgery and Organ Transplant Surgery will be covered subject to a waiting period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance as long as the Insured Person has been insured continuously under the Policy without any break, unless due to an accident

3. **30-day waiting period/ Initial Waiting Period - Code- Excl03**
   a. 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.
   b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve

months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

However, such waiting Period can be reduced to number of days as opted by you and mentioned in your policy schedule

4. Investigation & Evaluation- Code- Excl04

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

5. Rest Cure, rehabilitation and respite care- Code- Excl05

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

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

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

except to the extent covered under **SECTION 9. HOME (DOMICILIARY) HOSPITALIZATION** if opted by You.

6. Obesity/ Weight Control: Code- Excl06

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

i. Surgery to be conducted is upon the advice of the Doctor

ii. The surgery/Procedure conducted should be supported by clinical protocols

iii. The member has to be 18 years of age or older and

iv. Body Mass Index (BMI);

a) greater than or equal to 40 or

b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

7. Change-of-Gender treatments: Code- Excl07

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

8. Cosmetic or plastic Surgery: Code- Excl08

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

9. Hazardous or Adventure sports: Code- Excl09

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

However, You would be covered if you participate in a non-professional capacity for any recreational sport which may be under the supervision of a trained professional

10. Breach of law: Code- Excl10

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

11. Excluded Providers: Code- Excl11

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

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**

15. **Refractive Error: Code- Excl15**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

16. **Unproven Treatments: Code- Excl16**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

17. **Sterility and Infertility: Code- Excl17**
Expenses related to sterility and infertility. This includes:
    i. Any type of contraception, sterilization
    ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    iii. Gestational Surrogacy
    iv. Reversal of sterilization

This exclusion stands deleted to extent of the coverage provided under **SECTION 2. INFERTILITY TREATMENT COVER**, if opted by You.

18. **Maternity: Code Excl18**
    i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

This exclusion stands deleted to the extent of the coverage provided under **SECTION 7. MATERNITY BENEFIT & NEWBORN BABY COVER**, if opted by You.

II. SPECIFIC EXCLUSIONS

19. **Artificial Life Maintenance**
Artificial Life Maintenance, including life support machine used, where such treatment is used to maintain the Insured/Patient in a vegetative state. However, expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the Policy

20. **Suicide and Self-Injury**
We do not cover treatment directly or indirectly arising from or contributed or aggravated or accelerated by any of the following:
    a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
    b. Intentional self-injury
    c. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

21. **Circumcision, Aesthetic reasons**
    a. Treatment for alopecia, baldness, wigs, or toupees and all treatment related to the same.
    b. Circumcision unless necessary for the treatment of a disease or necessitated by an Accident;
    c. Aesthetic of any description.

22. **External Congenital Anomaly**
Screening, Counselling or treatment related to external Congenital Anomaly.

23. **Geography**
Any treatment received outside India is not covered under this Policy.

24. **Defence Operation**
We will not pay any claim under this Policy, whilst You are involved in naval, military, air force operation

25. **Non-Medical Expenses**

Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies including but not limited to charges for admission, discharge, administration, registration, documentation and filing. (Please refer Annexure A provided in the policy document or visit our website for complete list of non-medical items)

26. Insufficient Document

We have tried to reduce the number of documents you need to share but we shall not be liable to pay any claim in case all the necessary mandatory documents as mentioned in Our claims process are not submitted to Us.

27. Preventive Treatment

We do not cover inoculations, vaccinations or other treatment, for example drugs or Surgery, which aims to prevent a disease or Illness except:

a. For an active vaccination for dog or animal bite;
b. To the extent covered under **SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER** if opted by You.

28. Sexual disorder and Erectile Dysfunction

Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction.

29. Sexually Transmitted Infections & Disease

Screening, prevention and treatment for sexually transmitted infection or disease including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis is not covered.

30. Sleep Disorders and Sleep Problems

We do not cover treatment directly or indirectly related to sleep disorders and sleep problems, such as snoring, insomnia or sleep apnoea (when breathing stops temporarily during sleep) including but not limited to expense related to purchase of CPAP, BIPAP or similar instruments except as mentioned by Us and covered under **Section1.B6. Bariatric Surgery Cover.**

31. Spectacles, Hearing aids & other Expenses

Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

32. Stem Cell Transplant: Any stem cell transplant other than for Bone Marrow Transplant

33. Unjustified or Unwarranted Hospitalization

Admission solely for Physiotherapy, evaluation, investigations, diagnosis or observation service unless a claim is accepted under **Section1 - A. Accidental Hospitalization Cover** and/or **B. Accidental & Illness Hospitalization Cover.**

34. War and hazardous substances

We do not cover treatment directly or indirectly arising from or required as a consequence of:

War, invasion, acts of foreign enemy hostilities (whether or not War is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, attempted overthrow of Government or any acts of terrorism.

Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel.

35. Legal Liability

Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

36. Substance abuse and Addictions

a. Expenses incurred for the treatment of any Illness or accidental Injury caused due to:
    i. Use/misuse/abuse of Alcohol, opioids or nicotine or drugs (whether prescribed or not) by the Insured unless associated with Psychiatric Illness.
    ii. Withdrawal and de-addiction treatment taken by the Insured.
b. Any claim in respect of Cancer of Oral, Oropharynx and respiratory system is specifically excluded in cases where Insured is a tobacco user.

SPECIFIC ONES (CAN'T BE WAIVED)

37. Eye Sight & Optical Services

a) We do not cover treatment for:
   1. Correction of refractive errors of the eye including but not limited to short-sight or long-sight, such as glasses, contact lenses or laser eyesight correction Surgery

b) We do not cover Femto Laser Procedure and multifocal lenses.

c) Our Maximum Liability in respect of Cochlear Implant Procedure will be restricted to 50% of the Sum Insured opted under **Section 1.A. Accidental Hospitalization Cover** and/or **Section 1.B. Accidental & Illness Hospitalization Cover**

38. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

39. Specific Treatments

We will not pay for expenses related to administration of medications or procedures including but not limited to expense related:

a. Hyaluronic acid, Remicade or similar medications
b. Intra-articular/intra thecal or cortico-steroid injections,.
c. Predictive Genome testing

SPECIFIC ONES (CAN BE WAIVED IN LIEU OF ADDITIONAL PREMIUM)

40. Dental Treatment

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva, unless requiring Hospitalisation due to Accident or if You have opted for **SECTION 8. OUT-PATIENT (OPD) BENEFIT.**

41. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment. However, We will pay for treatments mentioned under **SECTION 4. ALTERNATE TREATMENT (AYUSH) COVER,** if You have specifically opted for it.

42. Organ Donor

The Expenses incurred by You on organ donation, except for those covered under **SECTION 3. ORGAN DONOR,** if opted by You.

43. Weight loss Surgery

We do not cover treatment that is directly or indirectly related to:
Bariatric Surgery (weight loss Surgery), such as gastric banding or a gastric bypass, or the removal of surplus or fat tissue, unless You have specifically opted for **SECTION 1.B. Accidental & Illness Hospitalization Cover which covers Bariatric Surgery.**

44. Our Maximum Liability in respect of 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% (unless specifically agreed otherwise and mentioned in the Policy Schedule/Certificate of Insurance) of Sum Insured opted under **Section 1.A. Accidental Hospitalization Cover and/or Section 1.B. Accidental & Illness Hospitalization Cover**:

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.

E. GENERAL TERMS AND CLAUSES

I. STANDARD GENERAL TERMS AND CLAUSES

CONDITIONS PRECEDENT TO THE CONTRACT

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact 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 tale informed decision in the context of underwriting the risk.

2. Condition Precedent to admission of Liability

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

3. Nomination

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee, as named in the Policy Schedule/Policy Certificate/Endorsement(if any), and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

CONDITION APPLICABLE DURING THE CONTRACT

4. Special Conditions Applicable for Policies issued with premium Payment on Instalment basis

i. 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/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)Grace Period of 15 Days would be given to Pay the instalment premium due for the Policy.
ii. During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.
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

5. Possibility of Revision of Terms of the Policy Including the Premium Rates

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

6. Withdrawal of Product

i. In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the Policy.
ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period, as per IRDAI guidelines, provided the policy has been maintained without a break

7. 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

8. Cancellation

A. Cancellation by You

1. The policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Short Period Scale

Period in Risk	Premium Refund
Within 3 months	65.00%
Exceeding 3 months but less than 6 months	45.00%
Exceeding 6 months but less than 9 months	25.00%
Exceeding 9 months	0.00%

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.

B. Cancellation by Company

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure 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.

C. In case of Death of Insured Person

i. Individual Policy

In case, no claim has been made, and termination takes place on account of death of the insured person, We shall refund a portion of the premium as per short term premium mentioned in 8.A.1, subject to the terms and conditions of the Policy. There will be no change in premium for other family members covered under the policy for the remaining duration of the policy.

ii. Family Floater Policy.

In case of death of Insured Family Member, cover shall continue for the remaining family members till the end of Policy Period. Provided no claim has been made, revised premium would be calculated basis new family composition and revised premium would be calculated on short-term basis as per table mentioned in 8.A.1, subject to the terms and conditions of the Policy. Difference between short-term premium of new family composition with old family composition shall be considered for refund.

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

9. Free Look Period

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.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

10. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

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

v. If two or more policies are taken by You during the period for which You are covered under this Policy from one or more insurers, the contribution clause shall not be applicable where the cover/ benefit offered:

- is fixed in nature i.e. Critical Illness Benefit Cover, Cancer Benefit Cover and Daily Hospital Cash Benefit Cover,
- does not have any relation to the treatment costs;

vi. If You are covered under multiple policies providing Critical Illness Benefit, Cancer Benefit and Daily Hospital Cash Benefits, We shall make the claim payments independent of payments received under other similar polices in respect of the covered event.

11. Fraud

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

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/Policyholder(s), who has made that particular claim, who shall be jointly and severely liable for such repayment to the insurer

For the purpose of this clause, the expression "Fraud" means any of the following acts committed by the insured person or by his agents or the hospital/Doctors/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

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

The company shall not repudiate the claim and/or forfeit the policy benefits on the grounds 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 intension to supress the fact or that such misstatement of or suppression of such material fact are within the knowledge of the Insurer.

12. Claim Settlement (provision for Penal Interest)

a. 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.
b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
c. 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 or reject the claim within 45 days from the date of receipt of last necessary document.
d. In case of delay beyond stipulated 45 days, the company shall be liable to pay interest to the policyholder 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.

13. Complete Discharge

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

CONDITIONS FOR RENEWAL OF THE CONTRACT

14. Renewal

i. The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
ii. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. 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.
vi. No loading shall apply on renewals based on individual claims experience.

15. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the 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 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

16. 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 → Click Here
https://d2h44aw7l5xdvz.cloudfront.net/policyDocuments/Guidelines%20on%20Migration%20and%20Portability%20of%20health%20insurance%20policies.pdf

17. 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/

The contact details of the Insurance Ombudsman Centres are mentioned in **Annexure B**.

II. SPECIFIC TERMS AND CLAUSES

CONDITIONS PRECEDENT TO THE CONTRACT

18. Zone wise Classification
Based on your city of residence, we have classified you within three Zones. In case of family floater policies, a single zone shall be applied to all the members covered under the policy. The three Zones are defined below: -

Zone A Delhi/NCR, Mumbai including (Navi Mumbai, Thane and Kalyan),
Zone B Hyderabad and Secunderabad, Bangalore, Kolkata, Ahmedabad, Vadodara, Chennai, Pune and Surat.
Zone C Rest of India apart from Zone A and Zone B cities are classified as Zone C.

Zone opted by you is mentioned in your Policy Schedule / Certificate of Insurance.

Note:
1. If You have availed choice of Zone B at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 10% Co-pay would be applicable on admissible claim amount.
2. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone B, 10% Co-pay would be applicable on admissible claim amount.
3. If You have availed choice of Zone C at the time of Policy Inception and availing treatment in a Hospital which is situated in Zone A, 20% Co-pay would be applicable on admissible claim amount.

19. Alterations to the Policy
This Policy constitutes the complete contract of insurance. This Policy cannot be changed or edited by anyone (including an insurance agent or intermediary) except Us (subject to necessary approval from the Insurance Regulatory and Development Authority of India), and any change We make will be through a written endorsement signed and stamped by Us, only on the request from Group Manager/ Insured Member.

20. Non-Disclosure or Misrepresentation:
If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the

proposal form either physically or electronically or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured
Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

a) cancelled ab initio i.e. from the inception date or the renewal date (as the case may be),
b) or the Policy may be modified by Us, at Our sole discretion, upon 30 days' notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance;
c) the claim under such Policy if any, shall be rejected/repudiated forthwith.

21. Insured Person

b. Only those persons named as an Insured Person in the Policy Schedule / Certificate of Insurance shall be covered under this Policy.
c. You can add more persons during the Policy Period but only after payment of an additional premium and subject to acceptance of Proposal by Us (wherever necessary) and after We have issued an endorsement confirming the addition of such person as an Insured Person.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

22. Arbitration

If we have any differences with respect to the claim amount to be paid under this policy, it will be referred to arbitration in accordance with the Indian Arbitration and conciliation act 1996, as amended. The making of an award under such arbitration proceedings shall be a condition precedent for the Company to be liable to make any payment under this policy.

23. Claims Notification and Procedure

In the event of any accidental injury or illness or condition that may result in a claim under this policy, it is a condition precedent to Our liability under the Policy that below procedure should be followed depending on the type of claim:

A. Cashless Claim Process:

Cashless Facility can be availed from our network hospitals only. This is facilitated by our Service Provider / Third Party Administrator (TPA) and we would make a direct payment to the Network Hospital to the extent of Our Liability provided that:

1. We are given a notice at least 72 hours before any planned hospitalization or within 24 Hours of hospitalization in case of an emergency situation.
2. For Cashless Facility You shall follow the below Procedure:
   a. Share the Health Card/Copy of E-Cards along with ID Proof with the Hospital Authority & Obtain the Pre-Authorization Form from the Hospital.
   b. Submit Duly filled & Signed Pre-Authorization Form to the Hospital Counter.
   c. Ensure that the Hospital shares the Duly filled & Signed Pre-Authorization Form to Service Provider / Third Party Administrator (TPA) for further Processing.
   d. Service Provider / Third Party Administrator (TPA) will inform the decision and may issue authorization letter depending on the Policy Terms and Conditions to the Hospital directly.
   e. Once the request for Pre-Authorization has been granted, the treatment must take place within 15 days of the Pre-Authorization Approval Date or the Policy Expiry Date whichever is earlier and shall be valid only if all the details of the Authorised details, Hospital and Location including Dates match with the details of the Actual Treatment Received.
   f. We reserve the right to modify, add or restrict any Network Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of Network Providers.
   g. For any queries designated Service Provider / Third Party Administrator (TPA) may be contacted on the contact details mentioned on the Health Card/Copy of E-Cards issued to You.

B. Reimbursement Claim Process:

Reimbursement Facility can be availed from any hospital within India of Your Choice Wherein You will have to make payment directly to the Hospital and submit the documents to Service Provider / Third Party Administrator (TPA) for processing the reimbursement of the claim amount provided that:

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of Admission.
2. For Reimbursement Claim You shall follow the below Procedure:
   a. 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.
   b. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
   c. 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 or reject the claim within 45 days from the date of receipt of last necessary document.

d. In case of delay beyond stipulated 45 days, the company shall be liable to pay interest to the policyholder 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. In case of Your Death, We shall reimburse the claim amount to Your Nominee as named in Your Policy Schedule / Certificate of Insurance or Your Legal representative holding a valid succession certificate.

