Part A

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

Dear << Master Policyholder's Name>>,

Sub: Your Master Policy no. <<>>HDFC Life Group Health Shield

We are glad to inform you that your proposal has been accepted and the HDFC Life Group Health Shield ("Master Policy") being this Master Policy has been issued. We have made every effort to design your Master Policy in a simple format. We have highlighted items of importance so that you may recognize them easily.

Cancellation in the Free-Look Period:

<< In case you are not agreeable to any of the terms and conditions stated in the Master Policy, a period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If policyholder is not satisfied with any of the terms and conditions, policyholder has the option to cancel the policy
Irrespective of the reasons mentioned, the policyholder 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. >>

Contacting us:
The address for correspondence is specified below. To enable us to serve you better, you are requested to quote your Master Policy number in all future correspondence. To contact us in case of any grievance, please refer to Part G. In case you are not satisfied with our response, you can also approach the Insurance Ombudsman in your region.

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 >>

Agency/Intermediary Code: <<Agency/Intermediary Code>>
Agency/Intermediary Name: <<Agency/Intermediary Name>>
Agency/Intermediary Telephone Number: <<Agency/Intermediary mobile & landline number>>
Agency/Intermediary Contact Details: <<Agency/Intermediary address>>

Address for Correspondence: HDFC Life Insurance Company Limited, 11th Floor LodhaExcelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai-400011.

*Regd. Off:*LodhaExcelus, 13th Floor, Apollo Mills Compound, N. M. Joshi Marg, Mahalaxmi, Mumbai - 400 011.
Call 1860-267-9999 (local charges apply). DO NOT prefix any country code e.g. +91 or 00. Available Mon – Sat from 10 a.m. to 7 p.m.| Email – service@hdfclife.com| NRIservice@hdfclife.com (For NRI customers only) Visit – www.hdfclife.com . CIN: L65110MH2000PLC128245.

MASTER POLICY DOCUMENT- HDFC Life Group Health Shield

Unique Identification Number: <<101N116V05>>

Your Master Policy is a non-participating, non-linked, fixed benefit Pure Risk group health insurance Policy. This document is the evidence of a contract between HDFC Life Insurance Company Limited and the Master Policyholder as described in the Policy Schedule given below, who shall hold the same and all Benefits payable thereunder, upon trust, for the benefit of the persons to whom the said Benefits are payable (i.e. Scheme Members, or their nominees). The Master Policy is issued pursuant to a proposal made to the Insurer by the Master Policyholder along with the required documents, declarations, statements and other information received by the Company from the Master Policyholder for or on behalf of the Scheme Members on the date shown in the Policy Schedule for the benefit of Scheme Members ("Proposal").

Upon and subject to timely receipt of Premium by the Insurer from the Master Policyholder, the Insurer shall pay to the Scheme Member or their Nominees, the Benefits described in the Master Policy, in accordance with the terms of the Master Policy. This Master Policy is written under and will be governed by the applicable laws in force in India and all monies shall be payable in Indian Rupees at the office of the Insurer identified in the Policy Schedule.

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

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

POLICY SCHEDULE

1. **Master Policy Number:** << system/operations generated>>
2. **Date of Proposal**:<< system/operations generated>>
3. **Effective Date**:<< system/operations service generated>>
4. **Master Policyholder**:<<Name of Company/Group>>
5. **Name of the Scheme**: <<Name of Scheme>>
6. **Effective Date / Latest Annual Renewal Date**: <<Date, Month and Year>>
7. **Next Annual Renewal Date:** <<Date, Month and Year>>
8. **Eligibility to join the Scheme for the Scheme Member:**

Minimum Entry Age	*Benefit Option*	*Minimum Entry Age*
	Daily Hospital Cash Benefit	<<1 year>>
	Surgical Benefit	
	Critical Illness	<< 18 years>>
	Critical Illness excluding Cancer	
	Critical Illness excluding Cardiac	
	Critical Illness excluding Cancer and Cardiac	
	Cancer Cover	
	Cardiac Cover	
	Personal Accidental Cover	<<1 year>>
Maximum Entry Age	<<69>> years	

9. **Maximum Renewal Age**: 69 years
10. **Maximum cover ceasing age:** 70 years
11. **Minimum Number of Members:** <7>
12. **Frequency of Premium Payment:** Annual, Half-yearly, Quarterly, Monthly
13. **Cover Term:** Annually renewable
14. **Sum Insured and Benefit Options selected:**

Minimum Sum Insured per Member (Rs.)	*Benefit Option*	*Minimum Sum Insured (Rs.)*
	Daily Hospital Cash Benefit	10,000
	Surgical Benefit	10,000
	Critical Illness	
	Critical Illness excluding Cancer	
	Critical Illness excluding Cardiac	
	Critical Illness excluding Cancer and Cardiac	

	Cancer Cover	
	Cardiac Cover	
	Personal Accidental Cover	
Maximum Sum Insured per Member (Rs.)	*Benefit Option*	*Maximum Sum Insured (Rs.)*
	Daily Hospital Cash Benefit	2,00,000
	Surgical Benefit	25,00,000
	Critical Illness	50,00,000
	Critical Illness excluding Cancer	
	Critical Illness excluding Cardiac	
	Critical Illness excluding Cancer and Cardiac	
	Cancer Cover	
	Cardiac Cover	
	Personal Accidental Cover	

Full Member details as per Annexure []

15. **Office at which Monies are payable:**

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

Authorised Signatory

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

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

SPACE FOR ENDORSEMENTS

Part B

Definitions

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

(1) **Accident**-means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

(2) **Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders** - Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's Disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Scheme Member. This diagnosis must be supported by the clinical confirmation of an appropriate registered Medical Practitioner who is also a Neurologist and supported by the Company's appointed doctor.
The following is excluded:
i. Alcohol-related brain damage;

(3) **Angioplasty –**
i. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50% of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).
ii. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
iii. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

(4) **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;

(5) **Aplastic Anaemia** - Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:
i. Blood product transfusion;
ii. Marrow stimulating agents;
iii. Immunosuppressive agents; or
iv. Bone marrow transplantation.

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

(6) **Appointee**- means the person named by the Scheme Member and registered with us in accordance with the Nomination Schedule, who is authorized to receive the Benefits under the COI on the death of the Scheme Member while the Nominee is a minor;

(7) **Authority/ IRDAI** – means Insurance Regulatory and Development Authority of India;

(8) **Balloon Valvotomy or Valvuloplasty** - The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram or any other appropriate diagnostic test that is available.

The following are excluded:

i. Procedures done for treatment of Congenital Heart Disease within 4 years from the date of commencement of Scheme Member's cover or revival of coverage, whichever occurs later.

(9) **Benefit**- shall mean benefits as mentioned under Part C of the Master Policy;

(10) **Benign Brain Tumour –** is defined as a life threatening, non-cancerous tumour in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI.
This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical Symptoms for a continuous period of at least 90 consecutive days or
ii. Undergone surgical resection or radiation therapy to treat the brain tumour.

The following conditions are excluded:
Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumours, tumours of skull bones and tumours of the spinal cord.

(11) **Blindness –**

i. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.
ii. The Blindness is evidenced by:
   a. corrected visual acuity being 3/60 or less in both eyes or;
   b. the field of vision being less than 10 degrees in both eyes.
iii. The diagnosis of Blindness must be confirmed and must not be correctable by aids or surgical procedure.

