PART A

<< Date >>
<< Master Policyholder's Name>>
<< Master Policyholder's Address>>

Dear << Master Policyholder's Name>>,

Sub: Your HDFC Life Group Credit Protect Plus Insurance Plan **Master Policy Number << >>**

We are glad to inform you that your Proposal has been accepted and the Insurance Policy has been issued. We have made every effort to design your Policy Document in a simple format. We have highlighted items of importance so that you may recognize them easily.

Cancellation in the Look-in Period:
In case You are not agreeable to any of the terms and conditions stated in the Policy, You have the option to return the Policy to Us for cancellation stating the reasons thereof, within 30 days from the date of receipt of the Policy(whether received electronically or otherwise).

On receipt of the cancellation letter along with the original Policy document, irrespective of the reasons mentioned, you shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges .

A Policy once returned shall not be revived, reinstated or restored at any point of time and a new proposal will have to be made for a new Policy.

Contacting us
The address for correspondence is given in the Policy document. To enable us to serve you better, you are requested to quote your Policy number in all future correspondence.

To contact us in case of any grievance, please refer to "Grievance Redressal – Contact Details Annexure attached". In case you are not satisfied with our response, you can also approach the Insurance Ombudsman in your region whose address is available on our website www.hdfclife.com.

Thanking you for choosing HDFC Life Insurance Company Limited and looking forward to serving you in the years ahead,

Yours sincerely,
<< Designation of the Authorised Signatory >>
Branch Address: <<Branch Address>>
Agency/Intermediary Code: <<Agency Code>>
Agency/Intermediary Name: <<Agency Name>>
Agency/Intermediary Telephone Number: <<Agency mobile & landline number>>
Agency/Intermediary Contact Details: <<Agency address>>

Address for Correspondence: HDFC Life Insurance Company Limited, 11th Floor Lodha Excelus, Apollo Mills Compound, N.M. Joshi Road, Mahalaxmi, Mumbai-400011.
Registered Office: HDFC Life Insurance Company Limited, Lodha Excelus, 13th Floor, Apollo Mills Compound, Mahalaxmi Mumbai- 400 011.
Contact number: 6751 6218/6215

HDFC LIFE GROUP CREDIT PROTECT PLUS INSURANCE PLAN (UIN – 101N096V06)

Unique Identification Number: <<101N096V06>>

This group Policy is granted by HDFC Life Insurance Company Limited having its Registered Office at HDFC Life Insurance Company Limited, Lodha Excelus, 13th Floor, Apollo Mills Compound, Mahalaxmi Mumbai- 400 011 (hereinafter called "the Insurer") to the Master Policyholder identified in the Schedule hereto who shall hold the same and all benefits payable there under upon trust for the benefit of the persons to whom the said benefits are payable.

The Policy is numbered as shown in the Schedule and consists of this page, the Schedule, the Policy Provisions referred to in the Schedule, and any pages issued by the Insurer to amend the policy.

The Policy is issued pursuant to a Proposal made to the Insurer by the Master Policyholder on the date shown in the Schedule for the benefit of Scheme Members. The Policy witnesses a contract between the Master Policyholder and the Insurer.

Upon receipt of the premium by the Insurer from the Master Policyholder, the Insurer shall pay to the Policyholder, the benefits described in the Policy upon the occurrence of specified insured contingencies, subject only to the terms of the Policy.

All monies payable under the Policy to or by the Insurer shall be payable in Indian Rupees at the office of the Insurer identified in the Schedule.

Notwithstanding the date of the Proposal and the date on which the Policy is signed, the Policy shall have effect or be deemed to be effective from the date shown in the Schedule as the Effective Date.

In witness whereof, this Policy is signed at the end of the Schedule by a person duly authorised by the Insurer.

POLICY SCHEDULE

1. **Master Policy Number:**
   << Policy Number>>
2. **Name of the Scheme:**
   << Scheme Name>>
3. **Date of Proposal:**
   << Proposal Date>>
4. **Effective Date:**
   << Effective Date >>
5. **Master Policyholder:**
   << Master Policyholder>>
6. **Eligibility to join the Scheme for the Scheme Member**

Eligibility	**Age (last birthday) (in years)**
Minimum Age at Entry	14
Maximum Age at entry	70
Minimum Maturity Age	15
Maximum Maturity Age	75

7. **Minimum Number of Members:** **<>**
8. **Option Chosen : <<**Plan Option(s)**>>**
9. **Cover Option:** <Decreasing Term Assurance / Level Term Assurance>
10. **Benefit Schedule:** << shown in Appendix A>> << N.A. for Level Cover>>

Signed at Mumbai on <<>>
For HDFC Life Insurance Company Limited

In case you notice any mistake, you may return the Policy document to us for necessary correction.

SPACE FOR ENDORSEMENTS

Part B

Definitions

The following capitalised terms wherever used in this Policy shall have the meaning given hereunder:

1. **"Accidental Death"** means the specified benefit will be payable on an accidental death. Accidental Death shall be defined as a bodily Injury leading to death caused solely and directly by outward, violent and visible means and independent of all other causes of death. Death due to an accident must be caused within 90 days of any bodily injury.

2. "Authority" means the Insurance Regulatory and Development Authority of India established under the provisions of section 3 of the Insurance Regulatory and Development Authority Act, 1999.

3. **"Benefit Schedule"** defines the scale of the benefit payable to a Scheme Member over the Coverage Term with respect to the Sum Assured selected at the membership inception.

4. **"Critical Illness Benefit Term (CI Benefit Term)"** means the period for which the critical illness cover is provided to individual Scheme Member where Critical Life Option 1, Critical Life Option 2, Critical Life Option 3 or Critical Life Option 4 are chosen.

5. **"Cover Option"** indicates whether the Master Policyholder has selected a Level Term Assurance type or a Decreasing Term Assurance type.

   In the instances where the Level Term Assurance is selected, the sum assured in respect of any Scheme Member will stay constant during all the years of the Scheme membership. In the instances where the Decreasing Term Assurance is selected, the sum assured reduces over the Coverage Term based on the Benefit Schedule defined at inception.

6. ***Critical Illness(es)*** **-** The Critical Illnesses covered under this benefit option are as follows:

S. No	Name of Disease	Definitions of Critical Illnesses
1	Cancer of specified severity	A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma. The following are excluded - 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	Open Chest CABG	The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner. The following are excluded:

		i. Angioplasty and/or any other intra-arterial procedures ii. any key-hole or laser surgery.
3	First Heart Attack – of specified severity	The first occurrence of 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 this will be evidenced by all of the following criteria: i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain) ii. new characteristic electrocardiogram changes iii. elevation of infarction specific enzymes, Troponins or other specific biochemical markers. The following are excluded: i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T ii. Other acute Coronary Syndromes iii. Any type of angina pectoris.
4	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 (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.
5	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
6	Stroke resulting in permanent symptoms	Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced. The following are excluded: i. Transient ischemic attacks (TIA) ii. Traumatic injury of the brain iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.
7	Apallic Syndrome	Universal necrosis of the brain cortex with the brainstem remaining intact. Diagnosis must be confirmed by a neurologist acceptable to the Company and the condition must be documented for at least one month.
8	Benign Brain Tumour	A benign tumour in the brain where all of the following conditions are met: • It is life threatening; • It has caused damage to the brain; • It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit such as (but not restricted to) characteristic symptoms of increased intracranial pressure such as papilloedema, mental seizures and sensory impairment; and • Its presence must be confirmed by a neurologist or neurosurgeon acceptable to the Company and supported by findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging technique. The following are excluded: • Cysts; • Granulomas; • Vascular malformations; • Haematomas; • Tumours of the pituitary gland or spinal cord; and

