Digit Life Healthy Long Term Group Policy

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

UIN: GODHLGP24114V012324

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 (i.e., I. Digit Group Complete Secure Policy) and life insurance product (i.e., II. Digit Life Group Long Term Plan). Digit Group Complete Secure Policy is being offered by Digit General Insurance Limited and Digit Life Group Long Term Plan 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: 1800-296-2626 or mail us at lifeclaims@godigit.com.

I. Digit Group Complete Secure Policy

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 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/Limits mentioned against each Section, 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.
The benefit under each Section will be payable provided that an event or occurrence described under the Sections/Covers occurs during the Policy Period mentioned in Your Policy Schedule/Certificate of Insurance.
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:**
   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: Congenital anomaly which is not in the visible and accessible parts of the body.
   b) External Congenital Anomaly: Congenital anomaly which is in the visible and accessible parts of the body
8. **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 Sections for example: Accidental Death, Critical Illness Benefit Cover Daily Cash Benefit, Fixed Cash Benefit and any other relevant section.)

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
    a) has qualified nursing staff under its employment;
    b) has qualified medical practitioner/s in charge;
    c) has fully equipped operation theatre of its own where surgical procedures are carried out;
    d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
11. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    a) undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    b) 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.
    For an updated list of Day Care Procedures kindly visit our website.

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:**
    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:
    a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b) 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) and 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 inpatient beds in all other places;
    c) has qualified medical practitioner(s) in charge round the clock;
    d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e) maintains daily records of patients and 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/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.
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 (ICU)** 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 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:
    a) is required for the medical management of the illness or injury suffered by the insured;
    b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c) must have been prescribed by a medical practitioner;
    d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
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. **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.
38. **Pre-hospitalization Medical Expenses**
    Pre-hospitalization Medical Expenses means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
39. **Post-hospitalization Medical Expenses:**
    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:
    a. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
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.

I. SPECIFIC DEFINITIONS

46. **Activities of daily/independent living** means:
    a) Washing: the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;
    b) Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
    c) Transferring: The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;
    d) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
    e) Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
    f) Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence
47. **Allopathic treatment or medicine or allopathy** is a pejorative used by proponents of alternative medicine to refer to modern scientific systems of medicine, such as the use of pharmacologically active agents or physical interventions to treat or suppress symptoms or pathophysiologic processes of diseases or conditions.
48. **Alternative/Ayush Treatment** means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
49. **Claim** means a claim under an Operative clause in respect of an insured event that has taken place.
50. **Common Carrier** means any civilian land or water conveyance or Scheduled Airline in each case operated under a valid license for the transportation of passengers for hire.
51. **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
52. **Dentist** means a person who is registered with (i) the Dental Council of India, (ii) State Dental Councils, (iii) Joint State Dental Councils or any other Dental council recognized as per Dentists Act, 1948 and its subsequent amendments thereof.
53. **Fracture** means a complete or incomplete break in a bone resulting from the application of excessive force.
54. **General 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.
55. **Hazardous or Adventure Sports** means any sport or activity, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. These activities shall be considered to be hazardous irrespective of the safety precautions taken while undergoing these activities/sports. Such sport/Activity includes, but not limited to, list of sports/ activity as provided in Annexure B. Level 0 (Zero) sports/ activities as provided in Annexure B, will not be considered as hazardous or adventure sports under the scope of this policy.
56. **Network Facilitator** means an organization which has, including without limitation, tie-ups with Hospital, Diagnostic Centers, Clinics, Doctors, Medicine and drug vendors, medical service providers, home care treatment providers, Health Care Workers and whose services can be utilized by an Insured and approved by Us.
57. **Ophthalmic Treatment** means a treatment related to eye(s).
58. **Ophthalmologist** means medical practitioner, or an eye specialist whose deals with the diagnosis and treatment of eye disorders.
59. **Pathology** means laboratory testing blood and other bodily fluids, tissues, and microscopic evaluation of individual cells.
60. **Permanent Total Disablement** shall mean either of the following:
    a. Total Paralysis
    b. Total and irrecoverable loss of sight of both eyes, or
    c. Total and irrecoverable physical separation of or the loss of ability to use two Limbs (both hands or both feet or one hand and one foot), or
    d. Total and irrecoverable loss of sight of one eye and physical separation of or the loss of ability to use a limb (either one hand or one foot), or

e. Total and irrecoverable loss of speech and hearing of both ears

For the purpose of this definition,

1. Total Paralysis means complete and irreversible loss of motor function leading to the total loss of function of the entire body from neck down due to an accidental injury to the spinal cord.
2. Limb means a hand at or above the wrist or foot above the ankle.
3. Loss of Limb means the physical separation of or the loss of ability to use a limb above the wrist and/or ankle respectively.

61. **Pharmacy** means drugs, medicines and consumables as prescribed by Medical Practitioner.
62. **Policy** means the Proposal, the Policy Schedule / Certificate of Insurance (and any endorsement attaching to or forming part thereof) and the Policy Wordings.
63. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule /Certificate of Insurance and includes both the commencement date as well as the expiry date. The policy period could be different for different sections of the policy as opted by You and defined in policy schedule/certificate of insurance against respective section(s) of the policy.
64. **Policy Schedule/Certificate of Insurance** means the Policy Schedule attached to and forming part of this Policy specifying the details of the Insured Persons, the Sum Insured, the Policy Period and the Sub-limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest intime.
65. **Principal Outstanding Amount** means the principal amount of the Loan outstanding as on the date of any occurrence or event which gives rise to a claim under the Policy, less the portion of principal component included in the EMIs, payable but not paid, from the date of the loan agreement till the date of such occurrence or event. For the purpose of avoidance of doubt, it is clarified that any:
    i. EMIs that are overdue and unpaid to the financial institution prior to such occurrence or event,
    ii. any additional amounts imposed by a financial institution, or otherwise falling due as a penalty or by way of a default in repayment, will not be considered for the purpose of the Policy and shall be payable by the Insured Person.
66. **Professional Sports** means the sports in which the sportsperson or the athlete receives payment for their performance.
67. **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.
68. **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**.**
69. **Specialist Medical Practitioner** means a medical practitioner holding specialized qualification and having additional specialized expertise in any one or more type of medicine, including but not limited to Orthopaedic, Paediatrics, cardiologist, gastroenterologist, ENT Specialist, Neurologist, Urologist, Dermatologist, Radiologist, Psychiatrist, Rheumatologist, Pulmonologist.
70. **Terrorism or act of Terrorism** means an act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), or unlawful associations, recognized under Unlawful Activities (Prevention) Amendment Act, 2008 or any other related and applicable national or state legislation formulated to combat unlawful and terrorist activities in the nation for the time being in force, committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public or any section of the public in fear for such purposes.
71. **Tertiary Care** constitutes of Specialized Advanced Care Unit designed to care to complex medical condition involving super specialist consultant like Neurosurgeon, Neurologist, Spine Surgeons and Reconstructive Surgeons.
72. **Time Excess** means a cost sharing requirement that provides that the insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the insurer.
73. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited
74. **You, Your, Yours, Yourself, Policyholder, Insured, Insured Member (s) Insured Person(s) means** the Individual Group Members who will be treated as Insured beneficiary both Named and Unnamed as described in the Policy Schedule/Certificate of Insurance.

CRITICAL ILLNESS DEFINITIONS:

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 leukaemia, 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 ($PaO_2 < 55mmHg$); 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:**
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 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.

17. BLINDNESS

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

II. The Blindness is evidenced by:
   a. corrected visual acuity being 3/60 or less in both eyes or;
   b. the field of vision being less than 10 degrees in both eyes.

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

18. DEAFNESS

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing" in both ears.

19. LOSS OF SPEECH

I. Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

20. THIRD DEGREE BURNS

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

II. SPECIFIC DEFINITIONS:

21. 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.

22. ABDOMINAL AORTA ANEURYSM

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.

a. 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.
b. Congenital conditions are excluded

23. CARDIOMYOPATHY

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.

The following conditions are excluded:

• Cardiomyopathy secondary to alcohol or drug abuse.
• All other forms of heart disease, heart enlargement and myocarditis.

24. 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.

25. 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.

26. PARKINSON'S DISEASE

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to Us. The diagnosis must be supported by all of the following conditions:

a. the disease cannot be controlled with medication;
b. signs of progressive impairment; and
c. inability of the Insured Person to perform at least 3 of the 6 activities of daily living (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.

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

27. MUSCULAR DYSTROPHY

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

a. Family history of muscular dystrophy;
b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
c. Characteristic electromyogram; or
d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 activities of daily living (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.

28. 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.

29. 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.

30. BACTERIAL MENINGITIS

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant,

irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living.
This diagnosis must be confirmed by:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b. A consultant neurologist certifying the diagnosis of bacterial meningitis.

Bacterial Meningitis in the presence of HIV infection is excluded.

31. 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.
The following conditions are however not covered:

a. non-organic diseases such as neurosis and psychiatric Illnesses;
b. alcohol related brain damage; and
c. any other type of irreversible organic disorder/dementia.

32. 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.
Exclusions:

• Encephalitis in the presence of HIV infection is excluded.

33. 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 Activities of Daily Living .

34. 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:

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

35. 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*).

36. FULMINANT HEPATITIS

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

a. Rapid decreasing of liver size;
b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;
c. Rapid deterioration of liver function tests;
d. Deepening jaundice; and
e. Hepatic encephalopathy.

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

37. 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:

• Removal of a lobe of the lungs (lobectomy)
• Lung resection or incision

38. 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.

39. MEDULLARY CYSTIC DISEASE

I. Medullary Cystic Disease where all the below criteria are met:
i. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
ii. clinical manifestations of anemia, polyuria, and progressive deterioration in kidney function; and
iii. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

II. Isolated or benign kidney cysts are specifically excluded from this benefit.

40. INFECTIVE ENDOCARDITIS

Inflammation of the inner lining of the heart arising out of infection, where all the below criteria are met:
i. Positive result of the blood culture proving presence of the infection;
ii. Presence of valvular incompetence (regurgitant fraction of >=20%) or moderate heart valve stenosis (Mitral Valve area upto 2.5 cm^2) attributable to Infective Endocarditis; and
iii. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a qualified cardiologist.

41. DISSECTING AORTIC ANEURYSM

A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a qualified cardiologist/Cardio Thoracic Surgeon supported by computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram etc. where surgical correction is required.

42. SYSTEMIC LUPUS ERYTHEMATOUS WITH LUPUS NEPHRITIS

I. A multi-system autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. In respect of this Cover, systemic lupus Erythematous will be restricted to those forms of systemic lupus Erythematous which involve the kidneys **(Class III to Class V** Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Medical practitioner specializing in Rheumatology and Immunology. Class I AND II will not be covered under this coverage.

II. The WHO Classification of Lupus Nephritis:
Class I Minimal Change Lupus Glomerulonephritis
Class II Mesangial Lupus Glomerulonephritis

Class III Focal Segmental Proliferative Lupus Glomerulonephritis
Class IV Diffuse Proliferative Lupus Glomerulonephritis
Class V Membranous Lupus Glomerulonephritis.

43. CHRONIC ADRENAL INSUFFICIENCY (ADDISON'S DISEASE)

I. An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for lifelong glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Registered Medical practitioner who is a specialist in endocrinology through one of the following:
   i. ACTH simulation tests;
   ii. insulin-induced hypoglycemia test;
   iii. plasma ACTH level measurement;
   iv. Plasma Renin Activity (PRA) level measurement
II. Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.

44. PROGRESSIVE SCLERODERMA

I. A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.
II. The following are excluded:
   i. Localized scleroderma (linear scleroderma or morphea);
   ii. Eosinophilic fasciitis; and
   iii. CREST syndrome.

45. CHRONIC RELAPSING PANCREATITIS

I. An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Medical practitioner who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterized by irreversible morphological change and typically causing permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.
II. Relapsing Pancreatitis caused directly or indirectly, wholly or partly, due to intake of alcohol or any substance abuse is excluded.

46. BRAIN SURGERY

Any brain surgery under general anesthesia involving craniotomy is covered. Keyhole surgery is also included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolization's, thrombolysis and stereotactic biopsy are all excluded. The procedure must be considered medically necessary by a qualified Neurosurgeon.

47. CROHN'S DISEASE

I. Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:
   i. Stricture formation causing intestinal obstruction requiring admission to hospital, and
   ii. Fistula formation between loops of bowel, and
   iii. At least one bowel segment resection
II. The diagnosis must be made by a Registered Medical practitioner who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.

48. SEVERE RHEUMATOID ARTHRITIS

I. Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:
   i. Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
   ii. Permanent inability to perform at least two (2) "Activities of Daily Living"; as listed below:
      a. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
      b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
      c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
      d. Mobility: the ability to move indoors from room to room on level surfaces;
      e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
      f. Feeding: the ability to feed oneself once food has been prepared and made available.
   iii. Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
   iv. The foregoing conditions have been present for at least six (6) months from the date of diagnosis.

49. SEVERE ULCERATIVE COLITIS

I. Acute fulminant ulcerative colitis with life threatening electrolyte imbalance.

II. All of the following criteria must be met:

i. the entire colon is affected, with severe bloody diarrhea; and

ii. the necessary treatment is total colectomy and ileostomy; and

iii. the diagnosis must be based on histopathological features and confirmed by a Registered Medical practitioner who is a specialist in gastroenterology.

50. MULTIPLE SYSTEM ATROPHY

A Diagnosis of multiple system atrophy by a Specialist Medical Practitioner (Neurologist). There must be evidence of permanent clinical impairment for a minimum period of thirty (30) days of bladder control with postural hypotension and any 2 of the following:

i. Rigidity

ii. Cerebellar Ataxia

iii. Peripheral Neuropathy

DEFINITION, COMPLICATION & DIAGNOSTIC FOR SECTION 40- ILLNESS COVER

1. Cholera:

a. **Definition** - Cholera is an acute, diarrheal illness caused by infection of the intestine with the bacterium *Vibrio cholerae* and is spread by ingestion of contaminated food or water.

b. **Complications**: Persons with severe cholera can develop acute renal failure, severe electrolyte imbalances and coma.

c. **Diagnostics**: Faecal specimen (hanging drop) and PCR – Positive for **Vibrio cholerae**

2. Amoebiasis

a. **Definition:** Amoebiasis is an infection caused by Entamoeba Histolytica causing both intestinal and extraintestinal symptoms

b. **Complication:** Amoebic liver abscess

c. **Diagnostics:** Presence of amoeba cyst in the stool specimen, Ultrasound confirming liver abscess

3. Typhoid:

a. **Definition:** Typhoid fever also known as enteric fever caused by Salmonella enterica Typhi leading to Fever, Abdominal pain, weakness and rose-coloured rash

b. **Complications**: Ileal perforation and / or meningitis, Sepsis

c. **Diagnostics:** Blood culture, PCR, IgG and IgM studies

4. Viral Hepatitis:

a. **Definition:** Hepatitis is the infection to the liver due to Viral Infection caused by either Hep A, D or E (water borne). Hepatitis B and C are excluded (as they are chronic and caused from needles and body fluids)

b. **Complications:** Encephalopathy or liver failure

c. **Diagnostics:** IgG and IgM studies, Hepatitis A, D and E specific viral markers

5. Tuberculosis:

a. **Definition:** Tuberculosis is an chronic progressive infection caused by Mycobacterium tuberculosis in lungs, intestine, bones, nervous system and genital organs

b. **Complications:** Multi drug resistant tuberculosis and /or Tubercular meningitis

c. **Diagnostics:** Mantoux test, Interferon-gamma release assay, IgG and IgM studies

6. Plague:

a. **Definition:** Plague is a life-threatening bacterial infection to humans through fleas, contaminated fluid or droplets.

b. **Complications:** Pneumonia and Septicaemia

c. **Diagnostics:** Lymph node swelling (BUBO), CSF analysis, Blood and fluid culture tests

7. Diphtheria:

a. **Definition**: Diphtheria is an upper respiratory tract infection which spreads through touch and droplets starts with thick coating of throat, swelling of glands in neck and fever.

b. **Complications:** Respiratory failure, paralysis, myocarditis, polyneuropathy and death.

c. **Diagnostics:** Throat Swab Culture or Sample from a skin lesion (like a sore)

8. Typhus:

a. **Definition**: Typhus fevers are a group of diseases caused by bacteria that are spread to humans by fleas, lice, and chiggers

b. **Complications:** Acute respiratory distress, septic shock, myocarditis, meningoencephalitis

c. **Diagnostics**: Skin biopsy, western blot, immunofluorescence test

9. Leptospirosis:

a. **Definition**: Leptospirosis is a bacterial infection that affects that spreads from contact of unhealed break or injured skin with contaminated water or soil.
b. **Complications**: Kidney and Liver failure, Sepsis
c. **Diagnostics**: Microscopic Agglutination test and IgG/IgM studies

10. Dengue:

a. **Definition**: Dengue fever is caused by the virus spread through Aedes mosquito bite resulting to fever, severe headache, vomiting, skin rash and life-threatening internal bleeding.
b. **Complications**: Platelets count < 40k, Septic shock and death
c. **Diagnostics**: NS1 test, IgG/IgM studies, CBC with platelet counts

11. Malaria:

a. **Definition**: Malaria fever is caused by a protozoan – Plasmodium through female anopheles mosquito resulting in fever, weakness, chills, headache, vomiting and Jaundice
b. **Complications**: kidney failure, Seizures and cerebral malaria, Sepsis
c. **Diagnostics**: Blood smear, Rapid diagnostic test

12. Filariasis:

a. **Definition**: Filariasis is caused when the lymphatic system is blocked by microfilaria parasite leading to permanent changes in the limbs.
b. **Complications**: Permanent disability
c. **Diagnostics**: Blood smear and Antibodies

13. Kala Azar

a. **Definition**: A chronic and potentially fatal parasitic disease of the viscera (the internal organs, particularly the liver, spleen, bone marrow and lymph nodes) due to infection by the parasite called Leishmania donovani.
b. **Complications**: Anaemia, Septicaemia, Hyperpigmentation, Splenic Rupture.
c. **Diagnostics**: DAT and the rk39 dipstick tests

14. Chikungunya:

a. **Definition**: Chikungunya is caused by virus through Aedes mosquitoes leading to fever, weakness and severe joint pains
b. **Complications**: Severe joint pain with disability
c. **Diagnostics**: IgG and IgM studies

15. Japanese Encephalitis:

a. **Definition**: Inflammation of brain due to virus leading to disorientation, fever, vomiting, convulsions and death
b. **Complications**: Encephalopathy and death, Sepsis
c. **Diagnostics**: CSF and blood culture

16. HIV

Definition: "HIV Infection" means a positive HIV antibody testing (rapid or laboratory-based enzyme immunoassay). This is usually confirmed by a second HIV antibody test (rapid or laboratory-based enzyme immunoassay) relying on different antigens or of different operating characteristics.
and /or;
A positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virological test obtained from a separate determination.

17. Zika Virus:

a. **Definition**: Zika virus is caused by virus through mosquito bite leading to fever, rash, muscle pain and Joint pain. Pregnant women can transfer the virus to the unborn child leading to the microcephaly.
b. **Complications**: Birth defects in newborn
c. **Diagnostics**: RT-PCR, Urine analysis, IgG/IgM studies

18. Nipah Virus

a. **Definition**: Nipah Virus is caused by virus through Bats leading to drowsiness, disorientation and respiratory distress
b. **Complications**: Inflammation and irreversible damage to brain
c. **Diagnostics**: RT-PCR, Swab culture, CSF analysis

19. EBOLA

a. **Definition**: Ebola virus disease is a deadly disease which spreads from few animals like Monkeys, Bats etc., through body fluids and mucus membranes leading to Fever, severe body ache, rashes and Diarrhoea
b. **Complications**: Septic shock and death
c. **Diagnostics**: RT – PCR and Ebola Antigen tests

20. Swine Influenza Virus & H1N1 Virus

a. **Definition**: A rapidly contagious infection transmitted from animals and spread through droplet circulation leading to fever, cough and severe respiratory symptoms.
b. **Complications**: Pneumonia leading to Respiratory arrest, Lung fibrosis, renal failure, septic shock and death
c. **Diagnostics**: IgG/IgM studies, Swab cultures (throat), PCR

21. COVID-19, SARS and MERS

a. **Definition**: A rapidly contagious infection caused by a virus from Coronavirus Family, transmitted from animals and spread through droplet circulation leading to fever, cough, mild to severe respiratory symptoms.
b. **Complications**: Pneumonia leading to Respiratory arrest, Lung fibrosis, renal failure, septic shock and death
c. **Diagnostics**: IgG/IgM studies, Swab cultures (throat), PCR

Important Note: In respect of any claim, We will consider the medical practices prevailing at the time of claim for the Disease(s), Condition(s) and/or Virus(es) opted by You and mentioned in Your Policy Schedule.

C. BENEFITS COVERED UNDER THE POLICY

I. COVERAGE

SECTION 1. ACCIDENTAL DEATH

If You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your Death within twelve (12) months from the date of accident, then We will pay 100% of the Sum Insured, as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

Inbuilt Benefits:

Below are the inbuilt benefits under **Section 1. Accidental Death** and We will pay 100% of the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, in the below events:

a. **Disappearance:** We shall be liable to be pay under this benefit, 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 Policy Period, where it is reasonable to believe that such Insured Member has died as a result of an Accidental Injury.

b. **Drowning:** We shall be liable to be pay under this benefit, if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the Policy Period, where it is reasonable to believe that such Insured Member has died as a result of drowning.

   For both (a) and (b) above, We will only pay, when the nominee or the legal heir 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 Accidental death benefit, it is discovered that the Insured Person is still alive, all payments shall be repaid in full to Us.

   Once a claim has been accepted under this Section, this Policy will immediately and automatically cease in respect of that Insured Person. Also, **"Section 5. Children Education Benefit", "Section 6. Marriage Expense for Children", "Section 7. Orphan Benefit for Children", "Section 8. Funeral Expenses", "Section 9. Transportation Expenses", "Section 10. Trauma Counselling"**, **"Section 16. Compassionate Visit"** wherever opted, will cease on payment of entire Sum Insured in respect of the Insured Person against whom a claim has been accepted under this Section.

This Cover is subject to terms, conditions, limitations, sum insured basis and exclusions mentioned in the Policy.

SECTION 2. PERMANENT TOTAL DISABLEMENT

If You have opted for this Cover, and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your **"Permanent Total Disablement"** within twelve (12) months from the Date of accident, then We will pay 100% of Sum Insured, as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

Specific Conditions:

1. If the Insured Member suffers Accidental Injuries resulting in more than one of the Permanent Total Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned against this Section.
2. Once a claim has been accepted under this Section, this Policy will immediately and automatically cease in respect of that Insured Person. Also, **"Section 5. Children Education Benefit", "Section 6. Marriage Expense for Children", "Section 10. Trauma Counselling", "Section 20. Lifestyle Modification Benefit", "Section 15. Expense for External Aids & Appliances", "Section 16. Compassionate Visit"** wherever opted, will cease on payment of entire Sum Insured in respect of the Insured Person against whom a claim has been accepted under this Section.

This Cover is subject to terms, conditions, limitations, sum insured basis and exclusions mentioned in the Policy.

SECTION 3. PERMANENT PARTIAL DISABLEMENT

If You have opted for this Cover, and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your Permanent Partial Disablement within twelve (12) months from the Date of accident, then We will pay the percentage of Sum Insured, as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, as per the following Scale.

Permanent Partial Disablement –Table of Benefits

Nature of Injury	% of Sum Insured
Loss of each arm at the shoulder joint	70%
Loss of each leg above centre of the femur	70%

Loss of each arm to a point above elbow joint	65%
Loss of each leg up to a point below the femur	65%
Loss of each arm below elbow joint	60%
Loss of each hand at the wrist	55%
Complete and irrecoverable loss of sight of an eye	50%
Loss of each leg to a point below the knee	50%
Loss of each leg up the centre of tibia	45%
Loss of each foot at the ankle	40%
Loss of hearing in each ear	30%
Loss of each thumb	20%
Loss of each index finger	10%
Loss of sense of smell	10%
Loss of each other finger	5%
Loss of each big toe	5%
Loss of sense of taste	5%
Loss of each other toe	2%

For the purpose of this Cover, Loss means:

a. The physical separation of a body part, or
b. The total loss of functional use of body part or organ provided this has continued for at least 12 calendar months from the date of accident, provided that We must be satisfied at the expiry of the 12 calendar months that there is no reasonable medical hope for improvement.

Specific Conditions:

1. If the Insured Member suffers Accidental Injuries resulting in more than one Permanent Partial Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.
2. If the Insured Member suffers from a Permanent Partial Disablement not listed in the above table then an external medical advisor will determine the disablement percentage. For this section External Medical Advisor refers to an independent physician/surgeon who is an expert in the subject matter and is not working as on roll or off roll/ contract basis with the Insurer.
3. On acceptance of a claim under this Benefit, the Insured Member's Cover under this Benefit and Other Benefit opted under this Policy shall continue, subject to the availability of the Sum Insured, terms, conditions and Exclusion of this Policy.