(12) **Cancer of Specified Severity**

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

The following are excluded:

i. All Tumours 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 & 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 tumours 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 leukemia 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;

(13) **Carcinoma-in-situ** (CIS)- shall mean a histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma in any one of the following covered organ groups, and subject to any classification stated:

i. breast, where the tumour is classified as Tis according to the TNM Staging method;
ii. corpus uteri, vagina, vulva or fallopian tubes where the tumour is classified as Tis according to the TNM Staging method or FIGO* Stage 0;
iii. cervix uteri, classified as cervical intraepithelial neoplasia grade III (CIN III) or as Tis according to the TNM Staging method or FIGO* Stage 0;
iv. ovary –include borderline ovarian tumours with intact capsule, no tumour on the ovarian surface, classified as T1aN0M0, T1bN0M0 (TMN Staging) or FIGO 1A, FIGO 1B
v. Colon and rectum;
vi. Penis;
vii. Testis;
viii. Lung;
ix. Liver;
x. Stomach and esophagus;
xi. Urinary tract, for the purpose of in-situ cancers of the bladder, stage Ta of papillary
xii. carcinoma is included
xiii. Nasopharynx

For purposes of this Master Policy, Carcinoma-in-situ must be confirmed by a biopsy.
*FIGO refers to the staging method of the Federation Internationale de Gynecologie et d'Obstetrique
Pre-malignant lesions and Carcinoma-in-situ of any organ unless listed above are excluded;

(14) **Cardiomyopathy -** An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent, for at least six (6) months based on the following classification criteria:

i. Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced and

ii. Echocardiography findings confirming presence of cardiomyopathy and Left Ventricular Ejection Fraction (LVEF %) of 40% or less

The following are excluded:

i. Cardiomyopathy directly related to alcohol or drug abuse.

(15) **Certificate of Insurance(COI) -**"certificate of insurance" means a certificate issued by an insurer to the insured member in pursuance of non-employer-employee group policy giving details of the group insurance policy viz., the schedule of benefits, period of cover, the premium to be paid by the individual member, the premium payment frequency, term of the policy, premium paying term, exclusions, etc.

(16) **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;

(17) **Congenital Anomaly**-means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or positions.

i. Internal Congenital Anomaly: Congenital Anomaly which is not in the visible and accessible parts of the body.
ii. External Congenital Anomaly: Congenital Anomaly which is in the visible and accessible parts of the body;

(18) **Cover Term –**in respect of a Scheme Member,means a period of 12 months or part thereof for which insurance cover is provided to the Scheme Member at the Entry Date;

(19) **Critical Illness –**shall mean any of the Illness or surgeries listed under Part C Clause 1 (C)(ii)

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

(21) **Dental Treatment**-means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and Surgery

(22) **Early Stage Cancer** -shall mean the presence of one of the following malignant conditions:

i. Tumour of the thyroid histologically classified as T1N0M0 according to the TNM classification;
ii. Prostate tumour should be histologically described as TNM Classification T1a or T1b or T1c are of another equivalent or lesser classification.
iii. Chronic lymphocytic leukemia classified as RAI Stage I or II;
iv. Basal cell and squamous skin cancer that has spread to distant organs beyond the skin,
v. Hodgkin's lymphoma Stage I by the Cotswolds classification staging system.
vi. All tumours of the urinary bladder histologically classified as T1N0M0 (TNM Classification).

The Diagnosis must be based on histopathological features and confirmed by a Pathologist. Pre-malignant lesions and conditions, unless listed above, are excluded;

(23) **Effective Date -** means the date from which the Scheme shall first commence as set out in the Schedule;

(24) **Eligible Person -** means, any person who has satisfied the eligibility criteria set out in Part C Clause 2 (Eligibility) in the Master Policy;

(25) **End Stage Liver Failure-**

i. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   a. Permanent jaundice; and
   b. Ascites; and
   c. Hepatic encephalopathy.
ii. Liver failure secondary to drug or alcohol abuse is excluded;

(26) **End Stage Lung Failure -** End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO2 < 55mmHg); and
iv. Dyspnea at rest.

(27) **Entry Date -** in relation to a Scheme Member shall mean the actual date on which an Eligible Person is first admitted by the Insurer as a Scheme Member;

(28) **Exit Date** - means the date on which the coverage of the Scheme Member ceases due to occurrence of any of the following events:
i. Death of the Scheme Member,
ii. the Scheme Member ceases to satisfy the eligibility criteria,
iii. Master Policy being terminated or lapsed,
iv. Expiry of Cover Term,
v. Free Look Cancellation;
vi. Payment of Sum Insured under the Benefit Options

(29) **Free Look period** - means the period specified under Part D clause 6 from the receipt of the Policy during which Master Policyholder/Scheme Member can review the terms and conditions of this Master Policy and where if the Master Policyholder/Scheme Member is not agreeable to any of the provisions stated in the Policy, he/ she has the option to return this Policy

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

(31) **Heart Transplant** - The actual undergoing of a transplant of human heart that resulted from irreversible end stage heart failure. The undergoing of a heart transplant has to be confirmed by a specialist Medical Practitioner.

(32) **Hospital** -means any institution established for Inpatient care and day care treatment of Illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56 (1) of the said Act or complies with all minimum criteria as under:
i. has qualified nursing staff under its employment round the clock;
ii. has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

iii. has qualified Medical Practitioner(s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out;
v. Maintains daily records of patients and will make these accessible to the Company's authorised personnel;

(33) **Hospitalisation-** means admission in a Hospital for a minimum period of 24 consecutive Inpatient care hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours;

(34) **Illness-** means a sickness or a disease or pathological condition leading to the impairment of normal physiological condition which manifests itself during the Cover Term and requires medical treatment.

i. Acute condition - Acute condition is a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/Illness/Injury which leads to full recovery
ii. Chronic condition - A chronic condition is defined as a disease, Illness, or Injury that has one or more of the following characteristics:
a. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
b. It needs ongoing or long-term control or relief of Symptoms
c. It requires Scheme Member's rehabilitation or to be specially trained to cope with it
d. It continues indefinitely
e. It recurs or is likely to recur

(35) **Implantable Cardioverter Defibrillator** - Insertion of a permanent cardiac defibrillator as a result of serious (Life Threatening) cardiac arrhythmia which cannot be treated via any other means. Cardiac arrhythmias to be evidenced by 24 hour Holter monitoring report or any such other established diagnostic reports. The insertion of the cardiac defibrillator must be certified as absolutely necessary, beneficial, and effective by a Consultant Cardiologist.

(36) **Infective Endocarditis** - Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

i. Positive result of the blood culture proving presence of the infectious organism(s)
ii. Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of twenty percent (20%) or above) or moderate heart valve stenosis (resulting in heart valve area of thirty percent (30%) or less of normal value) attributable to Infective Endocarditis; and
iii. The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a cardiologist.

(37) **Injury -** means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner;

(38) **Inpatient Care** - means treatment for which the Scheme Member has to stay in a hospital for more than 24 hours for a covered event.;

(39) **Insertion of Pacemaker -** Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a specialist in the relevant field. Cardiac arrhythmias to be evidenced by 24 Holter monitoring report or any such other established diagnostic reports. The insertion of any type of temporary cardiac pacing is specifically excluded. Devices with in-built pacemaker functionality are specifically excluded and shall be considered to qualify under Implantable cardioverter defibrillator.
The following are excluded:

i. Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of Scheme Member's cover or revival of coverage, whichever occurs later.

(40) **Insurer, Company, Us, us, We, we** - means HDFC Life Insurance Company Limited;

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

(42) **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;

(43) **Latest Annual Renewal Date** - is the date on which the coverage under the Certificate of Insurance was last renewed by the Insurer and is specified in the Schedule.