Sr. No	List of Documents / Information	Hospitalization Claim	Out-Patient (OPD) Claim	Critical Illness/Cancer Claim	Daily Hospital Cash Claim
1	Duly Filled and Signed Claim form	√	√	√	√
2	Discharge Summary	√	×	×	√
3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)	√	×	√	×
4	Original Hospital Main Bill	√	×	×	×
5	Original Hospital Bill Break Up	√	×	×	×
6	Original Pharmacy Bills	√	√	×	×
7	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	√	×	×
8	Consultation Papers	√	√	√	×
9	Investigation Reports	√	√	√	×
10	Digital Images/CDs of the Investigation Procedures (if required)	√	√	×	×
11	MLC/FIR Report (If applicable)	√	×	√	×
12	Original Invoice/Sticker (If applicable)	√	×	×	×
13	Post Mortem Report (If applicable)	√	×	×	×
14	Disability Certificate (If applicable)	√	×	√	×
15	Attending Physician Certificate (If applicable)	√	×	√	×
16	Ante-natal Record (If applicable)	√	×	×	×
17	Birth discharge Summary (If applicable)	√	×	×	×
18	Death Certificate (If applicable)	√	×	√	×
19	*KYC (Photo ID card) (If applicable)	√	√	√	√
20	Bank Details with Cancelled Cheque	√	√	√	√

Note: There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions A.1, B.1 and B.2.a may be considered where the reason for delay is proved to our satisfaction.

*KYC documents shall be required at the claim settlement stage where claims pay-out to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per claim.

CONDITIONS FOR RENEWAL OF THE CONTRACT

24. Continuity Benefits

We will grant continuity of benefits which were available to the Insured Members under a health insurance policy which provides similar indemnity benefits in the immediately preceding Cover Year provided that:

i. We shall be liable to provide continuity of only those benefits (for e.g.: Initial wait period, wait period of Specific Diseases pre-existing disease etc) which are applicable under this Policy;

ii. Any other wait period that is applicable specific to this policy but was permanently excluded in the previous policy will not be given any credit.

Annexure-A
List I – Optional Items

Sl No	Item
1.	BABY FOOD *(Not Payable)*
2.	BABY UTILITIES CHARGES *(Not Payable)*
3.	BEAUTY SERVICES *(Not Payable)*
4.	BELTS/BRACES *(PAYABLE INCASES WHERE INSURED HAS UNDERGONE SURGERY OF THORACIC OR LUMBAR SPINE)*
5.	BUDS *(Not Payable)*
6.	COLD PACK/HOT PACK *(Not Payable)*
7.	CARRY BAGS *(Not Payable)*
8.	EMAIL/ INTERNET CHARGES *(Not Payable)*
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) *(Not Payable)*
10.	LEGGINGS *(Payable in Bariatric and Varicose Vein Surgery and may be considered for at least these conditions where Surgery itself is Payable)*
11.	LAUNDRY CHARGES *(Not Payable)*
12.	MINERAL WATER *(Not Payable)*
13.	SANITARY PAD *(Not Payable)*
14.	TELEPHONE CHARGES *(Not Payable)*
15.	GUEST SERVICES *(Not Payable)*
16.	CREPE BANDAGE *(Not Payable)*
17.	DIAPER OF ANY TYPE *(Not Payable)*
18.	EYELET COLLAR *(Not Payable)*
19.	SLINGS *(Reasonable costs for one sling in case of upper arm fractures should be considered)*
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES *(Part Of Cost Of Blood, Not Payable)*
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	Television Charges *(Payable Under Room Charges Not if separately levied)*
23.	SURCHARGES *(Part of Room Charge Not Payable Separately)*
24.	ATTENDANT CHARGES *(Part of Room Charge Not Payable Separately)*
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) *(Patient Diet provided by hospital is Payable)*
26.	BIRTH CERTIFICATE *(Not Payable)*
27.	CERTIFICATE CHARGES *(Not Payable)*
28.	COURIER CHARGES *(Not Payable)*
29.	CONVEYANCE CHARGES *(Not Payable)*
30.	MEDICAL CERTIFICATE *(Not Payable)*
31.	MEDICAL RECORDS *(Not Payable)*
32.	PHOTOCOPIES CHARGES *(Not Payable)*
33.	MORTUARY CHARGES *(Payable upto 24 Hours. Shifting charges not Payable)*
34.	WALKING AIDS CHARGES *(Not Payable)*
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) *(Not Payable)*
36.	SPACER *(Not Payable)*
37.	SPIROMETRE *(Device Not Payable)*
38.	NEBULIZER KIT *(Not Payable)*
39.	STEAM INHALER *(Not Payable)*
40.	ARMSLING *(Not Payable)*
41.	THERMOMETER *(Not Payable)*
42.	CERVICAL COLLAR *(Not Payable)*
43.	SPLINT *(Not Payable)*
44.	DIABETIC FOOTWEAR *(Not Payable)*
45.	KNEE BRACES (LONG/ SHORT/ HINGED) *(Not Payable)*
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER *(Not Payable)*
47.	LUMBO SACRAL BELT *(Payable only where Insured has undergone Surgery of Lumbar Spine)*

48.	NIMBUS BED OR WATER OR AIR BED CHARGES *(Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadriplegia for any reason and at reasonable cost of approximately Rs. 200 / day*
49.	AMBULANCE COLLAR *(Not Payable)*
50.	AMBULANCE EQUIPMENT *(Not Payable)*
51.	ABDOMINAL BINDER *(Not Payable)*
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES *(Post hospitalization nursing charges not Payable)*
53.	SUGAR FREE Tablets *(Payable. Sugar free variants of admissible medicines are Not excluded)*
54.	CREAMS POWDERS LOTIONS *(Toiletries are not payable, only prescribed medical pharmaceuticals payable)*
55.	ECG ELECTRODES *(Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be Payable)*
56.	GLOVES *(Sterilized Gloves Payable / Unsterilized Gloves not payable)*
57.	NEBULISATION KIT *(Payable Reasonably only if used during Hospitalization)*
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, etc.]
59.	KIDNEY TRAY *(Not Payable)*
60.	MASK *(Not Payable)*
61.	OUNCE GLASS *(Not Payable)*
62.	OXYGEN MASK *(Not Payable)*
63.	PELVIC TRACTION BELT *(Not Payable)*
64.	PAN CAN *(Not Payable)*
65.	TROLLY COVER *(Not Payable)*
66.	UROMETER, URINE JUG *(Not Payable)*
67.	AMBULANCE *(Payable Reasonably only if used during Hospitalization upto sub-limit mentioned in the policy schedule)*
68.	VASOFIX SAFETY *(Not Payable)*

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

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED) *(Not Payable)*
2	HAND WASH *(Not Payable)*
3	SHOE COVER *(Not Payable)*
4	CAPS *(Not Payable)*
5	CRADLE CHARGES *(Not Payable)*
6	COMB *(Not Payable)*
7	EAU-DE-COLOGNE/ ROOM FRESHNERS *(Not Payable)*
8	FOOT COVER *(Not Payable)*
9	GOWN *(Not Payable)*
10	SLIPPERS *(Not Payable)*
11	TISSUE PAPER *(Not Payable)*
12	TOOTHPASTE *(Not Payable)*
13	TOOTHBRUSH *(Not Payable)*
14	BED PAN *(Not Payable)*
15	FACE MASK *(Not Payable)*
16	FLEXI MASK *(Not Payable)*
17	HAND HOLDER *(Not Payable)*
18	SPUTUM CUP *(Payable Under Investigation Charges, Not as Consumable)*
19	DISINFECTANT LOTIONS *(Not Payable-Part of Dressing Charges)*
20	LUXURY TAX *(Only Actual Tax Levied by Government is Payable - Part of Room Charge for Sub Limits)*
21	HVAC *(Part of Room Charge Not Payable Separately)*
22	HOUSE KEEPING CHARGES *(Part of Room Charge Not Payable Separately)*
23	AIR CONDITIONER CHARGES *(Payable Under Room Charges Not if separately levied)*
24	IM IV INJECTION CHARGES *(Part of Nursing Charges, Not Payable)*
25	CLEAN SHEET *(Part of Laundry/housekeeping Not Payable Separately)*
26	BLANKET/WARMER BLANKET *(Not Payable- Part of Room Charges)*
27	ADMISSION KIT *(Not Payable)*

28	DIABETIC CHART CHARGES *(Not Payable)*
29	DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES *(Not Payable)*
30	DISCHARGE PROCEDURE CHARGES *(Not Payable)*
31	DAILY CHART CHARGES *(Not Payable)*
32	ENTRANCE PASS/ VISITORS PASS CHARGES *(Not Payable)*
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE *(To be Claimed by Patient under Post - Hospitalization where admissible)*
34	FILE OPENING CHARGES *(Not Payable)*
35	INCIDENTAL EXPENSES/ MISC. CHARGES (NOT EXPLAINED) *(Not Payable)*
36	PATIENT IDENTIFICATION BAND/ NAME TAG *(Not Payable)*
37	PULSEOXYMETER CHARGES *(Not Payable)*
38	Nursing, DMO/ RMO charges included in room rent under associated medical expenses *(Not Payable)*

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

Sl No.	Item
1	HAIR REMOVAL CREAM *(Not Payable)*
2	DISPOSABLES RAZORS CHARGES (for site preparations) *(Payable for site preparations)*
3	EYE PAD *(Not Payable)*
4	EYE SHIELD *(Not Payable)*
5	CAMERA COVER *(Not Payable)*
6	DVD, CD CHARGES *(Payable only if CD is specifically sought by Insurer/TPA)*
7	GAUSE SOFT *(Not Payable)*
8	GAUZE *(Not Payable)*
9	WARD AND THEATRE BOOKING CHARGE *(Payable Under OT Charges, Not Payable Separately)*
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS *(Rental Charged By The Hospital Payable. Purchase of Instruments Not Payable.)*
11	MICROSCOPE COVER *(Payable Under OT Charges, Not Payable Separately)*
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER *(Payable Under OT Charges, Not Payable Separately)*
13	SURGICAL DRILL *(Payable Under OT Charges, Not Payable Separately)*
14	EYE KIT *(Payable Under OT Charges, Not Payable Separately)*
15	EYE DRAPE *(Payable Under OT Charges, Not Payable Separately)*
16	X-RAY FILM *(Payable Under Radiology Charges, Not as Consumable)*
17	BOYLES APPARATUS CHARGES *(Part Of OT Charges, Not Separately)*
18	COTTON *(Not Payable-Part of Dressing Charges)*
19	COTTON BANDAGE *(Not Payable-Part of Dressing Charges)*
20	SURGICAL TAPE *(Not Payable-payable by the Patient when Prescribed, otherwise included as Dressing Charges)*
21	APRON *(Not Payable -Part of Hospital Services/Disposable Linen to be Part of OT/ICU Charges)*
22	TORNIQUET *Not payable (service is charged by hospital, consumables cannot be separately charged.*
23	ORTHOBUNDLE, GYNAEC BUNDLE (Part of Dressing Charges)

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

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES *(Not Payable)*
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE *Unless A Claim Is Accepted Under Section1 - A. Accidental Hospitalization Cover And/Or B. Accidental & Illness Hospitalization Cover*
3	URINE CONTAINER *(Not Payable)*
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES *(Not Payable)*
5	BIPAP MACHINE *(Not Payable)*
6	CPAP/ CAPD EQUIPMENTS *(Device Not Payable)*
7	INFUSION PUMP- COST *(Device Not Payable)*
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC (May be Payable when prescribed for patient, not Payable for hospital use in OT or ward or for dressings in hospital)

9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES *(Patient diet provided by hospital is payable)*
10	HIV KIT *(Payable Only as Pre-Operative Screening)*
11	ANTISEPTIC MOUTHWASH *(Payable when prescribed)*
12	LOZENGES *(Payable when prescribed)*
13	MOUTH PAINT *(Payable when prescribed)*
14	VACCINATION CHARGES *(Except to the extent covered under SECTION 7. MATERNITY BENEFIT & NEW BORN BABY COVER if opted & For dog or animal bite)*
15	ALCOHOL SWABES *(Not Payable. Part of hospital's own internal cost)*
16	SCRUB SOLUTIONISTERILLIUM *(Not Payable. Part of hospital's own internal cost)*
17	Glucometer& Strips *(Not Payable pre hospitalization or post hospitalization / Reports and Charts required/ Device not payable)*
18	URINE BAG *(Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs)*

List V – Additional Non Payable Items

Sr. No	List of Expenses Generally Excluded ("Non-medical")
1.	BRUSH
2.	COSY TOWEL
3.	MOISTURISER PASTE BRUSH
4.	POWDER
5.	BARBER CHARGES
6.	OIL CHARGES
7.	BED UNDER PAD CHARGES
8.	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS, ETC.,
9.	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
10.	HOME VISIT CHARGES
11.	DONOR SCREENING CHARGES
12.	BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES
13.	BLADE
14.	MAINTENANCE CHARGES
15.	PREPARATION CHARGES
16.	WASHING CHARGES
17.	MEDICINE BOX
18.	COMMODE
19.	DIGESTION GELS
20.	NOVARAPID
21.	VOLINI GEL/ ANALGESIC GEL
22.	ZYTEE GEL
23.	AHD (ANCILLARY AND HOSPITAL DISINFECTION (EG.,BIOMEDICAL WASTE DISPOSAL/MANAGEMENT, SANITATION, SANITIZATION/FUMIGATION CHARGES ETC.)
24.	VISCO BELT CHARGES
25.	EXAMINATION GLOVES
26.	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
27.	PAPER GLOVES
28.	REFERRAL DOCTOR'S FEES
29.	SOFNET
30.	SOFTOVAC
31.	STOCKINGS

II. Digit Life Group Term Life Insurance

PART - B

Important Terms and Definitions

DEFINITIONS

In this Policy, unless the context requires otherwise, the following words and expressions shall have the meaning assigned to them respectively herein below:

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

2. **Accidental Death** The Accident shall result in Bodily Injury or injuries to the Insured Member independently of any other means. Such injury or injuries shall, within 180 days of the occurrence of the Accident, directly and independently of any other means, cause the death of the Insured Member. Such a death is defined as "Accidental Death". The date of the Accident should be after the Risk Commencement Date and before the termination/ expiry of the Insured Member's Insurance Coverage.

3. **Accidental Total & Permanent Disability (ATPD)** Accidental Total and Permanent Disability refers to a disability, which
   a) Is caused by Bodily Injury resulting from an Accident; and
   b) Occurs solely and directly due to the said Bodily Injury and shall be independent of any other cause; and
   c) Occurs within 180 days of the occurrence of such Accident; and
   d) Results in (i) Total and irrecoverable loss of sight of both eyes, or; (ii) Physical separation or loss of use of both hands or feet, or; (iii) Physical separation or loss of use of one hand and one foot, or; (iv) loss of sight of one eye and Physical separation or loss of use of hand or foot; (v) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Member from engaging in any employment or occupation of any description whatsoever.

   The above is exclusive of and without prejudice to the other causes of total and permanent disability.

   Where, Physical separation shall mean physical severance of the hand at or above the wrist or physical severance of the foot at or above the ankle.
   The date of the Accident should be after the Risk Commencement Date and before the termination/ expiry of the Insured Member's Insurance Coverage.

4. **Age** shall be Age of the Member as at last birthday on the Risk Commencement Date for existing Insured Members, and age as on Entry Date for new Members and as recorded with the Company.

5. **Appointee** shall mean a person who is appointed by the Insured Member to receive the Benefits on behalf of the Nominee, if the Nominee is a minor on the date of the payment of such Benefit on the happening of the death of Insured Member.

6. **Assignee** is the person to whom the rights and Benefits under this Policy are transferred by virtue of an Assignment.

7. **Assignment** is the process of transferring the rights and Benefits to an "Assignee," in accordance with the provisions of Section 38 of Insurance Act, 1938, as amended from time to time.

8. **Assignor** means the person who transfers the rights and Benefits under this Policy to the Assignee by virtue of an Assignment.
9. **Authority** means Insurance Regulatory and Development Authority of India (IRDAI).