		• Tumours of acoustic nerve (acoustic neuroma).
9	Coma of specified severity	A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following: 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. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.
10	End Stage Liver Disease	End-stage liver disease or cirrhosis means chronic end-stage liver failure that causes all of the following: • Uncontrollable ascites; • Permanent jaundice; • Oesophageal or gastric varices; or • Hepatic encephalopathy. Liver disease secondary to alcohol or drug abuse is excluded.
11	End Stage Lung Disease	Final or end-stage of lung disease, causing chronic respiratory failure, as demonstrated by all of the following: • FEV1 test results consistently less than 1 litre; • Requiring permanent supplementary oxygen therapy for hypoxemia; • Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO2 < 55mmHg); and • Dyspnea at rest. The diagnoses must be confirmed by a qualified pulmonologist acceptable to the Company.
12	Open Heart Replacement or repair of heart valve	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.
13	Loss of Independent Existence	Confirmation by a consultant physician acceptable to the Company of the loss of independent existence due to illness or trauma, which has lasted for a minimum period of 6 months and results in a permanent 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 hope of recovery with current medical knowledge and technology. Activities of Daily Living are:- 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 or 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. The following is excluded: Any injury or loss as a result of War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion
14	Loss of Limbs	The loss by severance of two or more limbs at or above the wrist or ankle. The following are excluded: • Loss of limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded. • Any injury or loss as a result of War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.

15	Loss of Sight	Total and irreversible loss of sight in both eyes as a result of illness or accident. The blindness must be confirmed by an ophthalmologist acceptable to the Company. The blindness must not be able to be corrected by medical procedure. The following is excluded: Any injury or loss as a result of War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
16	Major Burns	Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Life Assured's body. The condition should be confirmed by a consultant physician/specialist acceptable to the Company. The following is excluded: Any injury or loss as a result of War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
17	Major Head Trauma	Accidental head injury resulting in permanent neurological deficit to be assessed no sooner than 6 weeks from the date of the accident. This diagnosis must be confirmed by a consultant neurologist acceptable to the Company and be supported by unequivocal findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means, independently of all other causes. The accidental head injury must result in a permanent 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 hope of recovery with current medical knowledge and technology. The following are excluded: • Spinal cord injury; • Head injury due to any other cause; and • Any injury or loss as a result of War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
18	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.
19	Surgery of Aorta	The actual undergoing of surgery (including key-hole type) for a disease or injury of the aorta needing excision and surgical replacement of the diseased part of the aorta with a graft. The term "aorta" means the thoracic and abdominal aorta but not its branches. Stent-grafting is not covered.

7. **"Effective Date"** is the date mentioned as the Effective Date in the Schedule.

8. **"Eligible Person"** means any person who satisfies all of the following conditions to participate in the Scheme:
   a. person not older than maximum age for membership of the Scheme as on the Entry Date; and
   b. person not younger than minimum age for membership of the Scheme as on the Entry Date; and

9. **"Entry Date"** shall mean (a) The Effective Date, or (b) the actual date on which an Eligible Person is admitted as a Scheme Member, whichever is later.

10. **"Insurer"** or **"Insurance Company"** means HDFC Life Insurance Company Limited.

11. **"Injury"** means accidental physical bodily harm excluding illness and disease. It must be solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

12. "Maturity benefit" means sum assured on maturity, any additional and accrued benefit, which is payable on maturity in accordance with the terms and conditions of the policy.

13. **Medical Practitioner -** means a person who holds a valid registration from the medical council of any state or India or Council of Indian Medicines or for Homeopathy setup by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction and is acting within the scope and jurisdiction of license but excluding the practitioner who is:
a)Insured/ Master Policyholder himself or an agent of the Insured;
b)Insurance Agent, business partner(s) or employer/employee of the Insured; or
c) A member of the Insured's immediate family.

14. ***Master Policyholder, You, you, Your, your*** **–** means the institution which has entered into a contract with the Company for providing insurance cover to Members of this Policy, as defined in the Schedule.

15. **Pre-existing disease (PED)** means any condition, ailment, injury or disease:
a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or
b) for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

16. **"Scheme Member"** means an Eligible Person who satisfies all of the following conditions to participate in the Scheme:
a. who has satisfactorily furnished the necessary declarations as required by the Insurer including the underwriting requirements as applicable; and
b. who has paid the requisite premium; and
c. whose application to join the Scheme has been accepted by the Insurer.

Every Eligible Person desiring to become a Scheme Member may do so at any well defined date during the currency of the Policy and, provided the application is accepted by the Insurer, the insurance cover for such a Scheme Member shall be in force from the Entry Date till the Terminal Date.

17. **"Scheme"** means the Scheme described in the Schedule.
18. "**Service Provider/s**" means the third party service providers engaged by the Insurer for providing the Wellness services mentioned in this Product.

19. **"Sum Assured"** means an absolute amount of benefit which is guaranteed to become payable on death, disability or illness of the life assured as specified in the Benefit Schedule.

20. **"Surrender"** means complete withdrawal or termination of the entire policy contract.

21. **"Surrender value" means an amount, if any, that becomes payable on surrender of a policy during its term, in accordance with the terms and conditions of the policy.**

22. **"Term of Membership"** or **"Coverage Term"** means the period for which insurance cover is provided to individual Scheme Member at the Entry Date.

23. **"Terminal Date"** means in respect of each Scheme Member, the date on which the Coverage Term expires.

24. **"Terminal Illness"** is defined as a condition, which in the opinion of two practicing medical consultants specializing in the relevant field of medicine, is highly likely to lead to death within six months. The Scheme Member should no longer be receiving treatment other than that for symptomatic relief.

25. **"Total Permanent Disability"** means disablement of the life assured which meets the definitions in any of parts A & B as defined below.

Part A: Unable to work:

The life assured suffers an injury/accident and:
1. The injury causes the insured person to be unable to engage in any occupation or employment or business for remuneration or profit for an uninterrupted period of at least six months; and
2. The injury means that the insured person is unlikely to ever be able to engage in any occupation or employment or business for remuneration or profit

Part B: Physical Impairments:
The life assured suffers an injury/accident and the insured person suffers from total and irrecoverable loss of:
1. The use of two limbs; or
2. The sight of both eyes; or
3. The use of one limb and the sight of one eye; or
4. Loss by severance of two or more limbs at or above wrists or ankles; or
5. The total and irrecoverable loss of sight of one eye and loss by severance of one limb at or above wrist or ankle.

The above disabilities for loss of use of limb/s or sight (as defined in point 1 to 3 above) must have lasted, without interruption, for at least six consecutive months and must, in the opinion of an appropriate Medical Practitioner appointed by the Company, be deemed permanent. For disabilities defined in point 4 and 5 above the claim will be paid immediately.

26. "Total premiums paid" means total of all the premiums paid under the base product, excluding any extra premium and taxes, if collected explicitly.

27. “Unique identification number (UIN)” means a unique number allotted to each product which is required to be disclosed in product related literature, policy documents and any other supporting documents for such product.