(44) **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 scope of recovery with current medical knowledge and technology.
"Activities of Daily Living" are**:** -

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
iii. Transferring: the ability to move from a bed or an upright chair or wheelchair and vice versa.
iv. Mobility: The ability to move indoors from room to room on level surfaces.
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

The following is excluded:

i. 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;

(45) **Loss of Limbs** - The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of Injury or disease. This will include medically necessary amputation necessitated by Injury or disease. The separation has to be permanent without any chance of surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted Injury, alcohol or drug abuse is excluded.

(46) **Loss of Speech** - Total and irrecoverable loss of the ability to speak as a result of Injury or disease to the Vocal Cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, and Throat (ENT) specialist.

(47) **Major Cancer** - A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy and confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.
The following are excluded -

i. Tumours showing the malignant changes of Carcinoma in situ &Tumours which are histologically described as premalignant or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
ii. Any skin cancer other than invasive malignant melanoma
iii. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
iv. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
v. Chronic lymphocytic leukemia less than RAI stage 3

vi. All tumours of the urinary bladder histologically classified as T1N0M0 (TNM Classification) or below

(48) **Major Head Trauma** - Accidental head Injury resulting in permanent neurological deficit to be assessed no sooner than 3 months from the date of the Accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, 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 an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this Benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology;

The Activities of Daily Living are:

i. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
iv. Mobility: the ability to move indoors from room to room on level surfaces;
v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
vi. Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:
Spinal cord Injury

(49) **Major Organ / Bone Marrow Transplant -** 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.

The following are excluded:

i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

(50) **Major Surgery of Aorta -** The actual undergoing of major Surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches (including

aortofemoral or aortoiliac bypass grafts). The surgery must be determined to be medically necessary by a Consultant Cardiologist / Surgeon and supported by imaging findings.

The following are excluded:

i. Surgery performed using only minimally invasive or intra-arterial techniques.
ii. Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of Scheme Member's cover or revival of coverage, whichever occurs later.

(51) **Master Policyholder, You, you, Your, your** -means the company/group named in the Schedule as the Master Policyholder;

(52) **Medical Advice** -means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription;

(53) **Medically Necessary:** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

i. is required for the medical management of the Illness or Injury suffered by the Scheme Member;
ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. must have been prescribed by a Medical Practitioner;
iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India;

(54) **Medical Practitioner** - shall mean a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The person shall not be the Scheme Member himself/herself;

(55) **Medullary Cystic Disease** - Medullary Cystic Disease where the following criteria are met:

i. The presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;
ii. Clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and
iii. The Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this Benefit.

(56) **Metastasis** - The spread of cancer cells from the place where they first formed to another part of the body.

(57) **Minimally Invasive Surgery of Aorta** - The actual undergoing of minimally invasive surgical repair (i.e. via percutaneous intra-arterial route) of a diseased portion of an aorta to repair or correct an aneurysm, narrowing, obstruction or dissection of

the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

The following are excluded:

i. Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of Scheme Member's cover or revival of coverage, whichever occurs later.

(58) **Motor Neuron Disease With Permanent Symptoms** -Motor neuron disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months;

(59) **Multiple Sclerosis with Persisting Symptoms** -The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis; and
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE (Systemic Lupus Erythematosus)isexcluded;

(60) **Muscular Dystrophy** - Diagnosis of muscular dystrophy by a Registered Medical Practitioner who is a neurologist based on three (3) out of four (4) of the following conditions:

i. Family history of other affected individuals;
ii. Clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
iii. Characteristic electromyogram; or
iv. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Scheme member to perform (whether aided or unaided) at least three of the six "Activities of Daily Living" as defined earlier, for a continuous period of at least six months.

The following are excluded:

i. Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of Scheme Member's cover or revival of coverage, whichever occurs later.

(61) **Myocardial Infarction (First Heart Attack of specific severity)** -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 should be evidenced by all of the following criteria:

i. a history of typical clinical Symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
ii. new characteristic electrocardiogram changes

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

The following are excluded:

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

(62) **Next Annual Renewal Date -**is the date on which the term of the Master Policy is due for renewal and is specified in the Schedule;

(63) **Nominee** - means the person named by the Scheme Member (who is also the Life Assured) under this policy and registered with us in accordance with the Nomination Schedule, who is authorized to receive the Death Benefit under this Master Policy, on the death of the Life Assured;

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

The following are excluded:

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

(65) **Open Heart Replacement or Repair of Heart Valves** - 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.

(66) **Parkinson's Disease -** Unequivocal Diagnosis of Parkinson's disease by a registered Medical Practitioner who is a neurologist where the condition:

i. cannot be controlled with medication;
ii. shows Signs of progressive impairment; and
iii. Activities of Daily Living assessment confirms the inability of the Scheme Member to perform at least three (3) of the Activities of Daily Living as defined in the Master Policy, either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons for a continuous period of six months.

Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinson's Disease are excluded;

(67) **Pericardectomy -** The undergoing of a pericardectomy performed by open heart Surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consultant cardiologist.
The following are excluded:
i. Other procedures on the pericardium including pericardial biopsies and pericardial drainage procedures by needle aspiration.

(68) **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 scope of recovery and must be present for more than 3 months;

(69) **Policy, Master Policy**- means this Policy;

(70) **Policy Term –**means a period for which this Master Policy shall continue unless terminated by the Master Policyholder.

(71) **Policy Year**- means a period of 12 months starting with the Effective Date/ Latest Annual Renewal Date

(72) **Poliomyelitis –** means the occurrence of Poliomyelitis where the following conditions are met:
i. Poliovirus is identified as the cause and is proved by Stool Analysis,
ii. Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

(73) **Pre-existing disease -** 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.

(74) **Primary (Idiopathic) Pulmonary Hypertension –**

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

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

(75) **Progressive Scleroderma** -A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.
The systemic involvement should be evidenced by any one of the following findings -

i. Lung fibrosis with a diffusing capacity (DCO) of less than 70% of predicted
ii. Pulmonary hypertension with a mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterisation
iii. Chronic kidney disease with a GFR of less than 60 ml/min (MDRD-formula)
iv. Echocardiographic findings suggestive of Grade III and above left ventricular diastolic dysfunction

The diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist.
The following are excluded:

i. Localised scleroderma (linear scleroderma or morphea);
ii. Eosinophilic fascitis; and
iii. CREST syndrome.

(76) **Pulmonary Thrombo Embolism** - The blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs), angiography or echocardiography, with evidence of right ventricular dysfunction and requiring medical or surgical treatment on an inpatient basis.

(77) **Scheme** - means the Scheme named in the Schedule;

(78) **Scheme Member** - means an Eligible Person who is included in the Scheme as per the Scheme rules as member of that scheme;

(79) **Secondary Cancer –** means the Cancer that has spread (metastasized) from the place where it first started to another part of the body. Secondary cancers are the same type of cancer as the original (primary) cancer.

(80) **Sign –** means any objective evidence of a disease which can be detected by someone other than the individual affected by the disease.

(81) **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;

(82) **Sum Insured** - means the amount specified in the Certificate of Insurance, as per the Benefit Option(s) elected by the Scheme Member during Cover Term subject to terms, conditions and provisions of this Master Policy.

(83) **Surrender** - means withdrawal of the Certificate of Insurance at the request of the Scheme Member or withdrawal/ termination of Master Policy at the request of the Master Policyholder.

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

(85) **Surgery for Cardiac Arrhythmia -** Procedures like Maze Surgery, RF Ablation therapy or any relevant procedure/Surgery deemed absolutely necessary by a cardiologist to treat life threatening arrhythmias. Diagnosis must be evidenced by monitoring through a Holter monitor, event monitor or loop recorder and should be confirmed by a consultant cardiologist.

The following are excluded:

i. Cardio version and any other form of non-surgical treatments
ii. Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of Scheme Member's cover or revival of coverage, whichever occurs later.