10. **Benefit/s** means the Death Benefit, inbuilt optional Benefits which are additional Accidental Death Benefit, additional Accidental Total and Permanent Disability Benefit, accelerated Terminal Illness Benefit, additional Critical Illness Benefit, accelerated Critical Illness Benefit, other add-on Benefits like Voluntary Insurance Coverage, Spouse Cover, Surrender Benefit, or any other Benefit as applicable and availed under the terms of this Policy.

11. **Beneficiary** means the Master Policyholder or the Member or Nominee/(s).

12. **Certificate of Insurance** means in the case of Non-Employer Employee Group, a certificate issued by Us, on the basis of the Member's enrolment details provided, to each Member evidencing the acceptance of risk on the life of the Member under the Master Policy; The Certificate of Insurance shall be attached to and form part of this Master Policy for the respective Member. In the event of any inconsistency or contradiction between the Policy and the Certificate of Insurance, the terms and conditions contained in the Policy will prevail.

13. **Claimant** means the Master Policyholder or the Member or the Nominee who is entitled to register a claim for the insured event under the Master Policy; and where there is no Beneficiary(s), then the Insured Member's legal heir or legal representative or the holder of a succession certificate.
14. **Coverage End Date** The date of the expiry of Insurance Coverage as provided to the Insured Member under this Master Policy.

15. **Death Benefit** means the Benefit which is agreed to be paid by Us on occurrence of Member's death subject to Clause 4.1 in Part C of this Policy Document and as specified in the Certificate of Insurance/ Register of Insured Members.

16. **Disappearance** means if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months , following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such Insured Member was known to have been travelling as a fare paying passenger or in any event arising as a result of Act of God Perils during the Member Coverage Term, where it is reasonable to believe that such Insured Member has died as a result of an Accidental Injury. Disappearance shall be covered under additional Accidental Death Benefit as specified in Clause 4.2.1 of Part C.

17. **Drowning** means if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the Member Coverage Term, where it is reasonable to believe that such Insured Member has died as a result of drowning. Drowning shall be covered under additional Accidental Death Benefit as specified in Clause 4.2.1 of Part C.

18. **Critical Illness (CI) Condition** means the first diagnosis of any of the covered Critical Illnesses or undergoing any surgery, as per chosen CI variant listed in Clause 4.2.4 in Part C of this Policy Document.

Following are the definitions of such listed **Critical Illnesses / surgical procedures**:

I. Standard Definitions

1) **Cancer Of Specified Severity**
   a) A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, lymphoma and sarcoma.
   b) The following are excluded:
      i) All tumors which are histologically described as carcinoma in situ, benign, pre- malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN - 2 and CIN-3.
      ii) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond.
      iii) Malignant melanoma that has not caused invasion beyond the epidermis.
      iv) All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
      v) All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below.
      vi) Chronic lymphocytic leukaemia less than RAI stage 3.
      vii) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification.
      viii) All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs.
2) **Myocardial Infarction** (First Heart Attack of specific severity)
   a) The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
      i) A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g., typical chest pain)
      ii) New characteristic electrocardiogram changes
      iii) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
   b) The following are excluded:
      i) Other acute Coronary Syndromes
      ii) Any type of angina pectoris
      iii) A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.
3) **Open Heart Replacement Or Repair Of Heart Valves**
   a) The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to balloon valvotomy/valvuloplasty are excluded.
4) **Primary (Idiopathic) Pulmonary Hypertension**

a) An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.
b) The NYHA Classification of Cardiac Impairment are as follows:
   i) Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
   ii) Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
c) Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

5) **Open Chest CABG**
   a) The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
   b) The following are excluded:
      i) Angioplasty and/or any other intra-arterial procedures
6) **End Stage Lung Failure**
   a) End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
      i) FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
      ii) Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
      iii) Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and
      iv) Dyspnoea at rest.
7) **End Stage Liver Failure**
   a) Permanent and irreversible failure of liver function that has resulted in all three of the following:
      i) Permanent jaundice; and
      ii) Ascites; and
      iii) Hepatic encephalopathy.
   b) Liver failure secondary to drug or alcohol abuse is **excluded.**
8) **Kidney Failure Requiring Regular Dialysis:** End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
9) **Major Organ /Bone Marrow Transplant**
   a) The actual undergoing of a transplant of:
      i) One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
      ii) Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.
   b) The following are excluded:
      i) Other stem-cell transplants
      ii) Where only Islets of Langerhans are transplanted
10) **Benign Brain Tumor**
   a) Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.
   b) This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.
      i) Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
      ii) Undergone surgical resection or radiation therapy to treat the brain tumor.
   c) The following conditions are **excluded:**
      i) Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.
11) **Coma Of Specified Severity**
   a) A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
      i) no response to external stimuli continuously for at least 96 hours;
      ii) life support measures are necessary to sustain life; and
      iii) permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
   b) The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.
12) **Major Head Trauma**

a) Accidental head injury resulting in permanent Neurological deficit is to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means, and independently of all other causes.
b) The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.
c) The Activities of Daily Living are:
   i) Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
   ii) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii) Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   iv) Mobility: the ability to move indoors from room to room on level surfaces;
   v) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   vi) Feeding: the ability to feed oneself once food has been prepared and made available.
d) The following are excluded:
   i) Spinal cord injury

13) **Permanent Paralysis Of Limbs:** Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.
14) **Stroke Resulting In Permanent Symptoms**
   a) Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolization from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.
   b) The following are excluded:
      i) Transient ischemic attacks (TIA)
      ii) Traumatic injury of the brain
      iii) Vascular disease affecting only the eye or optic nerve or vestibular functions.
15) **Motor Neuron Disease With Permanent Symptoms:** Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.
16) **Multiple Sclerosis With Persisting Symptoms**
   a) The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
      i) investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
      ii) there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
   b) Other causes of neurological damage such as SLE are excluded.

II. Specific Definitions:

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

2) Abdominal Aorta Aneurysm
a) An abdominal aortic aneurysm (AAA) is a swelling/dilatation (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body.
b) The diagnosis must be supported by a CT scans or CTA (Angiography) and requiring Endovascular aneurysm repair and the realization of surgery has to be confirmed by a cardiovascular surgeon.
c) Congenital conditions are excluded.

3) Cardiomyopathy
a) A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist). There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least Class 3 of the New York Heart Association classifications of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain) and LVEF of 40% or less.

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

4) **Pulmonary Artery Graft Surgery:** The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

5) **Apallic Syndrome:** Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

6) **Parkinson's Disease**

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

b) The diagnosis must be supported by all of the following conditions:
- **i)** the disease cannot be controlled with medication;
- **ii)** signs of progressive impairment; and
- **iii)** inability of the Insured Person to perform at least 3 of the 6 activities of daily living (either with or without the use of mechanical equipment, special devices or other aids and Adaptations in use for disabled persons) for a continuous period of at least 6 months.

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

7) **Muscular Dystrophy**

a) A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following four conditions:
- **i)** Family history of muscular dystrophy;
- **ii)** Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
- **iii)** Characteristic electromyogram; or
- **iv)** Clinical suspicion confirmed by muscle biopsy.

b) The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities Of daily living (either with or without the use of mechanical equipment, special devices Or other aids and adaptations in use for disabled persons) for a continuous period of at least 6 months. Activities of daily living means:
- **i)** Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means
- **ii)** Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- **iii)** Transferring: The ability to move from a bed to an upright chair or wheel chair and vice versa;
- **iv)** Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- **v)** Feeding: the ability to feed oneself, once food has been prepared and made available.
- **vi)** Mobility: The ability to move indoors from room to room on level surfaces

8) **Progressive Supranuclear Palsy:** A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days.

9) **Creutzfeldt-Jakob Disease (CJD):** A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required. Social functioning is defined as the ability of the individual to interact in the normal or usual way in society. Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

10) **Bacterial Meningitis:** Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living. This diagnosis must be confirmed by:
- **i)** The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
- **ii)** A consultant neurologist certifying the diagnosis of bacterial meningitis.

11) **Alzheimer's Disease:** Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality. Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our Appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must

result in a permanent inability to perform three or more Activities with Loss of Independent Living or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

a) The following conditions are however not covered:

i) non-organic diseases such as neurosis and psychiatric Illnesses;

ii) alcohol related brain damage; and

iii) any other type of irreversible organic disorder/dementia.

12) Encephalitis: Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist). The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.

13) Loss Of Independent Existence: Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of Activities of Daily Living.

14) Systemic Lupus Erythematous: A multi-system, multifactorial, autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. Systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specializing in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only hematological and joint involvement are however not covered. The WHO lupus classification is as follows:

i) Class I: Minimal change – Negative, normal urine.

ii) Class II: Mesangial – Moderate proteinuria, active sediment.

iii) Class III: Focal Segmental – Proteinuria, active sediment.

iv) Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.

v) Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

15) Goodpasture's Syndrome: Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for continuous period of atleast ***30 Days***. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist *or Nephrologist*).

16) Fulminant Hepatitis: A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria. This diagnosis must be supported by all of the following:

i) Rapid decreasing of liver size;

ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework;

iii) Rapid deterioration of liver function tests;

iv) Deepening jaundice; and

v) Hepatic encephalopathy.

17) Pneumonectomy: The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured. The following conditions are excluded:

i) Removal of a lobe of the lungs (lobectomy)

ii) Lung resection or incision

18) Aplastic Anaemia

a) Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

i) Blood product transfusion.

ii) Marrow stimulating agents.

iii) Immunosuppressive agents; or

iv) Bone marrow transplantation.

b) The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

i) Absolute Neutrophil count of 500 per cubic millimetre or less;

ii) Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and

iii) Platelet count of 20,000 per cubic millimetre or less.

19. **Employer-Employee Group** means group where an employer-employee relationship exists between the Master Policyholder and the Member, in accordance with the relevant laws.

20. **Entry Date** means in relation to the Members admitted to this Master Policy, and shall be the Risk Commencement Date.

21. **Eligible Member** means a person who meets and continues to meet all the eligibility criteria as detailed out in Clause 1 and 2 of Part C of this Policy Document.

22. **Free Cover Limit** means the amount of Sum Assured granted on life of the Member without any need for individual underwriting for assessment of risk on account of Benefits offered under this Master Policy. Sum Assured in excess of Free Cover Limit may be accepted subject to evidence of insurability satisfactory to the Company. Such Free Cover Limit shall be determined by the prevailing underwriting policy of the Company and subject to amendment from time to time.

23. **Grace Period** means the time granted by the Company from the due date for the payment of Premium without levy of any interest or penalty during which time the Policy or Member's Insurance Coverage, as the case may be, is considered to be In Force without any interruption. The Grace Period so granted is fifteen (15) days for monthly Premium payment frequency and thirty (30) days for other available Premium payment frequencies from the respective Premium payment due date.

24. **Hospital** means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:
    a) has qualified nursing staff under its employment round the clock.
    b) 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.
    c) has qualified medical practitioner(s) in charge round the clock.
    d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

25. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours. Inpatient care means treatment for which the Insured Member has to stay in a Hospital for more than 24 hours for an insured event.

26. **In Force** means status of the Policy / Member's Insurance Coverage being active, all due Premiums have been paid and the Policy / Member's Insurance Coverage is not terminated or in Lapsed Status.

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

28. **Insurance Coverage** means the risk cover under this Master Policy issued to the Member as per the Benefit/s In Force under the Master Policy.

29. **Lapsed Status** means state of a non-active life insurance contract on account of non-payment of Premium within the Grace Period.

30. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The registered practitioner should not be the insured or close member of the family. All medical professionals mentioned in this Master Policy Document, that is, cardiologist, neurologist, consultant neurologist, rheumatologist, nephrologist, specialist in respiratory medicine shall be registered Medical Practitioners.

31. **Master Policy / Policy** means the contract of insurance entered into between the Master Policyholder and the Insurer as evidenced by the Master Policy Document.

32. **Master Policy Document / Policy Document** means this Digit Life Group Term Life Insurance Policy comprising the necessary documents including terms and conditions, Master Policy Schedule, the signed Proposal Form, any endorsements in this document issued by Us from time to time and the annexures, if any.

33. **Master Policyholder** shall mean the owner of this Policy and is referred to as the proposer in the Proposal form and is named as such in the Master Policy Schedule.

34. **Master Policy Schedule** means the Policy Schedule set out above in Part A that We have issued, along with any annexures, tables and/or endorsements, attached to it from time to time and forming part of this Policy and if any update Schedule is issued, then the Schedule which is latest in time.

35. **Member/Insured Member** means an individual who satisfies the eligibility criteria and is covered under this Master Policy.

36. **Member Coverage Term** means duration of Insurance Coverage of Insured Member from date of joining the Master Policy.

37. **Master Policy Commencement Date** is the Date, Month and Year the Master Policy comes into effect after We have accepted the risk under the Proposal Form and is as specified in the Master Policy Schedule.
38. **Nomination** is the process of nominating a person(s) in accordance with provisions of Section 39 of the Insurance Act, 1938 as amended from time to time.

39. **Nominee/s** means a person nominated by the Member to receive the applicable Benefit/(s) under this Policy in case of death of the Member and whose name is mentioned in the Certificate of Insurance / Register of Insured Members.

40. **Non-Employer-Employee Group** means group other than employer-employee, where a clearly evident relationship between the Member and the Master Policyholder, for services other than insurance, exist.

41. **Policy End Date** means the date of completion of the Policy Term as specified in the Policy Schedule.

42. **Policy Renewal Date** means date in case of One Year Renewable scheme, on which the Master Policy is due for renewal as stated in the Master Policy Schedule or any **Change of Policy Renewal date** as specified in Clause 4.3.6 of Part C of this Policy Document.

43. **Policy Term** means the tenure of this Policy as specified in the Policy Schedule.

44. **Policy Year or Coverage Year** means a period of twelve (12) consecutive months starting from the Master Policy Commencement Date or Risk Commencement Date respectively and ending on the day immediately preceding the following Policy anniversary date / Insurance Coverage anniversary date and each subsequent period of twelve (12) consecutive months thereafter, if applicable.

45. **Premium/s** means the contractual amount payable by the Master Policyholder or the Insured Member during the Premium Payment Term on the Premium due date as set out in the Master Policy Schedule or Certificate of Insurance or Register of Insured Members, as applicable, to secure the Benefits under this Policy. Applicable tax, cess and other levies if any are payable in addition.

46. **Pre-existing Disease** means any condition, ailment, Injury or disease:
    a) that is/are Diagnosed by a physician within 48 months prior to the effective date of the Insurance Coverage issued by Us or;
    b) for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Insurance Coverage or its Revival or its Reinstatement.

47. **Premium Payment Term (PPT)** means the period in years or months during the Policy Term / Member Coverage Term in which Premiums are payable by the Policyholder / Insured Member under the Policy, as specified in the Master Policy Schedule / Certificate of Insurance / Register of Insured Members.

48. **Proposal** Form means the form filled in and completed by You for the purpose of obtaining Insurance Coverage under this Master Policy.

49. **Register of Insured Members** means a record maintained by Us or the Master Policyholder containing details of each Insured Member including but not limited to unique identification number or membership number, name, Age, gender, Beneficiary, Entry Date, Premium payable, Premium Payment Term and instalment Premium due date (if applicable), Benefit options chosen and Sum Assured under various Benefit options, as applicable and any special conditions applicable to the Insured Member.

50. **Regular Pay** means the Premium Payment Term is equal to Policy Term / Member Coverage Term and as specified in Master Policy Schedule / Certificate of Insurance/Register of Insured Members.

51. **Revival** means restoration of Insurance Coverage under a Master Policy / Insurance Coverage with respect to any Member, which are in a Lapsed Status due to non-payment of due Premium, to the In-Force status subject to terms and conditions of the Master Policy and as specified in Clause 2 of Part D.

52. **Reinstatement** means restoration of Insurance Coverage under a Master Policy, which is in Lapsed Status due to non-payment of due Premium, to In-Force status subject to terms and conditions of the Master Policy and as specified in Clause 2 of Part D.

53. **Risk Commencement Date** means the date on which the Insurance Coverage under the Master Policy in respect of the Insured Members commences which will be later of the date of realization of the full Premium by Us or the date of underwriting decision communicated by Us or the date specified towards the respective Insured Member in the Register of Insured Members.