28. **Wellness Benefit:**

Below listed benefits will be made available under wellness benefit program

1.	Virtual Consultations (Instant Telecommunications)
2.	Out Patient Consultations
3.	Doctor Prescribed Diagnostics
4.	Preventive Health Check Up Benefit
5.	Network Discounts
6.	Diet & Nutritionist Consultations
7.	Mental Wellness Consultations
8.	Prescribed Pharmacy Discount
9.	Gym & Fitness Benefit
10.	Chronic Care Management
11.	Personal Health Concierge

Here MPH has an option choose any one out of 7 options mentioned below as provided by our service provider:

Benefits	Speciality	Utilization Mode	Capping (If Any)			
				Option 1	Option 2	Option 3
Teleconsultations	All Specialities	Cashless	2 per month	✓	✓	✓
	Psychologists & Psychiatrists		2 per month	✗	✗	✓
	Dieticians & Nutritionists		2 per month	✗	✗	✓
Preventive Health	Includes up to 68	Cashless	1 Annually	✓	✗	✗

Check Up	Tests					
	Includes up to 82 Tests			✗	✓	✓
Combined Wellness Benefit	OPD In-Clinic Benefit	Cashless/Re-imbursement	-	₹ 1,000	₹ 2,000	₹ 5,000
	Prescribed lab & radiology	Cashless	-			
Prescribed Pharmacy Benefit		Cashless	-	Up to 10%	Up to 10%	Up to 10%
Network Discounts		In-App services	-	Up to 10%	Up to 10%	Up to 15%
Chronic Care Management (Diabetes, Thyroid, Cardiac, Obesity)		In-App services	-	Included	Included	Included
Personal Health Concierge		On-Demand Service	-	✗	✗	1 per Quarter
Members Covered				1 Adult	1 Adult	1 Adult

Benefits	**Option 4**	**Option 5**	**Option 6**	**Option 7**
Health Benefits	**0.4% of Sum Assured**	**50% of Premium**by tenure	**50% of Premium by tenure**	**0.8% of Sum Assured**
Doctor – Tele	24 TeleConsultations P.A.	25% of Premium**by tenure**	25% of Premium by tenure	24 TeleConsultations P.A.
Doctor – OPD	✗			0.4% of Sum Assured P.A.
Prescribed Lab & Radiology	0.4% of Sum Assured P.A.	25% of Premium**by tenure**	25% of Premium by tenure	0.4% of Sum Assured P.A.
Wellness Benefits	-	**50% of Premiumby tenure**	**50% of Premium by tenure**	-
Health Check-up Voucher	✗	25% of Premium**by tenure**	25% of Premium by tenure	1 Voucher P.A.
Mental Wellbeing	✗	25% of Premium**by tenure**	25% of Premium by tenure	✗
Fitness Benefits	-	-	**50% of Premium by tenure**	-
Gym & Fitness	✗	✗	25% of Premium by tenure	✗
Diet & Nutrition Management	✗	✗	25% of Premium by tenure	12 sessions P.A.
Care Circle	✗	✓	✓	✗
Additional Benefits				
Network Discount	✗	✓	✓	✓
Pharmacy Discount	✗	✗	✗	✓
Health Camps	✗	✗	✗	✗
Perceived Value	-	**1X of Premium**	**1.5X of Premium**	-
Members Covered	1 Adult	up to 2	up to 2	1 Adult

Above benefit options can be offered up to the policy tenure. In case of multi-year policies, all un-utilized benefits will lapse at the policy anniversary and all valid benefits will be re-instated for next year.

Benefits Inclusions and Exclusions:
1.Virtual Consultations (Insta Tele Consultation) <Twice per month/24 p.a.>

Coverage:

If the Insured member/s is suffering from any illness or injury he/she can consult Medical Practitioner listed on the Life Rewards mobile app via, audio, video, or chat channel, where the Insured Member will be able to select the speciality of Doctor and will be able to consult the Doctor available at the time of call. This service shall be in compliance with the Telemedicine Practice Guidelines dated 25th of March 2020, as amended from time to time. This is a cashless service.

Exclusion:
i. Reimbursement of tele-consultation benefit is excluded.
ii. Only 1 active Doctor consultation is allowed at any given time and the Insured Member can book/utilize next consultation post completion of ongoing consultation.

2. Outpatient Consultations (OPD In-Clinic Doctor Consultation)

Coverage:
If the Assured member/s is suffering from any illness or injury he/she can consult Doctor/Medical Practitioner in person from prescribed network centres of concerned service providers up to the limit as specified in the Policy Schedule. This service can be availed on cashless/re-imbursement basis.
If there is no facility of cashless Doctor Consultation in insured's location, then Insured Beneficiary/s can consult the Doctor/Medical Practitioner of their choice and claim the charges/consultation fees by way of reimbursement process as defined under claim process.

Exclusion:
I. Investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items are not covered under this section.
II. All applicable doctor specialties mentioned below.
III. Only 1 (one) active Doctor Consultation is allowed at any given time and the Insured Beneficiary can book/utilize next consultation post completion of ongoing consultation.
IV. Maximum doctor consultation fees applicable as below,
i. General Physician - ₹ 500/-
ii. Specialist/Super Specialist - ₹ 1,000/-

Below is the doctor specialties covered:
• General Physician: General Physician, Homeopathy, Ayurveda
• Specialist: Gynaecologist & Obstetrician, Homeopath, Dentist, Dermatologist, Orthopaedic, Paediatrician, Unani, Ophthalmologist, Ayurveda, ENT, General Surgeon, Anaesthesiologist, Radiologist, Pathologist, Sexologist, Dermatologist, ENT Surgeon, Haematologist, Preventive medicine specialist
• Super Specialist: Paediatric surgeon, Dental Surgeon, Cardiologist, Pulmonologist, Diabetologist, Oncologist, Neurologist, Gastroenterologist, Nephrologist, Urologist, Orthodontic, Orthopaedics & Joint Replacement, Rheumatologist, Endocrinologist, Laparoscopic

3. Doctor Prescribed Diagnostics (Doctor Prescribed Lab & Radiology) <0.4% of Sum Assured p.a.>

Coverage:
The Insured member/s can avail the cashless service for investigations prescribed by the Medical Practitioner for pathology or radiology from network provider/ health service provider up to the limit as specified.

Exclusion:
I. Claims without prescription shall not be covered.
II. Preventive health tests shall not be covered under this benefit.

4. Preventive Health Check-Up (82 Tests Packages/62 Tests Packages)

Coverage:
One voucher for Preventive Health Check-Up (List of tests mentioned below) is provided per year. The Assured member/s can avail the voucher on cashless basis only in the network centres of our Service Provider. The list of tests covered may vary subject to availability with service provider.

82 components Tests Package:

Test Name

Haemogram (CBC + ESR) (27)
Kidney Function Test (KFT) (11)
Lipid Profile (9)
Liver Function Test (LFT) (12)
Urine Routine & Microscopic Examination (23)

68 components Tests Package:

Test Name
Haemogram (CBC + ESR) (26)
Kidney Function Test (KFT) (7)
Lipid Profile (2)
Liver Function Test (LFT) (10)
Urine Routine & Microscopic Examination (23)

Exclusion:
I. The complete list of tests as given above has to be completed in a single appointment.
II. Reimbursement of preventive health check-up expenses is excluded from the scope of the Policy. This rule shall be by-passed on exception scenarios to provide reimbursement up to defined limits for customers residing in locations where the services could not be provided.

5. Network Discounts

Coverage:
The Assured member can opt for discounts on in-clinic doctor consultations and Lab & radiology bookings with partners listed on the Life Rewards app.

Exclusion:
I. Multiple benefits cannot be clubbed at any given point of time.
II. Reimbursement under benefit is excluded from scope of cover.

6. Diet & Nutrition Consultations

Coverage:
The Assured member can consult with dietician and nutritionist for health coaching and diet chart preparation.