(86) **Surgery to place Ventricular Assist Devices or Total Artificial Hearts -** The actual undergoing of open heart Surgery to place a Ventricular Assist Device or Total Artificial Heart medically necessitated by severe ventricular dysfunction or severe heart failure, with cardiac echocardiographic evidence of reduced left ventricular ejection fraction of less than 30%.

The following are excluded:

i. Ventricular dysfunction or Heart failure directly related to alcohol or drug abuse is excluded.

(87) **Symptom -** means a subjective evidence of the presence of disease and is a physical or mental feature which indicates the disease's presence. Such features are apparent to the person having the disease.

(88) **Systematic Lupus Erythematosus with Renal Involvement** - Multi-system, autoimmune disorder characterized by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of "Critical Illness", SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only hematological and joint involvement are specifically excluded.
Abbreviated ISN/RPS classification of lupus nephritis (2003):

i. Class I - Minimal mesangial lupus nephritis
ii. Class II - Mesangial proliferative lupus nephritis
iii. Class III - Focal lupus nephritis
iv. Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis
v. Class V - Membranous lupus nephritis
vi. Class VI - Advanced sclerosing lupus nephritis the final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

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

(90) **Unclaimed Benefit Sum Insured:** Unclaimed Benefit Sum Insured shall (except for Cardiac Cover Benefit Option and Cancer Cover Benefit Option) mean the Benefit Option Sum Insured as reduced by any claims already made for the Benefit since the date of commencement of Scheme Member's coverage or the date of renewal of coverage, whichever is later. For Cardiac Cover Option and Cancer Cover Option, Unclaimed Benefit Sum Insured shall mean Benefit Option Sum Insured as reduced by any claims already made for the Benefit since the date of commencement of Scheme Member's coverage.

Part C

1. Benefits:

Subject to the Scheme Rules, Master Policyholder or Scheme Member can choose from the Benefit Options provided in the table herein below. The choice of various Benefit options shall be subject to conditions stated in the "Limitations on Choice" column of this table.

Where multiple Benefit options are chosen, the Benefits payable under each Benefit option shall be independent of Benefits payable under other Benefit options.

Option	Benefit Option	Limitations on choice
A	Daily Hospital Cash Benefit (DHCB)	
B	Surgical Benefit (SB)	
C	Critical Illness	Only one out of Options C, D, E, & F can be chosen
D	Critical Illness excluding Cancer	
E	Critical Illness excluding Cardiac	
F	Critical Illness excluding Cancer and Cardiac	
G	Cancer Cover	Not available with Options C & E
H	Cardiac Cover	Not available with Options C & D
I	Personal Accidental Cover (PAC)	

A. Daily Hospital Cash Benefit ("DHCB") Option:

i. This Benefit shall be payable to the Scheme Member in the event of Hospitalisation during the Cover Term due to any Injury, sickness or disease.
ii. The DHCB amount shall be the aggregate of DHCB (as applicable) for each day of Hospitalisation beginning from the second day.
iii. Upon admission into non-ICU rooms, 2.5% of the DHCB Sum Insured will be payable to the Scheme Member. Upon admission into ICU Rooms, 5% of the DHCB Sum Insured will be payable to the Scheme Member.
iv. Benefit payable towards any claim shall not exceed the Unclaimed Benefit Sum Insured.
v. The coverage under this Benefit Option shall cease once the DHCB Sum Insured is exhausted.
vi. The Benefit will be payable after the completion of each Medically Necessary continuous Hospitalisation for more than 24 hours as a result of Injury, sickness or disease subject to the limits specified above.
vii. A waiting period as mentioned under Part F (Clause 1) is applicable from the Effective Date, date of commencement of Scheme Member's coverage or revival of coverage whichever occurs later for availing the DHCB except for an Injury caused due to an Accident.

viii. The waiting period will not be applicable on subsequent renewals of the Certificate of Insurance under the same Master Policyholder.

B. Surgical Benefit ("SB") Option:

i. Surgical Benefit shall be payable, provided all the following conditions are satisfied:
   a. The Scheme Member has undergone any Medically Necessary Surgery of the 138 Surgeries listed in Annexure III;
   b. The Surgery is performed by a qualified surgeon for a Surgical operation;
   c. The Surgery is performed at a Hospital due to Injury or sickness for the covered Surgical Procedures and is advised by a Medical Practitioner; and
   d. The Surgery is performed during the Cover Term.
   e. Where more than one Surgeries are performed on the Scheme Member through the same incision or by making different incisions during the same surgical sessions, the Company shall only pay for any one of the Surgeries performed.

ii. In case the Scheme Member has to undergo a Surgery during the Cover Term, then the Benefit payable (a fixed % of SB Sum Insured) shall be ascertained on the basis of the category of the Surgery under Annexure III.

Category 1	Category 2	Category 3	Category 4
100% of the SB Sum Insured	60% of the SB Sum Insured	40% of the SB Sum Insured	20% of the SB Sum Insured

iii. The Scheme Member shall not be allowed to claim for the same Surgery more than once. However, multiple claims from the same category can be made.

iv. A waiting period as mentioned under Part F (Clause 1) is applicable from the Effective Date, date of commencement of Scheme Member's coverage or revival of the coverage whichever is later for availing SB except for an Injury caused due to an Accident.

v. The coverage under this Benefit Option shall cease once 100% of SB Sum Insured is paid against all valid claims during the Cover Term.

vi. Benefit payable towards any claim shall not exceed the Unclaimed Benefit Sum Insured.

C. Critical Illness Benefit Option:

i. This Benefit shall be payable to the Scheme Member in the event of:
   a. The Scheme Member being diagnosed on first occurrence of any of the Critical Illnesses during the Cover Term; or
   b. The Scheme Member undergoing any of the surgeries listed in the Categories below during the Cover Term.

ii. The Critical Illnesses covered under this Master Policy are as mentioned below:

Category A. Cardiac related
   1. Myocardial Infarction (First Heart Attack of specific severity)
   2. Open Heart Replacement or Repair of Heart Valves

Category B. Cancer related
   1. Cancer of specified severity

Category C. Others
   1. Kidney failure requiring regular dialysis
   2. Stroke resulting in permanent Symptoms

3. Alzheimer's Disease
4. Apallic Syndrome
5. Coma of specified severity
6. End Stage Liver Failure
7. End Stage Lung Failure
8. Loss of Independent Existence
9. Blindness
10. Third Degree Burns
11. Major Head Trauma
12. Parkinson's Disease
13. Permanent paralysis of limbs
14. Multiple Sclerosis with persisting Symptoms
15. Motor Neuron Disease with permanent Symptoms
16. Benign Brain Tumour
17. Major Organ/ Bone Marrow Transplant
18. Progressive Scleroderma
19. Muscular Dystrophy
20. Poliomyelitis
21. Loss of Limbs
22. Deafness
23. Loss of Speech
24. Medullary Cystic Disease
25. Systematic lupus Eryth with Renal Involvement
26. Aplastic Anaemia

iii. The Scheme Member must survive for a period of 30 days following the date of occurrence of the Critical Illness or undergoing Surgery covered under this Benefit, as the case may be, for the Benefit to be payable.

iv. If the diagnosis of the Critical Illness or undergoing Surgery covered under this Benefit, as the case may be, is within the Cover Term and the survival period crosses the end of the Cover Term, a valid claim arising as a result of such diagnosis or Surgery shall not be denied.

v. The coverage under this Benefit Option shall cease upon making a valid claim.

vi. For any claims made for Open Heart Replacement or Repair of Heart Valves, in addition to satisfying the criteria specified in the Definitions and Exclusions under Part F (Clause 1), the procedure or Surgery must be determined to be Medically Necessary by a Consultant Cardiologist / Surgeon and must be supported by relevant imaging findings & evidenced by established diagnostic reports.

vii. The Benefit amount under this Benefit Option shall be limited to 100% of the Critical Illness Benefit Sum Insured.

viii. The Benefit under this Benefit Option shall be subject to waiting period and exclusions under Part F of this Master Policy.