54. **Single Pay** means the Policy / Insurance Coverage in which the Premium for the chosen Policy Term / Member Coverage Term is paid only once at the time before Master Policy Commencement Date / Risk Commencement Date, as applicable.

55. **Scheme Rules / Rules of Scheme** means the rules that may be framed by the Master Policyholder for the scheme and approved by Us from time to time, governing the grant of Benefits to the Insured Members of the scheme.

56. **Sum Assured** means an absolute amount of Benefit which is guaranteed to become payable on the occurrence of Death of Insured Member (lumpsum Sum Assured in case of Death Benefit) or other insured events with respect to inbuilt optional Benefits chosen in accordance with the terms and conditions of this Policy and is specified as such in the Certificate of Insurance or Register of Insured Members. In case of any of the regular income Benefit options, for presentation purpose, Sum Assured shall be defined as the total income payable in the next 12 months following the death of Insured Member.

57. **Surrender** means complete withdrawal/ termination of the Master Policy or exit by the Member from the Master Policy before completion of Policy Term / Member Coverage Term, as the case may be, at the request of the Master Policyholder or the Member, as applicable.

58. **Survival Period** means the period of 30 days from the date of the first diagnosis of covered Critical Illness Condition that the Insured Member has to survive to be eligible for receiving Critical Illness Sum Assured (if opted for).

59. **Terminal Illness** means an advanced or rapidly progressing incurable and un-correctable medical condition which, in the opinion of two independent Medical Practitioners specializing in treatment of such illness, certifies that the illness is expected to lead to death of the Member within 6 months of the date of diagnosis of the Terminal Illness.
The Company reserves the right for an independent assessment by two different Medical Practitioners other than the Medical Practitioner whose diagnosis has been provided by the insured Member.

60. **Total Premiums Paid** means total of all the Premiums received, excluding any extra Premium, any rider premium and taxes.

61. **Unexpired Risk Premium Value (Surrender Value)** means an amount, if any, that becomes payable in case of Surrender, in accordance with the terms and conditions of the Policy as mentioned in Part D.

62. **Waiting Period** means a period of 90 days starting from the Risk Commencement Date for the Member or from the date of Revival or date of Reinstatement of Insured Member's Insurance Coverage. No amount shall be payable in case of occurrence of covered Critical Illness Condition within the Waiting Period. Waiting Period shall not be applicable in case Critical Illness condition/(s) manifests due to an Accident. Waiting Period shall not be applicable for the Insured Member(s) whose Insurance Coverage is renewed with the Company before due date or Grace period, if any, provided who have already completed their Waiting Period fully. In cases where the Waiting Period is only partially exhausted at the time of renewal, the balance Waiting Period shall be applicable on the renewed Insurance Coverage.

63. **"We", "Us", "Our" "Ours", "Digit" "Digit Life" "Digit Life Insurance", "Insurer" and "Company"** refers to Go Digit Life Insurance Limited.

64. **"You", "Your", "Yours"** refers to the Master Policyholder named in Master Policy Schedule and Insured Member named in Certificate of Insurance (if applicable).

PART - C

Product Core Benefits (Benefits Payable Under This Policy)

1. Eligibility Criteria For An Insured Member

a) A person shall be eligible to become an Insured Member ("Eligible Member") if such person is:

i) above or equal to the minimum Age at Entry Date and below or equal to the maximum Age at Entry Date as specified in the Master Policy Schedule.

ii) Employees or contract staff or part time staff in case of Employer Employee (EE) groups.

iii) Where Master Policy is issued in lieu of Employee's Deposit Linked Insurance (EDLI) Scheme, such employee shall be eligible as long as his/her provident fund is deducted by the Master Policyholder under provident fund scheme. This point is only applicable to Employer Employee (EE) groups.

iv) The Person forms part of the specified Group having a clearly evident relationship between him/her and the Master Policyholder.

b) We will cover an Eligible Member from the Risk Commencement Date provided that:

i) We have received the Premium along with applicable taxes for such Eligible Member; and

ii) The Eligible Member satisfies underwriting criteria as per Our prevailing underwriting policy; and

iii) We have received all documentation in respect of that Eligible Member as required.

iv) The Eligible Member fulfils Eligibility Criteria as mentioned in Clause 1(a) above of this Part C.

2. Membership Provisions

a) An Eligible Member will become an Insured Member only when We or the Master Policyholder has entered the member's details into the Register of Insured Members and as per the provisions defined in the Scheme Rules (if applicable), subject to terms and conditions of this Policy.

b) Any Member shall have only one /single enrolment under the Master Policy.

c) Master Policyholder is responsible for providing the data on the Insured Members and for ensuring that it is accurate. Master Policyholder shall intimate Us of any change in the details of the Insured Members and addition of new member(s) and deletion of the Insured Member(s) in any month, within timelines as mentioned in the Scheme Rules.

d) Master Policyholder agrees to indemnify and hold Us harmless from and against any and all losses, costs, expenses, actions or proceedings suffered by Us in relation to any error or deficiency in or in respect of providing the data on Members.

e) We may seek additional information and/or documentation in respect of any Insured Member at any time. If the information and/or documentation for such Insured Member is not received by Us within timelines as mentioned in the Master Policy/ Scheme Rules, the name of the Insured Member shall be deemed to have been removed from the Register of Insured Members effective from the date of Our request of such information and/or documentation, and the Certificate of Insurance issued, if any, shall no longer be valid.

3. Insurance Coverage under Master Policy

a) We may provide Insurance Coverage to a person under this Master Policy who satisfies the eligibility criteria as provided in Clause 1 and 2 above in this Part C.

b) Every Member or Master Policyholder on behalf of Member shall produce evidence of insurability in the form and manner as prescribed by Us before effecting the Insurance Coverage on Member under this Master Policy or before effecting any change in the terms of Insurance Coverage extended including increase/decrease in Sum Assured, if any.

c) After the Master Policy Commencement Date or the Policy Renewal Date, an Eligible Member can become an Insured Member only after due intimation to Us and submission of all information and details in the form and manner specified by Us along with requisite Premium amount including applicable taxes.

d) Subject to terms and conditions of the Master Policy, Rules of Scheme and prevailing underwriting policy of Company, Insured Member will get the choice to opt from various options made available by the Master Policyholder under the Policy with respect to applicable Benefit options, Coverage Term, Premium Payment Term, Premium payment frequency, Sum Assured, other applicable options, if any.

e) The Company shall have the right to vary the terms and conditions of the Master Policy including the Premium payable for new Members or to discontinue adding new Members to/terminate the Master Policy, by giving a written notice of 30 days in advance. In case the Policy is terminated for any reason, the Company shall continue to cover the risk for lives of Members covered under the Policy till such termination subject to receipt of Premiums for the continuing Members as and when due.

4. Benefits: Subject to this Master Policy / Member's Insurance Coverage, as the case may be, being In-Force and all due Premiums have been received at the time of occurrence of insured event and other terms and conditions mentioned in this Master Policy Document, We agree to pay to the Claimant, the Death Benefit and any other additional Benefit depending upon the inbuilt optional Benefit chosen and as specified in the Master Policy Schedule/Certificate of Insurance/Register of Insured Members. Maximum Sum Assured (and Income Benefit, if chosen, in case of Death Benefit) allowed for each Member

under Death Benefit or each of the Inbuilt Optional Benefits (if any) shall be subject to prevailing underwriting policy of the Company.

4.1 Death Benefits & Death Benefit Payout Options: Death Benefit is the compulsory Benefit under this Master Policy and shall be payable in case of death of the Insured Member. Any one or combination of the following payout options can be chosen under Death Benefit subject to acceptance by the Company.

a) Lumpsum Sum Assured *:* Under this option (if chosen), a lumpsum amount shall be payable following death of Insured Member.

b) Regular Income till the retirement Age of Insured Member : Under this option (if chosen), regular income shall be payable following date of Insured Member's death till his/her retirement age as specified in Master Policy Schedule / Certificate of Insurance / Register of Insured Members.

c) Regular Income linked to the age of Insured Members' child/children: Under this option (if chosen), regular income shall be payable following date of Insured Member's death till attainment of certain age (not exceeding 25 years as on last birthday) by his/her child/children.

d) Regular Income for a specified period : Under this option (if chosen), regular income shall be payable following date of Insured Member's death till the end of chosen number of years (but not exceeding 40 years).

Regular Income chosen can be level or increasing with income increasing at specified simple rate of up to 10% per annum. Any one of Annual, half-yearly, quarterly or monthly mode can be chosen to receive the regular income pay-outs. Option to choose Income Benefit is available in case of Death Benefit only.

In case of any of the regular income options mentioned above, for presentation purpose, Sum Assured shall be defined as the total income payable in the next 12 months following the death of Insured Member.

The Death Benefit amount payable on death for an Insured Member shall be the chosen lumpsum Sum Assured and / or regular income as per the options chosen for that Member. Insured Members of the same Master Policy can have different lumpsum Sum Assured amount and regular income amount. The lumpsum Sum Assured and / or regular income amount for each individual Insured Member will be specified at Risk Commencement Date or the Policy Renewal Date. Any changes in the lumpsum Sum Assured or regular income amount during the Policy Term will be as per the Master Policyholder's request and subject to Our acceptance.

On death of Insured Member

In the event of death of the Insured Member during the Member Coverage Term, and provided that the Master Policy/ Insurance Coverage to the Member under this Policy is In Force as on the date of death of the Member, Death Benefit as lumpsum Sum Assured or as regular income or as combination of lumpsum Sum Assured and regular income as chosen and as specified in the Certificate of Insurance or Register of Insured Members or any endorsement issued from time to time, shall be payable to the Claimant.

On payment of the Death Benefit, the Insurance Coverage for such Member for all the Benefits, including inbuilt optional Benefits (if any) under this Master Policy shall immediately and automatically terminate.

We shall not pay the Death Benefit when the Master Policy / Insurance Coverage to the Member is in Lapsed Status.

4.2 In-built Optional Benefits

The Master Policyholder can choose one or more of the following in-built optional Benefit before Master Policy Commencement Date or Policy Renewal Date subject to Our acceptance and Members can choose from the such available inbuilt optional Benefits under the Master Policy, subject to prevailing underwriting policy of the Company and terms and conditions of this Policy. For inbuilt optional Benefits, only lumpsum sum assured shall be available. Option to choose Income Benefit is available in case of Death Benefit only.

In case the Insured Member has to pay the Premiums for the in-built optional Benefits chosen by the Master Policyholder, he/she has the option to not opt for the same.

The Certificate of Insurance/Register of Insured Members will specify the in-built optional Benefits chosen under the Master Policy in respect of the Insured Member. Once opted, the in-built optional Benefit/(s) can only be changed at subsequent Policy Renewal Date subject to Our prevailing underwriting policy.

4.2.1 Additional Accidental Death Benefit (Additional ADB):

In the event of death of the Insured Member due to an Accident, provided that the Accident has occurred during the Member Coverage Term and Master Policy / Insurance Coverage of such Insured Member is In Force, in addition to the Death Benefit, the Accidental Death Benefit Sum Assured as specified in the Certificate ofInsurance or Register of Insured Members shall be payable in lumpsum. A claim under this Benefit Option shall be admitted provided that the death:

i. is caused by Injury resulting from an Accident,

ii. occurs solely and directly due to the Injury, and independent of any other causes,

iii. occurs within 180 days of the occurrence of Accident and

iv. is not a result from any of the causes listed in the exclusions for Accidental Death Benefit specified in Annexure IV.

In case, the Accident occurs while the Insured Member's Additional ADB Insurance Coverage is In-force, but the Accidental Death occurs after the end of the Member Coverage Term and within 180 days of the Accident, Additional ADB Sum Assured applicable at the time of such Accident shall be payable.

We shall be liable to pay this Benefit in following conditions as well
a. Disappearance, as defined in Part B of this Policy.
b. Drowning as defined in Part B of this Policy

For both (a) and (b) above, We will only pay, when the Claimant provides a legally binding indemnity bond or any other document as required by Us which guarantees, that, if at any time, after the payment of the additional Accidental Death Benefit, it is discovered that the Insured Member is still alive, all payments shall be repaid in full to Us.
On payment of the additional Accidental Death Benefit, the Insurance Coverage for such Member for all the Benefits, including inbuilt optional Benefits (if any) under this Master Policy shall immediately and automatically terminate.
We shall not pay the additional Accidental Death Benefit when the Master Policy / Member's Insurance Coverage is in Lapsed Status.

4.2.2 Additional Accidental Total and Permanent Disability (ATPD) Benefit

Subject to the Policy / Insurance Coverage for the Insured Member being In Force and applicable exclusions specified in Annexure V and other terms and conditions of this Master Policy, ATPD Sum Assured which is in addition to Death Benefit and other in-built optional Benefits (if any) and as specified in the Certificate of Insurance/Register of Insured Members, shall be payable as lump sum upon occurrence of Accidental Total & Permanent Disability due to an Accident where such Accident happens while the Insured Member's ATPD Insurance Coverage is In Force.

In case, the Accident occurs while the Insured Member's Additional Accidental Total and Permanent Disability Benefit Insurance Coverage is In-Force, but the Accidental Total and Permanent Disability (ATPD) occurs after the end of the Member Coverage Term and within 180 days of the Accident, additional ATPD Sum Assured applicable at the time of such Accident shall be payable.
We shall not pay the Additional ATPD Benefit when the Master Policy/Insurance Coverage to the Member is in Lapsed Status.
On payment of the additional ATPD Benefit, Member's Insurance Coverage for this Benefit under Master Policy terminates, however, Member's Insurance Coverage under this Master Policy shall continue for In Force Death Benefit and other In Force in-built optional Benefits (if any) for the remaining of the Member Coverage Term .

4.2.3 Accelerated Terminal Illness Benefit (Accelerated TI Benefit)

Subject to the terms and conditions of this Policy, TI Sum Assured as specified in the Certificate of Insurance/Register of Insured Members shall be payable as lump sum upon the occurrence of Terminal Illness condition in respect of the Insured Member, where such an occurrence happens while the Insured Member's TI Insurance Coverage is In Force.

TI Benefit is an Accelerated Benefit, which means payment of this Benefit shall not be in addition to lumpsum Death Benefit chosen and it only facilitates an earlier payment of lumpsum Death Benefit on prior occurrence of the Terminal Illness. Accelerated TI Benefit can be opted for when lumpsum Sum Assured under Death Benefit is chosen (either standalone or in combination with any of the regular income benefit options). It is payable only once during the life time of the Insured Member and shall not exceed lumpsum Sum Assured under Death Benefit.

Where the TI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and Income Benefit option is not chosen additionally, the Insurance Coverage for all the Benefits, including inbuilt optional Benefits (if any) in respect of the Insured Member shall terminate immediately upon diagnosis of Terminal Illness and payment of accelerated TI Benefit. However, if in such case, Income Benefit is also chosen additionally, Insurance Coverage with respect to Accelerated Terminal Illness Benefit, lumpsum Sum Assured under Death Benefit and other inbuilt optional Benefits shall terminate, whereas Insurance Coverage with respect to only Income Benefit under Death Benefit shall continue for the remaining of Member Coverage Term.

Where the TI Sum Assured is less than the lumpsum Sum Assured under Death Benefit, on payment of the TI Sum Assured, the lumpsum Sum Assured under Death Benefit will be reduced to the extent of the TI Sum Assured paid and this change shall be effective from the date of payment of accelerated TI Benefit. On payment of the accelerated TI Benefit, the Insurance Coverage for such Member in respect of other inbuilt optional Benefits (if any) under this Master Policy shall immediately and automatically terminate.

We shall not pay the accelerated TI Sum Assured when the Master Policy / Insurance Coverage to the Member is in Lapsed Status.

The Terminal Illness must be diagnosed and confirmed by Medical Practitioners. We reserve the right for an independent assessment by two different Medical Practitioners other than the Medical Practitioner whose diagnosis has been provided by the Insured Member.