Exclusion:
Reimbursement under benefit is excluded from scope of cover.

7. Mental Wellness Consultation

Coverage:
If the Assured member is witnessing some emotional issues, the assured member can consult psychologists and maintain a consult for a healthier life and emotional wellness.

Exclusion:
Reimbursement under benefit is excluded from scope of cover.

8. Prescribed Pharmacy Discounts

Coverage:
The Assured member can order prescribed pharmacy up to the discount amount mentioned under plan with partners listed on the Life Rewards app.

Exclusion:
I. Minimum order value ₹ 250.
II. Reimbursement under benefit is excluded from scope of cover.

9. Gym & Fitness

Coverage:
The Assured member can book and visit gyms, yoga and fitness centers listed on the Life Rewards app.

Exclusion:
I. Reimbursement under benefit is excluded from scope of cover.
II. Services are subject to availability of network.

10. Chronic Care Management

Coverage:
The Assured member can sign up for chronic care management programs available on Life Rewards app namely: Diabetes care, Cardiac care, Weight management, Thyroid care. The assured can log their vitals and track progress on application.

Exclusion:
Reimbursement under benefit is excluded from scope of cover.

11. Personal Health Concierge

Coverage:
The Assured member can connect over call through dedicated contact number with concierge to avail/claim services, book appointments and place orders with network partners and healthcare providers available. Healthcare services will be arranged for and coordinated by the concierge for Assured member.

Exclusion:
i. The dedicated concierge facility can be availed for services only by the members covered under the plan.
ii. The concierge service can be utilized only once per quarter.
iii. Appointment requests received shall be dependent on availability and sole discretion of service provider as per policy coverage.
iv. Emergency support is discouraged, if requested, concierge will be able to support basis availability, and the company shall not be liable for any liability for loss or damage of whatsoever nature.
v. Reimbursement under this benefit is excluded from scope of cover.

12. Care Circle

Coverage:
The Assured member can add and compete with their family & friends under step tracker. Also, the Assured member can add close family members in their inner circle which helps them keep motivated to track & maintain their health, diet and vitals.

Exclusion:
Reimbursement under benefit is excluded from scope of cover

General Exclusions for all Benefits:
1. All benefits provided under this option are subject to
- Terms and conditions stated under each benefit;
- Exclusions stated under the benefit;
- Availability of the Sum Insured/limits; and
- Availability of appointment (for availing cashless services)

2. Any unutilized benefit(s) availed during the Policy Year shall not be carried forward.
3. All the benefits under this option are non-transferable in nature, therefore the benefit(s) must necessarily be availed only by and pertain only to member Insured under this option
4. The services provided under the various benefits are assisted by Service Provider and we are not responsible for any kind of liability arising out of them. Thus, benefits availed under this option shall not be valid for any medico-legal cases.

5. We do not represent correctness of consultations, laboratory & radiology tests and shall not assume or deem to 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 whether from or outside service provider's network.
6. Choosing the services under this option is purely upon the Insured member's own discretion and at own risk. The services provided under the various covers are via service provider's network and the Insurer is not responsible for liability arising out of the services provided by these third parties.
7. Benefits under this option can be availed on cashless basis via Life Rewards mobile app and are subject to the terms, conditions, waiting periods and exclusions.
8. All other general terms & conditions, exclusions, clauses and definitions applicable to the Base Product will apply to this option unless specifically stated otherwise in this document.
9. All necessary documents as required on Life Rewards mobile app need to be submitted by assured member for reimbursement claims, wherever applicable.
10. 30-day Waiting Period from the Risk Commencement Date is applicable.

As part of the policy, Members can avail Wellness benefits that can be accessed seamlessly via HDFC Life LifeRewards mobile app. All benefits adhere to the specific terms, conditions, exclusions, and waiting period outlined under each benefit.

Part C

Benefits

A. Benefits on Death or diagnosis of Contingency covered

1. Plan options available under the product and their respective benefits are as follows:

Plan Options	Death Benefit	Other Benefits
Life Option	Sum Assured	None
Extra Life Option	None	Sum Assured upon Accidental Death
Terminal Life Option	None	Acceleration of Death Benefit upon diagnosis with Terminal Illness
Critical Life Option 1	None	Acceleration of Death Benefit upon diagnosis with one of the specified Critical Illnesses (with the CI benefit term equal to main benefit term or 5 years whichever is lower)
Critical Life Option 2	None	Acceleration of Death Benefit upon diagnosis with one of the specified Critical Illnesses (with the CI benefit term equal to main benefit term or 10 years whichever is lower)
Critical Life Option 3	None	Acceleration of Death Benefit upon diagnosis with one of the specified Critical Illnesses (with the CI benefit term equal to main benefit term or 15 years whichever is lower)
Critical Life Option 4	None	Acceleration of Death Benefit upon diagnosis with one of the specified Critical Illnesses (with the CI benefit term equal to main benefit term or 20 years whichever is lower)
Life Disability Option	None	Acceleration of Death Benefit upon Total and Permanent Disability
Wellness Benefit	None	Health and Wellness benefits

2. The benefits specified above are payable provided the death or accidental death or terminal illness or total and permanent disability or Critical Illness has occurred during the Coverage Term for the insured Scheme Member.

   After the death benefit or acceleration of the death benefit, the coverage shall cease and policy shall terminate.

   The acceleration of death benefit in respect of Critical Life Option 1, Critical Life Option 2, Critical Life Option 3 or Critical Life Option 4 is payable provided the Critical Illness has occurred during the CI Benefit Term for the insured Scheme Member.
   After the expiry of the CI benefit term, the critical illness benefit shall expire but the main death benefit and any other option if chosen shall continue for the remainder of its coverage term.

3. The Scheme Member can choose multiple options along with Life Option. However, only 1 of 4 Critical life option can be chosen by the Scheme Member.

4. The Sum Assured specified above shall mean:
   - Original Sum Assured for level term assurance coverage
   - Decreasing Sum Assured for the decreasing term assurance coverage

5. For Joint Life cases, the benefits will be payable on a first-claim basis and upon the payment of benefit in respect of the first claimant, the cover for the other life will terminate. For the avoidance of doubt, it is clarified that in respect of Critical Life Option 1, Critical Life Option 2, Critical Life Option 3 or Critical Life Option 4, if the Critical Illness claim has been made in respect of one of the lives, the Critical Illness coverage as well as death benefit coverage will terminate for both the lives.

6. This product also offers Health & Wellbeing Management Services, under Wellness Benefit, across the member coverage term such as Virtual Consultations (Instant Teleconsultations),Out Patient Consultations, Doctor Prescribed Diagnostics, Preventive Health Check-Up Benefit, VAS Discounts etc. All the benefits under Wellness benefit will be offered through a third party vendor. The detailed description of the list of all benefits and terms & conditions applicable to this benefit are provided in the Certificate of Insurance. The utilization of these services by the customer does not impact the other benefits in the product. If the policy gets terminated due to surrender or death, the benefits under Health & Wellness also stand terminated.
7. As part of the policy, Members can avail Wellness benefits that can be accessed seamlessly via HDFC Life LifeRewards mobile app. All benefits adhere to the specific terms, conditions, exclusions, and waiting period.
8. The Certificate of Insurance issued to a Scheme Member will set out the benefit payable in respect of that Scheme Member during the Coverage Term.

9. The payment of Death Benefit shall be made to the Master Policyholder to the extent of the outstanding loan balance amount, provided, the Master Policyholder is financial institution.