D. Critical Illness excluding Cancer Benefit Option:

i. This Benefit shall be payable to the Scheme Member on the occurrence of any of the following events during the Cover Term:

a. The Scheme Member being diagnosed on first occurrence of any of the Critical Illnesses in Category A and C of the Critical Illness Benefit Option during the Cover Term; or
b. The Scheme Member undergoing any of the surgeries listed in Category A and C of the Critical Illnesses during the Cover Term.

ii. The Scheme Member must survive for a period of 30 days following the date of diagnosis/Surgery of the Critical Illness or undergoing Surgery covered under this Benefit, as the case may be, for the Benefit to be payable.
iii. If the diagnosis of the Critical Illness in Category A and C of the Critical Illness Benefit Option is made within the Cover Term and the survival period crosses the end of the Cover Term, a valid claim arising as a result of such diagnosis shall not be denied.
iv. The coverage under this Benefit Option shall cease upon making a valid claim.
v. For any claims made for Open Heart Replacement or Repair of Heart Valves, in addition to satisfying the criteria specified in the Definitions and Exclusions under Part F (Clause 1), the procedure or Surgery must be determined to be Medically Necessary by a Consultant Cardiologist / Surgeon and must be supported by relevant imaging findings & evidenced by established diagnostic reports.
vi. The lump sum Benefit amount under this Benefit Option shall be limited to 100% of the Critical Illness excluding Cancer Benefit Sum Insured.
vii. The Benefit under this Benefit Option shall be subject to waiting period and exclusions under Part F of this Master Policy.

E. Critical Illness excluding Cardiac Benefit Option:

i. This Benefit shall be payable to the Scheme Member on the occurrence of any of the following events during the Cover Term:
   a. The Scheme Member being diagnosed on first occurrence of any of the Critical Illnesses in Category B and C of the Critical Illness Benefit Option; or
   b. The Scheme Member undergoing any of the surgeries listed in Category B and C of the Critical Illnesses during the Cover Term
ii. The Scheme Member must survive for a period of 30 days following the date diagnosis of the Critical Illness or undergoing Surgery covered under this Benefit, as the case may be, for the Benefit to be payable.
iii. If the diagnosis of the Critical Illness in Category B and C of the Critical Illness Benefit Option is made within the Cover Term and the survival period crosses the end of the Cover Term, a valid claim arising as a result of such diagnosis shall not be denied.
iv. The coverage under this Benefit Option shall cease upon making a valid claim.
v. The lump sum Benefit amount under this Benefit Option shall be limited to 100% of the Critical Illness excluding Cardiac Benefit Sum Insured.
vi. The Benefit under this Benefit Option shall be subject to waiting period and exclusions under Part F of this Master Policy.

F. Critical Illness excluding Cancer and Cardiac Benefit Option:

i. This Benefit shall be payable to the Scheme Member on the occurrence of any of the following events during the Cover Term:
   a. The Scheme Member being diagnosed on first occurrence of any of the Critical Illnesses in Category C of the Critical Illness Benefit Option; or

b. The Scheme Member undergoing any of the surgeries listed in Category C of the Critical Illnesses during the Cover Term

ii. The Scheme Member must survive for a period of 30 days following the date diagnosis of the Critical Illness or undergoing Surgery covered under this Benefit, as the case may be, for the Benefit to be payable.
iii. If the diagnosis of the Critical Illness in Category C of the Critical Illness Benefit Option is made within the Cover Term and the survival period crosses the end of the Cover Term, a valid claim arising as a result of such diagnosis shall not be denied.
iv. The coverage under this Benefit Option shall cease upon making a valid claim.
v. The Benefit amount under this Benefit Option shall be limited to 100% of the Critical Illness excluding Cancer and Cardiac Benefit Sum Insured.
vi. The Benefit under this Benefit Option shall be subject to waiting period and exclusions under Part F of this Master Policy.

G. Cancer Cover Option

i. This Benefit shall be payable to the Scheme Member on the diagnosis of the Scheme Member with any of the following during the Cover Term:
   - Early Stage Cancer
   - Carcinoma-in-situ (CIS)
   - Major Cancer.

ii. On diagnosis of Early Stage Cancer or CIS or Major Cancer during the Cover Term, subject to applicable exclusions, the following Benefits will be payable to the Scheme Member:

A lump sum Benefit, as per the table below:

Diagnosis of	**% of Applicable Cancer Cover Sum Insured**
Early Stage Cancer or CIS	25% **of Cancer Cover Sum Insured**
Major Cancer	100% **of Cancer Cover Sum Insured**less Early Stage Cancer or CIS claims, if any

iii. The Scheme Member has to survive for a period of 7 days from the date of the diagnosis for the Benefit under this Option to become payable.
iv. If the diagnosis is made within the Cover Term and the survival period crosses the end point of the Cover Term, a valid claim arising as a result of such a diagnosis shall not be denied.
v. Multiple claims can be made for diagnosis of Early Stage cancer or CIS occurring in a different body organ, part or system and not being classified as Secondary Cancer or Metastasis.
vi. Claim for recurrence of Early Stage Cancer or CIS in the same body organ, body part or system shall not be payable.
vii. Benefit payable towards any claim shall not exceed the Unclaimed Benefit Sum Insured.
viii. The coverage under this Benefit Option shall cease once 100% of Cancer Cover Sum Insured is paid.

ix. The Benefit under this Benefit Option shall be subject to waiting period and exclusions under Part F of this Master Policy.

H. Cardiac Cover Option

i. This Benefit shall be payable to the Scheme Member on the first occurrence/diagnosis of the conditions listed in Group A, B or C below or undergoing of the Surgery and subsequent recurrences of such conditions or undergoing of surgeries as listed in Group A, B or C below during the Cover Term:

Group A: High Severity conditions:

a. Myocardial Infarction (First Heart Attack – of Specific Severity)
b. Open Chest CABG
c. Open Heart Replacement or Repair of Heart Valves
d. Major Surgery of Aorta
e. Heart Transplant
f. Cardiomyopathy
g. Primary (Idiopathic) Pulmonary Hypertension

Group B: Moderate Severity conditions:

a. Surgery to place Ventricular Assist Devices or Total Artificial Hearts
b. Implantable Cardioverter Defibrillator (ICD)

Group C: Mild Severity conditions:

a. Pericardectomy
b. Minimally Invasive Surgery of Aorta
c. Angioplasty
d. Infective Endocarditis
e. Surgery for Cardiac Arrhythmia
f. Insertion of Pacemaker
g. Pulmonary Thrombo Embolism
h. Balloon Valvotomy or Valvuloplasty

ii. On occurrence of any of the abovementioned conditions, the following lump sum Benefit shall be payable to the Scheme Member:

On occurrence of conditions falling under:	**Lump sum Benefit as % of Cardiac Cover Sum Insured**
Group A	100 % **of Cardiac Cover Sum Insured**
Group B	50 % **of Cardiac Cover Sum Insured**
Group C	25 % **of Cardiac Cover Sum Insured**

iii. The claim under this Benefit Option will be paid only if the Scheme Member survives for a period of 30 days following the date of occurrence of any of the above condition.