4.2.4 Critical Illness Benefit (CI Benefit)

Subject to Waiting Period, Survival Period, applicable exclusions referred under Critical Illness Condition in Part B and Annexure VI of this Master Policy and the other terms and conditions of this Policy , CI Sum Assured as specified in the Certificate of Insurance/Register of Insured Members shall be payable as lumpsum upon the occurrence of covered Critical Illness Condition in respect of the Insured Member, where such an occurrence happens while the Insured Member's CI Insurance Coverage is In Force.

We shall not pay the CI Sum Assured when the Master Policy / Insurance Coverage to the Member is in Lapsed Status.
The CI Benefit can be either chosen as additional Benefit to the Death Benefit or as an accelerated Benefit by the Member before Risk Commencement Date.

If CI Benefit is chosen as Additional CI Benefit - On admission of a claim under the Additional CI Benefit, the CI Sum Assured shall be payable to the Claimant. On payment of additional CI Benefit, Member's Insurance Coverage for this Benefit under the Master Policy shall terminate, however Member's Insurance Coverage shall continue in respect of In Force Death Benefit and other In Force in-built optional Benefits (if any) for the remaining of the Member Coverage Term.

If CI Benefit is chosen as Accelerated CI Benefit – Accelerated Benefit means payment of this Benefit shall not be in addition to lumpsum Death Benefit chosen and it only facilitates an earlier payment of lumpsum Death Benefit on prior occurrence of the Critical Illness. Accelerated CI Benefit can be opted for when lumpsum Sum Assured under Death Benefit (either standalone or in combination with any of the regular income benefit options) is chosen and shall not exceed lumpsum Sum Assured under Death Benefit. On admission of claim under the accelerated CI Benefit:
Where the CI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and Income Benefit option under Death Benefit is not chosen additionally, the Insurance Coverage for the all Benefits, including in-built optional Benefits (if any) in respect of the Insured Member shall cease immediately upon diagnosis of Critical Illness and payment of CI Benefit. However, if in such case, Income Benefit option is also chosen additionally, then Insurance Coverage with respect to Accelerated CI Benefit and lumpsum Sum Assured under Death Benefit shall terminate, whereas the Insurance Coverage for Income Benefit option under Death Benefit and other inbuilt optional Benefits, if any, shall continue for remaining of Member Coverage Term.
Where the CI Sum Assured is less than the lumpsum Sum Assured under Death Benefit, on payment of the CI Sum Assured, the lumpsum Sum Assured under the Death Benefit will be reduced to the extent of the CI Sum Assured payable, and such change in the lumpsum Sum Assured under Death Benefit shall be effective from the date of the payment of the accelerated Critical Illness Benefit. Such Member's Insurance Coverage under this Policy in respect of other In Force inbuilt optional Benefits (if any) shall continue for the remaining of the Member Coverage Term.
The claim for Critical illness Benefit shall be accepted only if covered Critical Illness condition has happened to Insured Member for the first time in life and is not a consequence of or arising out of any Pre-existing Condition/disease.

Once a claim has been accepted under Critical Illness Benefit, Insurance Coverage for the Insured Member under this Policy with respect to CI Benefit shall cease and no further payment will be made for any consequent Critical Illness disease or any dependent Critical Illness/Illnesses.

Critical Illnesses (CI) Variants: There are three CI variants offered under this CI Benefit and only one of them can be chosen by the Member before Risk Commencement Date, subject to terms and conditions of this Master Policy.

Variant 1 (14 Critical Illnesses)
Variant 2 (20 Critical Illnesses)
Variant 3 (34 Critical Illnesses)

Following is the list of Critical Illnesses /Surgical procedures covered under these three variants.

Sr. No	Category	Critical Illness	Variant 1	Variant 2	Variant 3
1	**Cancer**	Cancer of Specified Severity	Covered	Covered	Covered
2	**Cardiovascular system**	Myocardial Infarction	Covered	Covered	Covered
3		Open Heart Replacement or Repair of Heart Valves	Covered	Covered	Covered
4		Surgery to Aorta	Covered	Covered	Covered
5		Primary (Idiopathic) Pulmonary Hypertension	Not Covered	Covered	Covered
6		Aneurysm of Abdominal Aorta	Not Covered	Not Covered	Covered

7		Cardiomyopathy	Not Covered	Not Covered	Covered
8		Pulmonary artery graft surgery	Not Covered	Not Covered	Covered
9		Open Chest CABG	Covered	Covered	Covered
10	Major Organ Transplant	End Stage Lung Failure	Covered	Covered	Covered
11		End Stage Liver Failure	Covered	Covered	Covered
12		Kidney Failure Requiring Regular Dialysis	Covered	Covered	Covered
13		Major Organ/ Bone Marrow Transplant	Covered	Covered	Covered
14	Nervous System	Apallic Syndrome	Not Covered	Covered	Covered
15		Benign Brain Tumour	Covered	Covered	Covered
16		Coma of Specified Severity	Covered	Covered	Covered
17		Major Head Trauma	Covered	Covered	Covered
18		Permanent Paralysis of Limbs	Covered	Covered	Covered
19		Stroke Resulting in Permanent Symptoms	Not Covered	Covered	Covered
20		Motor Neurone Disease with Permanent Symptoms	Not Covered	Covered	Covered
21		Parkinson's Disease	Not Covered	Not Covered	Covered
22		Muscular Dystrophy	Not Covered	Not Covered	Covered
23		Progressive Supranuclear Palsy	Not Covered	Not Covered	Covered
24		Creutzfeldt-Jakob disease (CJD)	Not Covered	Not Covered	Covered
25		Bacterial Meningitis	Not Covered	Not Covered	Covered
26		Alzheimer's disease	Not Covered	Not Covered	Covered
27		Encephalitis	Not Covered	Not Covered	Covered
28		Multiple Sclerosis with Persisting Symptoms	Covered	Covered	Covered
29	Others	Loss of Independent Existence	Not Covered	Covered	Covered
30		Systemic lupus erythematosus	Not Covered	Not Covered	Covered
31		Goodpasture's syndrome	Not Covered	Not Covered	Covered
32		Fulminant Viral Hepatitis	Not Covered	Not Covered	Covered
33		Pneumonectomy	Not Covered	Not Covered	Covered
34		Aplastic Anaemia	Not Covered	Covered	Covered

4.3 Other Add-on Benefits

4.3.1 Spouse cover: Under this Policy, Insurance Coverage can be offered to the spouses of respective Members, if this option is chosen by the Master Policyholder, subject to the submission of the evidence of insurability and evidence of health to Us, as per Our underwriting policy and upon payment of an additional Premium for such Insurance Coverage to Us. The Insurance Coverage on the life of a Member's spouse will be subject to and will be governed by all the terms and conditions of this Policy. The Insurance Coverage on the life of a Member's spouse will terminate in accordance with the terms of the Master Policy.

4.3.2 Voluntary Insurance Coverage: The Member has an option to choose for voluntary Insurance Coverage provided Master Policyholder has chosen this option, subject to following conditions:

i. A written request submitted by You to Us along with the evidence of insurability and evidence of health to Us as per Our prevailing underwriting policy and on payment of an additional Premium.

ii. Maximum Sum Assured allowed shall be as per prevailing underwriting policy of the Company

iii. The premium rate applicable for Sum Assured under this Voluntary Insurance Coverage shall be independently derived based on the expected risk profile and take-up rates.

Some of the coverages where this option could be utilized, including but not limited to cover the following:

i. Coverage towards Credit card outstanding

ii. Coverage for Funeral expenses

iii. Coverage for Child education

4.3.3 Profit Sharing Option: If the Master Policy Schedule specifies that profit sharing option has been availed by the Master Policy Holder then the Master Policy Holder shall be entitled to profit sharing Benefit where in in case of favourable claims experience, the Master Policyholder would be refunded back a part of the Premium depending on the formula mutually

agreed between Master Policyholder and the Company for the same. Any profit sharing arrangement shall be as prescribed by IRDAI Circular No. IRDAI/ACTL/CIR/PRO/207/10/2022 dated 4th October 2022, as amended from time to time.

4.3.4 Risk Sharing and Risk Capping

This option provides for the coverage of risk beyond certain limit at Master Policy or Member level, subject to prevailing underwriting policy of the Company. Following options under this are available at Master Policy and Member level:

Options at Member Level:

Proportional sharing: The Master Policyholder can choose the option to insure a certain percentage (lesser than 100%) of applicable Benefits for each Member where the Insurance Coverage / claim liability for Us will be limited to the opted percentage of Benefits / claims for each Member.

Excess level sharing: The Master Policyholder can choose the option to insure the Benefits above certain threshold level for each applicable Member where the Insurance Coverage / claim liability for Us will be the amount of Benefits / claims in excess of the opted threshold limit for each applicable Member.

Options at Master Policy Level:

Proportional sharing: The Master Policyholder can choose the option to insure a certain percentage (lesser than 100%) of applicable Benefits capped to maximum limit at Master Policy level, applicable for the entire group where the Insurance Coverage / claim liability for Us towards the group will be limited to the opted percentage of Benefits / claims at the concerned group level.

Excess level sharing: The Master Policyholder can choose the option to insure the Benefits above certain threshold level capped to maximum limit at Master Policy level, where the Insurance Coverage / claim liability for Us will be the amount in excess of the opted threshold limit at the concerned group level.

If any of the options at Master Policy level is chosen, any Benefit payable will further be subject to the arrangement agreed at Master Policy level.

4.3.5 Sum Assured Reset Benefit: Provided the Insurance Coverage for the Insured Member is In Force, the lumpsum Sum Assured or regular income amount under Death Benefit for each Insured Member can be increased or decreased during the Policy Term, subject to prevailing underwriting policy. The pro-rated excess Premium will be payable by or payable to the Master Policyholder, as the case may be.

4.3.6 Change of Policy Renewal date: The Master Policyholder shall have the option to modify the Policy Renewal Date at any time during the Policy Term. Premium applicable from the modified Policy Renewal Date will be calculated based on the latest data provided, adjusting for the Premium for the unexpired period up to the original Policy Renewal Date on a pro-rata basis.

The option to choose Spouse cover and Voluntary Insurance Coverage will not be available for Policy issued in lieu of Employee's Deposit Linked Insurance.

4.4 Other Benefits

a) **Wellness Benefit Program:** This program intends to incentivize the Insured Member for taking care of his/her health/fitness and maintaining healthy lifestyle through such preventative and wellness services. The applicability of the Wellness Benefit program and its features may be amended from time to time as per the prevailing underwriting policy of the Company. The list of Benefits under this program and terms and conditions applicable to it are provided in Annexure VII.

4.5 Survival/Paid-up/Maturity Benefits: There is no survival/paid-up/maturity Benefit payable under this Master Policy.

5. Premium under this Master Policy: The Master Policyholder/Member, as the case may be, shall ensure that all due Premiums as calculated by the Company are paid in full, on each instalment Premium due date as per the In-Force Premium paying frequency or on Master Policy Commencement Date or Policy Renewal Date, as applicable. The Master Policyholder shall pay the Premium for new Members as per the Premium paying frequency selected on Processing Date or shall keep an advance deposit with Us.

In case, Insurance Coverage under any of the inbuilt optional Benefits ceases before the completion of Member Coverage Term, while Member's Insurance Coverage for Death Benefit and other inbuilt optional Benefits (if any) is still In-Force, no further Premium shall be payable for the remaining Premium Payment Term, if any, for inbuilt optional Benefit/(s) which have been terminated.

For Premium payment frequency other than annual, instalment Premiums paid are calculated by applying the loading factor as given below on annual premium:

Premium paying frequency	Loading factor
Semi-annual	2%

Quarterly	3%
Monthly	4%

Subject to the Policy discontinuance and Revival or Reinstatement provisions, We must receive all due Premiums in order for the Insurance Coverage with respect to a Insured Member to remain In Force.

The Insurance Coverage for the Members in respect of whom the Premium has been so calculated would commence on receipt of the full Premium respect of such Members and on acceptance of risk on underwriting, if any, by Us.

6. Grace Period (applies to Master Policyholder and Insured Member)

In the event where the Master Policyholder or Insured Member (as applicable) fails to pay the due Premium on the instalment Premium due date, We will allow a Grace Period to pay the due Premium while continuing the applicable Insurance Coverage and Benefits under it. After the expiry of the Grace Period without receipt of the Premium in full, the Benefits under Master Policy/Insurance Coverage for the respective Insured Member(s), as the case may be, shall lapse and all Our liability shall immediately and automatically cease. A Grace Period of 15 days in respect of monthly Premium payment frequency and 30 days in other applicable frequencies from the instalment Premium Due Date shall be provided for one year renewable term (except for annual premium payment frequency in one year renewable term in which Grace Period shall not be applicable) and Regular Pay Policy for paying overdue Premium to Us without any penalty/late fee during which Death Benefit and all the chosen inbuilt optional Benefits under Master Policy/Insurance Coverage of Insured Member will be considered to be In Force with the risk cover without any interruption as per the terms of the Master Policy.

If the contingent event of Death/ Terminal Illness/ Critical Illness/ ADB/ ATPD or any other event, if it is covered under this Policy (and as applicable to Member) occurs during the Grace Period, Benefits as applicable shall be payable as mentioned under Part C subject to receipt of unpaid Premium for Master Policy, where Premium is paid by the Master Policyholder. However, in a Policy, where Premium is paid by the Member, the applicable Benefit shall be payable subject to deduction of unpaid due Premium for the respective Member. In case the Premium which was due with respect of any Insured Member, is collected by the Master Policyholder within Grace period but is not remitted to Us for some reason, then the Insurance Coverage for such Insured Member will continue even on expiry of Grace period, provided Member has the receipt of payment of such Premium to the Master Policyholder within Grace Period. The Company reserves the right to recover such Premium from the Master Policyholder.

PART - D
Policy Servicing Related Aspects

1. **Free Look Provisions:**
   a) **At Master Policy Level**: If You do not agree with the terms and conditions of the Master Policy, You have the option to request for cancellation of the Master Policy by returning the original Master Policy Document along with a written request stating the reasons for objection to Us within 15 days (30 days in case the Policy is sourced through distance marketing# mode) from the date of receipt of Master Policy. Upon the receipt of such a cancellation request, the Company will cancel the Master Policy and refund the Premiums received after deducting proportionate risk premium for the period of Insurance Coverage and expenses incurred on medical examination of Members, if any and applicable stamp duty. All Insured Members' Insurance Coverage and Benefits under it will cease post the request for free look cancellation by the Master Policyholder.

   b) **At Member Level:** If the Insured Member does not agree with the terms and conditions specified in Certificate of Insurance, he/she has the option of returning the Certificate of Insurance (if applicable) to the Company stating the reasons thereof, within 15 days (30 days in case the Policy is sourced through distance marketing# mode) from the date of receipt of the Certificate of Insurance. Upon receipt of the free look cancellation request and Certificate of Insurance (if applicable), we shall refund the Premium received in respect of insured Member, subject to deduction of the proportionate risk premium for the period of Insurance Coverage, expenses incurred on medical examination of such Member, if any and applicable stamp duty for that Insured Member. The Insurance Coverage for the Insured Member will cease post the request for such free look cancellation.

For Administrative purposes, all free-look requests should be registered by the Master policyholder on behalf of the Insured Member.

#Distance Marketing includes every activity of solicitation (including lead generation) and sale of insurance products through the following modes: (i) voice mode, which includes telephone-calling (ii) short messaging service (SMS) (iii) electronic mode which includes e-mail, internet and interactive television (DTH) (iv) physical mode which includes direct postal mail and newspaper and magazine inserts and (v) solicitation through any means of communication other than in person.