This Cover is subject to terms, conditions, limitations, sum insured basis and exclusions mentioned in the Policy.

SECTION 4. TEMPRORARY TOTAL DISABLEMENT

If You have opted for this Cover, and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of a Temporary Total Disablement and which completely prevents You from performing each and every duty pertaining to Your employment or occupation on a temporary basis, then We will pay a weekly benefit, amount of which is mentioned in Your Policy Schedule/Certificate of Insurance against this Section, provided that:

1. The Temporary Total Disablement is certified by a Medical Practitioner and submission of supporting documents/reports with respect to clinical examination, radiological scanning or imaging and/or neurological fallout testing as submitted to US, failing which We shall not be liable for any claim under this Section.
2. We will stop making payments when We are satisfied that You can engage in Your occupation again or when We have made payments for number of weeks as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance for any one injury calculated from the date of commencement the temporary total disablement as certified by the treating Medical Practitioner, whichever is earlier.
3. We shall not be liable to make any payment under this Benefit in respect of the Insured Person for more than the Total Number of weeks as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance for any and all claims arising within the Policy Period under this Benefit.
4. The benefit shall not be paid for the Time Excess mentioned in Your Policy Schedule/Certificate of Insurance i.e. for the number of days as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance calculated from the date of commencement of Temporary Total Disablement.

5. In case the Temporary Total Disablement is for a period less than a week, the benefit payable shall be calculated on proportionate basis in relation to the weekly benefit.
6. We will not pay any amount in excess of the Insured Person's base weekly income net of tax and other deductions, excluding overtime, bonuses, tips, commissions, or any other special compensation.
7. In case of any dispute with respect to the duration of Temporary Total Disablement, the duration shall be finally determined by a Doctor/Medical Practitioner mutually appointed by the Insured and Insurer, who certifies the final date upon which the Insured recovered and fit to perform each and every duty pertaining to his / her employment or occupation.

This Cover is subject to terms, conditions, time excess, limitations and exclusions mentioned in the Policy.

SECTION 5. CHILDREN EDUCATION BENEFIT

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**" and/or "**Section 2. Permanent Total Disablement**", then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards the cost of education of Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.
2. The dependent child (children) pursuing an education course is a full-time student at an educational institution.
3. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule/Certificate of Insurance. However, in case the dependent child (children) is/ are girl(s), then We will pay an amount equivalent to the percentage of the Sum insured as opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this section.
4. Any Claim under this Section that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal heirs.
5. For the purposes of this Section, Child (Children) means those who has/have been born out of a marriage which is legally valid as on the date of the accident and/or those who has/have been adopted in accordance with Indian Law.

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

SECTION 6. MARRIAGE EXPENSE FOR CHILDREN BENEFIT

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**" and/or "**Section 2. Permanent Total Disablement**", then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards the marriage expenses of Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.
2. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule/Certificate of Insurance.
3. Any Claim under this Section that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal heirs.
4. For the purposes of this Section, Child (Children) means those who has/have been born out of a marriage which is legally valid as on the date of the accident and/or those who has/have been adopted in accordance with Indian Law.

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

SECTION 7. ORPHAN BENEFIT FOR CHILDREN

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**" for the Insured Person who is a parent and while as a result of same accident or separate accident occurring during the Policy Period the Insured Person's Spouse (who may or may not be an Insured Person) has also died, then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section to Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.
2. The dependent child (children) does not have any independent source of income.
3. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule/Certificate of Insurance.
4. Any Claim under this Section that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal guardian/heirs.
5. For the purposes of this Section, Child (Children) means those who has/have been born out of a marriage which is legally valid as on the date of the accident and/or those who has/have been adopted in accordance with Indian Law.

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

SECTION 8. FUNERAL EXPENSES

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**", then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards funeral, cremation and/or burial of the body of the deceased Insured Person.

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

SECTION 9. TRANSPORTATION EXPENSES

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**", then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards the expenses of transporting the mortal remains of the Insured Person from the place of death to a cremation ground or burial ground or to the residence of the Insured Person.
This cover will be restricted to within India only, unless specifically waived off and mentioned in Policy Schedule.

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

SECTION 10. TRAUMA COUNSELLING

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**" and/or **"Section 2. Permanent Total Disablement"** and/or **"Section 3. Permanent Partial Disablement"**, and the treating Medical Practitioner advises Professional Counselling sessions for the psychological upliftment, changes in daily diet or nutrition intake, Psychotherapy or Medications, then We will reimburse up to the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards the expenses incurred for the counselling session, provided that, Coverage needs to be availed within Six months from the date of incident (i.e. date of injury/ accident) covered under this Section and is applicable to:

a. Insured Person's Parents, Spouse and Children – In case of **accidental death** of the Insured Person.
b. Insured Person – In case of **Permanent Total Disablement** and/or **Permanent Partial Disablement** sustained by the Insured during the Policy Period.

This Cover is subject to terms, conditions, Co-Payment, limitations and exclusions mentioned in the Policy.

SECTION 11. COMA BENEFIT COVER

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Your hospitalization in an Intensive Care Unit of a Hospital in a state of Coma, within 30 days of date of accident, then We will pay You the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, provided that:

1. The Coma is confirmed by a specialist Medical Practitioner in writing which includes:
   a. no response to external stimuli continuously for at least 96 hours; and
   b. life support systems and measures are necessary to sustain life.
2. Permanent neurological deficit must be assessed at least 30 days after the onset of the coma and the reports to be submitted to Us for any benefit to be payable under this Section.
3. Coma resulting directly from alcohol or drug abuse or any other illness other than Accidental Bodily Injury is excluded.

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

SECTION 12. FRACTURE COVER

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Fracture(s) of Bone(s), then We will pay the percentage shown in the below table of benefits applied to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

Fracture Cover - Table of Benefits

Nature of Fracture	% of Sum Insured
Hip or Pelvis (excluding thigh or coccyx)	
Open Fracture of more than one bone with flail pelvis	100%
Open Fracture of more than one bone without flail pelvis	50%
Open Fracture of one bone	50%
Closed Fracture of more than one bone with flail pelvis	50%
Closed Fracture of more than one bone without flail pelvis	25%
Closed Fracture one bone	15%
Thigh	
Open Fracture of neck of Femur	60%
Open Fracture of shaft of femur	45%
Closed Fracture of neck of Femur	25%
Closed Fracture of shaft of femur	25%
Fracture of condyles /patella	15%

Lower Leg	
Open Fracture of more than one bone	60%
Open Fracture of one bone	45%
Closed Fracture of more than one bone	25%
Closed Fracture one bone	15%
Fracture Ribs	
Fracture of Multiple Ribs with Flail Chest	25%
Fracture of Multiple Ribs with without Flail Chest	20%
Fracture of Single rib / Fracture of sternum	10%
Elbows, Arm (including wrist but excluding Colles type fractures)	
Open Fracture of more than one bone	45%
Open Fracture of one bone	35%
Closed Fracture of more than one bone	20%
Closed Fracture one bone	15%
Colles type fracture of the lower arm	
Open Fracture	25%
Closed Fracture	10%
Skull	
Fracture of the skull needing surgical Intervention	60%
Fracture of the skull not needing surgical Intervention	20%
Shoulder Blade, Rib(s), Knee cap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes or heel)	
Open Fracture	30%
Closed Fracture	15%
Spinal Column (Vertebrae but excluding coccyx)	
Compression fractures of more than one vertebrae	40%
Spinous, transverse process of pedicle fractures of more than one vertebrae	40%
Permanent Spinal Cord damage	40%
Fractures of Single Vertebra	15%
Lower Jaw	
Open Fracture	25%
Closed Fracture	10%
Cheekbone, Clavicle, Coccyx, Upper Jaw, Nose, Toe(s), Finger(s), Ankle, Heel	
Open Fracture of more than one bone	15%
Open Fracture of one bone	12%
Closed Fracture of more than one bone	4%
Closed Fracture one bone	2%
Dislocations requiring surgery under anaesthesia	
Spine	35%
Back (Excluding slipped disc)	35%
Hip	25%
Knee (left or right)	20%
Wrist (left or right)	15%
Elbow (left or right)	15%
Ankle (left or right)	10%
Shoulder Blade (left or right)	10%
Collar bone	10%
Fingers (left or right hand)	5%
Toes (left or right foot)	5%
Jaw	5%
Internal Injuries	
Internal injuries resulting in open abdominal or Thoracic Surgery	25%
Intracranial haemorrhage and/ or physical brain injury	25%

Specific Conditions:

1. If You suffer a Fracture not specified in the below table but the fracture is due to an injury solely and directly due to an accident, then Our Medical Practitioner will decide the amount payable, if any. For this section the Company's Medical Practitioner refers to the medical practitioner who is working as an off roll /contract basis with the Insurer.
2. A fracture which results due to any illness or disease (including malignancy) or due to osteoporosis shall not be payable under this benefit.

3. A fracture where the broken bone penetrates the skin is an Open Fracture and where the broken bone does not penetrate the skin is a Closed Fracture.
4. If the Insured Member suffers Accidental Injuries resulting in more than one fractures, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

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

SECTION 13. BURNS COVER

If You have opted for this Cover and You sustain Second Degree Burns or Third Degree Burns solely and directly due to an accident, then We will pay the percentage shown in the below table of benefits applied to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

Burns Cover - Table of Benefits

Nature of Burns	% of Sum Insured
SECOND DEGREE BURNS	
Head	
Second degree burns of 30% or more of the total head surface area	50%
Second degree burns of 20% or more, but less than 30% of the total head surface area	40%
Second degree burns of 10% or more, but less than 20% of the total head surface area	30%
Rest of the Body	
Second degree burns of 20% or more of the total body surface area	50%
Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
Second degree burns of 5% or more, but less than 10% of the total body surface area	10%
THIRD DEGREE BURNS	
Head	
Third degree burns of 30% or more of the total head surface area	100%
Third degree burns of 20% or more, but less than 30% of the total head surface area	80%
Third degree burns of 10% or more, less than 20% of the total head surface area	60%
Rest of the Body	
Third degree burns of 20% or more of the total body surface area	100%
Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
Third degree burns of 10% or more, less than 15% of the total head body area	60%
Third degree burns of 5% or more, less than 10% of the total head body area	20%

For the purpose of this cover,

1. Burns means an injury caused by exposure to heat or flame including chemical and electric burns.
2. **Second Degree Burns** means Burns which involve the epidermis and part of the dermis layer of skin, causing the burn site to appear red, blistered, and may be swollen and painful.
3. **Third Degree Burns** (full thickness burns) means the burns that destroy the outer layer of the skin (epidermis) and the entire layer beneath i.e. the dermis. It also affects deeper tissues resulting in white or blackened, charred skin that may cause numbness, loss of fluid and sometimes shock.

Specific Conditions:

1. The burns that are self-inflicted by You in any way will not be covered under this Benefit;
2. A Medical Practitioner has to confirm the percentage of the surface area of the burn and the diagnosis of the burn to Us in writing.
3. If the Insured Member suffers Accidental Injuries resulting in more than one of the nature of burns mentioned in the above table of benefits, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

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

SECTION 14. LIFESTYLE MODIFICATION BENEFIT

If You have opted for this Cover and We have accepted a claim under "**Section 2. Permanent Total Disablement**" and/or "**Section 3. Permanent Partial Disablement**", and/or **Section 20. Critical Illness Benefit Cover** and/or **Section 21. Critical Illness Hospitalization Cover** (wherever opted), then We will reimburse the Reasonable and Customary Charges/Expenses incurred for improvements to be carried out in the Insured Person's residence and/or vehicle which are certified in writing by a Medical Practitioner to be necessary and following the accident or diagnosis of critical illness, up to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

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

SECTION 15. EXPENSE FOR EXTERNAL AIDS & APPLIANCES

If You have opted for this Cover and We have accepted a claim under "**Section 2. Permanent Total Disablement**" and/or "**Section 3. Permanent Partial Disablement**", and/or **Section 20. Critical Illness Benefit Cover** and/or **Section 21. Critical Illness Hospitalization Cover** (wherever opted), then We will reimburse the Reasonable and Customary Charges incurred towards purchase of support items such as artificial limbs, crutches, stretcher, tricycle, wheelchairs or any other item which is prescribed by a Medical Practitioner following an injury sustained in the accident or critical illness, up to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section
This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 16. COMPASSIONATE VISIT

If You have opted for this Cover and We have accepted a claim under **"Section 1. Accident Death"** and/or **"Section 2. Permanent Total Disablement"** and/or **"Section 26.A. Accidental Hospitalization"** due to an accident in a location situated outside the City/Town of Your usual place of residence mentioned in Your Policy Schedule/Certificate of Insurance, then We will reimburse the actual cost incurred for to and fro economy class transportation by the most direct route via a common carrier, up to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, for one of the Insured's "**Immediate Family Member"** to travel to the place of accident or the Hospital in which the Insured Person is hospitalized.

For the purpose of this Section, the term "**Immediate Family Member**" would mean the Insured Person's spouse, siblings, Children above age of 18 years, parents or parents in law.

Specific Conditions:

The benefit is payable under this Section subject to:

1. The Insured Member's treating Medical Practitioner has advised in writing the personal attendance of an Immediate Family Member.
2. The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence.

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

SECTION 17. MISCARRIAGE DUE TO ACCIDENTAL INJURY

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in **Miscarriage** of a Pregnant Insured Member within 15 days of such accident, then We will pay a lumpsum amount as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance, provided that:

a. The miscarriage shall not be attributed to any natural causes and/or sickness relating to pregnancy or child birth.
b. We shall not be liable for voluntary termination of pregnancy.
c. This benefit is applicable only to the female Insured Member covered under this Policy.

For the purpose of this Cover, **Miscarriage** shall mean the spontaneous or unplanned expulsion of a foetus from the womb within the first 20 weeks of gestation.

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

SECTION 18. HAZARDOUS OR ADVENTURE SPORTS COVER

This Policy has exclusion for any accidental bodily injury sustained while participating in **Hazardous or Adventure Sports**. By Opting this section "HAZARDOUS OR ADVENTURE SPORTS COVER", You can choose to remove the abovementioned exclusion for the following 3 sections as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance.

a. Section 1- "**Death**"
b. Section 2- "**Permanent Total Disablement**"
c. Section 30 A- "**Accidental Hospitalization**"

Provided You are participating in a non-professional capacity and under the supervision of a trained professional. Claim Assessment will be as per the terms and condition of the respective section.

Hazardous or Adventure Sports cover are bifurcated into various level (Level 0, 1, 2 & 3) as mentioned in **Annexure - B**. You can choose to cover the level of **Hazardous or Adventure Sports cover** which will be mentioned in Your Policy Schedule/Certificate of Insurance under specific conditions for this section.

- If You have paid the required additional premium for **Hazardous or Adventure Sports cover** in Level 3, You will be covered for all sports and activities listed as Level 0 (Zero), 1, 2 and 3.
- If You have paid the required additional premium for **Hazardous or Adventure Sports cover** in Level 2, You will be covered for all sports and activities listed as Level 0 (Zero), 1 and 2 while level 3 will remain as exclusion.
- If You have paid the required additional premium for **Hazardous or Adventure Sports cover** in Level 1, You will be covered for all sports and activities listed as 0 (Zero) and Level 1 while level 2 and 3 will remain as exclusion.
- This cover is subject to some special condition and exclusions on individual sports and activities as mentioned in **Annexure – B** against respective sport/activity**.**

Specific Conditions:

1. The cover for the Insured Member under this Section shall terminate immediately once a claim is admitted and paid under the **Hazardous or Adventure Sports cover** for "**Death**" or "**Permanent Total Disablement**".
2. Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against the respective Sections.
3. We will not pay any claim under this Cover, whilst You are Training for or taking part in sport as a:
   - professional for which You are paid or funded by sponsorship or grant; or
   - as an amateur sportsperson; or
   - You are not performing the activity under the supervision of a trained professional. The Hazardous or adventure sport service provider must be Government/ Relevant Authority certified.
   - The insured shall be older than 18 years of age and his informed consent must have been taken prior to undertaking the activity. The insured should have been informed of the risks associated with the activity by a professional trainer (employee of service provider) prior to commencement of activity.
   - At the time of claim, the onus shall lie on the Insured to prove that he/she had undertaken all the necessary safety precautions as were recommended to him including the use of protective gear and had followed the trainer's instructions. The company is at a right to confirm from the service provider the Insured's participation in this activity and the extent of precautions taken by the insured.
   - The insured shall not be undertaking these activities in case he/she suffers from pre –existing health conditions which may hamper his/her health or lead to potential medical emergencies whilst undertaking these activities.

Specific Exclusions applicable to Section 18 – Hazardous or Adventure Sports:

1. Competing at an international event as a national representative.
2. Participation in any Hazardous or adventure sports, activities where you don't select the appropriate Hazardous or adventure sports level upgrade or where it is specifically excluded (including Special Exclusion (i)-(iv) mentioned in **Annexure B**)
3. You go against local authority warnings or enter closed or restricted areas or places or situations known to be unsafe or dangerous.
4. Damage to any sporting equipment while in use; damage or theft of any sporting equipment left unattended.
5. Racing, except on foot and up to marathon level; participating in speed or time trials.
6. Motorsports – shows, races, competitions or training.
7. For motorised vehicles:
   a. not wearing a helmet regardless of the local laws; and
   b. operating any motorised vehicle without a valid licence for the same class of vehicle or watercraft in Your country of residence and as required in the relevant country where you're travelling.
8. Where You don't meet the Special Conditions (a)-(e) (mentioned in **Annexure B**) as specified in the list of the Special Conditions applicable to Hazardous or Adventure Sports Cover.
   a. Undertaking or working in any dangerous, extreme or hazardous activities, and/or participating in any sports or activities in hazardous locations, such as for example: base jumping, wingsuit flying, cliff diving, martial arts competitions, motor sports, piloting an aircraft, stunt flying/aerobatics, rodeo, bull riding/Running of the Bulls;
   b. taking part in dangerous expeditions; mountaineering expeditions or expeditions to the Arctic, Antarctica or Greenland, unless specifically approved by us;
   c. crewing of a vessel more than 60 miles from a protected body of water;
   d. work as a guide where ropes or other specialist climbing equipment is required;
   e. work offshore or underground, including in caves;
   f. work operating machinery or heavy/industrial equipment;
   g. work at height without proper safety equipment. Work at height is further restricted to a maximum of two metres; or
   h. work in close proximity to dangerous animals including, for example, hippopotami, crocodiles, alligators, sharks, elephants, bears, big cats and deadly snakes.

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

SECTION 19. HIV 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 first diagnosed to be suffering from an HIV Infection during the Policy Period and provided that HIV Infection is caused by any of the reasons other than Transmission through unprotected sex (Heterosexual, Homosexual or Bisexual).

For the purpose of this cover,
"HIV Infection" means a positive HIV antibody testing (rapid or laboratory-based enzyme immunoassay). This is usually confirmed by a second HIV antibody test (rapid or laboratory-based enzyme immunoassay) relying on different antigens or of different operating characteristics.
and /or;
a positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virological test obtained from a separate determination.

Special Terms and Conditions Applicable to this Section

a. Coverage under this Section shall terminate in respect of the Insured Member against whom a claim has been accepted. However, the coverage under the Policy for other Sections (if opted) for that Insured Member shall continue under this Policy.
b. Any Claim with respect to an HIV infection detected, diagnosed or which manifested prior to Policy Start Date or during Initial Waiting Period as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance is excluded from the Scope of the Cover provided under this Section.

SECTION 20. CRITICAL ILLNESS BENEFIT COVER

If You have opted for this Cover, We will pay You the Sum Insured opted by you for 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 per the Plan Opted by You and mentioned in Your Policy Schedule/Certificate of Insurance as specified below Provided that,

a) This Critical illness or covered surgical procedure has happened to you for the first time in Your life and during the Policy Period.
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 "Digit Group Complete Secure Policy" with Us covering Critical Illness benefit.
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) No Claim under this option shall be admissible if the Critical Illness /or covered Surgical Procedure claim 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.
e) Once a claim has been Paid under Critical Illness and / or covered Surgical Procedure, Cover under this Section shall cease and no further payment will be made for any consequent disease or any dependent disease.
f) The List of Plan wise covered Critical Illness is mentioned in **Annexure C.**

This Cover is subject to terms, conditions, limitations, sum insured basis and exclusions mentioned in the Policy.

SECTION 21. 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 per the Plan Opted by You and mentioned in Your Policy Schedule/Certificate of Insurance, 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 and/or covered surgical procedure has happened to you for the first time in Your life and during the Policy Period.
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 "Digit Group Complete Secure Policy" with us covering critical illness hospitalization.
c) No Claim under this option shall be admissible if Critical Illness and/or covered Surgical Procedure 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) In this section we will not cover any expense related to Pre-Hospitalization and Post-Hospitalization.
e) The List of Plan wise covered Critical Illness is mentioned in **Annexure C.**

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

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

SECTION 22. 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 and during the Policy Period. 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 "Digit Group Complete Secure Policy" with us covering Cancer Benefit.
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.
e. In case You are a woman and have opted to limit the coverage under this cover only to cancers specific to women, then coverage under this section will be limited only to the diagnosis of Cancers as mentioned in Your Policy Schedule/Certificate of Insurance.

This Cover is subject to terms, conditions, limitations, sum insured basis and exclusions mentioned in the Policy.

SECTION 23. 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 and 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 "Digit Group Complete Secure Policy" with us covering Cancer Hospitalization.
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.
c) In this section we will not cover any expense related to Pre-Hospitalization and Post-Hospitalization.

d) In case You are a woman and have opted to limit the coverage under this cover only to cancers specific to women, then coverage under this section will be limited only to the hospitalisation due to women specific cancers as mentioned in Your Policy Schedule/Certificate of Insurance.

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

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

SECTION 24. HEART PROTECT 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 for one of the below heart conditions for the first time in Your life and during the Policy Period:

i. Myocardial Infarction
ii. Open Heart Replacement or Repair of Heart Valves
iii. Surgery to Aorta
iv. Open Chest CABG

Provided that,

a. We will not make any payment if You are diagnosed as suffering from Heart condition 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 "Digit Group Complete Secure Policy" with us covering "Heart Protect Benefit Cover".
b. You survive for a minimum period of at least 30 days from the date of diagnosis of such from Heart condition, unless this condition is specifically waived by Us.
c. No Claim under this option shall be admissible if the Heart condition 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 covered Heart condition and no further payment will be made for any consequent disease or any dependent disease.

This Cover is subject to terms, conditions, limitations, sum insured basis and exclusions mentioned in the Policy.

SECTION 25. HEART PROTECT HOSPITALIZATION COVER

If You have opted for this Cover and You are diagnosed as suffering from below Heart conditions for the first time in Your life and 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 below Heart conditions up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

i. Myocardial Infarction
ii. Open Heart Replacement or Repair of Heart Valves
iii. Surgery to Aorta
iv. Open Chest CABG

Provided that,

a) We will not make any payment if You are diagnosed as suffering from the above listed Heart conditions 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 "Digit Group Complete Secure Policy" with us covering "Heart Protect Hospitalization Cover".

b) No Claim under this option shall be admissible if Heart conditions 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.

c) In this section we will not cover any expense related to Pre-Hospitalization and Post-Hospitalization.

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

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

SECTION 26. ORGAN FAILURE 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 from one of the below organ failure for the first time in Your life and during the Policy Period:

i. End Stage Lung Failure
ii. End Stage Liver Failure
iii. Kidney Failure Requiring Regular Dialysis

Provided that,

a. We will not make any payment if You are diagnosed as suffering from above listed organ failure 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 "Digit Group Complete Secure Policy" with us covering "Organ Failure Benefit Cover".
b. You survive for a minimum period of at least 30 days from the date of diagnosis of such organ failure, unless this condition is specifically waived by Us.
c. No Claim under this option shall be admissible if the organ failure 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 covered organ failure and no further payment will be made for any consequent disease or any dependent disease.

This Cover is subject to terms, conditions, limitations, sum insured basis and exclusions mentioned in the Policy.

SECTION 27. ORGAN FAILURE HOSPITALIZATION COVER

If You have opted for this Cover and You are diagnosed as suffering from below organ failure for the first time in Your life and 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 organ failure up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

i. End Stage Lung Failure

ii. End Stage Liver Failure
iii. Kidney Failure Requiring Regular Dialysis

Provided that,

a. We will not make any payment if You are diagnosed as suffering from the above listed organ failure 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 "Digit Group Complete Secure Policy" with us covering "Organ Failure Hospitalization Cover".
b. No Claim under this option shall be admissible if organ failure 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.
c. In this section, We will not cover any expense related to Pre-Hospitalization and Post-Hospitalization.
d. In this section, We will not cover any expense related to organ harvesting.