   The payment of Death Benefit to the Master Policyholder may be made by the Insurer subject to the below mentioned conditions and in compliance with guidelines set forth by IRDAI in this regard:
   i. There is an authorized assignment made by the Scheme Member in favour of the Master Policyholder of the Policy as on the date of the contingent event
   ii. There is an authorized assignment made by the Scheme Member in favour of the Master Policyholder of the Policy as on the date of the contingent event
   iii. The balance of claim (i.e. the difference between the sum assured and the outstanding loan amount as on the date of occurrence of the contingent event) is paid directly to the Nominee
   iv. The complete details of claim amount settled, the remittances made to the Master Policyholder towards outstanding loan balance and the balance claim amount payable to the Nominee shall be communicated by the Insurer directly to the nominee/ beneficiary

10. Upon the payment of the benefits as mentioned above with respect to the options availed, the cover for that Scheme Member shall cease.

11. The benefit as set out in the Scheme Member's Certificate of Insurance at the inception of membership shall be paid to the Nominee of the deceased Scheme Member. If the benefit is in the form of an acceleration of the death benefit and the Scheme Member is alive, then the benefit shall be payable to the Scheme Member.

12. In the instances where the insurance cover is sought for an institution's members unconnected with a loan, the benefit as set out in the member's Certificate of Insurance shall be payable.

B. Maturity Benefits

No benefits are payable on the expiry of the Coverage Term.

C. Surrender Benefits

1. A Scheme Member may surrender his Certificate of Insurance during the Coverage Term and obtain a surrender value, calculated using the formula specified below for each option:

$$70\% \; x \; Single\ Premium \; x \frac{Unexpired\ Coverage\ Term\ (in\ complete\ months)}{Original\ Coverage\ Term\ (in\ months)} \; x \frac{Current\ Sum\ Assured}{Initial\ Sum\ Assured}$$

   For the avoidance of doubt, it is clarified that the Current Sum Assured and the Initial Sum Assured shall be the same for level term assurance cases.

2. The premium for the purpose of calculating the surrender value does not include:
   b) Taxes & Levies; and
   c) Any underwriting extra premium charged

3. The surrender value payout will be reduced by any applicable Taxes & Levies.

D. Premiums

1. Separate premiums are payable in respect of every Scheme Member insured under the Policy.

2. The product is a single premium product.

3. New members are allowed to join the Scheme at any time, provided the application is accepted by the Insurer. Insurance cover for new members shall not commence before the receipt of premium.

4. In addition to the base premium, taxes and levies, duties and levies (including education cess or any other charge thereon) shall be payable.

5. Scheme Members will have the option to continue the Insurance cover in the event of foreclosure of loan or transfer of loan to another financial institution.

6. The Insurer reserves the right to collect any additional taxes or levies that may be introduced in the future by the government, as and when such taxes become effective.

E. Closure to New Members

1. The Insurer reserves the right to close the Scheme for the new members at its sole discretion after providing a notice of up to 30 days to the Master Policyholder.

2. In the instance where the Insurer has exercised such right to close the Scheme for the new members, the Insurer shall continue to provide the insurance cover for the existing Scheme Members for their respective unexpired Coverage Terms.

F. Variation of Terms and Conditions

The Insurer reserves the right to vary the Policy Provisions and the Schedule due to legal or regulatory changes after intimating the Master Policyholder of its intention to do so in writing.

G. General

1. Any information needed to administer the Policy must be furnished by the Master Policyholder.

2. If the information provided by the Master Policyholder in the application form is incorrect or incomplete, the Insurer reserves the right to vary the benefits which may be payable.

3. The Insurer reserves the right to change any of these Policy provisions if it becomes impossible or impractical to execute the provision.

4. The Insurer can check, at any time, if the benefit payments are being made to the correct person as and when due.

5. The insured Scheme Members can nominate the recipient of any death benefits at the time the Policy is purchased, and can change this nomination at a later date by notifying the Insurer in writing. In accepting or recording a nomination or a change of nomination we do not accept any responsibility or express any opinion as to its legal validity.

6. Nomination:

a) The Scheme Member shall nominate the person to whom the money secured by the policy shall be payable in the event of death of the policyholder.

b) Nominee can be changed any time during the term of the policy.

Part D

Commencement and Expiry of Insurance

1. The Insurer shall grant Insurance in accordance with these Provisions in respect of each Scheme Member.

2. The Insurer at his sole discretion may require the Master Policyholder to furnish the proof of eligibilities of the Scheme Member so as to administer the Policy properly.

3. In respect of every Scheme Member covered under the Scheme, the insurance cover shall be deemed to have been terminated under any of the following circumstances, whichever is earliest:
   - on the Scheme Member attaining the age of maximum age for membership in the Scheme; or
   - on the Scheme Member surrendering their membership; or
   - upon the payment of a death claim by the Insurer in respect of such Scheme Member; or
   - upon the payment of claim in respect of Other Benefit (specified in Part C); or
   - on the expiry of the Term of Membership; or
   - on the payment of Sum Assured for one of the members in case of joint life cover

4. In respect of every Scheme Member covered under the Scheme with Plan Options Critical Life Option 1, Critical Life Option 2, Critical Life Option 3 or Critical Life Option 4, the critical illness insurance cover shall be deemed to have been terminated under any of the following circumstances, whichever is earliest:
   - on the Scheme Member attaining the age of maximum age for membership in the Scheme; or
   - on the Scheme Member surrendering their membership; or
   - upon the payment of a death claim by the Insurer in respect of such Scheme Member; or
   - upon the payment of a critical illness claim (in the form of acceleration of death benefit) by the Insurer in respect of such Scheme Member; or
   - on the expiry of the CI Benefit Term; or
   - on the payment of Sum Assured for one of the members in case of joint life cover

5. Free Look Cancellation:

By Master Policy Holder:

(1) In case you, the Master Policyholder, are not satisfied with the terms and conditions specified in the Master Policy Document, you have the option of returning the Master Policy Document to us stating the reasons thereof, within 30 days from the date of receipt of the Master Policy Document whether received electronically or otherwise)

(2) On receipt of the letter along with the Master Policy Document, irrespective of the reasons mentioned, you shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges

By Scheme Member:

(1) In case the Member is not satisfied with the terms and conditions specified in the Certificate of Insurance, he/she has the option of returning the Certificate of Insurance to us stating the reasons thereof, within 30 days from the date of receipt of the Certificate of Insurance whether received electronically or otherwise)

(2) On receipt of the letter along with the Certificate of Insurance, irrespective of the reasons mentioned, the member shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges

For administrative purposes, all Free-Look requests should be registered by you, on behalf of Scheme Member.

Part E

1. **Additional Servicing Charges**
   Nil

Part F

1. Exclusions

A. Critical Illness

No Critical Illness benefit will be paid out if the Critical Illness has occurred directly or indirectly as a result of any of the following.

- Any of the listed dread disease conditions where death occurs within 30 days of the diagnosis
- <Any sickness related condition manifesting itself within 90 days of the commencement of the policy/Risk Commencement Date or reinstatement, whichever is later.>
- Intentionally self-inflicted injury or attempted suicide, irrespective of mental condition.
- Alcohol or solvent abuse, or the taking of drugs except under the direction of a registered medical practitioner.
- War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
- Service in any military, police, paramilitary or similar organisation.
- Taking part in any act with a criminal intent.
- <Any Pre-existing medical condition>.
- Unreasonable failure to seek medical advice
- Radioactive contamination due to nuclear accident
- Diagnosis or treatment outside India

Conditions under which claims will not be payable
Only one claim will be payable and no more than one claim will be paid in respect of Critical Illness benefit.