iv. For any claims other than claims made for Pulmonary Thrombo Embolism, Myocardial Infarction (First Heart Attack of specific severity), Cardiomyopathy, Primary (Idiopathic) Pulmonary Hypertension and Infective Endocarditis, in addition to satisfying the criteria specified in the Definitions and Exclusions under Part F (Clause 1), the procedure or

Surgery must be determined to be Medically Necessary by a Consultant Cardiologist / Surgeon and must be supported by relevant imaging findings & evidenced by established diagnostic reports.

v. Multiple claims can be made only for condition/s falling under the Group B and C.

vi. Cooling off periods applicable after occurrence of conditions covered under Group A, B and C under this Benefit option ("Covered Condition") resulting into valid claim and corresponding benefit amount are given below:

Scenario 1: Recurrence of Covered Condition

Cooling off period	365 days
Benefit amount	Nil

Scenario 2: Occurrence of other Covered Condition from the same or lower severity category

Cooling off period	90 days
Benefit amount	Nil

Scenario 3: Occurrence of other Covered Condition from higher severity category

Cooling off period	90 days
Benefit amount	Applicable benefit amount less claims made during immediately preceding 90 days

Scenario 4: Occurrence of other Covered Condition not related to any disease/disorder of the heart or Covered Condition/s, claimed earlier. This must be certified by a cardiologist appointed by the Company. The cost of certification shall be borne by the Company.

Cooling off period	Nil
Benefit amount	Applicable Benefit amount

For a given claim due to one of the Covered Conditions, the remaining Covered Conditions are referred to as "other Covered Conditions"

The aforesaid cooling off period shall apply afresh on each valid claim.

vii. In an event where more than one covered condition occurs, the claim shall be payable for only one covered condition.

viii. Benefit payable towards any claim shall not exceed the Unclaimed Benefit Sum Insured.

ix. The coverage under this Benefit Option shall cease once 100% of Cardiac Cover Sum Insured is paid.

I. Personal Accidental Cover ("PAC") Option

The following Benefits are offered under this Option:

i. **Accidental Death Benefit:**
   a. In case of Accidental Death of the Scheme Member during the Cover Term, one hundred percent (100%) of the PAC Sum Insured shall be payable to the his/her Nominee
   b. Accidental Death means death by or due to a bodily Injury caused by an Accident, independent of all other causes of death.
   c. Accidental Death must be caused within 180 days of any bodily Injury. If the bodily injury occurs within the Cover Term and the Accidental Death is caused after the Cover Term but within 180 days of the bodily injury, a valid claim arising as a result of such Accidental Death shall not be denied.
   d. Once the Benefit amount is claimed, the coverage under PAC Option shall terminate.
   e. In lieu of lumpsum benefit amount for Accidental Death, depending upon the payout option chosen, the Nominee may receive Benefit as:
      - Regular monthly Income equal to 1% of PAC Sum Insured payable for 10 years, or
      - Part of Benefit amount as lump sum immediately on Accidental Death and regular monthly income @ 1% of balance benefit amount (i.e.,100% of PAC Sum Insured as reduced by part lump sum already paid) for 10 years
   f. The choice of benefit payout as lumpsum or income or combination thereof can be exercised on or before the claim is made.

ii. **Income Benefit on Accidental Disability:**
   a. On the Total Permanent Disability of the Scheme Member due to an Accident i.e. ATPD during the Cover Term, a regular monthly income equal to 1% of the PAC Sum Insured shall be payable for a period of 10 years subject to point (c) under ATPD. In case of death of the Scheme Member during the payout period the Income Benefit shall be payable to the Nominee.
   b. Total Permanent Disability means the condition when the Scheme Member is totally, continuously and permanently disabled and meets either of the two definitions below:

(1) Unable to work:
Disability as a result of Injury or Accident and is thereby rendered totally incapable of being engaged in any work or any occupation or employment for any compensation, remuneration or profit and he/she is unlikely to ever be able to do so.

(2) Physical Impairments:
The Scheme Member suffers an Injury/Accident due to which there is total and irrecoverable loss of:
(a) The use of two limbs; or
(b) The sight of both eyes; or
(c) The use of one limb and the sight of one eye; or
(d) Loss by severance of two or more limbs at or above wrists or ankles; or

(e) Sight of one eye and loss by severance of one limb at or above wrist or ankle.

c. The disabilities as stated above in points (1) and (2) above must have lasted, without interruption, for at least 6 consecutive months and must, in the opinion of a Medical Practitioner be deemed permanent.
d. The benefit shall commence upon the completion of this uninterrupted period of 6 months. However, for the disabilities mentioned in (d) and (e) under point (2) above, such 6 months period would not be applicable and the Benefit shall be payable immediately.
e. Once the PAC Sum Insured is claimed under ATPD, the coverage under PAC Option shall terminate.

iii. **Accidental Partial Permanent Disability (APPD):**
If at any time during the Cover Term, the Scheme Member sustains any bodily Injury resulting solely and directly from an Accident, the following Benefit shall be payable:
a. If such Injury shall, within twelve months of its occurrence be the sole and direct cause of the total and irrecoverable loss by physical separation of one entire hand or of one entire foot, 50% of the PAC Sum Insured shall be payable.
b. If such Injury shall within twelve months of its occurrence be the sole and direct cause of the total and /or partial and irrecoverable loss of use or of the actual loss by physical separation of the following, then the percentage of the PAC Sum Insured as indicated below shall be payable:

Disability	***Benefit as a % of PAC Sum Insured***
Permanent total loss of hearing in both ears	75
Permanent total loss of use of one limb other than by physical separation or Permanent total loss of sight of one eye	50
Permanent total loss of use of four fingers and thumb of either hand	40
Permanent total loss of hearing in one ear or Permanent total loss of the lens in one eye	25
Permanent total loss of use of four fingers of either hand or Permanent total loss of use of one thumb of either hand or Ankylosis of the elbow, hip or knee	20
Permanent total loss of use of all toes	15
Permanent total loss of one finger of either hand	10

or Established non-union of fractured leg or kneecap	

c. The maximum Benefit payable to Scheme Member is limited to PAC Sum Insured. The coverage under this Option shall cease once the maximum Benefit has been claimed.
d. The disabilities as stated under clause iii(b) above must have lasted, without interruption, for at least 6 consecutive months and must, in the opinion of a Medical practitioner, be deemed permanent. However, for the disabilities mentioned in clause iii (a) above, such 6 months period would not be applicable.
e. In lieu of lumpsum benefit amount for APPD, depending upon the payout option chosen, the Scheme Member may choose to receive Benefit as:
    - Regular monthly Income equal to 1% of Benefit amount payable for 10 years, or
    - Part of Benefit amount as lump sum and a regular monthly income @ 1% of balance benefit amount (i.e.,100% of APPD claim entitlement as reduced by part lump sum already paid) for 10 years
f. The choice of benefit payout as lumpsum or income or combination thereof can be exercised on or before the claim is made.

Additional conditions applicable to all three Benefits under PAC Option:

a. If ATPD occurs after APPD, then 1% of the remaining amount (100% of PAC Sum Insured – APPD claims paid) shall be paid as a regular monthly income for 10 years.
b. If Accidental Death happens after APPD, then the remaining amount (100% of PAC Sum Insured - APPD claims paid) shall be paid as lump sum.
c. No Benefit shall be payable for Accidental Death and APPD following ATPD claim.
d. Benefit payable towards any claim shall not exceed the Unclaimed Benefit Sum Insured.
e. During the income period, future income payments or part thereof can be surrendered in exchange for a lump sum. This lump sum shall be discounted value of the future income payments at the prevailing revival rate charged by the Company.

2. Maturity Benefit

No Benefit is paid on maturity to the Scheme Member.