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

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

SECTION 28. EMI PROTECTION COVER

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Your "**Death**" or "**Permanent Total Disablement**" or **"Permanent Partial Disablement"** within twelve (12) months from the Date of accident or suffer from **"Critical Illness"** or "**Accidental & Illness Hospitalization"** or "**Loss of Employment"** or **"Listed Illness"** as per the contingency opted and mentioned in Your Policy Schedule/Certificate of Insurance against this Section and this completely prevents You from performing each and every duty pertaining to Your employment or occupation mentioned in Your Policy Schedule/Certificate of Insurance for a minimum period of 1 month, We will pay an amount equivalent to Your contribution in EMI of Your Loan from a Financial Institution, up to the Sum Insured and Number of Months opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, provided that:

a. Satisfactory proof is submitted confirming that "**Permanent Total Disablement**" or **"Permanent Partial Disablement"** or **"Critical Illness"** or **"Accidental & Illness Hospitalization"** or **"Loss of Employment"** or **Listed Illness** has completely prevented You from engaging in Your Employment or Occupation mentioned in Your Policy Schedule/Certificate of Insurance.
b. We will stop making payments when We are satisfied that You can engage in Your Employment or Occupation again or when We have made payments for a maximum period of months, as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance, beginning from the date You met with the Accidental Bodily Injury or were first Diagnosed with Critical Illness or first underwent Surgical Procedures mentioned under Critical Illness or Hospitalised due to accident or illness or Your loss of employment or You suffer from Listed Illness, whichever is earlier.
c. The EMI amount would not include any arrears/payment that are overdue and unpaid by the Insured Person prior to the date of accident, due to any reasons whatsoever.
d. The treatment required by the Insured Person is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

Cover under this Section shall cease upon payment of the compensation due to any contingency mentioned above and no further payment will be made for any contingency as mentioned above or any dependent contingency.

For the Purpose of this Cover;

a. **"Permanent Partial Disablement"** means:
- Loss of arm at the shoulder joint
- Loss of leg above centre of the femur
- Loss of arm to a point above elbow joint
- Loss of leg up to a point below the femur
- Loss of arm below elbow joint
- Loss of hand at the wrist
- Complete and irrecoverable loss of sight of an eye
- Loss of leg to a point below the knee
- Loss of leg up the centre of tibia
- Loss of foot at the ankle

b. **"Critical Illness"** shall mean the below listed illnesses that You are diagnosed as suffering from or Surgical Procedures that You are undergoing, for the first time in your life.

Provided that:

1. 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 "Digit Group Complete Secure Policy" with Us covering Critical Illness.
2. 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.
3. No Claim under this option shall be admissible if Critical Illness and/or covered Surgical Procedure 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.
4. The List of Plan wise covered Critical Illness is mentioned in **Annexure C.**

c. "**Accidental and Illness Hospitalization"** means You suffer an Accidental Injury or Illness during the Policy Period that requires Hospitalization as an inpatient.
   1. We will not make any payment if You are diagnosed as suffering from any 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 "Digit Group Complete Secure Policy" with us covering "**Accidental and Illness Hospitalization /EMI Protection Cover**".
   2. 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 "Digit Group Complete Secure Policy" with Us, provided that the Policy has been renewed continuously with Us without break.

d. **"Loss of Employment"** means You are terminated or dismissed or retrenched from Your Employment, by the Employer during the Policy Period as per the Employer's rules/regulations or executed/ implemented by the Employer in compliance of any laws for the time being in force or any directives by any Public Authority, subject to following exclusions:
   1. The Company shall not be liable to make any payment under this Section in the event of termination, dismissal, temporary suspension or retrenchment from employment of the Insured being attributed to any dishonesty or fraud or poor performance on the part of the Insured or his wilful violation of any rules of the employer or laws for the time being in force or any disciplinary action against the Insured by the employer.
   2. The Company shall not be liable to make any payment under this Policy in connection with or in respect of:
      a. Self-employed persons;
      b. Any claim relating to unemployment from a job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer;
      c. Any voluntary unemployment;
      d. Unemployment at the time of inception of the Policy Period;
      e. Unemployment within the number of days (ie. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first "Digit Group Complete Secure Policy" with Us covering Loss of Employment.
   3. Any unemployment from a job under which no salary or any remuneration is provided to the Insured.
   4. Any suspension from employment on account of any pending enquiry being conducted by the employer/ Public Authority
   5. Any unemployment due to resignation, retirement whether voluntary or otherwise
   6. Any unemployment due to non-confirmation of employment after or during such period under which the Insured was under probation.
   7. If the employment contract and Job Location was outside India.
   8. Any unemployment arising or resulting from the Insured committing any breach of the law with criminal intent.
   9. Any unemployment due to, or arising out of, or directly or indirectly connected with or traceable to, war, invasion, act of foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, Pandemic or Epidemic as declared by WHO, restraints and detainment of all Heads of State and citizens of whatever nation and of all kinds and acts of terrorism.
   10. Any unemployment directly or indirectly caused by or contributed to by or arising out of usage, consumption or abuse of alcohol and/or drugs.
   11. Any consequential or indirect loss or expenses arising out of or related to unemployment will not be covered.

12. We will not make any payment if You are diagnosed as suffering from any 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 "Digit Group Complete Secure Policy" with us covering "**Loss of Employment/EMI Protection Cover**".

e. "**Listed Illness"** means the coverage from following Illness:

1. We will not make any payment if You are diagnosed as suffering from any 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 "Digit Group Complete Secure Policy" with us covering "**Listed Illness/EMI Protection Cover**".

List of Disease/s and/or Conditions:

1. Cholera	2. Amoebiasis	3. Typhoid
4. Viral Hepatitis	5. Tuberculosis	6. Plague
7. Diphtheria	8. Typhus	9. Leptospirosis
10. Dengue	11. Malaria	12. Filariasis
13. Kala Azar	14. Chikungunya	15. Japanese Encephalitis
16. HIV	17. Zika Virus	18. Nipah Virus
19. EBOLA	20. Swine Influenza Virus	21. H1N1 Virus
22. COVID-19	23. SARS	24. MERS

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

SECTION 29. LOSS OF EMPLOYMENT

If You have opted for this Cover and You are terminated or dismissed or retrenched from Your Employment, by the Employer during the Policy Period as per the Employer's rules/regulations or executed/ implemented by the Employer in compliance of any laws for the time being in force or any directives by any Public Authority, We will pay on any one of the following Basis Opted by You at Policy Inception and mentioned in Your Policy Schedule/Certificate of Insurance:

Basis 1:

a. An amount equal to the EMI payable monthly as mentioned in Your Policy Schedule/Certificate of Insurance. Or
b. 70% of Net Monthly Salary (Take home salary) after deduction of income tax, professional tax, PF Contributions, Bonuses / One-time Variable Pay, Any other deductions, and any reimbursements from the monthly pay slips. For the calculation of Monthly Take home salary, we shall consider the last three months monthly average salary subject to all deductions mentioned above.

The Claim Payable under this Basis shall be restricted to number of months as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance and shall be lower of Point a. and b. above. However, if the number of Outstanding EMI remaining in Your Loan Repayment Schedule, post the commencement of the claim payable under this Section is less than the number months as opted by You, then We shall be restricting our payments to the number of EMI remaining for the related loan.

Basis 2:

a. Fixed Amount Per Month as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance.
b. Or 70% of Net Monthly Salary (Take home salary) after deduction of income tax, professional tax, PF Contributions, Bonuses / One-time Variable Pay, Any other deductions, and any reimbursements from the monthly pay slips. For the calculation of Monthly Take home salary, we shall consider the last three months monthly average salary subject to all deductions mentioned above.

The Claim payable under this Basis shall be restricted to number of months as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance and shall be lower of Point a. and b. above.

Specific Exclusions Applicable to this Section

1. The Company shall not be liable to make any payment under this Section in the event of termination, dismissal, temporary suspension or retrenchment from employment of the Insured being attributed to any dishonesty or fraud or poor performance on the part of the Insured or his wilful violation of any rules of the employer or laws for the time being in force or any disciplinary action against the Insured by the employer.
2. The Company shall not be liable to make any payment under this Policy in connection with or in respect of:
   a. Self-employed persons;
   b. Any claim relating to unemployment from a job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer;
   c. Any voluntary unemployment;
   d. Unemployment at the time of inception of the Policy Period;
3. Any unemployment from a job under which no salary or any remuneration is provided to the Insured
4. Any suspension from employment on account of any pending enquiry being conducted by the employer/ Public Authority
5. Any unemployment due to resignation, retirement whether voluntary or otherwise

6. Any unemployment due to non-confirmation of employment after or during such period under which the Insured was under probation.
7. If the employment contract and Job Location was outside India.
8. Any unemployment rising or resulting from the Insured committing any breach of the law with criminal intent.
9. Any unemployment due to, or arising out of, or directly or indirectly connected with or traceable to, war, invasion, act of foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of all Heads of State and citizens of whatever nation and of all kinds and acts of terrorism.
10. Any unemployment directly or indirectly caused by or contributed to by or arising out of usage, consumption or abuse of alcohol and/or drugs.
11. Any consequential or indirect loss or expenses arising out of or related to unemployment.

Special Terms and Conditions Applicable to this Section

a) **Re Employment**

In the event insured gets re-employed but with reduced monthly take home salary. The Company shall pay the 70% of difference between the reduced monthly take home salary and monthly take home salary prior to the insured event, subject to the maximum of the EMI amount and shall be restricted to number of months as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance.

The Claim payable under this policy shall continue to be paid in reduced proportion as per the calculation method above, even if reemployment takes place during the period of severance pay, or during deferred period of 30 days or even after the Claim payable has commenced.

b) Initial Waiting Period

Any claim shall not be Payable under this policy, if the Insured event triggers within number of days specified in the Policy Schedule/Certificate of Insurance from the risk inception date of Your policy or inception of the first "Digit Group Complete Secure Policy" with Us whichever is earlier.

Waiting Periods before the Benefit payment starts after an Insured Event

a. If the Employer pays any severance pay Benefit, then the claim payable under this section shall start only after the time period for which severance pay is applicable. For the calculation of "Time Period" for which severance pay shall be applicable, the company shall consider the Severance pay paid by the Employer divided by the monthly take home salary to consider the amount of period for which severance pay shall be applicable.
b. In addition to the point a. above, there will be a further waiting period of one month that shall be applicable before the claim payable under this policy Commences.

In the event, if the Insured has started working again during the waiting periods applicable above, this claim shall only be payable as per the reduced formulae as mentioned in "Re Employment" section above.

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

SECTION 30: 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 there is 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 30.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 **Section 30. 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 30.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 30. 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 30. 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 there is 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 30.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 30.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 30.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 30. 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 30. 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

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
     - 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 "Digit Group Complete Secure 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 "Digit Group Complete Secure Policy".
e) If you are porting an existing policy under Portability Guidelines, from some other General or Health Insurance Company where this cover was not there 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.
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

Psychiatric Illness is covered upto the Sum Insured available under **30 B. Accidental & Illness Hospitalization Cover**. However, if You have opted for this 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 "Digit Group Complete Secure 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 "Digit Group Complete Secure Policy".
c) Hospitalization under this benefit shall be subject to prior approval from Us, except in cases of emergencies.

B8. 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 31. INFERTILITY TREATMENT COVER

If You have opted for this Cover and if You are hospitalized on the advice of the Medical Practitioner for Infertility/ Subfertility Treatments then We will pay the Medical Expenses including but not limited to, IVF, IUI, ZIFT, ICSI, subject to below conditions:

a) This will be subject to a waiting period as number of days/ month/years as mentioned in the Policy Schedule which will apply from the date of inception of the first "Digit Group Complete Secure 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 "Digit Group Complete Secure Policy".
b) This section will not have a separate sum insured. This will be up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against **Section 30.B. Accidental & Illness Hospitalization Cover.** Further, Our maximum liability per Hospitalization shall be restricted to the limits 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, unless specifically waived by Us and mentioned in the **Policy Schedule / Certificate of Insurance**.

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

32. ORGAN DONOR

If You have opted for this Cover, We will pay You for the Medical Expenses incurred towards harvesting of the donated organ subject to following conditions:

a) This section will not have a separate sum insured. This will be up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover.** Further, Our maximum liability per Hospitalization shall be restricted to the limits as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
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 for a claim to be admissible in this section.
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 "Digit Group Complete Secure 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 "Digit Group Complete Secure Policy".

Provided that, We have accepted a claim under **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover.**

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

SECTION 33. 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 section will not have a separate sum insured, it will be up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental**

& Illness Hospitalization Cover. Further, Our maximum liability per Hospitalization shall be restricted to the limits as mentioned in Your Policy Schedule / Certificate of Insurance against this Section. 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 34. 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 provided that such Transportation in an airplane or helicopter has been prescribed by a Medical Practitioner and/or is Medically Necessary.
This section will not have a separate sum insured, it will be up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover.** Further, Our maximum liability per Hospitalization shall be restricted to the limits as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
Provided that, We have accepted a claim under **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover.**

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

SECTION 35. LONG HOSPITALIZATION CASH BENEFIT

If You have opted for this Cover and 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 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover,** and
b) The benefit is payable only once to an Insured Person during the Policy Year.

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 36. MATERNITY & NEWBORN BABY COVER

A. MATERNITY COVER

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) Expenses incurred towards your normal delivery and caesarean delivery will be as per the amount opted by You and as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
b) Female Insured Person's legally married spouse is also covered under this Policy, unless specifically waived by Us.
c) 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 "Digit Group Complete Secure Policy" with us, provided that the policy has been renewed continuously with us without break, with maternity as a benefit.
d) If you are porting an existing policy under Portability Guidelines, from some other General or Health insurance company where this cover was not there 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.
e) 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.
f) 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.

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.

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 30.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. NEW BORN BABY COVER

If You have opted for this Cover, we will pay the Medical Expenses, within the limit of the Sum Insured available under the **Section 36. Maternity & Newborn Baby Cover** of the Policy, provided that We have accepted a claim under **Section 36. A. Maternity Cover**, incurred towards:

a) The medical treatment of the Insured Person's Newborn Baby while the Insured Person is hospitalised as an inpatient for delivery.
b) The Newborn 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 Newborn 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 and New Born Baby Cover** as a benefit since inception of the first "Digit Group Complete Secure Policy".
d) If the Policy Expires before 90 days from the date of delivery, the Newborn 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 Newborn 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 37. 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) This section will not have a separate sum insured, it will be subject to availability of the sum insured under **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover.** Further, Our maximum liability per Hospitalization shall be restricted to the limits as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

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

SECTION 38. SUM INSURED REFILL BENEFIT

If you have opted for this Cover, We will refill 100% of the Sum Insured specified and utilized under **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover** for that particular Policy Period, provided that:

i. The refilled Sum Insured would be utilized if the cause of the Hospitalization is related or not related (as opted by You as mentioned in Your Policy Schedule / Certificate of Insurance against this Section) to or arising out of earlier Hospitalization, including its complications, for which a claim has already been availed during the same policy year for the same Insured Person.
ii. In case of related Hospitalization cooling off period of 45 days will be applicable.

iii. If the first claim amount exceeds the Sum Insured under **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover**, the refilled Sum Insured will not be applicable for the same hospitalisation.
iv. After the refill, the maximum amount payable for any single claim will not exceed the Sum Insured mentioned under **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover.**
v. 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.
vi. In case of Floater Policy, the refilled Sum Insured will be applicable on family floater basis.
vii. For this benefit sum Insured can only be utilized for hospitalization in India only.

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

SECTION 39. 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. The maximum claim payable under each sub -section under this cover shall be subject to the limits specified against the respective sub-sections and Sum Insured mentioned in **Policy Schedule/Certificate of Insurance** against this section. Benefit under this section should be provided through **Network Facilitator** as mentioned in Policy Schedule/Certificate of Insurance.

39.1. OPD Doctor Consultations –

If **You** have opted for this sub-section and suffer from an **Accidental Injury** or **Illness** during the **Policy Period, We** will indemnify **You** for the expenses incurred for the following options, upto the **Sum Insured** as mentioned in the **Policy Schedule/Certificate of Insurance**.

39.1.1. Physical General Consultation	Out-Patient allopathic physical consultations from a **General Medical Practitioner(s)**, subject to the number of consultations, per consultation limit and other terms as mentioned in the **Policy Schedule/Certificate of Insurance** against this option.
39.1.2. Physical Specialist Consultation	Out-Patient allopathic physical consultations from a **Specialist Medical Practitioner(s)**, subject to the number of consultations, per consultation limit and other terms as mentioned in the **Policy Schedule/Certificate of Insurance** against this option.
39.1.3. Telephonic/ Virtual General Consultations	Out-Patient allopathic telephonic/ virtual consultations from a **General Medical Practitioner(s)**, subject to the number of consultations, per consultation limit and other terms as mentioned in the **Policy Schedule/Certificate of Insurance** against this option.
39.1.4. Telephonic/ Virtual Specialist Consultations	Out-Patient allopathic telephonic/ virtual consultations from a **Specialist Medical Practitioner(s)**, subject to the number of consultations, per consultation limit and other terms as mentioned in the Policy Schedule/Certificate of Insurance against this option.

Specific Conditions Applicable to this Sub- section:

a. Benefit under this sub-section can be availed through **Network Facilitator** or by **Us,** as specifically mentioned in **Policy Schedule/Certificate of Insurance**.
b. Benefit under this sub-section will be provided subject to the availability of **General Medical Practitioner(s) or a Specialist Medical Practitioner(s)** at the time of appointment.
c. Coverage provided under this sub-section will be as per details mentioned in the Policy Schedule/ Certificate of Insurance.
d. In case of any emergency, Insured Person can take Out-patient consultation from any Network Facilitator other than as mentioned in **Policy Schedule/Certificate of Insurance**, provided that **Sum Insured** for emergency cases shall be limited and will be mentioned in **Policy Schedule/Certificate of Insurance.**
e. **You** can opt for sub-limit of the **Sum Insured** available under the section for **Psychiatric Illness,** upto the percentage as opted by **You** and mentioned in **Policy Schedule/Certificate of Insurance.**

39.2. Lab Test and Diagnostics-

If **You** have opted for this sub-section and suffer from an **Accidental Injury** or **Illness** during the **Policy Period**, We will indemnify **You** for the expenses incurred on Medically Necessary **Out-Patient** diagnostic procedures or lab tests prescribed by **Medical Practitioner(s)** including but not limited to Pathology, Radiology and x-rays to make a diagnosis for treatment, upto the **Sum Insured** as mentioned in Policy Schedule/Certificate, subject to the number of procedures or tests, per procedure limit or per tests limit or per prescription limit and other terms, conditions, deductible mentioned in the **Policy Schedule/Certificate of Insurance.**

Specific Conditions Applicable to this Sub-Section

a. Benefit under this sub-section can be availed through **Network Facilitator** or by **Us,** as specifically mentioned in **Policy Schedule/Certificate of Insurance**.
b. Benefit under this sub-section will be provided subject to the availability of lab/ diagnostic centre at the time of appointment**.**
c. Any Expenses incurred on diagnostic procedure or tests done as a health check-up will be excluded.

Specific exclusion applicable to this sub-section section

a. Expenses incurred on diagnostic procedure or tests done as a preventive health check-up.
b. Diagnostic procedure or lab test more than INR 3,000 will be excluded, unless specifically waived by **Us** and mentioned in the **Policy Schedule/ Certificate of Insurance**.

39.3. Pharmacy Cover

If **You** have opted for this sub-section and suffer from an **Accidental Injury** or **Illness** during the **Policy Period**, We will indemnify You for the expenses incurred on Pharmacy for the following options, upto the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance for:

39.3.1. Pharmacy exactly as per prescription	Pharmacy exactly as per prescription of Medical Practitioner, upto the Sum Insured as mentioned in Policy Schedule/Certificate.
39.3.2. Generic Form of Pharmacy	Generic form of prescribed Pharmacy, upto the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance.

Specific Conditions Applicable to this Sub-Section

a. Benefit under this section can be availed through **Network Facilitator** or by **Us,** as specifically mentioned in **Policy Schedule/Certificate of Insurance.**
b. Benefit under this sub-section will be provided subject to the availability of **Pharmacy** at the time of purchasing it.
c. Coverage provided under this section will be as per details as mentioned in the **Policy Schedule/ Certificate of Insurance.**

39.4. Out-Patient Dental Treatment

If **You** have opted for this sub-section, **We** will indemnify **You** for the **Out-Patient** Dental treatment expenses for the immediate relief as prescribed by **dentist(s)** for the following as opted mentioned in Policy Schedule/ Certificate of Insurance:

39.4.1. Dental Consultation	If You require dental treatment arising out of an Accidental injury or Illness, We will indemnify for Dental consultations from dentist (s) upto the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance subject to the number of consultations, per consultation limit and other terms as mentioned in the Policy Schedule/Certificate of Insurance against this option.
39.4.2. Dental Procedure	If You require dental treatment arising out of an Accidental injury or Illness, We will indemnify for dental procedures including but not limited to Dental X-rays, Extractions, Amalgam or composite fillings, root canal treatments upto the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance subject to the number of procedures, per procedure limit and other terms as mentioned in the Policy Schedule/Certificate of Insurance against this option**.**
39.4.3. Pharmacy for Dental treatment	If You require dental treatment arising out of an Accidental injury or Illness, We will indemnify for the Pharmacy for the dental treatment upto the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance subject to the terms, conditions as mentioned in the Policy Schedule/Certificate of Insurance against this option.
39.4.4. Cosmetic Dental Treatment	Any dental treatment that comprises cosmetic surgery, scaling and polishing, dentures, dental prosthesis, dental implants, orthodontics, teeth alignment , orthognathic surgery, jaw alignment or treatment for temporomandibular (jaw), or upper and lower jawbone surgery and surgery related to the temporomandibular (jaw) upto the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance subject to the number of sittings, per sitting limit and other terms as mentioned in the Policy Schedule/Certificate of Insurance against this option.

Specific Conditions Applicable to this sub-section:

a. Benefit under this section can be availed through **Network Facilitator** or by **Us,** as specifically mentioned in **Policy Schedule/Certificate of Insurance.**
b. Benefit under this section will be provided subject to the availability of **dentist(s)** at the time of appointment.
c. Coverage provided under this section will be as per subsection(s) details as mentioned in the **Policy Schedule/ Certificate of Insurance.**
d. If **You** have opted for this Section, point no. 8 “Cosmetic or plastic Surgery: Code- Excl08” and point no. 43 “Dental Treatment” as provided under “D – Exclusions” shall be deleted to the extent of coverage provided under this section.

39.5 Ophthalmic Treatment Expenses

If You have opted for this sub-section, We will indemnify You for the medical expenses incurred for Ophthalmic Treatment prescribed by Ophthalmologist(s) / Specialist Medical Practitioner(s) for the following as opted mentioned in Policy Schedule/Certificate of Insurance:

39.5.1. Eye Examination and Diagnostics	If You require for Ophthalmic Treatment arising out of an Accidental injury or Illness, We will indemnify for the Eye examinations and diagnostics up to the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance subject to the number of examinations/diagnostics, per

	examination/diagnostic limit and other terms as mentioned in the Policy Schedule/Certificate of Insurance against this option.
39.5.2. Pharmacy for Eye treatment	If You require for Ophthalmic Treatment arising out of an Accidental injury or Illness, We will indemnify for the Pharmacy related to Ophthalmic treatment up to the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance subject to the terms, as mentioned in the Policy Schedule/Certificate of Insurance against this option.
39.5.3. Eyewear Expenses	Any expenses related to eyewear including but not limited to contact lenses/spectacles/sunglasses upto the Sum Insured as mentioned in Policy Schedule/Certificate of Insurance subject to the number of eyewear, Per eyewear limit, and other terms as mentioned in the Policy Schedule/Certificate of Insurance against this option.

Specific Conditions Applicable to this sub-section:

a. Benefit under this sub-section can be availed through **Network Facilitator** or by **Us,** as specifically mentioned in **Policy Schedule/Certificate of Insurance.**
b. Benefit under this sub-section will be provided subject to the availability of **Ophthalmologist(s)** at the time of appointment.
c. Coverage provided under this sub-section will be as per details mentioned in the **Policy Schedule/ Certificate of Insurance.**
d. If **You** have opted for this Section, point no. 34 "Spectacles, Hearing aids & other Expenses" and 40 "Ear, Eyesight & Optical Services" as provided under "D – Exclusions" shall be deleted to the extent of coverage provided under this section.

Exclusion Applicable to this Section

1. Any Inpatient Treatment requiring **Hospitalization** and/ or Day Care Procedures.

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

SECTION 40. ILLNESS COVER

A. Hospitalization Cover

If You have opted for this cover and if You were Hospitalized due to Illness, as an inpatient, during the Policy Period, solely because You were Infected and Tested Positive due to one or more of the below mentioned Disease/s and/or Conditions as opted by You and stated in Your Policy Schedule / Certificate of Insurance, We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You, in respect of an admissible claim. It is important to note that any claim will be paid only in respect of the Disease/s and/or Conditions opted by You and stated in the Your Policy Schedule / Certificate of Insurance.