B. Accidental Death

No accidental death benefit is payable if death is caused directly or indirectly by any of the following:

- Infection : Death or Disability caused or contributed to by any infection, except infection caused by an external visible wound accidentally sustained
- Drug Abuse: Member under the influence of Alcohol or solvent abuse or use of drugs except under the direction of a registered medical practitioner
- Self-inflicted Injury: Intentional self- Inflicted injury.
- Criminal acts: Member involvement in Criminal and/or unlawful acts.
- War and Civil Commotion: War, invasion, hostilities, (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
- Nuclear Contamination: The radioactive, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature.
- Aviation: Member participation in any flying activity, other than as a passenger in a commercially licensed aircraft.
- Hazardous sports and pastimes: Taking part or practicing for any hazardous hobby, pursuit or any race not previously declared and accepted by the Company.
- Poison: Taking or absorbing, accidentally or otherwise, any poison.
- Toxic Gases: Inhaling any gas or fumes, accidentally or otherwise, except accidentally in the course of duty.
- Physical Infirmity: Body or mental infirmity or any disease.

C. Total Permanent Disability

Total Permanent Disability benefit will be paid only if the disability has persisted for at least 6 consecutive months and must, in the opinion of a registered Medical Practitioner appointed by us, deemed to be permanent.

The Total Permanent Disability benefit will not be paid due to:

- Pre-existing injuries
- Taking part in any hazardous sport or pastimes (including hunting, mountaineering, racing, steeple chasing, bungee jumping, etc)
- Self-inflicted injury or attempted suicide-whether sane or insane
- Service in any military, air force, naval, police, paramilitary or similar organisation
- Nuclear reaction, radiation or nuclear or chemical contamination
- Life Assured flying in any kind of aircraft, other than as a bona fide passenger (whether fare – paying or not) on an aircraft of a licensed airline
- Under influence or abuse of drugs, alcohol, narcotics or psychotropic substance not prescribed by a registered Medical Practitioner
- War , civil commotion, invasion, terrorism , hostilities (whether war be declared or not)
- The Life Assured taking part in any strike, industrial dispute , riot etc
- The Life assured taking part in any criminal or illegal activity or committing any breach of law.

D. Terminal Illness

No terminal illness benefit is payable if it is caused directly or indirectly by any of the following:

- Intentionally self-inflicted injury or attempted suicide, irrespective of mental condition.
- Alcohol or solvent abuse, or the taking of drugs except under the direction of a registered Medical Practitioner.
- War, invasion, hostilities (whether war is declared or not), civil war, rebellion, revolution or taking part in a riot or civil commotion.
- Taking part in any flying activity, other than as a passenger in a commercially licensed aircraft.
- Taking part in any act with a criminal intent.

E. Wellness

1.Virtual Consultations (Insta Tele Consultation) <Twice per month/24 p.a.>
Exclusion:
i. Reimbursement of tele-consultation benefit is excluded.
ii. Only 1 active Doctor consultation is allowed at any given time and the Insured Member can book/utilize next consultation post completion of ongoing consultation.

2.Outpatient Consultations (OPD In-Clinic Doctor Consultation)
Exclusion:
i. Investigations, medicines, surgical or non-surgical procedures or any medical, non-medical items are not covered under this section.
ii. All applicable doctor specialties mentioned below.
iii. Only 1 (one) active Doctor Consultation is allowed at any given time and the Insured Beneficiary can book/utilize next consultation post completion of ongoing consultation.
iv. Maximum doctor consultation fees applicable as below,
i.General Physician - ₹ 500/-
ii.Specialist/Super Specialist - ₹ 1,000/-

3. Doctor Prescribed Diagnostics (Doctor Prescribed Lab & Radiology) <0.4% of Sum Assured p.a.>
Exclusion:
i. Claims without prescription shall not be covered.
ii. Preventive health tests shall not be covered under this benefit.

4. Preventive Health Check-Up (82 Tests Packages/62 Tests Packages)
Exclusion:
I. The complete list of tests as given above has to be completed in a single appointment.
II. Reimbursement of preventive health check-up expenses is excluded from the scope of the Policy. This rule shall be by-passed on exception scenarios to provide reimbursement up to defined limits for customers residing in locations where the services could not be provided.

5. Network Discounts
Exclusion:
I. Multiple benefits cannot be clubbed at any given point of time.
II. Reimbursement under benefit is excluded from scope of cover.

6. Diet & Nutrition Consultations
Exclusion:
Reimbursement under benefit is excluded from scope of cover.

7. Mental Wellness Consultation
Exclusion:
Reimbursement under benefit is excluded from scope of cover.

8. Prescribed Pharmacy Discounts
Exclusion:
I. Minimum order value ₹ 250.
II. Reimbursement under benefit is excluded from scope of cover

9. Gym & Fitness
Exclusion:
I. Reimbursement under benefit is excluded from scope of cover.
II. Services are subject to availability of network.

10. Chronic Care Management
Exclusion:
Reimbursement under benefit is excluded from scope of cover.

11. Personal Health Concierge
Exclusion:
i. The dedicated concierge facility can be availed for services only by the members covered under the plan.
ii. The concierge service can be utilized only once per quarter.
iii. Appointment requests received shall be dependent on availability and sole discretion of service provider as per policy coverage.
iv. Emergency support is discouraged, if requested, concierge will be able to support basis availability, and the company shall not be liable for any liability for loss or damage of whatsoever nature.
v. Reimbursement under this benefit is excluded from scope of cover.

12. Care Circle
Exclusion:
Reimbursement under benefit is excluded from scope of cover

F, . Suicide Exclusion:

In case of death due to suicide within 12 months from the Risk Commencement Date under the policy or from the date of revival of the policy, as applicable, the nominee or beneficiary of the policyholder shall be entitled to at least 80% of the total premiums paid till the date of death or the surrender value available as on the date of death whichever is higher, provided the policy is in force

2. Claim Procedure

The Insurer shall not admit a claim in respect of a Scheme member under this Policy unless it receives the Scheme Members' death certificate or such other document that Insurer may decide, within the legal and regulatory framework in the circumstances of a particular case.

Basic documentation if death is due to Natural Cause:

- Claim form
- Original Certificate of Insurance
- Proof of death:
  Documents which can be considered as proof of Death are:

- Death Certificate of the Scheme Member issued by the Municipal Committee/ Corporation/ Govt. hospital/recognized hospital where the Scheme Member was receiving treatment, cremation/ burial ground; or
- Gram Panchayat certificate / Tehsildar certificate, Certified copy of village death records, or
- Certified copy of relevant extracts of Register of Births and Deaths,

Basic documentation if death is due to Unnatural Cause:

- Claim form
- Original Certificate of Insurance
- Proof of death:
  Documents which can be considered as proof of Death are:
- Death Certificate of the Scheme Member issued by the Municipal Committee/ Corporation/ Govt. hospital/recognized hospital where the Scheme Member was receiving treatment, cremation/ burial ground; or
- Gram Panchayat certificate / Tehsildar certificate, Certified copy of village death records, or
- Certified copy of relevant extracts of Register of Births and Deaths,
- Original First Information Report or Police Panchanama or Police Inquest Report or Post-Mortem Report, if the death occurs due to an accident

Proof of terminal illness/crucial illness/disability:
Documents which can be considered as proof of Terminal Illness/ Critical Illness/Disability are:

- Any medical reports by the family physician/doctor relevant to the Terminal Illness/ Critical Illness/Disability and its treatment, or
- Any other document that the Insurer may decide in the circumstances of a particular case.