2. **Revival and Reinstatement**
   a) **Revival:** If the due Premium is not received by the end of the Grace Period, the Policy / Member's Insurance Coverage shall lapse. The Company will consider requests to revive Policies / Member's Insurance Coverage in Lapsed Status from the date of first unpaid Premium, provided such requests are received within the original Policy Term / Member Coverage Term, as applicable. Any agreement to revive the Policy/ Member's Insurance Coverage would be subject to the Our prevailing underwriting policy. The Company shall collect all the Premiums due and other charges or late fee if any, as per the terms and conditions of the Policy, to revive the lapsed Master Policy / Member's Insurance Coverage, as the case may be.
   The late fees shall be calculated at such interest rate as may be prevailing at the time of the payment. The Revival interest rate compounding annually, will be set using prevailing interest rates. The prevailing interest rates will be derived from yields of the 30 years G-Sec security. Any change in the interest rate used will be in accordance with the formula below:.
   Annualized Yield on reference government bond + 100 basis points, rounded up to the nearest 25 basis points.
   The Revival interest rate for the financial year 2023-24 is 8.25% p.a.
   The Revival interest rate will be reviewed semi-annually and shall be revised using the above-mentioned formula and the change in the rate shall be effective from 25th February and 25th August each year.
   Any change on basis of determination of interest rate for revival can be done only after prior approval of the Authority.

   b) **Reinstatement -** If the due Premium is not received by the end of the Grace Period, the Policy shall lapse. The Lapsed Policy could then be reinstated and the Insurance Coverage will recommence from the date of Reinstatement and the Premium will be collected accordingly. The Company shall not collect any unpaid Premiums on Reinstatement, nor shall be liable to pay the claims occurring during the period for which the Master Policy is in Lapsed Status. In certain circumstances, the Company may also change certain terms of the Policy including the pricing. Such Reinstatement shall be as per the prevailing underwriting policy of the Company.

3. **Surrender Provisions:** In case of Surrender of the Master Policy by the Master Policyholder, the Members shall have an option to continue the Insurance Coverage till the end of the Member Coverage Term. Such Insurance Coverage with the applicable Benefits shall continue with the same terms and conditions as the original Insurance Coverage with respect to such Members under Master Policy and Company/ intermediary, if any, shall continue to be responsible to serve such Members till their Insurance Coverage is terminated. Unexpired Risk Premium Value (Surrender Value) for the such Members opting to continue the Insurance Coverage shall not be paid out.

   Following Unexpired Risk Premium Value (Surrender Value) shall be payable on Surrender:

Single Pay	In case of Surrender of the Master Policy or Member's Insurance Coverage where Premiums are paid by Member, an amount equal to 60% of the Single Premium adjusted for the unexpired duration of the Policy Term or Member Coverage Term of the discontinuing Members, as applicable, would be payable. In case of Surrender by Members for schemes where Premiums are paid by the Master Policyholder, an amount equal to the Single Premium adjusted for the unexpired duration of the Member Coverage Term of the discontinuing Member would be payable to the Master Policyholder.
One Year Renewable Term	In case of Surrender of the Master Policy, an amount equal to the instalment Premium for the unexpired Member Coverage Term of the discontinuing Members, less appropriate deduction for expenses, stamp duty paid, commission and taxes and levies as applicable shall be be payable. In case of Surrender by Members for schemes where Premiums are paid by the Master Policyholder, an amount equal to the instalment Premium for the unexpired duration of the Member Coverage Term for which the Instalment premium was applicable, in respect of the discontinuing Members, shall be payable to the Master Policyholder, who typically adjusts it against any Premiums payable.
Regular Pay	In case of Surrender of the Master Policy or Member's Insurance Coverage where Premiums are paid by Member, an amount equal to 60% of the instalment Premium adjusted for the unexpired duration of the Policy Term or Member Coverage Term, as the case may be, for which the instalment Premium was applicable in respect to discontinuing Members shall be payable. In case of Surrender by Members, for schemes where Premiums are paid by the Master Policyholder, an amount equal to the instalment Premium adjusted for the unexpired duration of Member Coverage Term for which the instalment Premium was applicable in respect of the discontinuing Members, shall be payable to the Master Policyholder, who typically adjusts it against any Premiums payable.

4. **Policy Loan:** This Policy does not offer loan facility.

5. **Addition of Member:** The Master Policyholder can choose to add new Members by paying the Premium for the Member Coverage Term for such Member. The Master Policyholder should inform or intimate the Company with the list of new joiners preferably within 45 days from the date of new joiners becoming eligible to be admitted under this Master Policy. The Risk Commencement Date for the new joiners shall be the date of joining of the Eligible Member or the date of intimation to Us, whichever is earlier. The Company shall communicate its decision on addition of Eligible Member based on its then prevailing underwriting policy. In case of inadequate Premium, the Insurance Coverage will begin from the date of receipt of the full Premium. Premium shall be deposited in advance for addition of new Members. The Premium charged shall be proportionate to the unexpired duration of the Policy Term / Policy Year, as applicable. Any applicable levies, taxes, duties or surcharges will also be charged. We will have right to discontinue addition of new Members by giving a notice of 30 days to Master Policyholder of this effect.

6. **Deletion of Member:** In case a Member leaves the scheme during the Member Coverage Term (due to reasons other than death), where Master Policyholder has paid the Premium, the Company will refund the pro-rata Premium to the Master Policyholder. The Master Policyholder should inform the Company of deletions for Members leaving the scheme. Such Members' Insurance Coverage will cease from the date of leaving the scheme. Member who has paid the Premium for his/her Insurance Coverage leaves the scheme, such Member shall continue his/her Insurance Coverage as per original terms and conditions of the Master Policy unless such Member informs the Company about discontinuance of the Insurance Coverage.

7. **Payment of Benefits** All Benefits and other sums specified under this Master Policy / Certificate of Insurance/ Register of Insured Members shall be payable in the manner and currency allowed/permitted under the Regulations and shall be payable by NEFT, account payee cheque or other permissible modes. The Company shall pay the applicable Benefits and other sums payable under this Master Policy / Member's Insurance Coverage. Any discharge given by the Claimant, in writing in respect of the Benefits or the sums payable under this Master Policy / Member's Insurance Coverage, shall constitute a valid discharge to the Company in respect of such payment. The Company's liability under the Master Policy / Certificate of Insurance/Register of Insured Members shall be discharged by such payment.

a) Where the Master Policy is issued under Lender-Borrower category and Master Policyholder is one of the following entities:

i) RBI regulated Scheduled Commercial Banks (including Co-operative Banks);
ii) NBFCs having Certificate of Registration from RBI;
iii) National Housing Bank (NHB) regulated Housing Finance Companies
iv) National Minority Development Finance Corporation (NMDFC) and its State channelizing agencies
v) Small Finance Banks regulated by RBI
vi) Mutually Aided Cooperative Societies formed and registered under the applicable State Act concerning such Societies
vii) Microfinance companies registered under section 8 of the Companies Act, 2013
viii) Any other category as approved by the Authority., in accordance with IRDAI guidelines as amended from time to time,

the Insured Member may give Us a written authorization in the form specified by Us to make payment towards Insured Member's outstanding loan balance amount to the Master Policyholder from lumpsum Death Benefit and certain inbuilt optional Benefits (if any) payable on happening of respective insured events during Member Coverage Term under this Master Policy. This written authorization may be given to Us at the stage of Eligible Member's addition to the Master Policy as an Insured Member or at a later date. If We have received such written authorization from the Insured Member, then We will pay an amount to the extent of outstanding loan to the Master Policyholder from the lumpsum Death Benefit and from Additional ADB, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit (if any of these inbuilt optional Benefits are chosen by the Member) on occurrence of respective insured events, while Member's Insurance Coverage is In-Force and on providing documents as mentioned in Scheme Rules. The remainder of the lumpsum Death Benefit, Additional ADB, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any shall be payable to the Claimant other than the Master Policyholder. We shall, under no circumstance, pay any amount more than the outstanding loan to the Master Policyholder. In case, Benefits other than those mentioned above in this para under Clause 7 (a) of Part D, are chosen by the Member, 100% of such Benefits shall be paid directly to the Claimant other than the Master Policyholder. Where no such authorization is received by Us from the Insured Member or the Master Policyholder does not fall under the above-mentioned regulated entities, We will pay the entire lumpsum Death Benefit and Additional ADB, Accelerated Terminal Illness Benefit, Accelerated Critical Illness Benefit, if any, directly to the Claimant other than the Master Policyholder.

b) **Benefit on Foreclosure of loan** In case of lender-borrower group**,** in the event where the Insured Member(s) makes a prepayment for closure of the loan to the Master Policyholder or where the lender borrower relationship between an Insured Member and the Master Policyholder comes to an end prior to Coverage End Date (other than due to death of Member), the Insurance Coverage provided to the Insured Member shall continue till the occurrence of covered insured event/s or end of the Coverage Term, whichever is earlier, as per Sum Assured specified in the Certificate of Insurance, subject to the Master Policy being In-Force. The Insured Member has the option to terminate his/her Insurance Coverage at the time of foreclosure of loan by applying for Surrender and receive the (Unexpired Risk Premium Value) Surrender Value as per Clause 3 of this Part D.

8. Termination

a) **Termination of Master Policy:** This Master Policy will terminate on the occurrence of the earliest of the following events:

i) the date on which We receive a Freelook cancellation request; or
ii) if the Policy in Lapsed Status has not been revived / reinstated; or
iii) the date of payment of the Unexpired Risk Premium Value (Surrender Value) under the Policy; or
iv) on the expiry of the Policy Term or on Policy Renewal Date, unless not revived / reinstated subject to term and conditions of Policy.

This Master Policy may be terminated by either You or by Us, by giving 30 days prior written notice. Upon termination of this Policy, no new enrollment forms for the Eligible Members will be accepted by Us. You will not add any new Eligible Member in the Register of Insured Members, from the date of such termination.

b) **Termination of Member's Cover under this Master Policy:** An Insured Member's Insurance Coverage under the Policy shall terminate upon the occurrence of the earliest of the following:

i) the date on which We receive a Freelook cancellation request from the Insured Member (for Non Employer-Employee Group) or
ii) the date on which We receive a Freelook cancellation request from the Master Policyholder (in case of Employer-Employee group);
iii) the Insured Member ceases to be an Eligible Member;
iv) Coverage End Date;
v) on Policy End Date (if Policy is not renewed further)
vi) in case of the death of the Insured Member;
vii) On payment of Accelerated TI/ Accelerated CI Benefit, where such Benefit is equal to lumpsum Sum Assured under Death Benefit (and with no Income Benefit chosen under Death Benefit)

viii) on the date of payment of Unexpired Risk Premium Value (Surrender Value) on Member leaving the scheme before completion of Member Coverage Term;

ix) On expiry of Revival period for Member's Insurance Coverage in Lapsed Status

x) On Policy Renewal Date, if the Insured Member attains the Age more than maximum Age at entry allowed

9. **Loss of Master Policy & Issuance of duplicate Master Policy:** In the event, if the Master Policy Document is lost or destroyed, You may make a written request for a duplicate Master Policy, which We will issue duly endorsed to show that it is in place of the original document, provided that, We receive the fee not exceeding Rs. 250 for issuing the duplicate Master Policy Document. Upon the issue of a duplicate Master Policy Document,

a) the original one shall cease to have any legal force or effect.

b) You agree that You shall indemnify and hold Us free and harmless from and against any and all claims, losses, costs expenses, awards, judgements, demands or damages that may arise under or in relation to the original Master Policy document.

c) You will not be entitled to any free-look period cancellation on duplicate Master Policy document / Certificate of Insurance issued. However, we may permit free-look period cancellation in cases where after investigation, it is evident that You did not receive the original Master Policy document/Certificate of Insurance.

PART - E

All the Applicable Charges, Fund Name, Fund Options, etc. (Applicable especially for ULIP Policies)

1) Not Applicable as this is a non-linked product.

PART - F
General Terms and Conditions

1) **Fraud, Misstatement and forfeiture:** In case of fraud or misstatement or forfeiture, the Policy shall be treated in accordance with the provisions of Section 45 of the Insurance Act, 1938 as amended from time to time.

   [A Leaflet containing the simplified version of the provisions of Section 45 is enclosed as Annexure I for reference]

2) **Misstatement of Age:** Subject to Section 45 of the Insurance Act, 1938 as amended from time to time. The Age of the Insured Member has been admitted on the basis of the declaration made by the Insured Member in Membership Form or the details of the Insured Members submitted by Master Policyholder based on which this Policy has been issued. If the Age of the Insured Member is found to be different from that declared, the Company may adjust the Premiums and/or the Benefits under this Policy and/or recover the applicable balance amounts, if any, along with interest thereon, as it deems fit. Insurance Coverage of the Insured Member shall however become void from Risk Commencement Date and We may refund the Premium as per provisions of Section 45 of the Insurance Act ,1938 as amended from time to time if at any time the Age of the Insured Member is found to be higher than the maximum or lower than the minimum Entry Age that was permissible under this Master Policy at the time of Risk Commencement Date.

3) **Assignment:** Assignment should be in accordance with provisions of Section 38 of the Insurance Act 1938 as amended from time to time.

   [A Leaflet containing the simplified version of the provisions of Section 38 is enclosed as Annexure II for reference].

4) **Nomination:** Nomination should be in accordance with provisions of Section 39 of the Insurance Act 1938 as amended from time to time.

   [A Leaflet containing the simplified version of the provisions of Section 39 is enclosed as Annexure III for reference]

5) **Review, revision**: The Company reserves the right to review, revise, delete and/ or alter any of the terms and conditions of this Policy, including without limitation the Benefits, the Premiums with the prior approval of IRDAI.

6) **Taxes, duties and levies and disclosure of information:**

   Taxes, duties and levies: It shall be the sole responsibility of the Master Policyholder/Claimant/Insured Member to ensure compliance with all applicable laws including Regulations, taxation laws, and payment of all applicable taxes in respect of the Premiums and Death Benefits or other payouts made or received by the Master Policyholder/Claimant under this Master Policy and the Company does not accept any liability or responsibility in this regard. Except as may be specifically required by the Regulations, the Company shall not be responsible for any tax liability arising in relation to this Master Policy, the Premiums payable or the Death Benefits or other payouts made in terms of this Master Policy.The Company shall be entitled to deduct such amounts towards taxes, duties or such other levies as may be required from any sum received by it or payable under this Master Policy, and deposit the amount so deducted with the appropriate government or regulatory authorities. Master Policyholder/Claimant/Insured Member acknowledge that they are solely responsible for understanding and complying with their respective tax obligations (including but not limited to,tax payment or filing of returns or other required documentation relating to the payment of all relevant taxes in all jurisdictions in which Your tax obligations arise and relating to the Services provided by Us.
   We do not provide any tax advice. Master Policyholder/Claimant/Insured Member is advised to seek independent legal and/or tax advice. We have no responsibility in respect of Master Policyholder/Claimant's/Insured Member tax obligations in any jurisdiction including but not limited to those that relate specifically to the Services provided by Us. Tax benefits, if any, may be available as per extant tax laws.

7) **Notice by the Company under the Policy:** We will send you the Master Policy Document in accordance with the applicable laws. We will send the communication or notices to You either in physical at Your registered address or in electronic mode (including sms) at registered e-mail id or registered mobile number and / or through facsimile provided by You in Proposal Form/Membership Form or otherwise notified to Us, or by issuing general notice, including by publishing such notices in newspapers and / or on Company's website. Any change in the registered address /email or registered mobile number of Master Policyholder/Insured Member or Claimant must be notified to Us immediately. This will help Us to serve You better.

8) **Electronic Transactions:** All transactions carried out by the Master Policyholder through Internet, electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication will be valid and legally binding on the Master Policyholder / Insured Member / Claimants as well as the Company. This will be subject to the relevant guidelines and terms and conditions as may be made applicable by the Company.

9) **Governing Law and Jurisdiction:** This Policy shall be governed by and interpreted in accordance with the laws of India. All actions, suits and proceedings under this Policy shall be subject to the exclusive jurisdiction of the courts in India.