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

List of Disease/s and/or Conditions:

1. Cholera	2. Amoebiasis	3. Typhoid
4. Viral Hepatitis	5. Tuberculosis	6. Plague
7. Diphtheria	8. Typhus	9. Leptospirosis
10. Dengue	11. Malaria	12. Filariasis
13. Kala Azar	14. Chikungunya	15. Japanese Encephalitis
16. HIV	17. Zika Virus	18. Nipah Virus
19. EBOLA	20. Swine Influenza Virus	21. H1N1 Virus
22. COVID-19	23. SARS	24. MERS

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 will be subject to a Daily Limit as opted and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover. Note: If there is a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization then our liability will be restricted to the same proportion as the 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 there is 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 including disposable kits, 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

Apart from above table, you will also be eligible for following benefits:

A1. Pre-Hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred. This will be paid for a period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance, 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 a Claim under **Section 40.A. Hospitalization Cover** of this Policy.

A2. Post-Hospitalization Expenses

We will pay for consultations, investigations and the cost of medicines incurred. This will be paid for a period as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance, 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 40. A. Hospitalization Cover** of this Policy.

A3. 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 40. A. Hospitalization Cover.**

b. The maximum liability per Hospitalization is restricted to amount as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance.

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.

A4. Second Medical Opinion

If 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:

a. We have received Your request to arrange for Second Opinion.

b. We will not provide more than one Opinion for the same Medical Condition within a Policy Period.

Medical Practitioner has Certified that You were Infected and Tested Positive due to the Conditions and/ or Disease defined and stated in the Policy Schedule / Certificate of Insurance.

B. Virus Detection and Quarantine Allowance

If You have opted for this Cover; We will pay you following benefits as opted by You and stated in Your Policy Schedule / Certificate of Insurance; subject to You being hospitalised for the minimum number of days as opted by You and stated in Your Policy Schedule / Certificate of Insurance; due to one or more of the below mentioned Disease/s and/or Conditions as opted by You and stated in Your Policy Schedule / Certificate of Insurance. It is important to note that any claim will be paid only in respect of the Virus(es) opted by You and stated in the Your Policy Schedule / Certificate of Insurance subject to Policy Terms & Conditions.

a) **Full Fixed Benefit:** If the result is positive, we will pay 100% of the Sum insured for the below mentioned Virus(es) as opted by You and stated in the Policy Schedule / Certificate of Insurance. This benefit will be paid only in respect to the Insured Person(s) whose test result are Positive during the Policy Period, provided that, the person(s) claiming has a Certificate from a Registered Medical Practitioner along with a Positive Virology Report from ICMR – National Institute of Virology Pune, India or Any other Laboratory Authorised by ICMR, confirming that the Insured Person(s) has been infected with the Virus(es) as opted and stated in the Policy Schedule / Certificate of Insurance; or

b) **Part Fixed Benefit:** If the result is negative, we will pay up to the percentage of sum insured as mentioned in the Policy Schedule / Certificate of Insurance. This benefit will be paid to the Insured Person(s) if quarantined, during the Policy Period, in dedicated Government Authorized Hospital for a minimum of 7 or 10 or 14 or 21 consecutive (continuous)

days, as opted and stated in the Policy Schedule / Certificate of Insurance, for observation and investigation of the below mentioned Virus(es) and the test results are negative.

Provided always that:

i. We will not pay for any self-Quarantine in any facility other than Government Authorised Hospital.
ii. Regardless of one or more claims during the policy period, the maximum amount payable under the policy for all the benefits under this Section put together shall be restricted to the Sum Insured as mentioned in the Policy Schedule / Certificate of Insurance against this Section in respect of the Insured Person(s).
iii. The Benefit under this Section will cease on payment of 100% of the Sum Insured for the respective Insured Person(s) against whom claim has been paid.
iv. We will not make any payment if You are diagnosed as suffering from below listed 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 "Digit Group Complete Secure Policy" with us covering Illness cover/ Virus Detection and Quarantine Allowance.
v. This benefit will be paid only once during Policy Period in respect of the Insured Person(s) against whom claim has been admitted.

List of Disease/s and/or Conditions:

1. Cholera	2. Amoebiasis	3. Typhoid
4. Viral Hepatitis	5. Tuberculosis	6. Plague
7. Diphtheria	8. Typhus	9. Leptospirosis
10. Dengue	11. Malaria	12. Filariasis
13. Kala Azar	14. Chikungunya	15. Japanese Encephalitis
16. HIV	17. Zika Virus	18. Nipah Virus
19. EBOLA	20. Swine Influenza Virus	21. H1N1 Virus
22. COVID-19	23. SARS	24. MERS

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

SECTION 41. DAILY CASH BENEFIT

If You have opted for this cover and You are hospitalized as an inpatient during the Policy Period due to one or more of the below mentioned contingencies as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance, we will pay a per day benefit as opted and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

This Benefit will be paid for each and every continuous and completed period of 24 hours of Hospitalisation for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Below are the contingencies, you can opt any one or more than one:

- **Accidental Hospitalization**
- **Accidental & Illness Hospitalization**
- **Critical Illness Hospitalization** as per the plan opted.
- **Maternity**

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 an amount equivalent to the percentage of the Daily Cash Allowance as opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this section.
Subject to following conditions,

a) In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year on Floater Sum Insured basis.
b) For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be one day.
c) 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.
d) This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

For the purposes of this cover, contingencies are defined below:

a) **Accidental Hospitalization:** Daily Cash allowance will be paid under this contingency only if you have been hospitalised due to accidental bodily injury.

b) **Accidental & Illness Hospitalization**

- Daily Cash allowance will be paid under this contingency only if you have been hospitalised due to any illness and Accidental bodily injury.
- We will not make any payment if You are diagnosed as suffering from any 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 "Digit Group Complete Secure Policy" with us covering "**Daily Cash Benefit /Accidental & Illness Hospitalization**".

- 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 "Digit Group Complete Secure Policy" with Us, provided that the Policy has been renewed continuously with Us without break.

c) Critical Illness Hospitalization

Critical Illness shall mean the listed illnesses as per the plan opted by You from **Annexure C** that You are diagnosed as suffering from or Surgical Procedures that You are undergoing, for the first time in your life.

Provided that:

- 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 "Digit Group Complete Secure Policy" with Us covering "**Daily Cash Benefit /Critical Illness Hospitalisation**".
- 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.
- No Claim under this option shall be admissible if Critical Illness and/or covered Surgical Procedure 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.
- The List of Plan wise covered Critical Illness is mentioned in **Annexure C.**

d) Maternity

- Daily Cash allowance will be paid under this contingency for the delivery of the Insured Person's child (including caesarean section) or for the Medically necessary and lawful termination of pregnancy.
- For "**Maternity**" contingency "Waiting Period" as mentioned in the Policy Schedule/Certificate of Insurance against this Section is applicable.
- In case of "**Maternity**" opted, "**Exclusion No. 17 Maternity (Exclusions which is applicable)**" of the Policy Wordings stands partially deleted to the extent of the Coverage provided under this Section.

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

SECTION 42. FIXED CASH BENEFIT

If You have opted for this cover and You are hospitalized as an inpatient during the Policy Period due to one or more below mentioned contingencies as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance, we will pay a Fixed Lump Sum Benefit as opted and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
This Benefit will be paid for each and every continuous and completed period of the number of days of Hospitalisation for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Below are the contingencies, you can opt any one or more than one:

- **Accidental Hospitalization**
- **Accidental & Illness Hospitalization**
- **Critical Illness Hospitalization** as per the plan opted.
- **Maternity**

Subject to following conditions,

a) In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year on Floater Sum Insured basis.
b) For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
c) 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.
d) This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

For the purposes of this cover, contingencies are defined below:

a) Accidental Hospitalization: Fixed lump sum amount will be paid under this contingency only if you have been hospitalised due to accidental bodily injury.

b) Accidental & Illness Hospitalization

- Fixed lump sum amount will be paid under this contingency only if you have been hospitalised due to any illness and Accidental bodily injury.
- We will not make any payment if You are diagnosed as suffering from any 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 "Digit Group Complete Secure Policy" with us covering "**Fixed Cash Benefit /Accidental & Illness Hospitalization**".
- 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 "Digit Group Complete Secure Policy" with Us, provided that the Policy has been renewed continuously with Us without break".

c) Critical Illness Hospitalization

Critical Illness shall mean the below listed illnesses as per the plan opted by You from **Annexure C** that You are diagnosed as suffering from or Surgical Procedures that You are undergoing, for the first time in your life.
Provided that:

- 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 "Digit Group Complete Secure Policy" with Us covering "**Fixed Cash Benefit /Critical Illness Hospitalisation**".
- 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.
- No Claim under this option shall be admissible if Critical Illness and/or covered Surgical Procedure 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.
- The List of Plan wise covered Critical Illness is mentioned in **Annexure C.**

d) Maternity

- Fixed lump sum amount will be paid under this contingency for the delivery of the Insured Person's child (including caesarean section) or for the Medically necessary and lawful termination of pregnancy.
- For "**Maternity**" contingency "Waiting Period" as mentioned in the Policy Schedule/Certificate of Insurance against this Section is applicable.
- In case of "**Maternity**" contingency is opted, "**Exclusion No. 17 Maternity (Exclusions which is applicable)**" of the Policy Wordings stands partially deleted to the extent of the Coverage provided under this Section.

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

SECTION 43. COMPANION BENEFIT CASH ALLOWANCE COVER

If You have opted for this cover, We will pay towards the expenses incurred on one of Your attendants, accompanying You at the Hospital/Nursing Home, in case of Your Hospitalization as an inpatient due to an Accidental bodily Injury and/or Illness during the Policy Period. We will pay You as per the **option opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.
The above is provided that:

1. Claim for Hospitalisation in respect of the Insured Person has been admitted,
2. Insured Person's attendant should be his/her spouse, siblings, Children above age of 18 years, parents or parents in law.

1. Per Day Benefit

If You have opted for this option, we will pay a per day benefit amount as 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 Insured Person's Hospitalisation arising out of accidental bodily injury and/or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

2. Fixed Lump Sum Benefit

If You have opted for this option, we will pay a Fixed lump sum benefit amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Insured Person's Hospitalisation arising out of accidental bodily injury and/or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

A. **Conditions Applicable**

a) In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year Per Family on Floater Sum Insured basis.
b) For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be one day.
c) 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.
d) We will not make any payment if You are diagnosed as suffering from any 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 "Digit Group Complete Secure Policy" with us covering "**Companion Benefit Cash Allowance Cover**".
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 Cover which shall apply from the date of inception of the first "Digit Group Complete Secure Policy" with Us, provided that the Policy has been renewed continuously with Us without break".

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

SECTION 44. PARENT ACCOMMODATION CASH ALLOWANCE COVER

If You have opted for this Cover, we will pay towards expenses incurred on accommodation of parents at the Hospital/Nursing Home, in case of Your Hospitalization as an inpatient due to an Accidental bodily Injury and/or Illness during the Policy Period. We will pay You as per the **option Opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover. The above is provided that:

1. Claim for Hospitalisation in respect of the Insured Person has been admitted;
2. The Insured Person hospitalized is a Child aged 16 Years or below, unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance.

1. **Per Day Benefit**

   If You have opted for this option, we will pay a per day benefit amount as 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 Insured Person's Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

2. **Fixed Lump Sum Benefit**

   If You have opted for this option, we will pay a Fixed lump sum benefit amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Insured Person's Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

A. **Conditions Applicable:**

   a) In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year Per Family on Floater Sum Insured basis.
   b) For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
   c) 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.
   d) We will not make any payment if You are diagnosed as suffering from any 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 "Digit Group Complete Secure Policy" with us covering "**Parent Accommodation Cash Allowance Cover**".
   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 Cover which shall apply from the date of inception of the first "Digit Group Complete Secure Policy" with Us, provided that the Policy has been renewed continuously with Us without break".
   f) This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 45. LOAN SHIELD

If You have opted for this cover and You suffer

- from any Accidental Injury that occurs during the policy period and that injury solely and directly results in Your "**Death"** or "**Permanent Total Disablement"** or **"Permanent Partial Disablement"** within twelve (12) months from the Date of accident
- or from **"Critical Illness"**

as per the contingency opted and mentioned in Your Policy Schedule/Certificate of Insurance against this Section. We will pay the bank / financial institution as specified in the Policy Schedule/Certificate of Insurance, an amount equal to the Insured Person's Principal Outstanding Amount, subject to this amount not exceeding the Sum Insured specified in the Policy Schedule / Certificate of Insurance, provided that:

1. The **Permanent Total Disability** continues for a period of at least 180 days from the commencement of the **Permanent Total Disability**, and the Disability Certificate issued by the treating Medical Practitioner at the expiry of the 180 days confirms that there is no reasonable medical hope of improvement. It is clarified that this condition is not application for any **Permanent Total Disability** in the nature of a physical separation.
2. If You suffer from Injury and/or illness resulting in more than one of the "**Permanent Total Disabilities"** or **"Permanent Partial Disabilities" or "Critical Illness",** then Our maximum, total and cumulative liability under this section shall be limited to the Principal Outstanding Amount, and further subject to such amount not exceeding the Sum Insured mentioned in the Policy Schedule / Certificate of Insurance.
3. Once the total claim amount paid under this section reaches 100% of Sum Insured for an Insured Person, the cover under this section will cease for the remainder of the Policy Period and the Insured Person will not be eligible for this section in any subsequent Policy Years.
4. We shall not be liable to make any payments that are overdue and unpaid by the Insured Person prior to the occurrence of the event giving rise to a claim under this section, and the same shall be deemed as paid by the Insured Person, unless this condition is specifically waived by Us and mentioned in your Policy Schedule/Certificate of Insurance

5. Cover under this Section shall cease upon payment of the compensation on the happening of any contingency mentioned above and no further payment will be made for any contingency as mentioned above or any dependent contingency.

For the Purpose of this Cover;

a. **"Permanent Partial Disablement"** means:
   - Loss of arm at the shoulder joint
   - Loss of leg above centre of the femur
   - Loss of arm to a point above elbow joint
   - Loss of leg up to a point below the femur
   - Loss of arm below elbow joint
   - Loss of hand at the wrist
   - Complete and irrecoverable loss of sight of an eye
   - Loss of leg to a point below the knee
   - Loss of leg up the centre of tibia
   - Loss of foot at the ankle

b. **"Critical Illness"** shall mean the illnesses that You are diagnosed as suffering from or Surgical Procedures that You are undergoing, for the first time in your life; as per the plan opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section from **Annexure C**.
   Provided that:
   1. 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 "Digit Group Complete Secure Policy" with Us covering "**Loan Shield/Critical Illness**".
   2. 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.
   3. No Claim under this option shall be admissible if Critical Illness and/or covered Surgical Procedure 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.
   4. The List of Plan wise covered Critical Illness is mentioned in **Annexure C.**

SECTION 46. LOSS OF PAY

If You have opted for this cover and due to death of Your **immediate family Member** during the Policy Period, You have to take leave without pay from Your employment as You do not have enough accrued leave to cover the absence from the employment, then we will pay the Percentage of Your **net per day salary** as mentioned in Your Policy Schedule/Certificate of Insurance for the period You have taken leave without pay, provided that:

1. taking 'leave without pay' without exhausting Your accrued leaves or taking leave from employment where there is no loss of pay will not be covered under this section;
2. maximum number of days for which loss of pay will be available under this section will be as mentioned in Your Policy Schedule/Certificate of Insurance;
3. claim under this section will be payable for number of days You were on leave without pay multiplied by percentage of Your net per day salary.
   For Example:
   - *Mr. A has net per day salary of INR 1,500.*
   - *He has taken 'leave without pay' from his employment for 10 days due to reasons admissible under this section.*
   - *% of Net Per day Salary as opted under this section is 60%.*
   - *Claim payable under this section will be 60% of INR 1,500*10 days ie. INR 9,000.*

Specific Definition applicable to this section

a. "**Immediate Family Member**" would mean the Insured Person's spouse, siblings, Children, parents or parents in law.
b. **"Leave without pay"** means leave or time off from work for the employee's personal reasons granted by the employer for which period the employee receives no pay.
c. **"Net Monthly Salary"** (take home salary) will be considered after deduction of income tax, professional tax, PF Contributions, Bonuses / One-time Variable Pay, Any other deductions, and any reimbursements from the monthly pay slips. For the calculation of Monthly Take home salary, we shall consider the last three months monthly average salary subject to all deductions mentioned above.
d. **"Net Per Day Salary"** shall mean Net Monthly Salary divided by number of days in the month.
   For example, Mr. X has Net Monthly Salary as INR 90,000. For the month of September, his Net Per Day Salary will be INR (90,000/ 30) = 3,000.

Specific Conditions Applicable to this section,

a) The Company shall not be liable to make any payment under this Policy in respect Self-employed persons.
b) The benefit under this section is payable only once to an Insured Person during the Policy Year.
c) We will not pay any compensation if the Insured Person is on their notice period or under probation period.

d) We will not pay any claim if any job under which no salary or any remuneration is provided to the Insured.
e) We will not pay if the employment contract and Job Location was outside India.
f) Any claim shall not be Payable under this policy, if the Insured event triggers within number of days (Initial Waiting Period) specified in the Policy Schedule/Certificate of Insurance from the risk inception date of Your policy or inception of the first "Digit Group Complete Secure Policy" with Us whichever is earlier.

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

SECTION 47. HEALTH CHECK UP

If You have opted for this Cover, we will indemnify You for health check-up expenses incurred as per following options as opted by You and mentioned in Policy Schedule/Certificate of Insurance.

47.1. Health Check-up from Day 1 of Policy: We will pay the expenses incurred towards cost of health check-up from Day 1 of the Policy and during the policy period up to the Sum Insured limit as mentioned in Policy Schedule/Certificate of Insurance subject to terms, conditions, deductible, limitations, and exclusions mentioned in the Policy Schedule/Certificate of Insurance.

47.2. Health Check-up at the end of each block of continuous years: If You have continued Your Policy with Us without any break, then at the end of each block of continuous years as mentioned in Policy Schedule/Certificate of Insurance, We will pay the expenses incurred towards cost of health check-up up to the Sum Insured limit as mentioned in Policy Schedule/Certificate of Insurance subject to terms, conditions, deductible, limitations, and exclusions mentioned in the Policy Schedule/Certificate of Insurance**.**

Specific Conditions Applicable to this section:

a) This benefit will not be carried forward if not utilized.
b) Benefit under this section should be provided through Network Facilitator as mentioned in Policy Schedule/Certificate of Insurance.
c) These services should be provided subject to the availability of lab / diagnostic centre at the time of appointment.
d) In case of Family Floater policy, Health Check-up Sum Insured as mentioned in Policy Schedule/Certificate of Insurance is the maximum total cost which is available for all insured persons put together.
e) If You have opted for this Section, point no. 4 "Investigation and Evaluation Code- Excl04" as provided under "D – Exclusions" shall be deleted to the extent of coverage provided under this section.

SECTION 48. WELLNESS BENEFIT PROGRAM

If You have opted for this Cover, 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 17 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 or a video 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, videos, webinar and online platform provide You 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 Your 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 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 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 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), orDigital 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 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/information or data 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 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 - Wheel-Chair, Patient Bed, Oxygen Cylinder etc.
   h. Doctor Visit
   i. Elderly care and senior living assistance related to their health condition.

   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 Facilitator 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 be borne by You. These may include the following but not limited to :-
    - Doctors' services
    - Nursing services
    - Dietitian services
13. **Mental wellbeing -** Upon Your 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 You.
14. **Physiotherapy -** Upon Your 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 You.
15. **Childcare/Children's activities** - Upon Your 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 You.
16. **Out-Patient (OPD) Services** - Upon Your 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 You.

17. **Fitness** – Upon your 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 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. We will not charge any premium amount for the services. You need 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 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.

CUMULATIVE BONUS

If You've been safe and healthy and have had No Claims made under the **Section 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness 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 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover**.

Note: *Cumulative bonus opted at the inception of the first* "Digit Group Complete Secure 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 arising out of 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
   1. 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)
   2. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.
   3. Cataract (up to the Limit mentioned in Policy Schedule), Glaucoma and Disorder of retina
   4. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele
   5. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease
   6. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.
   7. Hernia of all sites,
   8. Varicose veins of lower extremities,
   9. 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,
   10. 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),
   11. Internal Congenital Anomaly (this will not be applicable to Newborn baby cover),
   12. Psychiatric illness and Disorders listed below:

ICD Code	Psychiatric Illness & Disorders
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood [affective] disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F99-F99	Unspecified mental disorder

   13. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease
   14. 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 as long as the Insured Person has been insured continuously under the Policy without any break, unless due to an accident.
   15. Chronic Kidney disease and failure,
   16. Ischemic heart disease and Valvular heart diseases

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 amended to the 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 37 Home (Domiciliary)** 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 Apnoea
   iv. Uncontrolled Type2 Diabetes

Expenses related to the surgical treatment of obesity/ weight control will only be covered if You have specifically opted for **SECTION 30.B. Accidental & Illness Hospitalization Cover – B6. Bariatric Surgery Cover.**

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. **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.
10. **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.
11. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- **Excl12**
12. 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**
13. 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**
14. **Refractive Error: Code- Excl15**
    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
15. **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.
16. **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 31. INFERTILITY TREATMENT COVER**, if opted by You.
17. **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 36. MATERNITY COVER & NEWBORN BABY COVER and SECTION 41. DAILY CASH BENEFIT (MATERNITY BENEFIT) & SECTION 42. FIXED CASH BENEFIT (MATERNITY BENEFIT)**, if opted by You.

II. SPECIFIC EXCLUSIONS

18. **Artificial Life Maintenance**
    Artificial Life Maintenance, including life support machine used, where such treatment 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.
19. **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. Participation in any illegal or unlawful or criminal act

20. Cosmetic, Aesthetic and Re-Shaping Treatment & Surgeries

a. Plastic Surgery or Cosmetic Surgery or Treatments to change Your appearance, unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, Cancer or burns.
b. Treatment for alopecia, baldness, wigs, or toupees and all treatment related to the same.
c. Circumcision unless necessary for the treatment of a disease or necessitated by an Accident;
d. Aesthetic or change-of-life- treatments of any description such as sex transformation operations.

21. Pre-Existing Disability

a. Any Hospitalization for an existing disability from a previous Accident which has occurred prior to the first of this Policy.
b. Any additional Hospitalization Expenses not resulting from an accidental Injury.

22. Circumcision, Aesthetic reasons

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

23. Hazardous or Adventure sports:

Any accidental bodily injury or expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports as defined in the Policy.

This exclusion will be deleted to the extent of the coverage provided under **"Section 18 – Hazardous or Adventure Sports Cover"**, provided this section is opted by You.

24. Defence Operation/Aviation Activities

We will not pay any claim under this Policy, arising out of Your

a. whilst engaging in aviation or whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world and except to the extent covered under **"SECTION 18 – HAZARDOUS OR ADVENTURE SPORTS COVER"**, provided this section is opted by you.
b. whilst the Insured person is operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft, or Scheduled Airlines
c. Involvement in naval, military, air force operation.

25. External Congenital Anomaly

Screening, Counselling or treatment related to external Congenital Anomaly.

26. Geographical Limits

There are total 48 sections available under the product Digit Group Complete Secure Policy.

Section with Benefits	Geography Coverage
Section 1. Accidental Death	Worldwide
Section 2. Permanent Total Disablement	Worldwide
Section 3. Permanent Partial Disablement	Worldwide
Section 4. Temporary Total Disablement	Worldwide
Section 5. Children Education Benefit	Worldwide
Section 6. Marriage Expense for Children Benefit	Worldwide
Section 7. Orphan Benefit for Children	Worldwide
Section 8. Funeral Expense	Worldwide
Section 9. Transportation Expenses	Within India
Section 10. Trauma Counselling	Within India
Section 11. Coma Benefit Cover	Worldwide
Section 12. Fracture Cover	Worldwide
Section 13. Burns Cover	Worldwide
Section 14. Lifestyle Modification	Worldwide
Section 15. Expense for External Aids and Appliances	Worldwide
Section 16. Compassionate Visit	Worldwide
Section 17. Miscarriage Due to Accidental Injury	Worldwide
Section 18. Hazardous or Adventure Sports Cover	Worldwide/Within India (In case of Hospitalization)
Section 19. HIV Cover	Worldwide
Section 20. Critical Illness Benefit Cover	Worldwide
Section 21. Critical Illness Hospitalization Cover	Within India

Section 22. Cancer Benefit Cover	Worldwide
Section 23. Cancer Hospitalization Cover	Within India
Section 24. Heart Protect Benefit Cover	Worldwide
Section 25. Heart Protect Hospitalization Cover	Within India
Section 26. Organ Failure Benefit Cover	Worldwide
Section 27. Organ Failure Hospitalization Cover	Within India
Section 28 EMI Protection Cover	Worldwide (Claim Payment Can be done only if loan is availed from Indian Financial Institutions in INR)
Section 29. Loss of Employment	Within India
Section 30. Hospitalization Cover	Within India
Section 31. Infertility Treatment Cover	Within India
Section 32. Organ Donor	Within India
Section 33. Alternate Treatment (AYUSH) Cover	Within India
Section 34. Emergency Air Ambulance	Within India
Section 35. Long Hospitalization Cash Benefit	Within India
Section 36. Maternity Cover and New Born Baby Cover	Within India
Section 37. Home (Domiciliary) Hospitalization	Within India
Section 38. Sum Insured Refill Benefit	Within India
Section 39. Out-Patient (OPD) Benefit	Within India
Section 40. Illness Cover	Within India
Section 41. Daily Cash Benefit	Within India
Section 42. Fixed Cash Benefit	Within India
Section 43. Companion Benefit Cash Allowance Cover	Within India
Section 44. Parent Accommodation Cash Allowance Cover	Within India
Section 45. Loan Shield	Worldwide (Claim Payment Can be done only if loan is availed from Indian Financial Institutions in INR)
Section 46. Loss of Pay	Within India
Section 47. Health Check Up	Within India
Section 48. Wellness Benefit Program	Within India

This Policy covers all treatments received within India and Our liability will be to make Payment Indian Rupees Only. However, on payment of additional premium, the Geographical Limits can be extended to Asia / Worldwide Excluding USA & Canada / Worldwide Including USA & Canada, subject to:

1. Additional Co-payment Opted by You and mentioned in Your Policy Schedule for treatments outside India which will be over and above the Section Wise Co-payment Opted.
2. Prior intimation should be given and approval should be taken from Us for any treatment taken Outside India.