The Insurer will not accept the aforesaid documents unless it is issued by a person duly authorized to issue the same.

3. Assignment or Transfer

The Master Policyholder can assign or transfer the Policy in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time. Simplified version of the provisions of Section 38 is enclosed in Annexure I for reference.

4. Nomination

The Scheme Member can nominate a person/ persons in accordance with Section 39 of the Insurance Act, 1938 as amended from time to time. Simplified version of the provisions of Section 39 is enclosed in Annexure II for reference.

5. Prohibition of Rebates: In accordance with Section 41 of the Insurance Act, 1938 as amended from time to time:

a) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the Policy, nor shall any person taking out or renewing or continuing a Policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.

b) Any person making default in complying with the provisions of this section shall be punishable with fine, which may extend to ten lakh rupees.

6. Issuance of Duplicate Policy

The Master Policyholder may request for a duplicate copy of the Policy at the Insurer's offices along with relevant documents. Additional charges may be applicable for issuance of the duplicate Policy. While making an application for duplicate Policy the Master Policyholder is required to submit a notarized original indemnity bond on stamp paper.

7. Register of Members

(1) The Master Policyholder shall maintain a register of members which shall have the details of all the Scheme Members including nomination details. This register shall form an integral part of this Policy.
(2) An inspection of the register without notice may be conducted by the Insurer or the auditors of the Insurer and the Insurer may from time to time ask for the records and/or ask for a certificate from the auditor of the Master Policyholder.
(3) A person's name can be removed from the register at any time if he ceases to be an Eligible Person. If it is discovered that a person included in the register is not a Scheme Member, or has ceased to be a Scheme Member, the person's name will be removed from the register.
(4) The minimum number of Scheme Members required under this Policy is stated in the Policy Schedule.

8. Provision of information:

1. Before assuring any benefit under these Provisions in respect of an Eligible Person and to determine the rights and obligations of the Insurer under these Provisions, the Master Policyholder must provide the Insurer with such information, data and evidence as the Insurer considers necessary in such form as the Insurer instructs.

2. In the event of any change in the name or other particulars of a Scheme Member, the Master Policyholder must inform the Insurer of the change within 15 days of being informed of the same by such Scheme Member.

3. The Nominee or the Master Policyholder shall inform the Insurer of the death of a Scheme Member within 30 days of the death and the Nominee shall file a claim with the Insurer in the form prescribed by the Insurer and accompanied by all relevant documents as may be required by the Insurer, within 90 days from the date of death.

4. However, the Insurer will condone the delay in intimation of claims where such delay is proved to be for reasons beyond the control of the claimant.

5. Subject to Section 45 of the Insurance Act 1938 as amended from time to time, if any information, data or evidence given to the Insurer in respect of a deceased Scheme Member is discovered to be incorrect, the insurance cover in respect of such Scheme Member may be rendered void, at the instance of the Insurer.

6. The Insurer shall not be liable for any loss of benefit resulting from errors in or omissions from any information, data or evidence given to the Insurer by the Master Policyholder

9. Incorrect Information and Non-Disclosure

Fraud, misrepresentation and forfeiture would be dealt with in accordance with provisions of Section 45 of the Insurance Act 1938 as amended from time to time. Simplified version of the provisions of Section 45 is enclosed in Annexure III for reference.

10. Taxes

(1) Indirect Taxes

Taxes and levies shall be levied as applicable. Any taxes and levies becoming applicable in future may become payable by any method including by levy of an additional monetary amount in addition to premium and or charges.

(2) Direct Taxes

Tax, if any will be deducted at the applicable rate from the payments made under the Policy, as per the provisions of the Income Tax Act, 1961 as amended from time to time.

11. Modification, Amendment, Re-enactment of or to the Insurance laws and rules, regulations, guidelines, clarifications, circulars etc. there under

(1) This Policy is subject to-
   a. The Insurance Act, 1938 as amended from time to time,
   b. Amendments, modifications (including re-enactment) as may be made from time to time, and
   c. Other such relevant regulations, rules, laws, guidelines, circulars, enactments etc as may be introduced thereunder from time to time.

(2) We reserve the right to change any of these Policy provisions / terms and conditions in accordance with changes in applicable regulations or laws and where required, with the approval of IRDAI.

(3) We are required to obtain prior approval from the IRDAI before making any material changes to these provisions, except for changes of regulatory / statutory nature.

(4) We reserve the right to require submission by you of such documents and proof at all life stages of the Policy as may be necessary to meet the requirements under Anti- money Laundering/Know Your Customer norms and as may be laid down by IRDAI and other regulators from time to time when the same are notified by the authorities for this/similar plans.

12. Jurisdiction

This Policy shall be governed by the laws of India. The Courts of India shall have the exclusive jurisdiction to settle any disputes arising under this Policy.

13. Notices

Any notice, direction or instruction given to us, under the Policy, shall be in writing and delivered by hand, post, facsimile or from registered e-mail ID to:
HDFC Life Insurance Company Limited, 11th Floor, Lodha Excelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400011.
Registered Office: Lodha Excelus, 13th Floor, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400011.
E-mail: service@hdfclife.com or such other address as may be informed by us.
Similarly, any notice, direction or instruction to be given by us, under the Policy, shall be in writing and delivered by hand, post, courier, facsimile or e-mail ID to the updated address in the records of the Company.
You are requested to communicate any change in address, to the Company supported by the required address proofs to enable the Company to carry out the change of address in its systems. The onus of intimation of change of address lies with the Master Policyholder. An updated contact detail of the Master Policyholder will ensure that correspondences from the Company are correctly addressed to the Master Policyholder at the latest updated address.

Part G

1. Grievance Redressal Process

1) The Master Policyholder can contact us at any of our touchpoints or write to us at the below mentioned address in case of any complaint/ grievance:
   Grievance Redressal Officer
   HDFC Life Insurance Company Limited
   11th Floor, Lodha Excelus, Apollo Mills Compound,
   N. M. Joshi Marg, Mahalaxmi, Mumbai, Maharashtra - 400011
   Helpline number: 022-68446530 (Call Charges apply) | NRI Helpline number +91 89166 94100 (Call Charges apply)
   E-mail: service@hdfclife.com| nriservice@hdfclife.com (For NRI customers only)
2) All grievances (Service and sales) received by the Company will be responded to within the prescribed regulatory Turn Around Time (TAT) of 14 days.
3) Written request or email from the registered email id is mandatory.
4) If required, we will investigate the complaints by taking inputs from the customer over the telephone or through personal meetings.

5) We will issue an acknowledgement to the customer immediatelyon receipt of the complaint.
6) The acknowledgement that is sent to the customer has the details of the complaint number, the Policy number and the Grievance Redressal department who will be handling the complaint of the customer.
7) If the Master Policyholder's complaint is addressed before the acknowledgement, the resolution communication will also act as the acknowledgment of the complaint.
8) The final letter of resolution will offer redressal or rejection of the complaint along with the appropriate reason for the same.
9) In case the Master Policyholder is not satisfied with the decision sent to him or her, he or she may contact our Grievance Redressal Officer within 8 weeks of the receipt of the communication at any of the touch points mentioned in the document, failing which, we will consider the complaint to be satisfactorily resolved.
10) The following is the escalation matrix in case there is no response within the prescribed timelines or if you are not satisfied with the response. The number of days specified in the below- mentioned escalation matrix will be applicable from the date of escalation.