10) **Recovery:** We reserve the right to recover the amount from the Master Policyholder or the Insured Member or Claimant or any other person, if it is found that the Benefits are erroneously paid due to the fault of the Master Policyholder or the Insured Member or the Claimant. However, the Master Policyholder will not be liable or responsible for any wrong payments made by the Company without any fault on the part of the Master Policyholder, however the Company shall be entitled to recover the amount paid erroneously from the Insured Member or any other person deriving the Benefit of the said error.

11) **Policy Currency:** All Contributions/Premiums and Benefits payable shall be paid in Indian Rupees only.

12) **Suicide Exclusion:**

a) In case of schemes, where the Insurance Coverage is compulsory, suicide exclusion will not be applicable.

b) In case of schemes other than those mentioned in Clause 12 (a) of this Part, under which Eligible Members are covered on a voluntary basis and where the suicide exclusion clause is applicable, if the Insured Member commits suicide, whether sane or insane, within 12 (Twelve) months of continuous Insurance Coverage from the Risk Commencement Date or date of Revival or date of Reinstatement, as the case may be, the Claimant shall be entitled to get at least 80% of the total premiums paid till the date of death or the (Unexpired Risk Premium Value) surrender value available as on the date of death whichever is higher, provided the Policy or Member's Insurance Coverage, as applicable, is In-Force. Suicide exclusion shall not be applicable after 12 months from continuous Insurance Coverage from the Risk Commencement Date or from the date of Revival or date of Reinstatement of Insurance Coverage with respect to Insured Member, while the Master Policy/Insured Member's Insurance Coverage is In Force.

13) **Audit:**

a) In compliance with the Regulatory requirement prescribed under IRDAI Circular dated 26/09/2019 in regard to Circular on Group Life Insurance Products and other operational matters, the Company may cause the Master Policyholder to annually audit and provide Auditor Certificate for below as may be applicable**:**

i. In regard to the accuracy of the Credit account statements of the Insured Members in respect of which claims were settled on the completion of every financial year in respect of outstanding loan balance being shown in the credit account statement/claim discharge form being correct and if required the Company can conduct the Audit itself.

ii. In regard to the books and records of the Non-Employee-Employer Master Policyholders confirming compliance with this Circular

If required, the Company may carry out on its own such inspection/audit directly or through its identified auditors.

14) **Requirements for claims /Claim Procedure:** In order to register a claim under the Master Policy, the Claimant shall endeavor to inform Us in writing with the following documents (as applicable) along with Bank account details (Cancelled Cheque/copy of pass book with IFSC code) of the Claimant:

a) For Death Claim:

i) Duly completed Claim Form signed by Claimant.
ii) KYC document of Insured Member and Claimant
iii) Appraisal/Promotion Letter in case of Sum assured revision during Member Coverage Term
iv) In case of mid-term addition, Offer Letter or Appointment Letter
v) Attested copy of Death Certificate of the Insured Member issued by Indian Government Authority.
vi) Medical treatment records (discharge summary / death summary, investigation and treatment reports, postmortem report, etc) if Insured Member has taken treatment for illness leading to his/her death.

b) In case of Additional Accidental Death Benefit claim, following documents need to be submitted in addition to above requested documents:

i) Police Records – Attested copy of First Information Report, Panchnama / Inquest Panchnama
ii) Newspaper cutting/Photograph of the accident, in case of Accidental Deaths.
iii) Attested Copy of Post Mortem Report (Only if conducted).
iv) Attested Copy of Viscera report if any (Only if Post Mortem is conducted)

c) **For Accelerated Terminal Illness Benefit claim:**

i) Duly completed Claim Form signed by Claimant.
ii) Medical Report(s) including Investigation report(s), indoor case papers, Hospital Summary/Discharge Card
iii) Medical Practitioner's Certificate confirming the Illness/Treatment advise/Medical Reference
iv) KYC document of Claimant

d) **For Critical Illness Benefit claim:**
   i) Duly completed Claim Form signed by Claimant.
   ii) Medical Report(s)(current and past) including Investigation test(s), treatment report(s) and indoor case papers
   iii) Hospital Summary/Discharge Card
   iv) Medical Practitioner's Certificate confirming the current health status (Details of diagnosed Illness/Treatment advise)
   v) KYC document of Claimant

e) Additional Documents Specific to Critical Illness Benefit claim (In case of Non-Survival of Insured Member till end of Member Coverage Term):
   i) KYC document of Claimant and Insured Member
   ii) Medical certificate confirming the cause of death (Form 4A)
   iii) Attested copy of Death Certificate of the Insured Member issued by Indian Government Authority.
   iv) Death Summary which confirms the treatment given prior to death and what all conditions led to death (in case of Hospitalization death)
   v) In case of death at home – all the consultation and treatment record prior to death, medical certificate/Attending Physician statement confirming possible reason of death

f) For Accidental Total and Permanent Disability Benefit Claim:
   i) Claimants Statement For Disability Claim,
   ii) Attested copy of disability certificate from relevant Government Medical authority.
   iii) All investigation including Medical Records, Indoor Case papers, Lab tests reports confirming the disability
   iv) Complete treatment record with follow-up documentation
   v) Attested copy of FIR (if required)
   vi) Disability assessment report from Digit empanelled medical specialist (if required)
   vii) KYC document of Claimant

   Additionally, wherever applicable, following documents shall be submitted:
   i) Certificate of Insurance
   ii) Credit Account Statement from the lender in case of claims under lender-borrower schemes

Notwithstanding anything contained in Clause 14 above of this Part F, depending upon the cause or nature of the claim, the Company reserves the right to call for any other and/or additional documents or information, including documents/information concerning the title of the person claiming the Benefit/(s) under this Master Policy, to the satisfaction of the Company, for processing of the claim.

The claim should be intimated to the Company within a period of 90 days from the date of insured event, to treat the same as a valid claim. However, delay in intimation of claim or submission of documents should be supported by valid reasons. for the Company to condone such delay.

15) Claims Intimation

a) The claim can be notified with proof of claim to the Claims Department' at lifeclaims@godigit.com, and the claim documents to be simultaneously sent at Go Digit Life Insurance Limited, Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095.

b) Claims can also be intimated at Our helpline Number – 9960126126 and claim documents to be simultaneously sent at Digit Life Office address as mentioned above in (a).

c) Claim intimation to the Company can also be made in writing and delivered to the nearest branch office or Head Office address, which is currently as:

Claims department
Go Digit Life Insurance Limited
Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095
Helpline Number: 9960126126
Email id: lifeclaims@godigit.com

Any change in the address or details above will be communicated by the Company to the Master Policyholder.
Our liability under the Master Policy will be automatically discharged on payment to the Claimant.

PART – G

Grievance Redressal Mechanism and Ombudsman Details

1) Contact Information for Complaints & Grievance Redressal

a) Meet your Grievance Officer at Your nearest Digit Life Branch Office
b) Write to hellolife@godigit.com from Your registered email address
c) Call 9960126126 from your registered mobile number

2) Grievance Escalation Matrix

a) **Level 1:** In case the complainant is not satisfied with the response, the complainant can escalate the grievance to Chief Grievance Redressal Officer within 8 weeks from date of complaint resolution at **lifegro@godigit.com.**

Address:
The Chief Grievance Redressal Officer
Go Digit Life Insurance Limited.
Atlantis,95,4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095

b) **Level 2:** In case the complainant is not satisfied with the response or does not receive any response from the Chief Grievance Redressal Officer within 15 days, complainant may approach the grievance cell of the Insurance Regulatory and Development Authority of India (IRDAI):

IRDAI Grievance Call Centre (IGCC) Address:
Consumer Affairs Department, Insurance Regulatory and Development Authority of India
Survey No. 115/1, Financial District, Nanakramguda, Gachibowli, Hyderabad
Telangana State – 500032
Toll Free Number: 155255 (or) 1800 4254 732
Timings: 8 AM to 8 PM (Monday to Saturday)
Email: complaints@irdai.gov.in
Website: http://igms.irda.gov.in

c) **Level 3**

Manner of making complaints to Insurance Ombudsman: In case the complainant is not satisfied with the decision/resolution of the Company, or does not receive any response from the Company within 30 days of filing the complaint, the complainant may approach the nearest Insurance Ombudsman. Please refer the list of Insurance Ombudsman at Annexure B.

As per the provisions of Rule 13(1) of Insurance Ombudsman Rules, 2017, the Ombudsman shall receive and consider complaints or disputes relating to:

i) delay in settlement of claims
ii) any partial or total repudiation of claims
iii) disputes over premium paid or payable in terms of the policy
iv) misrepresentation of policy terms and conditions
v) legal construction of insurance policies in so far as the dispute relates to claim.
vi) servicing related grievances against insurers, their agents and intermediaries
vii) issuance of policy not in conformity with Proposal form submitted.
viii) non-issuance of insurance policy after premium receipt; and
ix) any other matter resulting from regulatory violation, related to issues mentioned at clauses a. to h.

As per the provisions of Rule 14 of Insurance Ombudsman Rules, 2017:

Rule 14(1), any person who has a grievance against an insurer, may himself or through his legal heirs, nominee or assignee, make a complaint in writing to the Insurance Ombudsman within whose territorial jurisdiction the branch or office of the insurer complained against or the residential address or place of residence of the complainant is located.

Rule 14(2), the complaint shall be in writing, duly signed by the complainant or through his legal heirs, nominee or assignee and shall state clearly the name and address of the complainant, the name of the branch or office of the insurer against whom the complaint is made, the facts giving rise to the complaint, supported by documents, the nature and extent of the loss caused to the complainant and the relief sought from the Insurance Ombudsman.

Rule 14(3), no complaint to the Insurance Ombudsman shall lie unless:

i) the complainant makes a written representation to the insurer named in the complaint and
(1) either the insurer had rejected the complaint; or

(2) the complainant had not received any reply within a period of one month after the insurer received his representation; or
(3) the complainant is not satisfied with the reply given to him by the insurer

ii) The complaint is made within one year—
(1) after the order of the insurer rejecting the representation is received; or
(2) after receipt of decision of the insurer which is not to the satisfaction of the complainant.
(3) after expiry of a period of one month from the date of sending the written representation to the insurer if the insurer named fails to furnish reply to the complainant.

Rule 14(4), the Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the insurer against the proposed condonation and after recording reasons for condoning the delay and in case the delay is condoned, the date of condonation of delay shall be deemed to be the date of filing of the complaint, for further proceedings under these rules.

Rule 14(5), no complaint before the Insurance Ombudsman shall be maintainable on the same subject matter on which proceedings are pending before or disposed of by any court or consumer forum or arbitrator.

IRDAI Notice - Beware of Spurious/Fraud Phone Calls: IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint**.**

ANNEXURE – I

Section 45 – Policy shall not be called in question on the ground of misstatement after three years

Provisions regarding Policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

1) No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 years from
   a) the date of issuance of Policy or
   b) the date of commencement of risk or
   c) the date of revival of Policy or
   d) the date of rider to the Policy,
   whichever is later.

2) On the ground of fraud, a Policy of Life Insurance may be called in question within 3 years from
   a) the date of issuance of Policy or
   b) the date of commencement of risk or
   c) the date of revival of Policy or
   d) the date of rider to the Policy
   whichever is later.

For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

3) Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance Policy:
   a) The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b) The active concealment of a fact by the insured having knowledge or belief of the fact;
   c) Any other act fitted to deceive; and
   d) Any such act or omission as the law specifically declares to be fraudulent.

4) Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.

5) No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / claimant can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the Policyholder, if alive, or claimant.

6) Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which Policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the Policy of life insurance is based.

7) In case repudiation is on ground of misstatement and not on fraud, the Premium collected on Policy till the date of repudiation shall be paid to the insured or legal representative or nominee or assignees of insured, within a period of 90 days from the date of repudiation.

8) Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance Policy would have been issued to the insured.

9) The insurer can call for proof of age at any time if he is entitled to do so and no Policy shall be deemed to be called in question merely because the terms of the Policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 45 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

ANNEXURE – II

Section 38 – Assignment and Transfer of Insurance Policies:

Provisions regarding assignment or transfer of a Policy in terms of Section 38 of the Insurance Act, 1938, as amended from time to time are as follows:

1) This Policy may be transferred/assigned, wholly or in part, with or without consideration.

2) An Assignment may be effected in a Policy by an endorsement upon the Policy itself or by a separate instrument under notice to the Insurer.

3) The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.

4) The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.

5) The transfer of assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorized agents have been delivered to the insurer.

6) Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.

7) On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.

8) If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the Policy is being serviced.

9) The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is
   a) not bonafide or
   b) not in the interest of the Policyholder or
   c) not in public interest or
   d) is for the purpose of trading of the Insurance Policy.

10) Before refusing to act upon endorsement, the Insurer should record the reasons in writing and communicate the same in writing to Policyholder within 30 days from the date of Policyholder giving a notice of transfer or assignment.
11) In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

12) The priority of claims of persons interested in an insurance Policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to Authority.

13) Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except
   a) where assignment or transfer is subject to terms and conditions of transfer or assignment OR
   b) where the transfer or assignment is made upon condition that
   c) the proceeds under the Policy shall become payable to Policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR
   d) the insured surviving the term of the Policy

Such conditional assignee will not be entitled to obtain a loan on Policy or surrender the Policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.

14) In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such person
   a) shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment and
   b) may institute any proceedings in relation to the Policy

c) obtain loan under the Policy or surrender the Policy without obtaining the consent of the transfer or assignor or making him a party to the proceedings.

15) Any rights and remedies of an assignee or transferee of a life insurance Policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act 2015 shall not be affected by this section.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 38 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

ANNEXURE – III

Section 39 – Nomination by Policyholder

Provisions regarding nomination of a Policy in terms of Section 39 of the Insurance Act, 1938, as amended from time to time are as follows:

1) The Policyholder of a life insurance on his own life may nominate a person or persons to whom money secured by the Policy shall be paid in the event of his death.

2) Where the nominee is a minor, the Policyholder may appoint any person to receive the money secured by the Policy in the event of Policyholder's death during the minority of the nominee. The manner of appointment is to be laid down by the insurer.

3) Nomination can be made at any time before the vesting of the Policy.

4) Nomination may be incorporated in the text of the Policy itself or may be endorsed on the Policy communicated to the insurer and can be registered by the insurer in the records relating to the Policy.

5) Nomination can be cancelled or changed at any time before Policy matures, by an endorsement or a further endorsement or a will as the case may be.

6) A notice in writing of Change or Cancellation of nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bona fide payment is made to the person named in the text of the Policy or in the registered records of the insurer.

7) Fee to be paid to the insurer for registering change or cancellation of a nomination can be specified by the Authority through Regulations.

8) On receipt of notice with fee, the insurer should grant a written acknowledgement to the Policyholder of having registered a nomination or cancellation or change thereof.

9) A transfer or assignment made in accordance with Section 38 shall automatically cancel the nomination except in case of assignment to the insurer or other transferee or assignee for purpose of loan or against security or its reassignment after repayment. In such case, the nomination will get affected to the extent of insurer's or transferee's or assignee's interest in the policy. The nomination will get revived on repayment of the loan.

10) The right of any creditor to be paid out of the proceeds of any Policy of life insurance shall not be affected by the nomination.

11) In case of nomination by Policyholder whose life is insured, if the nominees die before the Policyholder, the proceeds are payable to Policyholder or his heirs or legal representatives or holder of succession certificate.

12) In case nominee(s) survive the person whose life is insured, the amount secured by the Policy shall be paid to such survivor(s).

13) Where the Policyholder whose life is insured nominates his
    a) Parents, or
    b) Spouse, or
    c) Children, or
    d) Spouse, and children
    e) or any of them

The nominees are beneficially entitled to the amount payable by the insurer to the Policyholder unless it is proved that the Policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.

14) If nominee(s) die after the Policyholder but before his share of the amount secured under the Policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).

15) The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act 2015.

16) If Policyholder dies after maturity, but the proceeds and benefit of the Policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the Policy.