3. Death Benefit

No Benefit is payable on death other than Accidental Death as specified under Personal Accident Cover Option and as opted by the Master Policyholder or the Scheme Member.

4. Benefits on Surrender

i. Surrender Value as given below shall get immediately acquired on the Effective Date depending on scheme rules:

$$Max\ \{(PP - C - SAE - PRE - UWC), 0\}\ x\left(1 - \frac{D_E}{D_P}\right)$$

Term	Definition
PP	Premiums paid net of taxes since coverage inception / renewal
C	Commission paid since coverage inception / renewal
SAE	Re. 0.07 per thousand Rupees of Sum Insured
PRE	Premium Related Expenses
UWC	Underwriting cost. This shall be zero for surrender after 1st coverage period.
D_E	Elapsed days since coverage inception / renewal
D_P	Days for which premium is paid since coverage inception / renewal

ii. No surrender value shall be payable with respect to the Scheme Member for whom valid claims are made during the Cover Term.
iii. In case of surrender of the Master Policy, the Scheme Members shall have an option to continue the policy as an individual policy till the expiry of the term of the COI.

5. Lapse/Paid-Up Benefits

No paid-up Benefits are paid under the policy. On cessation of premiums during the Premium Paying Term, the Master Policy will lapse without value.

6. Eligibility:

(1) Any person who satisfies all of the following conditions shall be eligible to participate in the Scheme.
   a) Person is not aged less than 18 years (1 year for Daily Hospital Cash Benefit, Surgical Benefit and Personal Accidental Cover) foras set out in the Schedule,
   b) Person is not aged more than 69 years as at Entry Date as set out in the Schedule,
   c) Person who satisfies further eligibility criteria, as may be specified in the Schedule by the Insurer,
   d) Person who satisfies the underwriting requirements of the Insurer on his/her Entry Date and

(2) Continuing to participate in the Scheme.

a) No Scheme Member shall withdraw from the Scheme so long as he satisfies the conditions of Eligibility described above.
b) In case of employer – employee schemes, if the relationship between the Scheme Member and the Master Policyholder terminates then the Scheme Member shall no longer be eligible to continue to participate in the Scheme.

7. Commencement of Insurance:

(1) On the Effective Date and each Latest Annual Renewal Date, the Insurer shall grant Insurance in accordance with these provisions in respect of each person who is an Eligible Person on that date and who is accepted by the Insurer as a Scheme Member. In the event of any other person becoming an Eligible Person during the Policy Year and the requisite Premium and Taxes being received in full by the Insurer, he shall be accepted as a Scheme Member by the Insurer immediately on the Insurer being notified and being satisfied that such person has met all the conditions of eligibility. For this purpose, the Master Policyholder shall notify the Insurer in writing in such form and at such times as shall be prescribed by the Insurer, the names and full particulars of the persons as soon as they meet the eligibility conditions.

(2) The Master Policy is annually renewable and can be renewed by the Master Policyholder. In case the Master Policy is renewed within grace period, fresh waiting period will not apply for the Scheme Members who have already served the waiting period. In case the Master Policyholder does not renew the Master Policy, the Scheme Member will be provided an option to continue the cover till the end of Policy Term for the mid joiners.

8. Provision of information:

(1) Before assuring any Benefit 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 required/specified by the Insurer.
(2) In the event of any change in the name or other particulars of a Scheme Member during a Policy Year, the Master Policyholder must inform the Insurer of the change within 15 days of being informed of the same by the said Scheme Member or on the Master Policyholder becoming aware of the same, whichever is earlier**.**
(3) In the event of a Scheme Member ceasing to be eligible, the Master Policyholder must inform the Insurer of that event, within 30 days of that event. In the event of any person becoming an Eligible Person after the Effective Date, the Master Policyholder must inform the Insurer within 30 days of that event.
(4) Subject to Section 45 of the Insurance Act 1938, and as amended from time to time, if any information, data or evidence in respect of the Scheme Member that is given to the Insurer proves to be incorrect, the particular Insurance in respect of such Scheme Member shall be rendered voidable, at the instance of the Insurer.
(5) 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. Where a loss of Benefit is due to an error or omission by the Master Policyholder and the Insurer is required to pay for the Benefit in full, the Insurer will

pay the Benefit in full and seek compensation for the error from the Master Policyholder.

(6) The Master Policyholder shall arrange to submit to the Insurer evidence of age in respect of each Scheme Member at the time of entry into the Scheme, if required by the Insurer.

(7) Satisfactory evidence of health as required by the Insurer shall be furnished by every Eligible Person at the time of his entry into the Scheme. The terms of acceptance may be varied if in the opinion of the Insurer the evidence of health is not satisfactory or other special hazards exist.

9. Premiums:

(1) Prior to the Effective Date/Next Annual Renewal Date, the Insurer shall advise the Master Policyholder of the Premium and Taxes due, based on the information provided by the Master Policyholder.

(2) The Master Policyholder can request to have the Sum Assured revised in respect of a Scheme Member. A revision to the Sum Assured will be subject to the approval of the Insurer and payment of the additional premium.

(3) New Scheme Members can join the Scheme during the Policy Year at any well-defined date and existing Scheme Members can leave the Scheme. Premiums shall be collected in advance of cover being provided.

(4) Scheme Members joining the Scheme during the Policy Year will be charged the Premium and Taxes proportionate to the duration the Scheme Member is covered during the Policy Year.

(5) At Scheme level, the Insurer may permit individual Scheme Members to be covered for 1 year from their Scheme joining date.

(6) The Premium rate due would be valid for the relevant Policy Year and the Premium rates would be subject to change in each Policy Year.

(7) "Active Rewards" Discount shall be offered at each renewal of Benefit Option other than PAC Option, if the Scheme Member achieves the average step count target on the mobile application provided by us (or affiliated with us). The discount percentage (%) would be applied on gross Premium for Scheme Member as per the table below:

Average Daily Step Count	**Renewal Discount**
Upto 5,000	0%
5,001 to 8,000	2%
8,001 to 10,000	5%
Above 10,000	8%

To avail this benefit, the Scheme Member needs to download and register on the mobile application within 30 days of the date of commencement of Scheme Member's coverage. The average step count completed by a Scheme Member shall be tracked on this mobile application.

Average daily step count for each policy quarter shall be registered. Quarterly prorated discount entitlement shall be ascertained for average daily step count achieved in each quarter. Discount on renewal shall be aggregate of all 4 quarterly discount entitlements.

While determining a discount, the Company shall not consider any step count that could have been manipulated to take advantage of this feature. The Company reserves the right to remove or reduce any count of steps if found to be achieved in unfair manner by manipulation. The Company's decision with respect to the step count or the discount shall be final.

Part D

1. **Termination of Insurance:**
The Insurance on the life of a Scheme Member shall immediately terminate upon the happening of any of the following events and no Benefits will be payable thereafter:
(i) Free Look Cancellation,
(ii) death of the Scheme Member except in case of Personal Accident Cover,
(iii) the Scheme Member ceases to be Eligible Person under the Scheme,
(iv) expiry of Cover Term, or
(v) payment of all Benefit Sum Insured as provided in the COI.
(vi) Surrender by the Scheme Member

2. **Renewal:**
(i) The Master Policy is yearly renewable. Renewal of coverage under the Benefit Option(s) for individual members shall be subject to the Board Approved Underwriting Policy (BAUP).
(ii) If the Master Policy is renewed within grace period for renewal, only the remaining part of waiting period will apply.