27. 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)

28. Insufficient Document

Under **"General Condition - Claims Notification and Procedure"**, We have provided Section wise list of relevant necessary documents to be submitted at the time of claim. We shall not be liable to pay any claim in case all the relevant necessary documents are not submitted to Us and further We shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last necessary document.

29. Professional Sports

We will not pay any claim under this Policy, whilst You are under training or taking part in sport as a professional for which You are paid or funded by sponsorship or grant unless this specifically waived of and mentioned in policy schedule/Certificate of Insurance.

However, You would be covered if you participate in a non-professional capacity for any recreational sport which is **NOT** a **Hazardous Activity** and You are under the supervision of a trained professional.

30. 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 36. MATERNITY COVER & NEW BORN BABY COVER** if opted by You.
c. Forming part of treatment for accidental bodily Injury as prescribed by the Medical Practitioner.

31. 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.

32. 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.

33. 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 **Section 30.B.6. Bariatric Surgery Cover**

34. 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.

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

36. Unjustified or Unwarranted Hospitalization

Admission solely for Physiotherapy, evaluation, investigations, diagnosis or observation service unless a claim is accepted under **Section 30. A. Accidental Hospitalization Cover** and/or **30.B. Accidental & Illness Hospitalization Cover.**

37. 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.

38. War and hazardous substances

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

a. 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
b. Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel; or
c. any acts of terrorism, unless specifically agreed by Us and mentioned in Your Policy Schedule/Certificate of Insurance.

39. 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.

40. Ear, Eyesight & 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 30.A. Accidental Hospitalization Cover** and/or **Section 30.B. Accidental & Illness Hospitalization Cover**

41. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

42. 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

43. 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 and except to the extent covered under **Section 39. Out-Patient (OPD) Benefit,** if opted**.**

44. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment. However, We will pay for treatments mentioned under **SECTION 33. ALTERNATE TREATMENT (AYUSH) COVER,** if You have specifically opted for it.

45. Mental Disorders

Accidental **"Death"** or **"Permanent Total Disablement" or "Permanent Partial Disablement"** due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.

46. Organ Donor

The Expenses incurred by You on organ donation, except for those covered under **SECTION 32. ORGAN DONOR,** if opted by You.

47. 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 percentage of Sum Insured as opted under Section **30.A. Accidental Hospitalization Cover and/or Section 30.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

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)

i. 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 case of any admissible claim in a Policy year.
vii. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
viii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.
ix. If the claim amount is equivalent or higher than the balance of the instalment premiums payable in that Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person.
x. If the claim amount is lesser than the balance premium payable, then no claim would be payable till the applicable premium is recovered.
xi. Where Premium Payment is on Installment Basis, there will be no refund of premium in case of Policy Cancellation requested by You.

a) Important Note (ECS Or NACH Mode):

1. Installment can also be paid through ECS or NACH mode. In cases where monthly installment is allowed by NACH or ECS mandate, three (3) installments need to be paid at the inception of the Policy, unless this condition is specifically amended by Us.
2. We shall inform You in case of any change either in the terms and conditions of the Policy Contract or in the Premium Rate and afresh ECS authorization needs to be submitted by You.
3. You can withdraw from the ECS mode of payment at least fifteen days prior to the due date of instalment premium payable as per the ECS/NACH mandate form submitted by You, by submitting written communication to Us as well as Your Bank.

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 Policy

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
   A. For Non-Credit Linked Policies which are issued for a period of maximum up to one Year, the below scale mentioned under "**Fixed Sum Insured Basis - Cancellation Scale**" shall be applicable.
   B. For Credit linked Policies one of the below mentioned scales will be applicable depending on the Sum Insured Basis Opted by You i.e. Fixed Sum Insured or Reducing Sum Insured.
   C. The refund of premium under the Credit Linked Policies shall be as under:
      i. In the event of full prepayment of the Loan by the Insured, We shall refund a portion of the premium subject to the terms and conditions of the Policy as per the rates mentioned in the below table.
      ii. In event of part prepayment of the Loan, no refunds of premium shall be made under this Policy.
      iii. 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.

Fixed Sum Insured Basis - Cancellation Scale

Period in Risk	Premium Refund based on Policy Term				
	1 Year	2 Year	3 Year	4 Year	5 Year
Within 3 months	60%	60%	60%	60%	60%
Exceeding 3 months but less than 6 months	40%	50%	55%	55%	55%

Exceeding 6 months but less than 9 months	25%	40%	50%	50%	50%
Exceeding 9 months but less than 12 months	0%	35%	45%	45%	50%
Exceeding 12 months but less than 15 months	NA	25%	40%	40%	45%
Exceeding 15 months but less than 18 months	NA	20%	30%	40%	45%
Exceeding 18 months but less than 21 months	NA	10%	25%	35%	40%
Exceeding 21 months but less than 24 months	NA	0%	20%	30%	35%
Exceeding 24 months but less than 27 months	NA	NA	15%	25%	35%
Exceeding 27 months but less than 30 months	NA	NA	10%	25%	30%
Exceeding 30 months but less than 33 months	NA	NA	5%	20%	25%
Exceeding 33 months but less than 36 months	NA	NA	0%	15%	25%
Exceeding 36 months but less than 39 months	NA	NA	NA	10%	20%
Exceeding 39 months but less than 42 months	NA	NA	NA	5%	20%
Exceeding 42 months but less than 45 months	NA	NA	NA	5%	15%
Exceeding 45 months but less than 48 months	NA	NA	NA	0%	10%
Exceeding 48 months but less than 51 months	NA	NA	NA	NA	10%
Exceeding 51 months but less than 54 months	NA	NA	NA	NA	5%
Exceeding 54 months but less than 57 months	NA	NA	NA	NA	0%
Exceeding 57 months	NA	NA	NA	NA	0%

Reducing Sum Insured Basis – Cancellation Scale

Loan Period	**Cancellation Year**				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
1	-	-	-	-	-
2	35%	-	-	-	-
3	42%	19%	-	-	-
4	47%	27%	12%	-	-
5	50%	32%	18%	8%	-
6	52%	36%	22%	12%	-
7	53%	38%	25%	14%	-
8	54%	39%	26%	16%	-
9	54%	40%	28%	17%	-
10	55%	41%	28%	17%	-
11	55%	41%	29%	18%	-
12	55%	42%	30%	19%	-
13	55%	42%	30%	19%	-
14	56%	42%	30%	19%	-
15	56%	43%	31%	19%	-
16	56%	43%	31%	20%	-
17	56%	43%	31%	20%	-
18	56%	43%	31%	20%	-
19	56%	43%	31%	20%	-
20	56%	43%	31%	20%	-
21	56%	44%	32%	20%	-
22	56%	44%	32%	20%	-
23	56%	44%	32%	20%	-
24	56%	44%	32%	21%	-
25	56%	44%	32%	21%	-

26	56%	44%	32%	21%	-
27	56%	44%	32%	21%	-
28	56%	44%	32%	21%	-
29	56%	44%	32%	21%	-
30	56%	44%	32%	21%	-

Note: For Cancellation of Policies opted on Reducing Sum Insured Basis, No Refund will be made during the Last Year of the Policy Term/Period.

B. CANCELLATION BY US

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, 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, 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. 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. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

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.
vii. We shall not deny the renewal of Your policy on the ground that You had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates after the payment of Sum Insured (For Example: Accidental Death, Permanent Total Disablement, Permanent Partial Disablement, Critical Illness, Daily Hospital Cash Cover)

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: hellolife@godigit.com & healthclaims@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/

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

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

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.

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.
4. Zone based Co-pay as mentioned above will not be applicable in case of accidental injury.

19. Policy Period

This policy can be issued for a term of one year, except credit linked products where the term can be extended up to the loan period not exceeding five years.

20. CONDITIONS APPLICABLE FOR REDUCING SUM INSURED COVERS (applicable only for Credit Linked Policy)

The Sum Insured under the Policy on the date of occurrence of the Event covered under **"Section 1. Accident Death" and/or "Section 2. Permanent Total Disablement" and/or "Section 3. Permanent Partial Disablement" and/or "Section 20. Critical Illness" and/or "Section 22. Cancer Benefit Cover" and/or "Section 24. Heart Protect Benefit Cover" and/or "Section 26.**

Organ Failure Benefit Cover" and/or "Section 45. Loan shield" for the purpose of calculation of claim shall be the least of the following:

1. The Principal Outstanding in the books of the Bank/ Financial Institution as on the date of occurrence of the Insured Event; or

2. The Principal Outstanding as per the amortization schedule prepared by Bank/Financial Institution. In the event the Sum Insured as appearing against **"Section 1. Accident Death" and/or "Section 2. Permanent Total Disablement" and/or "Section 3. Permanent Partial Disablement" and/or "Section 20. Critical Illness" and/or "Section 22. Cancer Benefit Cover" and/or "Section 24. Heart Protect Benefit Cover" and/or "Section 26. Organ Failure Benefit Cover" and/or "Section 45. Loan shield"** of the Policy Schedule/ Certificate of Insurance is less than the total of the actual Loan disbursed up to the date of the occurrence of the Insured Event, then the Amortization schedule shall be calculated as if the actual Loan disbursed was equivalent to the Sum Insured.; or

3. The Sum Insured as appearing against **"Section 1. Accident Death" and/or "Section 2. Permanent Total Disablement" and/or "Section 20. Critical Illness" and/or "Section 22. Cancer Benefit Cover" and/or "Section 24. Heart Protect Benefit Cover" and/or "Section 26. Organ Failure Benefit Cover" and/or "Section 45. Loan shield"** of the Policy Schedule/ Certificate of Insurance.

Note: We will not consider any of below items while calculating our claim liability

a. Any Top-Ups or Enhancement of Initial Approved Loan amount
b. Any penalty, fee levied by the bank or financial institution
c. Increase in outstanding loan amount due to overdue payment or non-payment of EMI on timely basis

21. Insured Person

a. Only those persons named as an Insured Person in the Policy Schedule / Certificate of Insurance shall be covered under this Policy.
b. 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.

22. Assignment (If Opted) – It Is Hereby Declared and Agreed That:

a. from the Policy Start Date, the claim amount payable by Us to the Insured and all rights, title, benefits and interest of the Insured under this Policy stand assigned in favour of a person or an Institution or a company as named in the Policy Schedule/ Certificate of Insurance;
b. upon any claim amount becoming payable under this Policy the same shall be paid by Us to assignee as named in Policy Schedule/ Certificate of Insurance, without any reference/ notice to the Insured;

the receipt of such claim amount by the assignee as named in the Policy Schedule/ Certificate of Insurance and the Insured shall completely discharge Us from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.

23. Electronic Transactions

The Insured agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call 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, established by or on behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

24. No Constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Member which is in Our possession other than that information expressly disclosed in the Proposal Form or otherwise to Us, shall not be held to be binding or prejudicially affect Us.

25. 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 Proposer/Insured Member.

26. 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.

27. Insured Person

a. Only those persons named as an Insured Person in the Policy Schedule shall be covered under this Policy.
b. 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.

CONDITION APPLICABLE DURING THE CONTRACT

28. ALTERATIONS TO THE POLICY

This Policy constitutes the complete contract of insurance between the Policyholder and Us. 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.

29. MATERIAL CHANGE / CHANGE OF OCCUPATION

The Insured/ Insured Member shall immediately notify the Company in writing of any material change in the risk or change in business or occupation during the Policy Period. Insured should also at his own expense take precautions as circumstances may require ensuring safety thereby containing the circumstances that may give rise to a claim. The Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

The above notification is not mandatory when only the employer changes, but the nature of occupation does not change.

30. NO CONSTRUCTIVE NOTICE

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Member which is in Our possession other than that information expressly disclosed in the Proposal Form or otherwise to Us, shall not be held to be binding or prejudicially affect Us.

31. SPECIAL PROVISIONS

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

32. SPECIAL CONDITIONS RELATING TO GROUP POLICY

All group policies are subject to the following conditions:

a. The insured will maintain sufficient deposit or provide a Bank Guarantee to comply with the requirement of section 64VB.
b. New names can be added to the existing group policies by charging premium as agreed between Group Manager and Us.
c. For deletion of names from Group Policies during the Policy Period, refund of premium can be allowed only if there is no claim in respect of the particular insured Person as on date when request for deletion of name has been received

33. ADDITION /DELETION OF INSURED PERSON(S)

a. No person other than those persons named as the Insured Person(s) or those categories of the Insured specified in the Policy Schedule/ Certificate Of Insurance shall be covered under this Policy unless and until his/her name or the category has been notified in writing to the Company, any additional premium due has been paid and the Company's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person or category of persons as an Insured
b. Cover under this Policy shall be withdrawn from any Insured Person(s) named or any category of persons Insured immediately upon the Policyholder delivering written notice of the same to the Company.

34. ACCUMULATION CLAUSE

The Company's maximum liability in case of losses arising out of one event is limited to accumulation limit
Mentioned in Your Policy Schedule/Certificate of Insurance. In the event of claim where the single event loss amount limit exceeds the limit mentioned in Your Policy Schedule /Certificate of Insurance, the benefits payable under this policy to each Insured person will be reduced proportionately in ratio of the overall event limit mentioned in Your Policy Schedule /Certificate of Insurance to the total amount claimed cumulatively by all the affected Insured persons in that event.

35. LAW AND JURISDICTION

It is hereby declared and agreed that this contract of insurance and all claims thereunder shall be governed by Indian Law and any legal proceeding in respect thereof shall be raised a competent court of India. All claims shall be paid in Indian Rupees only.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

36. PHYSICAL EXAMINATION

Any medical official or other agent of the company shall be allowed to examine the Insured Person(s) in case of alleged injury or disablement when and as often as may be reasonably be required on behalf of the Company.

37. 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.

38. RECORDS TO BE MAINTAINED

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

39. POLICY DISPUTE

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

40. AUTOMATIC TERMINATION OF COVER FOR INSURED PERSON

The cover for the Insured Member shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under “Death” or “Permanent Total Disablement**”**.

41. 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 Facilitator for Cashless Facility in Our sole discretion.
   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 or Your Legal representative holding a valid succession certificate.

C. List of Claim Documents:

In addition to the Duly Completed Claim Form signed by the Insured/Insured's Nominee/Legal Heir & NEFT Details or Cancelled Cheque of the Insured/Insured's Nominee/Legal Heir, ID proof (KYC document) of insured and Nominee, address proof wherever applicable, We need to have the below documents, wherever applicable:

Section	Documents
Common Documents (Wherever Applicable)	• Duly Filled and Signed Claim form • Discharge Summary • Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.) • Copy of Hospital Main Bill • Investigation Reports & Consultation Papers • Positive Diagnostic Report for the Critical Illness and/or Surgical procedures as per the plan opted and stated in the Policy Schedule / Certificate of Insurance. • Attending Physician Certificate (If applicable) • Document to Confirm Relationship with the Patient for Companion Benefit / Parent Benefit/Companion Visit • *KYC (Photo ID card) (If applicable) • Bank details with Cancelled cheque
Hospitalization Claim	• Original Hospital Main Bill • Original Hospital Bill Break Up • Original Pharmacy Bills • Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital • Digital Images/CDs of the Investigation Procedures (if required) • MLC/FIR Report (If applicable) • Original Invoice/Sticker (If applicable) • Post Mortem Report (If applicable) • Disability Certificate (If applicable) • Attending Physician Certificate (If applicable) • Ante-natal Record (If applicable) • Birth discharge Summary (If applicable) • Death Certificate (If applicable)
Out – Patient (OPD) Claim	• Original Pharmacy Bills • Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital • Digital Images/CDs of the Investigation Procedures (if required)
Critical Illness/Cancer Claim	• MLC/FIR Report (If applicable) • Disability Certificate (If applicable) • Attending Physician Certificate (If applicable) • Copy of Hospital Summary • Death Certificate (If applicable)
Accidental Death, Hazardous or Adventure Sports Cover, Orphan Benefit For Children	• Copy of Address Proof (Ration Card or Electricity Bill Copy). • Attested Copy of Death Certificate. • Death Summary/Certificate from the hospital authority (wherever applicable) • Burial Certificate (wherever applicable). • Attested Copy of Statement of Witness, if any lodged with police authorities. (wherever applicable).

	• Attested Copy of FIR / Panchanama / Inquest Panchanama. (Wherever applicable). • Attested Copy of Post Mortem Report (Only if conducted). • Attested Copy of Viscera report if any (Only if Post Mortem is conducted). • For Hazardous or Adventure Sports Cover, please submit Certificate of Participation from Sports Event organizer/service provider / Pre-participation fitness certificate (wherever applicable). • Attested Copy of Passport or any other valid document which will suffice as a proof of relationship between the insured, insured's spouse and orphan child. (Applicable only for Orphan Benefit)
Permanent Total Disablement **Permanent Partial Disablement** **Hazardous or Adventure Sports Cover**	• Attested Copy of disability certificate from relevant government Medical authority. • Attested copy of FIR. (If required) • All Investigation reports confirming the disability. • Complete Treatment record with follow-up documentation. • For Hazardous or Adventure Sports Cover, please submit Certificate of Participation from Sports Event organizer/service provider / Pre-participation fitness certificate (wherever applicable). • Disability assessment report from Digit empanelled medical specialist (if required)
Temporary Total Disablement	• Attested copy of FIR. (If required) • All Investigation reports confirming the disability • For Employed persons: Certificate from HR with details of medical leave availed during the period of Injury • Certificate from the treating doctor mentioning the extent of Injury along with the period of disability • Certificate from Treating doctor with date of full recovery & resuming of duties
Children Education Benefit	• Bonafide Certificate from School / College or Certificate from the Educational Institution
Marriage Expense for Children Benefit	• Proof of Relationship with the Insured Person • Photo Identity Proof of Child • Age Proof of the Dependent Child
Funeral Expenses	• Original Invoice of Expenses Incurred during Funeral.
Transportation Expenses	• Original Invoices of expenses incurred for Carriage of Dead Body/repatriation of mortal remains.
Trauma Counselling	• Documents as mentioned under Section 1. Accidental Death and/or Section 2. Permanent Total Disablement and/or Section 3. Permanent Partial Disablement • Original Invoice of Expenses Incurred for Counselling. • Medical Practitioner's letter advising Counselling. • Treatment plan for Counselling from Specialist.
Long Hospitalization Cash Benefit	• Original Hospital Main Bill • Original Hospital Bill Break Up of Various Expenses • Original Pharmacy Bills • Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital • Digital Images/CDs of the Investigation Procedures (if required) • MLC/FIR Report (If applicable) • Original Invoice/Sticker (If applicable) • Post Mortem Report (If applicable) • Attending Physician Certificate (If applicable) • Death Certificate (If applicable)
Home (Domiciliary) Hospitalization	• Attending Physician Certificate mentioning the need for Home (Domiciliary Hospitalization) • Original Pharmacy Bills • Original Invoices in respect of payment made to the treating Medical Practitioner.
Emergency Air Ambulance	• Original bills and receipts paid for the transportation from Registered Ambulance Service Provider

	• Letter from Medical Practitioner indicating emergency need for such transportation and fitness for transportation.
Coma Benefit Cover	• Certificate from the Treating Medical Practitioner certifying the cause and severity of Coma. • All relevant medical summary leading to Coma.
Fracture Cover	• X Ray Confirming the Fracture & site of Fracture • Pre and post-operative radiological imaging reports with films confirming the extent of the fracture • Certificate from Treating Medical Practitioner with extent of Injury, Cause of injury, Site of Injury & Date of Injury. • Treatment Details •
Burns cover	• Certificate from Treating Medical Practitioner with extent of Burns Injury/Cause of Burns. • Treatment Details • Medico Legal Certificate copy / First Information Report Copy (If applicable) •
Lifestyle Modification	• Certification from Medical Practitioner necessitating the Modification. • Original Invoices of actual expenses incurred for the Modifications.
Expense for External Aids and Appliances	• Prescription of treating Medical Practitioner for use of External Aids and Appliance. • Original Invoices of actual expenses incurred for the purchase of External Aids and Appliance
Compassionate Visit	• Letter from Medical Practitioner advising presence of Immediate Family Member. • Original travel tickets / bills and receipts mentioning the actual expenses of the travel with the date of booking & date of travel • Age Proof of the Person who has visited the Insured
Miscarriage Due to Accidental Injury	• Treating Medical Practitioners Certificate mentioning reason for Miscarriage and date of accidental injury. • Medical Reports & Investigations Done •
HIV Cover	• Medical Reports/ Records • Copy of Hospital Summary/Discharge Card • Medical Practitioner's Certificate confirming the Illness /Treatment advise / Medical Reference.

EMI Protection cover	• Current Outstanding Loan Certificate from Financer.
	• Loan Disbursement Letter along with the payment record till the date of Accident or first diagnosis of Critical Illness or first underwent surgical procedure.
	• Certificate from HR with details of medical leave availed during the period of Injury.
	• Copy of Address Proof (Ration Card or Electricity Bill Copy).
	• In Case of Death
	  ○ Attested Copy of Death Certificate.
	  ○ Death Summary/Certificate from the hospital authority (wherever applicable)
	  ○ Burial Certificate (wherever applicable).
	  ○ Attested Copy of Statement of Witness, if any lodged with police authorities. (wherever applicable).
	  ○ Attested Copy of FIR / Panchanama / Inquest Panchanama. (wherever applicable).
	  ○ Attested Copy of Post Mortem Report (Only if conducted).
	  ○ Attested Copy of Viscera report if any (Only if Post Mortem is conducted).
	• In case of Permanent Total Disablement, Permanent Partial Disablement
	  ○ Attested Copy of disability certificate from relevant government Medical authority.
	  ○ Attested copy of FIR. (If required)
	  ○ All Investigation reports confirming the disability.

	○ Complete Treatment record with follow-up documentation. ○ Disability assessment report from Digit empanelled medical specialist (if required)
Loss of Employment	• Certificate from the Employer confirming the termination, dismissal, temporary suspension or retrenchment from employment of the Insured furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured with the reasons for the same. In case of temporary suspension, the period of suspension should also be mentioned in such certificate. • Appointment Letter • Latest Copy of Salary Revision, if any. • Last 3 Months Salary Slip • Form 16 • Loan Account Statements duly signed by the Financial Institution. • Contact details of Employer-Phone No. Mobile No., E-mail ID, Contact person in HR/Admin/Personnel dept. • Appointment Letter Employer if Re employed • Age proof of Insured: Aadhar Card, Election ID Card / PAN Card/ School Leaving • Form 26AS which shows tax deducted at source • Income tax return for relevant financial year • Self-declaration • Any other document as required by the Company /TPA to investigate the Claim or Our obligation to make payment for it, including documents related to proof that the insured has not found any job or has not started working again in family business or started his / her own venture.
Daily Cash Benefit/ Fixed Cash Benefit	• Detailed incident report • Medical records, Consultation papers, diagnostic reports, ICP papers. • Final claim bill with detailed break up. • Discharge summary from treating hospital. • FIR/MLC Report, in case of accident. • NEFT & KYC Documents of Customer. • Cancelled Cheque • PAN Card • Address Proof (Aadhar, Passport, Voter ID) • Any other documents/clarification may be requested on merits of case.
Illness Cover	**For Hospitalization** • Original Hospital Bill Break Up • Original Pharmacy Bills • Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital • Consultation Papers • Investigation Reports • Positive Diagnostic Report for the Conditions and/ or Disease defined and stated in the Policy Schedule / Certificate of Insurance • Digital Images/CDs of the Investigation Procedures (if required) • Original Invoice/Sticker (If applicable) • Attending Physician Certificate (If applicable) **Virus Detection and Quarantine Allowance** • Consultation Papers • Investigation Reports • Positive Diagnostic Report for the Conditions and/ or Disease defined and stated in the Policy Schedule / Certificate of Insurance • Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)
Loan Shield	• Investigation reports • Photograph of the injured with reflecting disablement • FIR / MLC Copy (if MLC is done) / Spot Panchnama-where applicable Attested by issuing authority

	• Disability Certificate from appropriate Government Authority Medical Certificate from treating Doctor • Copy of loan approval letter • Medical reports, case histories, investigation reports, treatment papers as applicable • Death Certificate attested by issuing/ appropriate authority • Post Mortem Report where applicable- attested by issuing authorities • Loan due statement • Last EMI paid proof
Loss of Pay	• Latest Copy of Salary Revision, if any. • Last 3 Months Salary Slip • Form 16 • Income tax return for relevant financial year • Self-declaration • Proof / declaration from employer that the Insured was granted leave without pay because all leaves of Insured are exhausted and due to death of immediate family member • Attendance proof

Any other additional documents required on case-to-case basis.