17) The provisions of Section 39 are not applicable to any life insurance Policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws (Amendment) Act 2015, a nomination is made in favour of spouse or children or spouse and children whether or not on the face of the Policy it is mentioned that it is made under Section 39. Where nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the Policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is not a comprehensive list of amendments. Policyholders are advised to refer to Section 39 of the Insurance Act, 1938, as amended from time to time for complete and accurate details].

Annexure IV

Exclusions to Additional Accidental Death Benefit (ADB)

No ADB benefit will be payable on death of the Insured Member occurring directly or indirectly as a result of any of the following:

1. Infection: Death caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
2. Intentional self-inflicted injury, attempted suicide / suicide while sane or insane.
3. Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered independent medical practitioner.
4. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
5. Participation by the Insured Member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
6. Participation by the Insured Member in a criminal or unlawful act with criminal intent.
7. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
8. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature. Biological, chemical or radioactive contamination.

Annexure V

Exclusions to Additional Accidental Total and Permanent Disability (ATPD) Benefit

No ATPD benefit will be payable, if ATPD to Insured Member is occurring directly or indirectly as a result of any of the following:

1. Infection: ATPD caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained.
2. Intentional self-inflicted injury, attempted suicide while sane or insane.
3. Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
4. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, willful participation in strikes / acts of violence.
5. Participation by the Insured Member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
6. Participation by the Insured Member in a criminal or unlawful act with criminal intent.
7. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
8. Nuclear contamination, the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature. Biological, chemical or radioactive contamination.

Annexure VI

Exclusions to Critical Illness (CI) Benefit

The Critical illness condition should have been diagnosed for the first time in life.
Claim for Critical Illness Benefit will be accepted subject to Survival Period of 30 days and Waiting Period of 90 days.
Once a claim has been paid under Critical Illness Benefit, Insurance Coverage under this Benefit shall cease and no further payment will be made for any consequent Critical Illness or any dependent disease.

Notwithstanding anything to the contrary stated herein and in addition to the foregoing exclusions, no Critical Illness Benefit will be payable if any of the above listed Critical Illness Conditions occurs from, or is caused by, either directly or indirectly, voluntarily or involuntarily, due to one of the following:

1) Congenital Condition: Any external congenital condition or related illness is not covered. In case any Internal congenital condition or related illness is known and was/is being treated, is disclosed at proposal stage and accepted, claims will be processed as per Policy terms and conditions.
2) Any covered condition or its signs or symptoms having occurred within the Waiting Period.
3) Drug Abuse: Insured Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered independent medical practitioner.
4) Pre-existing Disease: means any condition, ailment, Injury or disease:
    - that is/are Diagnosed by a physician within 48 months prior to the effective date of the Insurance Coverage issued by Company or
    - for which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Insurance Coverage or its Revival or its Reinstatement.

5) Self-inflicted Injury: Intentional self-inflicted injury by the Insured Member.
6) Suicide: If the Critical Illness was contracted due to attempted suicide.
7) Criminal Acts: Insured Member involvement in criminal activities with criminal intent.
8) War, invasion, act of foreign enemy, hostilities (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, wilful participation in strikes / acts of violence.
9) Nuclear Contamination: Exposure to radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature. Biological, chemical or radioactive contamination.
10) Aviation: Participation by the Insured Member in any flying activity, except as a bona fide fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable. However Pilots, Cabin crew, aeronautical staff members in a licensed passenger carrying commercial aircraft operating on a regular scheduled route will be covered under this product as per Board Approved Underwriting Policy.
11) Hazardous sports and pastimes: Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping, horse racing or any kind of race.
12) Any treatment of the donor for the replacement of an organ.
13) Unreasonable failure to seek or follow medical advice or treatment by a medical practitioner leading to occurrence of the insured event or member delaying medical treatment in order to circumvent the waiting period or other conditions and restrictions applying to this policy.

Annexure VII – Wellness Benefit Program

Below listed Benefits will be made available under Wellness Benefit Program

1) Doctor on Call

Upon Insured Member's request, we will facilitate an appointment, through our empaneled Service Provider, with a Medical Practitioner who can help Insured Member by providing round-the-clock medical helpline services through an online portal as a chat service, a call back service or a voice call service or a video call service.

2) **Wellness Coach**

In order to educate, empower and engage Insured Member to become more aware of his/her health and proactively manage it, We will, through periodic communications like e-mailers, blogs, videos, webinar and online platform provide him/her information on wellness coaching including but not limited to the areas as provided below:

a) Weight Management
b) Activity and Fitness
c) Nutrition
d) Tobacco Cessation
e) Alcohol Abuse de-addiction Program
f) Information on various diseases
g) Dietary Plans

3) Lab Services and Imaging (For Diagnostic Services)

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, Collection of test samples such as blood, urine, stool etc or imaging for further testing and analysis. The cost of these tests and reports will have to be borne by the Insured Member.

4) Pharmacy (Home Delivery)

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, home delivery of the Medications Prescribed by a Registered Medical Practitioner and nutritional supplement from the nearby Network Pharmacy, subject to copy of prescription being shared (where ever required) and availability of the medication with the Pharmacy.
The cost of the medication will have to be borne by the Insured Member.

5) **Vital/Physical Activity Monitoring Services**

Upon member's request, We will facilitate, through Our Empanelled Service Provider, the integration of his/her Health Device(s), or Digital Wearables or trackers such as Blood-Pressure Monitors, Glucometers, Wireless Pedometers, heart rate monitors, pulse oximeters, non-invasive wearable blood-sugar sensors, Smart Watches etc. to an online database that will track and asses his/her vitals as reported by the device. It can provide periodic updates and reports of Insured Member's health status. The cost of the device will have to be borne by the Insured Member.

6) Reminder Notifications

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, routine notification messages via mail or a messaging portal or a follow-up call to the Insured Member as a reminder to schedule his/her medical appointments and/or take daily dosage of his/her medicine as per the information shared by the him/her.

7) Medical Wallet

Upon Insured Member's request, We will arrange, through Our Empanelled Service Provider, for a medical wallet. This will be a digital cloud service which will allow the Insured Member to store all his/her medical reports online. It will provide easy access of Medical history and reports to the treating Medical Practitioners and to any other person with whom he/she may share the login and access codes, easing his/her need to physically carry documents with himself/herself.

8) Report Aggregation

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, for regular analysis of his/her health status as per the medical records/reports/information or data shared by him/her. It will highlight his/her wellbeing or any areas of concern or deterioration in his/her health, allowing him/her to take necessary calls about his/her health.

9) Home Care Services

Upon Insured Member's request, We will facilitate, through our Empaneled Service Provider, Home Care Services for him/her in case he/she are in need of services, including but not limited to the following:

a) Home Care Nursing
b) Patient Assistant
c) Physiotherapy
d) Yoga Trainer
e) Psychologist
f) Palliative Care
g) Renting Medical Equipment. For Example – Wheelchair, Patient Bed, Oxygen Cylinder etc.
h) Doctor Visit
i) Elderly care and senior living assistance related to their health conditions.

The cost of the Services/Equipment will have to be borne by the Insured Member.

10) Ambulance Arrangement Services

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, ambulance services for his/her transportation subject to availability of ambulance in the area where such service needs to be arranged. The cost of the transportation will have to be borne by the insured member.

11) Pick up and drop services for consultation

Upon Insured Member's request, We will facilitate, through Our Empanelled Service Provider, Pick-up and Drop Service, for his/her transportation to the Health Care Facility for treatment/Diagnostics subject to availability of vehicle/taxi in the area where such service needs to be arranged. The cost of the transportation will have to be borne by Insured Member.

12) Prioritizing Appointments

Upon Insured Member's request, We will facilitate through Our Empanelled Service Provider, prioritization of his/her appointment, based on the urgency, with the Network Providers offering the necessary consultation/ treatment/ diagnostics/ packages/ memberships/ risk assessment/ procedures subject to availability of the service(s). The cost of the Consultancy/Diagnostic will have to beborne by the Insured Member. These may include the following but not limited to:

a) Doctor's services
b) Nursing services
c) Dietitian services

13) Mental wellbeing

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, self- assessments, therapy sessions, activities and educational/awareness blogs, videos and webinars. The cost of these sessions will have to be borne by the Insured Member.

14) Physiotherapy

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, consultation and treatment sessions/packages, pain management sessions, ergonomics sessions. The cost of these services will have to be borne by the Insured Member.

15) Childcare/Children's activities

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, recreational/developmental activities for children of different age groups. The cost of these services will have to be borne by the Insured Member.

16) Out-Patient (OPD) Services

Upon Insured Member's request, We will facilitate, through Our empanelled Service Provider, outpatient care services like doctor consultation, pharmacy and diagnostics, both online and onsite. The cost of these services will have to be borne by the Insured Member.

17) Fitness

Upon Insured Member's request, we will facilitate, through our empanelled service provider, access to membership or classes of fitness activities like but not limited to sports, yoga, Zumba, Pilates, dance, fitness coach services at gymnasiums, health studios, fitness centres, sports centres and playgrounds. The cost of these services will have to be borne by the Insured Member.

Terms and Conditions applicable to Wellness Benefit Program

1) Any Information provided by the Insured Member shall be kept confidential.

2) For services which are provided through Our Empanelled Service Provider/Medical Experts/Centres, We are acting only as a facilitator, hence We would not be liable for any incremental costs or the services. We will not charge any premium amount for the services. Insured Member needs to pay directly to the Service Provider/Medical Experts/Centres for the services availed.

3) All medical services are being provided by Empanelled Service Provider/Medical Experts/Centres who are empanelled after full due diligence. Insured Member may however consult their Personal/Family Doctor before availing the medical services. The decisions to utilize the services will solely be at the discretion of the Insured Member.

4) We or its Group Entities, affiliates, officers, employees, agents, are not responsible for or liable for any actions, claims, demands, losses, damages, costs, charges, and expenses which an Insured Member may claim to have suffered or sustained or incurred by way of or on account of utilization of any benefits specified herein.

5) This shall not be deemed to substitute the Insured Member's visit or consultation to an Independent Medical Practitioner. The Insured Member is free to choose whether or not to undergo the same and if done whether or not to act on it.

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

Disclosures

1. The product is jointly offered by "Go Digit General Insurance Ltd" and "Go Digit Life Insurance Ltd."

2. The risks under the components of the Combi Product are distinct. Go Digit Life Insurance Ltd shall assume/accept the risk only in relation to the life insurance component of the Combi Product and Go Digit General Insurance Ltd shall assume/accept the risk only in relation to the health insurance component of the Combi Product.

3. The premium of the life insurance and health insurance components of the Combi Product are separate and have been separately identified and disclosed in the Combi Product policy document. The health insurance component of the Combi Product is entitled to be renewed at the option of the policyholder of Go Digit General Insurance Ltd.

4. You shall pay the integrated premium for the Combi Product to either of Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd. The insurer receiving the consolidated premium shall further transfer the relevant share of the premium to the other insurer. You shall be entitled to the underlying benefits of both life and health insurance components of the Combi Product from the date and time of acceptance of the integrated premium by Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd.

5. The Combi Product shall have a free look option, which shall be applied to the Combi Product as a whole. Provided where an existing policyholder of any health insurance product has migrated to the Combi Product, such policyholder is entitled to all the rights of migration as per the applicable portability norms.

6. At any time during the validity of the Combi Product policy, you shall be entitled to continue with either part of the Combi Product policy, discontinuing the other.

7. The liability to settle the claim vests with respective Insurers, i.e., for life insurance benefits, Go Digit Life Insurance Ltd and for health insurance benefits, Go Digit General Insurance Ltd.

8. All policy servicing requests pertaining to the Combi Product shall be received by either of the Insurers. However, Go Digit General Insurance Ltd, as the Lead Insurer of the Combi Product, shall play a facilitative role in policy servicing and shall be the nodal point for receiving the servicing requests, executing these requests and issuing acknowledgements as required.

9. All requests pertaining to the Combi Product impacting premium or policy terms of Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall be serviced by Go Digit Life Insurance Ltd for life products and by Go Digit General Insurance Ltd for health products, as the case may be.

10. Both Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall fulfil servicing requests received by them in accordance with the IRDAI (Protection of Policyholders' Interests) Regulations, 2017, as amended from time to time. Both Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall be responsible for the pro-active and speedy settlement of claims and other obligations in accordance with the terms and conditions of their respective life insurance or health insurance components of the Combi Product. The claim process is available on the website of both Go Digit Life Insurance Ltd and Go Digit General Insurance Ltd.

11. You may lodge a grievance with respect to either or both of the life insurance and health insurance components of the Combi Product at branches of either Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd. Complaint belonging to any product shall be routed to the respective insurer viz. Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd, who shall then respond/address to the Customer directly. Complaints shall be forwarded by Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd to each other for their respective Product. In the event you are not satisfied with the resolution offered, you may also approach the Insurance Ombudsman in your region. Please refer to the relevant grievance redressal mechanism section mentioned under each component of the Combi Product.

12. The legal/quasi legal disputes, if any, are dealt by Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd for their respective benefits. The legal disputes pertaining to life insurance benefits shall be dealt with by Go Digit Life Insurance Ltd and for health benefits all the legal disputes will be handled by Go Digit General Insurance Ltd.

13. You are to be advised to familiarize themselves with the policy benefits and policy service structure of the 'Combi Product' before deciding to purchase the policy.

14. Withdrawal of tie up between the Insurers:

Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd may terminate this tie up between them after obtaining the requisite approval from the IRDAI. Upon receipt of such approval from the IRDAI, Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd may terminate this tie up with notice period of ninety (90) days, or such other period as may be prescribed by the IRDAI, from the date of such approval. The insurers may mutually decide to terminate the Agreement and intimate the same to the customer ninety (90) days prior to the termination of the relationship. However, the Policy will continue until the expiry or termination of the coverage in accordance with the policy wordings for respective coverage.

In case of withdrawal of tie-up between insurers, the customer may choose to continue with either of the policies (health or life). However, the same will be subject to Migration guidelines with respect to health part of the combi product.

In the event of termination of this tie up, Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd shall mutually cooperate for providing customer support and policy servicing post termination of the tie up between Go Digit General Insurance Ltd and Go Digit Life Insurance Ltd. Further, Go Digit General Insurance Ltd or Go Digit Life Insurance Ltd, as the case may be, shall remain liable for its respective life insurance or health insurance components for all Combi Product policies in force at the time of termination of this tie up until their expiry.

Annexure B

Address and contact number of Council For Insurance Ombudsman

Office Location	Contact Details	Jurisdiction of Office Union Territory, District)
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	Gujarat, Dadra & Nagar Haveli, 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	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 Fax: 0755 – 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chhattisgarh
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 – 2596461 /2596455 Fax: 0674 – 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 – 2706196 / 2706468 Fax: 0172 – 2708274 Email: bimalokpal.chandigarh@cioins.co.in	Punjab, Haryana(excluding Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 – 24333668 / 24335284 Fax: 044 – 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 – 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi & Following Districts of Haryana – Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 – 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	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, N. C. Guards, Lakdi-Ka-Pool, Hyderabad – 500 004. Tel.: 040 – 23312122 Fax: 040 – 23376599 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur – 302 005. Tel.: 0141 – 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road,	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.

	Ernakulam – 682 015. Tel.: 0484 – 2358759 / 2359338 Fax: 0484 – 2359336 Email: bimalokpal.ernakulam@cioins.co.in	
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA – 700 072. Tel.: 033 – 22124339 / 22124340 Fax : 033 – 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow – 226 001. Tel.: 0522 – 2231330 / 2231331 Fax: 0522 – 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai – 400 054. Tel.: 022 – 26106552 / 26106960 Fax: 022 – 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

For updated details of Ombudsman details, request to please check Council of Insurance Ombudsmen website available on https://www.cioins.co.in/Ombudsman

Note: COUNCIL FOR INSURANCE OMBUDSMAN ,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.Tel.: 022 – 69038801/03/04/05/06/07/08/09 Email: inscoun@cioins.co.in