Level	**Contact**	**Response Time**	Email ID	Address
1st Level	Chief Manager or above Customer Relation	10 working days	escalation1@hdfclife.in	11th Floor, Lodha Excelus, Apollo Mills Compound, N M Joshi Marg, Mahalakshmi, Mumbai 400011
2nd Level (for response not received from Level 1)	VP or above- Customer Relations	7 working days	escalation2@hdfclife.in	11th Floor, Lodha Excelus, Apollo Mills Compound, N M Joshi Marg, Mahalakshmi, Mumbai 400011

You are requested to follow the aforementioned matrix to receive satisfactory response from us.

11) If you are not satisfied with the response or do not receive a response from us within 14 days, you may approach the Grievance Cell of IRDAI on the following contact details:
- Bima Bharosa system - IRDAI Portal at https://bimabharosa.irdai.gov.in/
- IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255/ 1800 4254 732
- Email ID: complaints@irdai.gov.in
- Online- You can register your complaint online at http://www.igms.irda.gov.in/
- Address for communication for complaints by fax/paper:
  General Manager
  Insurance Regulatory and Development Authority of India
  Policyholder's protection & Grievance Redressal Department – Grievance Redressal Cell.
  Sy No. 115/1, Financial District, Nanakramguda,
  Gachibowli, Hyderabad – 500 032,

2. In the event you are dissatisfied with the response provided by us, you may approach the Insurance Ombudsman in your region. The details of the existing offices of the Insurance Ombudsman are provided at http://www.cioins.co.in/

(1) **Details and addresses of Insurance Ombudsman**

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BHOPAL	Office of the Insurance Ombudsman, 1st floor, "JeevanShikha", 60-B,Hoshangabad Road, Opp.	Madhya Pradesh, Chattisgarh.

	GayatriMandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins.co.in	
BHUBANESWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar@cioins.co.in	Odisha.
BENGALURU	Office of the Insurance Ombudsman, Jeevan SoudhaBuilding,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.
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 - 4646394/ 2706468 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 / 24333678 Email: bimalokpal.chennai@cioins.co.in	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 – 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & Ffollowing Districts of Haryana - Gurugram, Faridabad, Sonepat&Bahadurgarh.
GUWAHATI	Office of the Insurance Ombudsman, JeevanNivesh, 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, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005.	Rajasthan.

	Tel.: 0141 – 2740363 / 2740798 Email: bimalokpal.jaipur@cioins.co.in	
KOCHI	Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College, M.G.Road, Kochi - 682 011. Tel.: 0484 – 2358759 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, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 – 22124339/ 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, JeevanBhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, 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, JeevanSevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 –69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region (excluding Navi Mumbai & Thane).
NOIDA	Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: GautamBuddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhandand the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, GautamBuddhnagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA	Office of the Insurance Ombudsman, 2nd Floor, LalitBhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE	Office of the Insurance Ombudsman,	Maharashtra,

	JeevanDarshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).

(2) Power of Ombudsman-

1) The Ombudsman shall receive and consider complaints or disputes relating to—

   (a) delay in settlement of claims, beyond the time specified in the regulations, framed under the Insurance Regulatory and Development Authority of India Act, 1999;
   (b) any partial or total repudiation of claims by the Company ;
   (c) disputes over premium paid or payable in terms of insurance policy;
   (d) misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
   (e) legal construction of insurance policies in so far as the dispute relates to claim;
   (f) policy servicing related grievances against insurers and their agents and intermediaries;
   (g) issuance of life insurance policy, general insurance policy including health insurance policy which is not in conformity with the proposal form submitted by the proposer;
   (h) non-issuance of insurance policy after receipt of premium in life insurance; and
   (i) any other matter resulting from the violation of provisions of the Insurance Act, 1938, as amended from time to time, or the regulations, circulars, guidelines or instructions issued by the IRDAI from time to time or the terms and conditions of the policy contract, in so far as they relate to issues mentioned at clauses (a) to (f).

2) The Ombudsman shall act as counsellor and mediator relating to matters specified in sub-rule (1) provided there is written consent of the parties to the dispute.

3) The Ombudsman shall be precluded from handling any matter if he is an interested party or having conflict of interest.

4) The Central Government or as the case may be, the IRDAI may, at any time refer any complaint or dispute relating to insurance matters specified in sub-rule (1), to the Insurance Ombudsman and such complaint or dispute shall be entertained by the Insurance Ombudsman and be dealt with as if it is a complaint made under Clause (3) provided herein below.

(3) Manner in which complaint is to be made -

1) Any person who has a grievance against the Company, 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 Company complained against or the residential address or place of residence of the complainant is located.

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 Company 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.

3) No complaint to the Insurance Ombudsman shall lie unless—

   (a) the complainant makes a written representation to the Company named in the complaint and—
      i. either the Company had rejected the complaint; or
      ii. the complainant had not received any reply within a period of one month after the Company received his representation; or
      iii. the complainant is not satisfied with the reply given to him by the Company;
   (b) The complaint is made within one year—
      i. after the order of the insurer rejecting the representation is received; or
      ii. after receipt of decision of the Company which is not to the satisfaction of the complainant;
      iii. after expiry of a period of one month from the date of sending the written representation to the Company if the Company fails to furnish reply to the complainant.

4) The Ombudsman shall be empowered to condone the delay in such cases as he may consider necessary, after calling for objections of the Company 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.

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.
6) **Implementation of Ombudsman Award:** The Insurer is required to comply with the award of the Insurance Ombudsman within 30 days of receipt of award by the Insurer. In case the Insurer does not honour the ombudsman award, a penalty of Rs. 5000/- per day shall be payable to the complainant. Such penalty is in addition to the penal interest liable to be paid by the Insurer under the Insurance Ombudsman Rules, 2017. This provision will not be applicable in case insurer chooses to appeal against the award of the Insurance Ombudsman.

Annexure I

Section 38 - Assignment

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015 dated 23.03.2015. The extant provisions in this regard 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 or 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 authorised 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 Master 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 Master Policyholder within 30 days from the date of Master 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

i. the proceeds under the policy shall become payable to Master policyholder or nominee(s) in the event of assignee or transferee dying before the insured OR

ii. 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 transferor 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, shall not be affected by this section.

Disclaimer: This is not a comprehensive list of amendments of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policy Holders are advised to refer to Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 for complete and accurate details.

Annexure II

Section 39 - Nomination by policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015 dated 23.03.2015.The extant provisions in this regard 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 to be laid down by the insurer.

(3) Nomination can be made at any time before the maturity 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 bonafide 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 not get cancelled 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 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 (i.e 23.03.2015).

(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 of Insurance Laws (Amendment) Act, 2015 and only a simplified version prepared for general information. Policy Holders are advised to refer to Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 for complete and accurate details.

Annexure III

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

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended by Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 are as follows:

(1) No Policy of Life Insurance shall be called in question **on any ground whatsoever** after expiry of 3 yrs from

a. the date of issuance of policy or

b. Risk Commencement Date 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. Risk Commencement Date 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 / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.

(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 mis-statement 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 of Insurance Laws (Amendment) Act, and only a simplified version prepared for general information. Policy Holders are advised to refer to Insurance Laws (Amendment) Act, 2015 dated 23.03.2015 for complete and accurate details.

Appendix A

Benefit Schedule

<< Repayment Schedule to be inserted for decreasing term assurance cases or 100% of the Sum Assured for level term assurance cases>>

Note: Kindly note that name of the Company has changed from "HDFC Standard Life Insurance Company Limited" to "HDFC Life Insurance Company Limited".