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

42. Continuity Benefits

We will grant continuity of benefits which were available to the Insured Members under a health insurance policy which provides same coverage 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 36. MATERNIT & 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

Annexure B

List of **Hazardous or Adventure sports cover:**

All the below given Adventure Sports/Hazardous Sports are subject to special conditions and special exclusions given below:

Special conditions are applicable to Section 18- Hazardous or Adventure sports cover, if mentioned against individual covers in below list:

a. You must be with a professional, qualified and licensed guide, instructor or operator.'

b. You must have the appropriate certification or license to participate in this sport, activity or experience at home. If operating a motor vehicle, the driver must hold the appropriate valid license in their country where such activity is being undertaken.
c. Within 60 miles of a safe haven (a protected body of water used by marine craft for refuge from storms or heavy seas).
d. Conventional skiing/snowboarding only. It is not a condition of cover that you ski or snowboard with a guide, however, you must follow the International Ski Federation code or the resort regulations; you must not venture into back country areas without taking local advice and appropriate rescue equipment.
e. Conventional scuba diving only. You are limited to your current qualification limit, unless accompanied by a qualified instructor, taking part in a recognized course requirement of your chosen Diving Association. You must hold a current P.A.D.I. (Professional Association of Diving Instructors), S.S.I. (Scuba Schools International), B.S.A.C. (British Sub Aqua Club), SAA (Sub Aqua Association), C.M.A.S. (Confederation Mondiale Des Activities Subaquatiques), or equivalent internationally recognized qualification and follow their relevant Association, Club or Confederation rules and guidelines at all times, or you must only dive under the constant supervision of a properly licensed Diving Instructor and follow their rules and instructions at all times.

Specific Exclusion for section 18 – Hazardous or Adventure sports cover will be applicable, if mentioned against the individual covers in below list:

i. Any competition, free-style skiing / snowboarding, ski/ snowboard jumping, ski-flying, ski / snowboard acrobatics, ski / snowboard stunting, or ski racing or national squad training, the use of skeletons.
ii. Any unaccompanied dive, any dive for gain or reward, any dive which takes you below your current qualification limits, or any dive below 50 metres under any circumstances.
iii. Free mountaineering, climbing in remote or inaccessible regions, exploratory expeditions and new routes, high altitude climbing over 6,000 metres, mountaineering expeditions or activities within Antarctica, the Arctic Circle or Greenland.
iv. Personal Accident

HAZARDOUS OR ADVENTURE SPORTS COVER	Level	SPECIAL CONDITIONS THAT APPLY	SPECIAL EXCLUSIONS THAT APPLY
Acrobatics	0		
Aerobics	0		
Air guitar	0		
Athletics	0		
Badminton	0		
Baseball	0		
Basketball	0		
Bowling (lawn, ten-pin, nine-pin, candlepin, duckpin and five-pin bowling, bowls, pétanque & boules)	0		
Canoeing (inland/coastal waters, grades 1-3 only)	0		
Cheerleading	0		
Cricket	0		
Croquet	0		
Curling	0		
Dance (ballet, ballroom, capoeira, salsa, interpretive dance)	0		
Darts	0		
Dodge ball	0		
Dragon boating (inland or coastal waters only)	0		
Fitness training	0		
Floorball	0		
Football (Soccer) including 5 a side	0		
Frisbee	0		
Golf	0		
Gym training (aerobics, spinning, Zumba, body pump, weight training, cross training, crossfit) (See also Boxing and Martial arts)	0		Policy excludes Power lifting
Gymnastics	0		
Handball	0		
Hockey	0		
Kayaking (inland/coastal waters, grades 1-3 only)	0		
Kite buggy	0		-
Kite flying	0		

Kite surfing	0		
Korfball	0		
Lacrosse	0		
Martial arts training (non-contact)	0		
Netball	0		
Orienteering	0		
Outdoor endurance	0		
Outrigger canoeing (inland or coastal waters only)	0		
Racquetball	0		
Roller hockey	0		
Roller skating	0		Policy excludes stunting
Rollerblading	0		Policy excludes stunting
Rounders	0		
Running/jogging (up to marathon distance)	0		Policy excludes Running of the Bulls.
Sandboarding/sand skiing	0		
Skateboarding (ramp, half pipe, skate park, street)	0		
Snooker	0		
Snorkelling	0		
Soccer	0		
Softball	0		
Squash/racquetball	0		
Stand up paddle surfing/paddle boarding	0		
Stilt walking	0		
Stoolball	0		
Surf boat rowing	0		
Surfing	0		
Table tennis	0		
Tchoukball	0		
Tennis	0		
Ultimate Frisbee	0		
Volleyball	0		
Wake skating	0		
Wakeboarding (see Water skiing)	0		
Yoga (class, alone/home practice)	0		
Yoga (teaching)	0	Special Condition (b)	-
Swimming (man-made swimming pool)	0		
Aqua zorbing (man-made swimming pool)	0		
Land zorbing (200 FT)	0		
Underwater walk	0		
Artificial rock climbing	0		
Buggy Ride	0		
Swoop Swing(100 Ft)	0		
Dirt Biking	0		
Gyro	0		
Rodeo-Bull ride	0		
Bubble Soccer	0		
Rocket Ejector	0		
Hard ball Net cricket	0		
Foosball	0		
American football (Gridiron)	1		Special Exclusion (iv)
Australian Rules Football (AFL)	1		Special Exclusion (iv)
Backpacking (2,000 up to 4,500 meters)	1		Special Exclusion (iii)
Banana boat rides	1	Special Condition (a)	
Bungee/bungy jumping	1	Special Condition (a)	
Bushwalking (2,000 up to 4,500 meters)	1		Special Exclusion (iii)

Camping up to 4,500 metres (see also Hiking and Mountaineering)	1		Special Exclusion (iii)
Canyon swing	1	Special Condition (a)	
Caving (sightseeing/tourist attraction)	1	Recreational visit only	
Clay pigeon shooting	1	Special Exclusion (a) or (b)	
Cycling (2000 to 4,500 meters – all styles including touring and organised tours)	1		Policy excludes Yungas Road/Death Road.
Dirt boarding	1		-
Dogsledding (on recognised trails)	1	Special Condition (a)	Policy excludes remote areas, racing, time trials and endurance events
Fencing	1		-
Fly by wire	1	Special Condition (a)	
Flying (as a fare paying passenger in a licensed scheduled or chartered aircraft or helicopter)	1	Special Condition (a)	
Flying (as a passenger of a private light aircraft)	1		Policy excludes stunt flying/aerobatics and commercial flying. Special Exclusion (iv)
High diving up to 10 metres	1		Policy excludes cliff diving
Hiking 2,000 metres up to 4,500 metres (scrambling, hillwalking) on recognised routes	1		Policy excludes where ropes, picks or other specialist climbing equipment is required. Special Exclusion (iii)
Horse riding (leisure/social, non-competitive equestrian, dressage, show jumping, eventing)	1		Policy excludes racing. Special Exclusion (iv)
Hunting (excluding big game hunting and hunting in India)	1	Special Condition (a) or (b)	Policy excludes Big Game Hunting.
Ice hockey	1		Special Exclusion (iv)
Ice skating (indoor or outdoor) on a commercially managed rink	1	Special Condition (a)	
Land surfing	1		-
Moped riding/Scooter biking	1	Special Condition (b); and a helmet must be worn	-
Motor racing experience (passenger only)	1	Special Condition (a)	
Motor biking	1	Special Condition (b); and a helmet must be worn	-
Mountain biking (up to 4,500 meters – all styles including touring and organised tours)	1		Policy excludes Yungas Road/Death Road.
Outward Bound	1	Special Condition (a)	
Quad biking	1	Special Condition (a) or (b); and a helmet must be worn	Special Exclusion (iv)
Rock climbing (bouldering)	1		Special Exclusion (iv)
Rowing/sculling (inland/coastal waters)	1		-
Safari tours	1	Special Condition (a)	Policy excludes handling and/or workwith dangerous animals including big cats, crocodiles, alligators, hippopotamuses, snakes, elephants or bears
Sailing	1	Special Condition (a) or (b); and Special Condition (c)	-
Segway tours	1	Special Condition (a); and a helmet must be worn	Special Exclusion (iv)
Sleigh rides	1	Special Condition (a)	Policy excludes remote areas.

Speed boating (inland/coastal waters only)	1	Special Condition (a) or (b)	Policy excludes speed boating on white water or outside coastal waters.
Swimming	1		Policy excludes swimming outside coastal waters.
Swimming with whales/whale sharks (inside or outside coastal waters)	1	Special Condition (a)	
Theme parks / fairgrounds	1	Special Condition (a)	
Water skiing/wakeboarding	1	Special Condition (a) or (b)	Policy excludes jumping.
Windsurfing (inland or coastal waters only)	1		-
Working - Non-manual work	1		-
Working - manual work	1		-
Zip line (Flying fox)	1	Special Condition (a)	
Abseiling (rappelling, rapping, rap jumping, deepelling, abbing); see also Climbing, and Mountaineering	2	Special Condition (a)	
Aerial safari	2	Special Condition (a)	Special Exclusion (iv)
Backpacking (4,500 up to 6,000 meters)	2		Special Exclusion (iii)
Boxing (gym or outdoor training)	2		Policy excludes boxing competition or bouts.
Bushwalking (4,500 up to 6,000 meters)	2		Special Exclusion (iii)
Camel riding/trekking	2	Special Condition (a)	
Camping 4,500 up to 6,000 metres (see also Hiking and Mountaineering)	2		Special Exclusion (iii)
Canyoning	2		Special Exclusion (iv)
Cave diving / Cavern diving	2	Special Condition (e)	Policy excludes cliff diving.
Cycling (4,500 up to 6,000 meters – all styles including touring and organised tours)	2		Policy excludes Yungas Road/Death Road.
Dune buggy	2	Special Condition (a) or (b)	-
Elephant riding/trekking	2	Special Condition (a)	-
Fishing	2	Sports / leisure fishing only. Special Condition (a) or (b); and Special Condition (c)	Policy excludes commercial fishing and rock fishing.
Glacier walking/ice walking	2	Special Condition (a)	Special Exclusion (iii)
Gliding	2	Special Condition (a) or (b)	Special Exclusion (iv)
Go karting	2	Special Condition (a)	-
Hiking 4,500 up to 6,000 metres (scrambling) on recognised routes	2		Policy excludes where ropes, picks or other specialist climbing equipment is required. Special Exclusion (iii)
Hot air ballooning (ballooning)	2	Special Condition (a) or (b)	-
Jet boating (inland/coastal waters only)	2	Special Condition (a) or (b)	-
Jet skiing (inland/coastal waters, grades 1-2 only)	2	Special Condition (a) or (b)	-
Kite boarding (on land or water)	2		
Mountain biking (4,500 up to 6,000 meters – all styles including touring and organised tours)	2		Policy excludes Yungas Road/Death Road.
Paint balling/airsoft	2	Special Condition (a)	-
Parachuting	2	Special Condition (a) or (b)	Policy excludes parachuting from a hot air balloon.
Rifle range/sports shooting	2	Special Condition (a) or (b)	-
River boarding/hydro speeding (grades 1-3)	2	Special Condition (a)	
Rock climbing (indoor)	2	Special Condition (a)	Policy excludes soloing. Special Exclusion (iv)
Scuba diving (to 50 metres)	2	Special Condition (e)	Policy excludes cliff diving. Special

			Exclusion (ii) and (iv)
Skiing / snowboarding (on piste, off piste, heli-skiing, heliboarding)	2	Special Condition (d)	Special Exclusion (i)
Sledding/Tobogganing/Snow Sleds/Snow Sleighs (on snow)	2		Policy excludes remote areas, racing, time trials and endurance events.
Snowmobiling Tandem skydiving	2	Special Condition (a) Special Condition (a)	Policy excludes remote areas, racing, time trials and endurance events.
	2		Policy excludes skydiving from a hot air balloon.
Tubing on rivers (see also Black water rafting)	2	Special Condition (a)	Special Exclusion (iv)
Via Ferrata	2		
Zorbing	2	Special Condition (a)	Special Exclusion (iv)
Backpacking (Above 6,000 meters)	3		Special Exclusion (iii) and (iv), except for high altitude climbing over 6,000 metres
Black water rafting (cave tubing) (grades 1-5)	3	Special Condition (a)	Special Condition (iv)
Bobsled/Bobsleigh	3	Special Condition (a)	Special Exclusion (i) and (iv)
Bushwalking (Above 6,000 meters)	3		Special Exclusion (iii) and (iv), except for high altitude climbing over 6,000 metres
Camping above 6,000 metres (see also Hiking and Mountaineering)	3	-	Special Exclusion (iii) and (iv), except for high altitude climbing over 6,000 metres
Free diving (up to 50 meters) Hang gliding	3	Special Condition (a)	Policy excludes cliff diving.
	3		Special Exclusion (iv)
Hiking above 6,000 metres (scrambling) on recognised routes	3		Policy excludes where ropes, picks or other specialist climbing equipment is required. Special Exclusion (iii)
Martial arts training	3	Special Condition (a); noncompetitive only	Special Exclusion (iv). Policy excludes cage fighting, mixed martial arts, kickboxing, Muay Thai and competition or bouts.
Mountaineering up to 6,000 metres (with ropes, picks or specialist climbing equipment)	3	We recommend you do not venture into any area without taking local advice and appropriate rescue equipment.	Special Exclusion (iii) and (iv)
Mountaineering above 6,000 metres (with ropes, picks or specialist climbing equipment)	3	We recommend you do not venture into any area without taking local advice and appropriate rescue equipment.	Special Exclusion (iii) and (iv), except for high altitude climbing over 6,000 metres
Paragliding/parapenting	3	Special Condition (a) or (b)	Special Exclusion (iv)
Parasailing/Parascending	3	Special Condition (a) or (b)	Special Exclusion (iv)
Rap jumping	3	Special Condition (a)	Special Exclusion (iv)
Rock climbing (outdoor/traditional/sport climbing/bolted/aid climbing/free climbing); see also Mountaineering	3		Policy excludes soloing. Special Exclusion (iv)
Skydiving (solo) Snow biking (on piste or off piste within resort boundaries)	3	Special Condition (a) Special Condition (a)	Policy excludes skydiving from a hot air balloon.
	3		Special Exclusion (i) and (iv)
	3	Special Condition (a)	Special Exclusion (iv)
Snow rafting	3	Special Condition (a)	Special Exclusion (iv)
Tubing on snow	3	Special Condition (a)	Special Exclusion (iv)

White water rafting (grades 1-5)	3	Special Condition (a)	Special Exclusion (iv)

Annexure C

Plan wise Covered Critical Illnesses

Sr. No.	Category	Critical Illness	Plan A	Plan B	Plan C	Plan D
1	Malignancy	Cancer of Specified Severity	Covered	Covered	Covered	Covered
2	Cardiovascular system	Myocardial Infarction	Covered	Covered	Covered	Covered
3		Open Heart Replacement or Repair of Heart Valves	Covered	Covered	Covered	Covered
4		Surgery to Aorta	Covered	Covered	Covered	Covered
5		Primary (Idiopathic) Pulmonary Hypertension	Not Covered	Covered	Covered	Covered
6		Aneurysm of Abdominal Aorta	Not Covered	Not Covered	Covered	Covered
7		Cardiomyopathy	Not Covered	Not Covered	Covered	Covered
8		Pulmonary artery graft surgery	Not Covered	Not Covered	Covered	Covered
9		Open Chest CABG	Covered	Covered	Covered	Covered
10		Infective Endocarditis	Not Covered	Not Covered	Not Covered	Covered
11		Dissecting Aortic Aneurysm	Not Covered	Not Covered	Not Covered	Covered
12	Major Organ Condition/Disease	End Stage Lung Failure	Covered	Covered	Covered	Covered
13		End Stage Liver Failure	Covered	Covered	Covered	Covered
14		Kidney Failure Requiring Regular Dialysis	Covered	Covered	Covered	Covered
15		Major Organ/ Bone Marrow Transplant	Covered	Covered	Covered	Covered
16		Medullary Cystic Disease	Not Covered	Not Covered	Not Covered	Covered
17		Chronic Relapsing Pancreatitis	Not Covered	Not Covered	Not Covered	Covered
18	Nervous System	Apallic Syndrome	Not Covered	Covered	Covered	Covered
19		Benign Brain Tumour	Covered	Covered	Covered	Covered
20		Coma of Specified Severity	Covered	Covered	Covered	Covered
21		Major Head Trauma	Covered	Covered	Covered	Covered
22		Permanent Paralysis of Limbs	Covered	Covered	Covered	Covered
23		Stroke Resulting in Permanent Symptoms	Not Covered	Covered	Covered	Covered
24		Motor Neurone Disease with Permanent Symptoms	Not Covered	Covered	Covered	Covered
25		Parkinson's Disease	Not Covered	Not Covered	Covered	Covered
26		Muscular Dystrophy	Not Covered	Not Covered	Covered	Covered
27		Progressive Supranuclear Palsy	Not Covered	Not Covered	Covered	Covered
28		Creutzfeldt-Jakob disease (CJD)	Not Covered	Not Covered	Covered	Covered
29		Bacterial Meningitis	Not Covered	Not Covered	Covered	Covered

30		Alzheimer's disease	Not Covered	Not Covered	Covered	Covered
31		Encephalitis	Not Covered	Not Covered	Covered	Covered
32		Multiple Sclerosis with Persisting Symptoms	Covered	Covered	Covered	Covered
33		Brain Surgery	Not Covered	Not Covered	Not Covered	Covered
34		Multiple System Atrophy	Not Covered	Not Covered	Not Covered	Covered
35	**Auto Immune Disorder**	Systemic lupus erythematosus	Not Covered	Not Covered	Covered	Covered
36		Goodpasture's syndrome	Not Covered	Not Covered	Covered	Covered
37		Aplastic Anaemia	Not Covered	Covered	Covered	Covered
38		Systemic Lupus Erythematous with Lupus Nephritis	Not Covered	Not Covered	Not Covered	Covered
39		Progressive Scleroderma	Not Covered	Not Covered	Not Covered	Covered
40		Crohn's Disease	Not Covered	Not Covered	Not Covered	Covered
41		Severe Ulcerative Colitis	Not Covered	Not Covered	Not Covered	Covered
42	**Others**	Loss of Independent Existence	Not Covered	Covered	Covered	Covered
43		Fulminant Viral Hepatitis	Not Covered	Not Covered	Covered	Covered
44		Pneumonectomy	Not Covered	Not Covered	Covered	Covered
45		Deafness	Not Covered	Not Covered	Not Covered	Covered
46		Loss of Speech	Not Covered	Not Covered	Not Covered	Covered
47		Third Degree Burns	Not Covered	Not Covered	Not Covered	Covered
48		Chronic Adrenal Insufficiency (Addison's Disease	Not Covered	Not Covered	Not Covered	Covered
49		Blindness	Not Covered	Not Covered	Not Covered	Covered
50		Severe Rheumatoid Arthritis	Not Covered	Not Covered	Not Covered	Covered

II. Digit Life Group Long Term Plan

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 (in case of Additional Accidental Death Benefit as mentioned in Clause 6.2.4.a. in Part C of this Master Policy Document) and within 12 months of the occurrence of the Accident (in case of Accidental Death Benefit under Additional Personal Accident Benefit, as mentioned in Clause 6.2.4.c. in Part C of this Master Policy Document), 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. **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.
4. **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.
5. **Assignee** is the person to whom the rights and Benefits under this Policy are transferred by virtue of an Assignment.
6. **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.
7. **Assignor** means the person who transfers the rights and Benefits under this Policy to the Assignee by virtue of an Assignment.
8. **Authority** means Insurance Regulatory and Development Authority of India (IRDAI).
9. **Benefit/s** means the Death Benefit, Inbuilt Optional Benefits which are Terminal Illness Benefit, Health Cover Benefit, Hospitalization Cover Benefit, Accidental Cover Benefit, Return of Premium in Term Insurance with Return of Premium option under Death Benefit as specified in Clause 6.1 of Part C of this Policy Document, Surrender Benefit, or any other Benefit as applicable and availed under the terms of this Policy.
10. **Beneficiary** means the Master Policyholder or the Member or Nominee/(s).
11. **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.
12. **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.
13. **Coverage End Date** The date of the expiry of Insurance Coverage as provided to the Insured Member under this Master Policy.
14. **Death Benefit** means the Benefit which is agreed to be paid by Us on occurrence of Member's death subject to Clause 6.1 in Part C of this Policy Document and as specified in the Certificate of Insurance/ Register of Insured Members.
15. **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 6.2.4.a of Part C of this Policy Document and Accidental Death Benefit under Additional Personal Accident Benefit as specified in Clause 6.2.4.c. of Part C of this Policy Document.
16. **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 6.2.4.a of Part C of this Policy Document and Accidental Death Benefit under Additional Personal Accident Benefit as specified in Clause 6.2.4.c. of Part C of this Policy Document.
17. **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 6.2.2 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 breastbone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
   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 breathlessness, 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.

18. **Domiciliary Hospitalization**: 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.
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. **Inbuilt Optional Benefits** means Terminal Illness Benefit, Health Cover Benefit, Hospitalization Cover Benefit, Accidental Cover Benefit as described in Clause 6.2 of Part C of this Master Policy Document
27. **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.
28. **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.
29. **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.

30. **Lapsed Status** means state of a non-active life insurance contract on account of non-payment of Premium within the Grace Period.
31. **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, pathologist shall be registered Medical Practitioners.
32. **Master Policy / Policy** means the contract of insurance entered into between the Master Policyholder and the Insurer as evidenced by the Master Policy Document.
33. **Master Policy Document / Policy Document** means this Digit Life Group Long Term Plan 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.

34. **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.
35. **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 updated Schedule is issued, then the Schedule which is latest in time.
36. **Member/Insured Member** means an individual who satisfies the eligibility criteria and is covered under this Master Policy.
37. **Member Coverage Term / Coverage Term** means duration of Insurance Coverage for Death Benefit and each of the Inbuilt Optional Benefits, respectively, with respect to Insured Member, from date of joining the Master Policy. Coverage Term of Inbuilt Optional Benefits will always be less than or equal to the Coverage Term of Death Benefit.
38. **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.
39. **Multi-Stage Cancer Conditions** means first diagnosis of any of the covered minor or major conditions under Additional Multi-Stage Cancer Benefit mentioned in Clause 6.2 in Part C of this Policy Document. Following are the definitions of such minor and major conditions covered under Additional Multi-Stage Cancer Benefit:
    1) **Carcinoma-in-Situ (CIS) of any organ (except skin)**
        a) It means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. Invasion means an infiltration and/or active destruction of normal tissue beyond the basement membrane.
        b) The diagnosis of Carcinoma-in-Situ must always be supported by a histopathological report.
        c) Furthermore, the diagnosis of Carcinoma-in-Situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard.
        d) In the case of cervix uteri, Pap smear alone is not acceptable and should be accompanied with cone biopsy and colposcopy with the cervical biopsy report clearly indicating presence of CIS.
        e) Clinical diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I and CIN II (where there is severe dysplasia without Carcinoma-in-Situ) does not meet the required definition and are specifically excluded.
        f) All CIS of skin are specifically excluded.
        g) This coverage is available to the first occurrence of CIS of same organ. Multiple claims from the same organ shall not be admissible.
    2) **Early-Stage Cancers**
        a) Early-Stage Cancer shall mean first ever diagnosis with presence of one of the following malignant conditions:
            i) Any malignant tumor of the thyroid, positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of the tissue, which is histologically classified as T1N0M0 according to the TNM classification system, or another equivalent classification.
            ii) Prostate tumor should be histologically described as TNM Classification T1a or T1b or T1c are of another equivalent classification.
            iii) Chronic lymphocytic leukaemia classified as RAI Stage I or II.
            iv) Basal Cell and Squamous skin cancer that has spread to distant organs beyond the skin
            v) Hodgkin's lymphoma Stage I by the Cotswold's classification staging system
            vi) All tumors of urinary bladder histologically classified as T1N0M0 (TNM Classification)

    The diagnosis must be based on histopathological features and confirmed by a pathologist. Pre-malignant lesions and conditions, unless listed above are excluded.
    3) **Cancer of Specified Severity** As defined in Definition 17 (1) in this Part B
40. **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.
41. **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.
42. **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.

43. **OPD Treatment**: OPD Treatment means the one in which the Insured Member 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.
44. **Policy Term** means the period for which Insurance Coverage is provided to each Insured Member by Us under this Master Policy and as specified in the Policy Schedule.
45. **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.
46. **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.
47. **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.
48. **Premium Payment Term (PPT)** means the period in years or months during the Policy Term / Member Coverage Term during 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.
49. **Proposal** Form means the form filled in and completed by You for the purpose of obtaining Insurance Coverage under this Master Policy.
50. **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), Coverage and Benefit options chosen and Sum Assured under various Benefit options, as applicable and any special conditions applicable to the Insured Member.
51. **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.
52. **Revival** means restoration of Insurance Coverage under a Master Policy / Insurance Coverage with respect to any Member, which is in a Lapsed Status or reduced paid-up status due to non-payment of due Premium (as stated in Clause 2 of Part D in this Policy Document), to the In-Force status as specified in Clause 4 of Part D in this Policy Document and subject to terms and conditions of the Master Policy.
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 Certificate of Insurance / 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. For Income Benefit option, Sum Assured shall be defined as the total income payable in the next 12 months following the death of Insured Member for presentation purpose.
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). Survival Period shall not be applicable for Additional Multi-Stage Cancer Benefit.
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 of this Policy Document.
62. **Waiting Period** means a period of 90 days for Accelerated Critical Illness, Additional Critical Illness Benefit, Additional Multi-

Stage Cancer Benefit (all sub-options under Health Cover Benefit) and 45 days for Additional Hospitalization Benefit (under Hospitalization Cover Benefit) starting from the Risk Commencement Date for the Member or from the date of Revival of Insured Member's Insurance Coverage. No amount shall be payable in case of occurrence of covered Critical Illness Condition or in case of occurrence of covered condition under Additional Multi-Stage Cancer Benefit or on Hospitalization under Additional Hospitalization Benefit within the Waiting Period. Waiting Period shall not be applicable in case Critical Illness condition/(s) or minor / major conditions under Additional Multi-Stage Cancer Benefit manifests due to an Accident. Similarly Waiting Period shall not be applicable in case of Member's Hospitalization due an Accident.

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

iv) In case of joint life cover, both the persons under joint life cover shall individually satisfy the eligibility criteria.

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, 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 may have choice to opt from various options made available by the Master Policyholder under the Policy with respect to options under Death Benefit, Inbuilt Optional Benefits, Coverage Term, Premium Payment Term, Premium payment frequency, joint life cover option, coverage option, Sum Assured amount, any other option, if applicable.

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. Joint Life Cover

This Policy offers joint life cover option, under which two persons can be insured under a single lumpsum Sum Assured and / or Income Benefit under Death Benefit and under single Sum Assured for each of the applicable sub-options under Inbuilt Optional Benefits, if chosen. Both the individuals to be covered shall have insurable interest to avail the Insurance Coverage on joint life basis. The Premium, as applicable, shall be collected for both the insured persons under joint life cover during the Premium Payment Term. For joint life cover, Death Benefit shall be payable in accordance with Clause 6.1 of this Part C and Inbuilt Optional Benefits, if chosen, shall be payable in accordance with Clause 6.2 of this Part C on occurrence of respective

insured events. The surviving Member shall receive the applicable Benefit payable on first occurrence of death under joint life cover. On payment of Death Benefit or on payment of Accidental Death Benefit (under Additional Accidental Death Benefit as mentioned in Clause 6.2.4.a. of this Part C or under Additional Personal Accidental Benefit as mentioned in Clause 6.2.4.c. of this Part C) or on payment of accelerated Benefits which leads to 100% exhaustion of applicable lumpsum Sum Assured under Death Benefit, provided income benefit option is not chosen, the Insurance Coverage for both the lives under Master Policy shall terminate and no further Benefits shall be payable under this Master Policy. On payment of 100% Sum Assured or 100% of applicable Benefit amount, as the case may be, for Additional Critical Illness Benefit/ Additional Multi-Stage Cancer Benefit/Additional Hospitalization Benefit/Additional Total and Permanent Disability Benefit/Additional Personal Accident Benefit, Insurance Coverage for these respective Benefits shall terminate for both the lives.

In case of simultaneous death of both the lives under joint life cover, Death Benefit and Accidental Death Benefit (under Additional Accidental Death Benefit as mentioned in Clause 6.2.4.a. of this Part C or under Additional Personal Accidental Benefit as mentioned in Clause 6.2.4.c. of this Part C), if applicable, shall be payable for one life only. In case of simultaneous or subsequent occurrence of insured events with respect to two lives for Inbuilt Optional Benefits, the total Benefit amount payable put together under each of the applicable sub-options under Inbuilt Optional Benefits (if chosen) shall be limited to 100% of the applicable respective Sum Assured or 100% of applicable respective Benefit amount, subject to terms and conditions of this Policy.

In case of simultaneous or subsequent claims under joint life cover, where claim against one life is repudiable, the claim on the other life shall prevail, if it is valid and subject to terms and conditions of this Policy.

5. Coverage Options

The Master Policyholder can choose any one or two or all three of the following Coverage Options at Master Policy Commencement Date and allow each Member to be covered in the Master Policy to choose any one of these options before Member's Risk Commencement Date.

a. Level Cover – Under this Coverage Option, Sum Assured shall remain constant throughout the Member Coverage Term
b. Decreasing Cover – Under this Coverage Option, Sum Assured as on Risk Commencement Date shall reduce over the Member Coverage Term as per the agreed schedule chosen before Risk Commencement Date and as specified in Certificate of Insurance.
c. Flexi Cover – This option offers a combination of Level Cover and Decreasing Cover and shall be subject to agreed schedule chosen before Risk Commencement Date and as specified in Certificate of Insurance.

6. 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(s) depending upon the Coverage Option/s and Inbuilt Optional Benefit(s) (as explained respectively in Clause 5 and Clause 6 of Part C of this Policy Document) chosen and as specified in the Master Policy Schedule/Certificate of Insurance/Register of Insured Members. Maximum Sum Assured (and / or Income Benefit, if chosen, in case of Death Benefit) allowed for each Member under Death Benefit or each of the applicable sub-options under Inbuilt Optional Benefits (if any) shall be subject to prevailing underwriting policy of the Company.

6.1 Death Benefits & Death Benefit Payout Options: Death Benefit is the base Benefit under this Master Policy and shall be payable in case of death of the Insured Member. Any one of the following Death Benefit options can be chosen by the Member before Risk Commencement Date:

- Term Insurance - Death Benefit shall be payable in the event of death of the Insured Member during the Member Coverage Term, provided all Premiums are paid as and when due and Member's Insurance Coverage is In Force. No survival Benefit or maturity Benefit shall be payable under this option.
- Term Insurance with Return of Premium (TROP) – Death Benefit shall be payable in the event of death of the Insured Member during the Member Coverage Term, provided all Premiums are paid as and when due. In case of survival of the Member (or survival of both individuals under joint life cover) till the end of Member Coverage Term, Total Premiums Paid shall be returned in lumpsum at the end of such Member Coverage Term.

Any one or combination of the following pay out 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) Income Benefit 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, which should not exceed 40 years less the chosen Member Coverage Term.

Income Benefit 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 before Master Policy Commencement Date / Risk Commencement Date (as the case may be) shall be available in case of Death Benefit only.

For Income Benefit option mentioned above, Sum Assured shall be defined as the total income payable in the next 12 months following the death of Insured Member for presentation purpose.

The Death Benefit amount payable on death for an Insured Member shall be the chosen lumpsum Sum Assured and / or Income Benefit as per the options chosen for that Member. Insured Members of the same Master Policy can have different lumpsum Sum Assured amount and / or Income Benefit amount. The lumpsum Sum Assured and / or Income Benefit amount for each individual Insured Member will be specified at Risk Commencement Date.

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 Income Benefit or as combination of lumpsum Sum Assured and Income Benefit 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.

Death Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Death Benefit	Death	In case of death of the Member (on occurrence of first death in case of joint life cover) during the Member Coverage Term, lumpsum Sum Assured and / or income benefit (if any), shall be payable.	**In case of Level Cover:** Lumpsum Sum Assured and / or income benefit under Death Benefit shall be payable. **Decreasing and Flexi Cover** – Prevailing lumpsum Sum Assured under Death Benefit, as per agreed schedule chosen before Risk Commencement Date, shall be payable. Decreasing and Flexi Cover shall not be applicable for Income Benefit

6.2 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.

6.2.1 Terminal Illness (TI) Benefit

Accelerated Terminal Illness (TI) Benefit shall be offered under this Inbuilt Optional Benefit and 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.

Since TI Benefit is an Accelerated Benefit, payment of this Benefit shall not be in addition to lumpsum Sum Assured under Death Benefit chosen and it only facilitates an earlier payment of lumpsum Sum Assured under 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 Income Benefit option). It is payable only once during the lifetime 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 no Income Benefit is chosen in addition to lumpsum Sum Assured under Death Benefit, the Insurance Coverage for all the Benefits, including Death Benefit and 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.

Where the TI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and Income Benefit is also chosen in addition to lumpsum Sum Assured under Death Benefit, on payment of TI Sum Assured, Accelerated TI Benefit along with lumpsum Sum Assured under Death Benefit and other Inbuilt optional Benefits, if any, shall terminate, however, Member's Insurance Coverage shall continue with respect to the In Force Income Benefit under Death Benefit.

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.

Accelerated Terminal Illness (TI) Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Accelerated Terminal Illness Benefit	Terminal Illness (TI)	In case of diagnosis of Terminal illness, lumpsum Sum Assured is payable. In case of joint life cover, Benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Terminal Illness condition.	**Level Cover:** TI Sum Assured, which will be acceleration of the lumpsum Sum Assured under Death Benefit shall be payable. **Decreasing & Flexi Cover:** TI Sum Assured, which will be acceleration of lumpsum Sum Assured under Death Benefit, prevailing as per agreed schedule chosen before Risk Commencement Date, shall be payable.

6.2.2 Health Cover Benefit:

Under this Inbuilt Optional Benefit, the following three sub-options are available. Members can choose only one of these three sub-options before Risk Commencement Date.

a) Accelerated Critical Illness (CI) Benefit

This is an accelerated Benefit and subject to the Waiting Period, Survival Period, applicable exclusions referred under Critical Illness Condition in Part B and Annexure IV 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.

Since this is an accelerated Benefit, payment of this Benefit shall not be in addition to lumpsum Sum Assured chosen under Death Benefit and it only facilitates an earlier payment of such lumpsum Sum Assured under Death Benefit on prior occurrence of the Critical Illness. Accelerated CI Benefit can be opted for when lumpsum Sum Assured under Death Benefit is chosen (either standalone or in combination with Income Benefit option). Accelerated CI Benefit 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 no Income Benefit is chosen in addition to lumpsum Sum Assured under Death Benefit, the Insurance Coverage for all the Benefits, including Death Benefit and Inbuilt Optional Benefits (if any) in respect of the Insured Member shall cease immediately upon diagnosis of Critical Illness and payment of Accelerated CI Benefit.

Where the CI Sum Assured is equal to the lumpsum Sum Assured under Death Benefit and Income Benefit is also chosen in addition to lumpsum Sum Assured under Death Benefit, on payment of CI Sum Assured, Accelerated CI Benefit along with the lumpsum Sum Assured under Death Benefit shall terminate, however, Member's Insurance Coverage shall continue with respect to the In Force Income Benefit under Death Benefit and other In Force Inbuilt Optional Benefits, if any, for remaining of the respective Member Coverage Terms.

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 paid, 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 respective Member Coverage Terms.

Accelerated Critical Illness (CI) Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Accelerated Critical Illness (CI) Benefit	Critical Illness (CI)	In case of diagnosis of any one of the covered Critical Illnesses, basis the CI variant chosen, lumpsum Sum Assured is payable.	**Level Cover:** CI Sum Assured, which will be acceleration of the lumpsum Sum Assured under Death Benefit, shall be payable.

		In case of joint life cover, this Benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Critical Illness condition.	**Decreasing & Flexi Cover :** CI Sum Assured, which will be acceleration of lumpsum Sum Assured under Death Benefit, prevailing as per agreed schedule chosen before Risk Commencement Date, shall be payable.

b) Additional Critical Illness (CI) Benefit

Subject to the Waiting Period, Survival Period, applicable exclusions referred under Critical Illness Condition in Part B and Annexure IV 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.

This is an additional Benefit and 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 Inbuilt Optional Benefits (if any) for the remaining of the respective Member Coverage Terms.

Additional Critical Illness (CI) Benefit payable under different Coverage Options

Benefit	**Insured Event**	**How and when Benefit shall be payable**	**Size of such Benefit**
Additional Critical Illness (CI) Benefit	Critical Illness	In case of diagnosis of any one of the covered critical illnesses, basis the CI variant chosen, lumpsum Sum Assured is payable. In case of joint life cover, this Benefit shall be payable in lumpsum, if any one of two lives is diagnosed first with Critical Illness condition.	**Level Cover**: CI Sum Assured shall be payable. **Decreasing Cover & Flexi Cover:** Prevailing CI Sum Assured as per agreed schedule chosen before Risk Commencement Date shall be payable.

For both Accelerated CI Benefit and Additional CI Benefit: We shall not pay the CI Sum Assured when the Master Policy / Insurance Coverage to the Member is in Lapsed Status. 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.

At the time of Critical Illness claim payment, the Claimant will have an option to receive the additional / accelerated CI Benefit (as chosen) in the form of regular income over a period not exceeding 5 years. Such income payment can be chosen to be received in monthly, quarterly, half-yearly or annual mode. The first instalment pay-out shall be made immediately on acceptance of the CI claim by the Company. The lumpsum CI sum assured will be converted to the income amount as per chosen payment frequency and payment period using an effective interest rate of 5% p.a.

Critical Illnesses (CI) Variants: There are three CI variants offered under Accelerated CI Benefit / Additional 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

c) Additional Multi-Stage Cancer (MSC) Benefit

Multi-stage Cancer (MSC) Benefit is an additional Benefit and subject to the Waiting Period, applicable exclusions mentioned under Additional Multi-Stage Cancer Condition in Part B and Annexure IV of this Master Policy and the other terms and conditions of this Policy, shall be payable in lumpsum as mentioned in table below upon diagnosis of the listed conditions during Multi-Stage Cancer Benefit's Coverage Term.

Level and covered conditions	**Additional MSC Benefit payable in lumpsum (as percentage of MSC Sum Assured)**
Minor Condition a. Carcinoma in-situ of any organ except skin b. Early-Stage Cancers	25%
Major Condition a. Cancer of specific severity	100% less minor condition claim earlier paid, if any

On diagnosis of one of the listed illnesses under minor conditions, 25% of MSC Sum Assured shall be payable in lumpsum and on diagnosis of any of the conditions under major condition category, 100% of MSC Sum Assured in lumpsum, less minor condition claim already paid, if any, shall be payable.

Claim shall be admissible only if the Member is diagnosed for the first ever occurrence of any of the listed conditions. Multiple claims for minor conditions shall be admissible during Additional Multi-Stage Cancer Benefit's Member Coverage Term as long as the total payout does not exceed 100% of the MSC Sum Assured. For multiple claims under minor conditions for a Member to be admissible, there needs to be a period of at least 6 months between the date of diagnosis of one minor condition claim and date of diagnosis of subsequent minor condition claim. However, this requirement of 6 months is not applicable in the case of diagnosis of major condition claim following a minor condition claim.

Multiple claims under minor conditions from the same organ shall not be admissible. For the purpose of claim, each group of the following sites are treated as one organ:

- Basal cell and squamous skin cancer
- Breast, where the tumor is classified as Tis according to the TNM Staging method
- Corpus uteri, vagina, fallopian tubes, cervix uteri, ovary

- Colon and rectum
- Penis, testis
- Stomach and esophagus

The total claims payable under this Benefit, including claims under minor and major conditions put together, shall not exceed 100% of the MSC Sum Assured. Upon payment of the 100% of MSC sum assured, 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 respective Member Coverage Terms.

Additional Multi-Stage Cancer Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Multi-Stage Cancer (MSC) Benefit	Minor or Major Conditions under Additional Multi-Stage Cancer Benefit	In case of diagnosis of minor or major conditions under Cancer, lump sum amount shall be payable. In case of joint life cover, lumpsum amount for minor conditions can be availed by both the lives separately. Minor condition Benefit already availed for any organ by one life shall be exhausted for both the lives. Lumpsum Benefit for major condition under cancer can be availed by any one of two lives, who is diagnosed first with such major condition.	**Level Cover:** 25% of MSC Benefit Sum Assured on diagnosis of minor condition. 100% of MSC Benefit Sum Assured, less claims earlier paid on account of minor condition(s), if any, shall be payable on diagnosis of a major condition. The Company's liability for payment of all the claims under additional MSC Benefit in aggregate during this Benefit's Coverage Term shall not exceed the 100% of MSC Sum Assured which includes multiple claims for minor conditions by the member (by both the lives put together in case of joint life cover) **Decreasing & Flexi Cover –** Not applicable

6.2.3 Hospitalization Cover Benefit:

Under this option, Additional Hospitalization Benefit (HB) shall be offered. Subject to terms and conditions of this Policy and applicable exclusions specified in Annexure V, a lumpsum amount equal to Additional Hospitalization Benefit (HB) Sum Assured shall be payable if a Member, on recommendation of a Medical Practitioner, is hospitalized, provided such Hospitalization happens for a continuous period of specified number of days between 1 to 15 days (number of days to be chosen by the Member before Risk Commencement Date) in a Coverage Year during Additional Hospitalization Benefit Coverage Term. For Insurance Coverage under Additional Hospitalization Benefit, completion of every 24 'in-patient care' hours in Hospital from the time of admission is considered to be a day.

It is important to note that Additional Hospitalization Benefit can be claimed only once in a Coverage Year, subject to maximum 5 times during this Benefit's Member Coverage Term.

Upon payment of maximum number of allowed claims, as applicable, under Additional Hospitalization Benefit during the Member Coverage Term, 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 respective Member Coverage Terms.

Hospitalization Cover Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Hospitalization Cover Benefit	Hospitalization	In case of Hospitalization of an Insured Member for a continuous period for specified number of days between 1 and 15 (as chosen by Member before Risk Commencement Date), a lumpsum Benefit shall be payable in case of such Hospitalization, only once in a Coverage Year, subject to maximum 5 times during Member Coverage Term of this Benefit. In case of joint life cover, the Hospitalization Cover Benefit can be availed once by only one of the two lives in each Coverage Year during the	**Level Cover** – A lumpsum amount equal to 100% of Hospitalization Benefit Sum Assured shall be payable on each Hospitalization. Hospitalization Cover Benefit can be claimed only once in a Coverage Year and not more than 5 times during the Member Coverage Term (across two lives put together in case of joint life cover). **Decreasing & Flexi Cover**: Not applicable

		Coverage Term, provided in each Coverage Year, it is claimed on occurrence of first such Hospitalization of only one of the two lives.	

6.2.4 Accidental Cover Benefit: Following three sub-options shall be offered under this Inbuilt Optional Benefit.

a) 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 VI.

The date of the Accident should be after the Risk Commencement Date and before the termination/ expiry of the Insured Member's Insurance Coverage.

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.

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.

Additional Accidental Death Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Accidental Death Benefit (ADB)	Death due to Accident	In case of death of Member due to Accident, where such Accident happens during the Member Coverage Term, a lumpsum amount shall be payable. In case of joint life cover, lumpsum Benefit shall be payable on happening of first death due to Accident.	**Level Cover** – A lumpsum amount equal to 100% of Additional ADB Sum Assured shall be payable. **Decreasing & Flexi Cover** – A lumpsum amount equal to 100% of prevailing ADB Sum Assured as on the date of Accident as per agreed schedule chosen before Risk Commencement Date, shall be payable.

b) 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 VII and other terms and conditions of this Master Policy, ATPD Sum Assured which is in addition to Death Benefit and other Inbuilt 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.

For the purpose of Additional Accidental Total and Permanent Disability Benefit mentioned here, 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.

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 shall terminate, 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 respective Member Coverage Terms.

Additional Accidental Total and Permanent Disability Benefit payable under different Coverage Options

Benefit	Insured Event	How and when Benefit shall be payable	Size of such Benefit
Additional Accidental Total and Permanent Disability (ATPD) Benefit	Total and Permanent Disability (ATPD) due to Accident	In case of ATPD due to accident, while such Accident happens during the Member Coverage Term, a lumpsum amount shall be payable. In case of joint life cover, lumpsum Benefit shall be payable on first occurrence of Total and Permanent Disability due to Accident to any one of the two lives.	**Level Cover** – A lumpsum amount equal to 100% of ATPD Sum Assured shall be payable. **Decreasing & Flexi Cover** – A lumpsum amount equal to 100% of prevailing ATPD Sum Assured as on the date of Accident as per agreed schedule chosen before Risk Commencement Date shall be payable.

c) Additional Personal Accident (PA) Benefit

Personal Accident Benefit shall be an additional Benefit and subject to terms and conditions of this Policy, following set of Benefits shall be payable under this sub-option on occurrence of specified insured events due to an Injury sustained by the Member on account of an Accident.

S.No.	Insured Event	Additional Personal Accident (PA) Benefit Payable
1	Accidental Death	100% of Additional PA Sum Assured shall be payable in lumpsum following death of Member, due to an Injury sustained in an Accident during the Member Coverage Term, provided that Member's death due to such Accident happens within 12 months from the date of such Accident. 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.
2.	Accidental Total and Permanent Disability (ATPD)	100% of Additional PA Sum Assured shall be payable in lumpsum if Member suffers Total and Permanent Disability of the nature specified below, solely, and directly due to an Accident during the Member Coverage Term, provided that the Total and Permanent Disability occurs within 12 months from the date of the such Accident: a) Total and irrecoverable loss of sight of both eyes, or; b) Physical separation or loss of use of both hands or feet, or; c) Physical separation or loss of use of one hand and one foot, or; d) loss of sight of one eye and Physical separation or loss of use of hand or foot; e) If such Injury shall as a direct consequence thereof, permanently, and totally, disables the Insured Person 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.
3.	Accidental Permanent Partial Disablement (APPD)	Benefits are payable in lumpsum, if the Member suffers Permanent Partial Disablement of the nature specified in the Table A given below, solely and directly due to an Accident during the Member Coverage Term, provided that the Permanent Partial Disablement shall occur within 12 months of the date of such Accident.

4	Accidental Temporary Total Disablement (ATTD)	If the Insured Member sustains an Injury in an Accident during the Coverage Term and which completely incapacitates the Insured Member from engaging in any employment or occupation of any description whatsoever which the Insured Member was capable of performing at the time of the Accident (Temporary Total Disablement), compensation shall be payable, at the rate of 0.2% of the PA Sum Assured per week, till the time the Insured Member is able to return to work, provided that: a. Such period of ATTD exceeds 4 weeks, however Benefit shall be payable for the entire duration of disablement. b. The compensation payable under this Benefit mentioned under point (a) above, shall not be payable for more than 100 weeks in respect of any one Injury calculated from the date of commencement of disablement and in no case shall exceed the PA Sum Assured. c. The Temporary Total Disablement is certified in writing by the treating Medical Practitioner to have commenced within 30 days from the date of the Accident. d. The compensation payable, shall be paid by the Company at quarterly intervals, after ascertaining the amount payable. If the period of temporary total disablement is for less than a quarter or three months, the compensation may be paid at the end of the disablement period. e. During the course of payment under this Benefit, the Company shall have right to call for a certification from an independent Medical Practitioner chosen by the Company, with regard to the continuity of temporary total disability specified under this ATTD.
5	Hospitalization due to Accident	A Daily Hospital Cash Benefit equal to a fixed percentage of PA Sum Assured, which is 1%/2%/3%/4%/5% (as chosen before Risk Commencement Date by the Member) shall be payable on Hospitalization due to an Accident. Daily Hospital Cash Benefit can be availed on Hospitalization of a minimum period of 24 hours and for a maximum period of up to 10 days per Coverage Year, subject to a maximum period of 30 days over the Member Coverage term, provided such Hospitalization happens due to an Accident. For Insurance Coverage under Hospitalization due to Accident, completion of every 24 'in-patient care' hours in Hospital from the time of admission is considered to be a day.

Table A

Losses under Accidental Permanent Partial Disablement (APPD)	Benefit payable as percentage of PA Sum Assured
1. Loss of Use/Physical Separation:	
One entire hand	50
One entire foot	50
2. Loss of Use of one eye	50
3. Loss of toes - all	20
Great both phalanges	5
Great –one phalanx	2
Other than great if more than one toe lost each	1
4. Loss of Use of both ears	50
5. Loss of Use of one ear	20
6. Loss of four fingers and thumb of one hand	40
7. Loss of four fingers	35
8. Loss of thumb – both phalanges	25
One phalanx	10
9. Loss of Index finger-three phalanges	10
Two phalanges	8
One phalanx	4

10. Loss of middle finger – three phalanges	6
Two phalanges	4
One phalanx	2
11. Loss of ring finger – three phalanges	5
Two phalanges	4
One phalanx	2
12. Loss of little finger – three phalanges	4
Two phalanges	3
One phalanx	2
13. Loss of metacarpus	
First or second (additional)	3
Third, fourth or fifth (additional)	2

Where, Losses under APPD shall be irrecoverable losses and result in loss of use or physical separation which arises solely and directly from an Injury, within 12 months from the date of Accident.
The Company's liability for payment of all claims under additional PA Benefit in aggregate during Coverage Term, in no case shall exceed 100% of PA Sum Assured with respect to the member.
If the Accident occurs during the Member Coverage Term, ADB, ATPD Benefit and APPD Benefit covered under Additional PA Benefit are payable, even if death or Total and Permanent Disability or Permanent Partial Disablement or any combination thereof occurs after the completion of Coverage Term, but within 12 months from the date of such Accident.
On payment of Accidental Death Benefit under Additional PA Benefit, the Member's Insurance Coverage under the Master Policy shall terminate and all other Benefits including Death Benefit shall also cease to exist with immediate effect.
On payment of 100% of PA Sum Assured on account of insured events other than Accidental Death under Additional PA Benefit, Additional Personal Accident (PA) Benefit terminates. However, In-Force Death Benefit, and all other In Force Inbuilt Optional Benefits, if any, shall continue as applicable.
Definitions and Exclusions with respect to additional PA Benefit are provided in Annexure VIII.

Additional Personal Accident Benefit payable under different Coverage Options

Benefit	**Insured Event**	**How and when Benefit shall be payable**	**Size of such Benefit**
Additional Personal Accident (PA) Benefit	- Accidental Death	**Accidental Death** – Lumpsum amount on death of Member due to Accident (on occurrence of first death due to accident in case of joint life cover)	**Level Cover:** **Accidental Death** – 100% of PA sum assured shall be payable.
	- Accidental Total & Permanent Disability (ATPD)	**ATPD** – Lumpsum amount on occurrence of ATPD (on first occurrence to anyone of two lives in case of joint life cover)	**ATPD** – 100% of PA sum assured shall be payable.
	- Accidental Permanent Partial Disablement (APPD)	**APPD** – Lumpsum amount as a percentage of PA sum assured (on occurrence to any of the two lives separately under joint life cover)	**APPD** – a fixed percentage of PA Sum Assured for APPD losses as specified under Additional Personal Accident (PA) Benefit in Table A above shall be payable.
	- Accidental Temporary Total Disablement (ATTD)	**ATTD** – On occurrence of temporary total disablement due to an accident during the Coverage Term, a fixed amount shall be payable every week during the period of such	**ATTD** – Benefit shall be payable as 0.2% of PA Sum Assured every week provided such period of ATTD is more than 4 weeks. The Benefit payable shall be

		disablement with respect to member (on occurrence to any of the two lives separately under joint life cover)	for a period not exceeding 100 weeks from date of commencement of ATTD.
	- Hospitalization due to Accident	Hospitalization due to Accident- On Hospitalization of the Member for at least 24 hours due to an Accident, a Daily Hospital Cash Benefit shall be payable (Hospitalization of any of the two lives separately in case of joint life cover)	Hospitalization due to Accident – A Daily Hospital Cash Benefit as a fixed percentage of PA sum assured (1%/2%/3%/4%/5%, as chosen by Member before Risk Commencement Date) shall be payable. This Benefit shall be payable on minimum 24 hours' Hospitalization and maximum for 10 days' Hospitalization in a Coverage Year (across two lives put together, in case of joint life cover), subject to maximum 30 days' Hospitalization during Coverage Term (across two lives put together in case of joint life cover). Completion of every 24 'in-patient care' hours in Hospital from the time of admission is considered to be a day. The claims payable on account all these insured events in aggregate under Additional PA Benefit shall not exceed 100% of PA sum assured in any case. (Including all the claims made by two lives put together in case of joint life cover) **Decreasing & Flexi Cover:** Not applicable

Additional PA Benefit cannot be chosen by the Member, in case, either of Additional ADB (mentioned in Clause 6.2.4.a), Additional ATPD Benefit (mentioned in Clause 6.2.4.b.) or Additional Hospitalization Benefit under Hospitalization Cover Benefit is chosen.

On occurrence of 'Disappearance' and 'Drowning' as mentioned in Clause 6.2.4.a and Clause 6.2.4.c in this Part C , 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 Accidental Death Benefit, it is discovered that the Insured Member is still alive, all payments shall be repaid in full to Us by the Claimant.

Rights of Recovery: In the event when claim has been received by the Company for either Disappearance or Drowning (mentioned above) and against which payment has been made by the Company to the Claimant and it is discovered that the Insured Member is still alive, the Company shall be entitled to recover amounts paid towards such Claim. The Insured Member shall take all steps necessary or such steps as are required by the Company to recover the amounts paid towards Claim received under Disappearance or Drowning and preserve the rights and remedies available in this matter. The Company shall be subrogated to all the Insured Member's rights of recovery whether or not the Insured Member have received any compensation or Benefit out of the said Claim. The Company shall be entitled to pursue and enforce such rights in the name of Insured Member, and the Insured Member shall provide the Company with all reasonable assistance and co-operation in doing so, including the execution of any necessary instruments and papers. The Insured Member shall do nothing to prejudice the Company rights under this clause. Any amounts recovered in accordance with this clause shall be applied in the following order: (i) to compensate the Company for the costs incurred in making the recovery; and (ii) to the Company up to the amount

of the Claim paid by the Company; and (iii) to the Insured Member for the costs incurred in making the recovery. In its sole discretion, the Insurer may, in writing, waive any of its rights set forth in this Subrogation Clause.

6.3 Other Add-on options

6.3.1 Profit Sharing Option:

Digit Life Group Long Term Plan provides the option to the Master Policyholder to avail the Profit-Sharing Option at Proposal stage. If the profit-sharing option has been availed by the Master Policyholder, then the Master Policy Holder shall be entitled to profit sharing, where 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.

6.4 Other Benefits

6.4.1 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 IX.

6.5 Survival/Maturity Benefits

Benefit Options	Survival / Maturity Benefit
Death Benefit with Term Insurance or if any Inbuilt Optional Benefit is chosen	No Survival / Maturity Benefit shall be payable
Death Benefit with Term with Return of Premium (TROP) option	Provided all the due Premiums have been paid and on survival of Member (survival of both lives in case of joint life cover) till the end of Member Coverage Term, total Premiums paid shall be returned on completion of such Member Coverage Term.

7. 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, 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 respective Member Coverage Term, while Member's Insurance Coverage for Death Benefit and other Inbuilt Optional Benefits (if any) if any, is still In-Force, no further Premium shall be payable for the remaining Premium Payment Term (if any), for corresponding Inbuilt Optional Benefit/(s) which have been terminated.

For Premium payment frequency other than annual, instalment Premiums payable 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 / Insurance Coverage discontinuance and Revival 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 in respect of such Members and on acceptance of risk on underwriting, if any, by Us.

8. 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. 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 limited and regular pay Policy / Member's Insurance Coverage 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/ minor or major conditions under Multi-Stage Cancer Benefit/ADB/ ATPD/ Hospitalization/insured events under Additional Personal Accident Benefit, as applicable or any other event, if applicable and covered under this Policy or Member's Insurance Coverage, occurs during the Grace Period, then Benefits as applicable shall be payable as mentioned under Part C subject to receipt of unpaid Premium for Master Policy in cases, 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. **Reduced Paid Up**
   For regular pay Death Benefit with Term Insurance option and regular pay Inbuilt Optional Benefits, if at any point of time during the Policy Term / Coverage Term, due Premium is not paid within Grace Period, the Master Policy / Member's Insurance Coverage shall lapse on expiry of Grace Period until it is revived as specified in Clause 4 of this Part D. No Benefits shall be payable when the Master Policy / Insurance Coverage is in Lapsed Status for these options.

   In case of limited pay Death Benefit with Term Insurance option, limited pay Inbuilt Optional Benefits and limited or regular pay Death Benefit with TROP option, if the Premiums are not paid for at least first two Coverage Years, the Insurance Coverage shall lapse on expiry of Grace Period until it is revived as specified in Clause 4 of this Part D. For these options mentioned in this para, no Benefits except for Unexpired Risk Premium Value (Surrender Value), if any, shall be payable when Insurance Coverage is in Lapsed Status. However, under these options mentioned in this para, if the Premiums are paid for at least first two Coverage Years and if further due Premium is not paid within the Grace Period, the Policy / Member's Insurance Coverage attains reduced paid-up status, wherein, Benefits under all applicable Insurance Coverages (risk covers) become reduced paid-up. Reduced Paid-up Benefit shall be calculated as stated below:
   Reduced Paid-up Sum Assured = Paid-up factor x Applicable Sum Assured
   Reduced Paid-up Income Benefit = Paid-up factor x Income Benefit
   Reduced Paid-Up survival / maturity Benefit = 100% of Total Premiums Paid for TROP option under Death Benefit (if TROP option is chosen)

   Where,

   Paid-up factor = Number of Premiums paid/Total number of Premiums payable over the Premium Payment Term
   Applicable Sum Assured = Sum Assured as per Benefit and coverage option and as per agreed schedule (if any) chosen before Risk Commencement Date
   Total Premiums Paid is the total of all the Premiums received, excluding any extra premium, any rider premium and taxes.

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 respective Member Coverage Term(s). 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 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:

a. For Death Benefit with Term Insurance and Inbuilt Optional Benefits chosen, if any:

Benefit	Option / Sub-option	Level Cover	Decreasing Cover	Flexi Cover
Death Benefit	Lumpsum	50% x ((Total Premiums paid) – (Total Premiums payable over the Premium Payment Term x Expired Coverage Term in months/Coverage Term in months)))	50% x ((Total Premiums paid) – (Total Premiums payable over the Premium Payment Term x Expired Coverage Term in months/Coverage Term in months))) x Current Sum Assured / Initial Sum Assured	
	Income Benefit			
Terminal Illness Benefit	Accelerated Terminal Illness (TI) Benefit			
Health Cover Benefit	Accelerated Critical Illness Benefit			
	Additional Critical Illness Benefit			
	Additional Multi-Stage Cancer Benefit			
Hospitalization Cover Benefit	Additional Hospitalization Benefit (HB)			
Accidental Cover Benefit	Additional Accidental Death Benefit (ADB)			
	Additional Accidental Total and Permanent Disability (ATPD) Benefit			
	Additional Personal Accident (PA) Benefit			

4. Revival

If the due Premium is not received by the end of the Grace Period, the Policy / Member's Insurance Coverage shall lapse / acquire reduced paid -up status as mentioned in Clause 2 of this Part D. The Company will consider requests to revive Policies / Member's Insurance Coverage in Lapsed Status / reduced paid-up status within five years from the due date of first unpaid Premium, provided such requests are received within the Policy Term / Member Coverage Term, as applicable. Any agreement to revive the lapsed or reduced paid-up Policy/ Member's Insurance Coverage would be subject to the Our prevailing underwriting policy. The Company shall collect all the due Premiums and other charges or late fee if any, as per the terms and conditions of the Policy for such Revival. 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.

5. Loan: This Policy does not offer loan facility.

6. 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 Insurance Coverage for these Members shall commence only if the personal statement / declaration of good health, if any, or other factor relating to the insurability of a life is to the satisfaction to the Company. The Company shall communicate its decision on addition of Eligible Member based on its then prevailing underwriting policy. The Company's decision thereon shall be final and binding on the Master Policyholder and the Member. 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. 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.

7. 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 Unexpired Risk Premium Value (Surrender Value), as applicable with respect to such Member(s) to the Master Policyholder in accordance with Clause 3 of this Part D.

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, 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.

8. **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 Accidental Death Benefit (ADB), Accidental Death Benefit covered under Additional Personal Accident Benefit, 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 Accidental Death Benefit (ADB), Accidental Death Benefit covered under Additional Personal Accident Benefit, 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 8 (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 shall pay the entire lumpsum Death Benefit and Additional Accidental Death Benefit (ADB), Accidental Death Benefit covered under Additional Personal Accident Benefit, 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 applicable 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.

c) In case of Lender-Borrower Group, Benefits payable shall not vary or be otherwise determined by the loan repayments, if any, already made by the Member or the outstanding loan amount, if any, of the Member, at the occurrence of an insured event giving rise to a claim under the Master Policy beyond the extent as provided in Sum Assured Schedule under Certificate of Insurance.

9. **Policyholder Covenants (in case of Lender-Borrower Groups)**

The Master Policyholder agrees to apply its prescribed norms and procedures for assessing all loan applications and apply its stipulated credit recovery procedures thereon, regardless of whether or not Insurance Coverage is sought on the lives of its borrowers. The Company reserves with it the right to call for the guidelines of Policyholder's credit criteria at any time, and

Policyholder shall provide the same to the Company within the time limits if any specified therein. The Policyholder (or any of its affiliated organization / entity) in its capacity as Group Organizer / Group Manager, with whatsoever nomenclature may be, is prohibited from collecting any amount other than the Insurance Premium payable to the Company with regard to the underlying Group Insurance under this Policy.

Policyholder shall collect the duly valid and complete Declaration of Good Health (Evidence of Good Health) along with such other documents as it may require for the purpose of the loan given to the Member. The Policyholder shall preserve and maintain it as an integral part of such loan documentation. The Policyholder shall allow the officers of the Company (including representatives authorized in writing by the Insurer), to inspect and make copies of all/any relevant records for the purposes of this Policy, at reasonable hours on any day. It shall be the duty of the Policyholder to ensure that the Declaration of Good Health is duly filled in and signed by the Member. In case a claim is settled by the Company on a Member's life, which would not have been covered under the Policy due to incomplete Declaration of Good Health submitted by the Policyholder, then the Policyholder shall indemnify the Company to the extent of the claim amount/payments made on such lives.

10. 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) the Policy in Lapsed Status and has not been revived; or

iii) the date of payment of the Unexpired Risk Premium Value (Surrender Value) under the 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 Insurance Coverage 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);

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) on Coverage End Date;

v) on termination of Master Policy;

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 (with no Income Benefit chosen under Death Benefit);

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

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

x) Member chooses to expressly discontinue the Insurance Coverage when the Master Policy is discontinued.

11. 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 12 (a) above of this Part F, 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, 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 of Insurance Coverage with respect to Insured Member, while the Master Policy/Insured Member's Insurance Coverage is In Force.
   c) In case of joint life cover, on occurrence of first death due to suicide in the above -mentioned scenarios in Clause 12 (a) and (b), the above-mentioned respective benefits shall be payable to the surviving Member and the Insurance Coverage shall terminate for both the lives.

13) **Audit:**
   In compliance with the Regulatory requirement prescribed under IRDAI Circular on Group Life Insurance Products and other operational matters dated 26/09/2019, the Policyholder shall obtain a Certificate of compliance from the Auditor of the group or the Manager of the group on every anniversary date of the Policy and submit the same to the Company at its request. Continuation of such Policy / Insurance Coverage will be subject to such submission of Certificate of compliance by the Policyholder to the Company. Or alternatively, the Company shall conduct the inspection of the books and records of the Policyholder to assess whether they are complying with the relevant IRDAI guidelines and in case of lender-borrower schemes, 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.

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, the 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 Postmortem Report (Only if conducted).
      iv) Attested Copy of Viscera report if any (Only if Postmortem 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 / Accidental Permanent Partial Disablement / Accidental Temporary Total Disablement Benefit Claim:

i) Claimants Statement For Disability Claim,
ii) Attested copy of disability certificate from relevant Government Medical authority.
iii) All investigation reports 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) Discharge summary from the Hospital (if applicable)
vii) Disability assessment report from Digit empanelled medical specialist (if required)
viii) KYC document of Claimant
ix) Additionally in case of Accidental Temporary Total Disablement, leave/absence certificate from the employer (if employed), Medical Practitioner's certificate confirming the Injury and advising rest / unfit to work for specified number of days, fitness certificate issued by the treating doctor.

g) For Multi-Stage Cancer Benefit Claim

i) Duly completed Claim Form signed by Claimant
ii) KYC document of the Claimant
iii) Medical Reports to include initial Diagnosis / findings, investigation reports, further follow-up treatment report, medicine prescriptions from initial treatment till date, any other relevant medical report pertaining to the Illness.
iv) Evidence provided by independent practicing medical consultant acceptable to the Company, should include current health status.
v) Appropriate Medical records and/or medical test or Investigation reports including, but not limited to, clinical treatment, radiological, histological and laboratory test evidence (e.g., 2D echocardiogram, treadmill test; USG etc.), indoor case papers, discharge summary
vi) Histopathology Report in case of cancer group claims

h) For Hospitalization due to Accident under Additional PA Benefit / Additional Hospitalization Benefit Claim

i) Duly completed Claim Form signed by Claimant
ii) KYC document of Claimant
iii) Medical and investigation reports, treatment and indoor case papers
iv) Discharge summary of present and past Hospitalizations
v) Treating Doctor's certificate
vi) All follow-up and consultation notes with respect to the Hospitalization
vii) Attested copy of FIR (if required)

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

i) For Survival / Maturity Benefit Claim

i) Discharge Voucher
ii) KYC document of the Claimant
iii) Certificate of Insurance, wherever applicable

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 – 1800-296-2626 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: 1800-296-2626
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 1800-296-2626 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**

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. Pls refer the list of Insurance Ombudsman at Annexure D.

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 Critical Illness (CI) Benefit / Multi-Stage Cancer Benefit

Claim for Critical Illness Benefit shall be accepted subject to Survival Period of 30 days and Waiting Period of 90 days. Claim for Multi-Stage Cancer Benefit shall be accepted subject to Waiting Period of 90 days.

Notwithstanding anything to the contrary stated herein and in addition to the foregoing exclusions, no Critical Illness Benefit / Multi-Stage Cancer Benefit will be payable if any of the covered conditions under Critical Illness / Multi-Stage Cancer occurs from, or is caused or aggravated, either directly or indirectly by, 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.

5) Self-inflicted Injury: Intentional self-inflicted injury by the Insured Member.
6) Suicide: If the condition covered under Critical Illness Benefit / Multi-Stage Cancer Benefit 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, willful 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.
10) Biological, chemical or radioactive contamination.
11) 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.
12) 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.
13) Any treatment of the donor for the replacement of an organ.
14) 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 V

Exclusions to Additional Hospitalization Benefit

No Benefits shall be payable with respect to any of the Hospitalization unless the entire period of confinement to Hospital and all the Hospital services rendered and performed there have been recommended by a registered medical practitioner and are in accordance with the diagnosis and treatment of the condition for which Hospitalization was required.

The Company shall not be liable to make any payment if Hospitalization or claims are attributable to, or based on, or arise out of, or are directly or indirectly connected to any of the following:

1. 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.

2. Hospitalization / treatment within the Waiting Period and Hospitalization / treatment following the diagnosis within the Waiting Period. However, Waiting Period shall not be applicable for Hospitalization due to Accidental Injuries.

3. 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.

4. 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.

5. 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.

6. Criminal Acts: Insured Member involvement in criminal activities with criminal intent.

7. 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.

8. Any treatment due to any external congenital conditions.

9. Any dental surgery, extraction of impacted tooth/teeth, orthodontics or orthognathic surgery, or tempero-mandibular joint disorder except as necessitated by an accidental injury;

10.Treatment arising from or traceable to pregnancy which shall include childbirth, infertility, miscarriage, abortion, sterilization and contraception including complications related thereto / treatment to assist reproduction including IVF treatment.

11.Hospitalization primarily for investigatory purpose, diagnosis, X-ray examinations, general physical or routine medical examinations; preventive treatment or medicines, treatments/ examinations specifically for weight management regardless of whether the same is caused by a medical condition; or any treatment or study related to sleep disorder or sleep apnoea syndrome.

12. Convalescence, general debility, custodial, sanitaria, rehabilitation centre, nature care clinics, or respite care or long-term nursing care.

13.Stem cell implantation or surgery, harvesting/storage/any other treatment using stem cells, or any type of hormone replacement therapy.

14.Any form of plastic surgery except to the extent that such surgery is necessary for the treatment of cancer, burns or Accidental Injuries happened during the contract period ;

15. Cosmetic or aesthetic treatments, treatment or surgery for change of life / gender

16. Treatment of xanthelasma, syringoma, acne and alopecia;

17. Circumcision unless necessary for treatment of a disease or necessitated due to an Accident;

18.Articial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health and/ or who has been declared brain dead, as demonstrated by:

- Deep coma and unresponsiveness to all forms of stimulation; or
- Absent pupillary light reaction; or
- Absent oculovestibular and corneal re-exes; or
- Complete apnea

19. Treatment for accidental physical injury or illness caused by violation or attempted beach of the law, or resistance to arrest;

20.Hospitalization and treatment of any kind not actually performed, not necessary or reasonable, or any kind of elective surgery or treatment which is not medically necessary.

21. Any treatment for any sexually transmitted disease (STD), and its related complications (except for HIV / AIDS); treatment of any sexual problem including impotence (irrespective of the cause) and sex changes / gender reassignments or erectile dysfunction.

22. Treatment for or arising from an Injury that is intentionally self-inflicted, including attempted suicide.

23. Hospitalization due to use and abuse of any substance, drug (not prescribed by registered independent medical practitioner) or alcohol or treatment for de-addiction / smoking cessation programs or taking of poison.

24.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.

25. Treatment for correction of eyesight due to refractive error less than 7.5 dioptres.
26. Routine eye examinations and ear examinations, cochlear implants, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, hair fall treatment & products, and all other similar external appliances and / or devices whether for diagnosis or treatment.
27. 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.
28. Any treatment related to donor screening or treatment including surgery to remove organs of a donor for the replacement of an organ (where Member is donor)
29. Ayurvedic, Homeopathy, Unani, Yoga and naturopathy, Siddha, reflexology, acupuncture, bone-setting, herbalist treatment, hypnotism, Rolfing, massage therapy, aroma therapy or any other treatments other than Allopathy/ western medicines.
30. Hospitalization / any treatment received outside India
31. Treatment for developmental problems including learning difficulties e.g. Dyslexia, behavioral problems
32. The following diseases/surgeries and any complications arising out of them will not be covered during the first two years from the Risk Commencement Date or date of Revival:

- Deviated Nasal Septum/Nasal and Paranasal Sinus Disorders
- Diseases of Tonsils / Adenoids
- Surgery of Thyroid Gland excluding Malignancy
- All types of Hernia
- Hydrocele / Varicocele / Spermatocele
- Piles / Fissure / Fistula-in-Ano / Rectal Prolapse
- Benign Prostatic Hypertrophy
- Menstrual Irregularities, Dysfunctional Uterine Bleeding
- Hysterectomy with or without Bilateral Salpingo-oophorectomy excluding Malignancy
- Uterine Fibroid
- Calculus Diseases
- Prolapsed Intervertebral disc
- Retinopathy /Retinal detachment
- Peripheral Vascular Diseases due to diabetes / diabetic foot
- Renal failure due to diabetes
- Osteoporosis / Pathologiocal Fracture
- Cataract
- Joint replacements except due to an accident (one knee or one hip replacement in a Coverage Year)
- Congenital Internal Disease or Anomalies or Disorder

Annexure VI

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.
9. Biological, chemical and radioactive contamination.

Annexure VII

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.
9. Biological, chemical and radioactive contamination.

Annexure VIII

Exclusions to Additional Personal Accident Benefit

No Benefit under Additional Personal Accident Benefit shall be payable, if insured events under this Benefit occur directly or indirectly as a result of any of the following:

1. Infection : Insured events under Additional Personal Accident Benefit caused or contributed to by any infection except, infection caused by an external visible wound accidentally sustained.
2. Intentional self-inflicted injury, suicide / 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.
9. Biological, chemical and radioactive contamination.
10. Hospitalization for treatment of accidental injuries which does not warrant Hospitalization, Domiciliary Hospitalization and OPD treatment are excluded.
11. Hospitalization / Treatment taken outside the geographical limits of India shall be excluded.
12. Hospitalization primarily for diagnostics and evaluation purpose.

Annexure IX

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 utilise 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 D

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,	Andhra Pradesh, Telangana, Yanam and

	N. C. Guards, Lakdi-Ka-Pool, Hyderabad – 500 004. Tel.: 040 – 23312122 Fax: 040 – 23376599 Email: bimalokpal.hyderabad@cioins.co.in	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, Ernakulam – 682 015. Tel.: 0484 – 2358759 / 2359338 Fax: 0484 – 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.
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	Bihar, Jharkhand.

	Email: bimalokpal.patna@cioins.co.in	
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