3. **Revival:**
(i) For policies other than annual premium payment mode policies, if the Premium is not received even after the completion of the grace period, coverage under COI lapses. We will consider requests from the Master Policyholder to revive the lapsed COI, provided such request is received within the outstanding period in the Cover Term.
(ii) The revival shall be subject to the BAUP and payment of unpaid premiums.
(iii) If the COI is revived within 60 days of lapsation, due to non-payment of premium, only the remaining part of waiting period shall apply.
(iv) In case of revival of COI after 60 days of lapsation due to the non-payment of premium, the waiting period shall apply afresh.
(v) The claims, if any occurring during the period of lapsation due to the non-payment of premium shall not be payable.

4. **Terms and Conditions:**
(i) The Insurer has the right to discontinue the Master Policy, on the Next Annual Renewal Date, with prior intimation, given in writing, to the Master Policyholder. On the same date, the Insurer also has the right to vary the Master Policy provisions and the Schedule after intimating the Master Policyholder in writing.
(ii) 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 Cover Term.
(iii) Scheme Members shall not be allowed to alter or amend Benefits once their respective Certificate of Insurance has been issued except to correct any factual error.
(iv) The Insurer may conduct, at its sole discretion, a surprise inspection of the records of the Master Policyholder to ensure compliance with these Policy provisions and

Scheme rules or alternatively allow the Master Policyholder's auditors to certify compliance with the same.

(v) The Master Policyholder will act for and on behalf of the Scheme Members in all matters relating to the Scheme and every act done by the Master Policyholder shall be binding on the Scheme Members.

5. Loans:

There is no facility of loan available from us under this Master Policy.

6. 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, , a period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If Master Policyholder is not satisfied with any of the terms and conditions, Master Policyholder has the option to cancel the policy (2) Irrespective of the reasons mentioned, the policyholder shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges (3) On receipt of the letter along with the Master Policy Document, we shall arrange to refund the premium paid by you, subject to deduction of the proportionate risk premium for period on cover plus the expenses incurred by us on stamp duty (if any)

By Scheme Member:

(1) In case the Member is not satisfied with the terms and conditions specified in the Certificate of Insurance, a period of 30 days (from the date of receipt of the policy document) is available to the policyholder to review the terms and conditions of the policy. If he/she is not satisfied with any of the terms and conditions, he/she has the option to cancel his/her policy

(2) Irrespective of the reasons mentioned, the policyholder 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.

7. Grace Period:

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

Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.
Grace period allowed for renewal of the coverage is 30 days from the expiry of the Cover Term. If the coverage is not renewed before the expiry of the grace period, the coverage shall lapse on expiry and any claims that occur after expiry of coverage period shall not be admissible.

Grace period allowed for payment of premiums is 15 days for monthly premium payment mode and 30 days for quarterly and half-yearly premium payment mode. The policy is considered to be in-force with the risk cover during the grace period without any interruption.

Part E

1. **Additional Servicing Charges**
   Nil

Part F

1. Waiting Period and Exclusions:

(i) 60 days waiting period for Daily Hospital Cash Benefit & Surgical Benefit

Daily Hospital Cash Benefit and / or Surgical Benefit shall not be payable for any treatment of illness/ailment/disease diagnosed or Hospitalisation taking place within 60 days from Effective Date or revival of cover whichever occurs later. This waiting period shall not apply for covered Surgical Procedures for Injury due to Accident or Hospitalisation arising out of Accident.

(ii) 90 days waiting period for Critical Illness Benefit

No Benefit shall be paid in case the Scheme Member is diagnosed with any of the applicable listed Critical Illnesses within 90 days from the Effective Date or revival of cover whichever occurs later except in cases where the Critical Illness occurs as a result of an Accident (such as Major Head Trauma).

(iii) 180 days waiting period for Cancer Cover and Cardiac Cover

No Benefit for Cancer Cover and / or Cardiac Cover shall be paid in case the Scheme Member is diagnosed with any of the condition covered under Cancer Cover and Cardiac Cover within 180 days from the Effective Date or revival of coverage, whichever occurs later.

(iv) Waiting period for Daily Hospital Cash Benefit & Surgical Benefit

In case of Hospitalisation or treatment of any of the following Injury, sickness, diseases or Surgical Procedure and any complications arising out of them during the waiting period as applicable based on the list below from the Effective Date of cover or revival of coverage, whichever occurs later, the Daily Hospital Cash Benefit or Surgical Benefit will not be payable.

Sr. No.	Injury / Sickness / Disease / Surgical Procedure 1 year waiting list
1	Tonsillitis / Adenoiditis
2	Hernia (Inguinal / Ventral / Umbilical / Incisional)
3	Hydrocoele / Varicocoele / Spermatocoele
4	Piles / Fissure / Fistula / Rectal prolapsed
5	Benign Enlargement of Prostrate
6	Degenerative joint conditions
7	Lumps, nodules, cysts and polyps
8	Chronic Suppurative Otitis Media / Tympanoplasty

Sr no.	Injury / Sickness / Disease / Surgical Procedure 2 year waiting list
1	Cataract
2	Menstrual irregularities
3	Hysterectomy or Myomectomy for benign conditions
4	Deviated Nasal Septum /Sinusitis
5	Thyroid Nodule / Multi Nodular Goitre
6	Cholecystitis or stones of the gall bladder / pancreatic system

7	Stones of the urinary tract
8	Treatment of Prolapsed Inter Vertebral Disc
9	Diabetes and it's complications

(v) Pre-Existing Disease for Daily Hospital Cash Benefit & Surgical Benefit

Benefits under Daily Hospital Cash Benefit & Surgical Benefit will not be available for any Pre-Existing Disease, until the Scheme Member has been continuously insured for a period of 36 months prior to the date of commencement of the policy issued by the insurer **Permanent Exclusions**

a. General Permanent Exclusions

These shall not apply for Personal Accidental Cover Option

Unless expressly stated to the contrary in this Master Policy, we will not make any payment for any claim in respect of any Scheme Member if it is directly or indirectly-caused by, arises from or is in any way attributable to any of the following:

1. External Congenital Anomaly: Treatment for external congenital disease or deformity, including physical defects present from birth will not be covered by the Master Policy.
2. Hospitalisation and/or Surgery is/are not in accordance with the diagnosis and treatment of the condition for which the hospital confinement or Surgery was required;
3. Diagnosis or Hospitalisation and / or treatment within the waiting period for the respective covered Benefit;
4. Hospitalisation following the diagnosis in the Waiting Period
5. Elective Surgery or treatment which is not medically necessary;
6. Weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition;
7. Study and treatment of sleep apnea;
8. Routine eye tests, any dental treatment or Surgery of cosmetic nature, extraction of impacted tooth/teeth, orthodontics or orthognathic Surgery, or tempero-mandibular joint disorder except as necessitated by an accidental Injury and warranting Hospitalisation.
9. Outpatient treatment
10. Hospitalisation and/or Surgery relating to infertility or impotency, sex change or any treatment related to it, abortion, sterilization and contraception including any complications relating thereto;
11. Hospitalisation and/or Surgery for treatment arising from pregnancy and its complications which shall include childbirth or miscarriage;
12. Hospitalisation primarily for any purpose which in routine could have been carried out on an out-patient basis and which is not followed by an active treatment or intervention during the period of Hospitalisation.
13. Experimental or unproven procedures or treatments, devices or pharmacological regimens of any description (not recognized by Indian Medical Council) or Hospitalisation for treatment under any system other than allopathy;
14. Admission to a nursing home or home for the care of the aged unless related to the treatment of an acute medical condition;

15. Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long term nursing care or custodial care and general debility or exhaustion (run down condition);
16. The influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
17. Directly or indirectly arising from or consequent upon war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, terrorism, rebellion, active participation in strikes, riots or civil commotion, revolution, insurrection or military or usurped power;
18. Cosmetic or plastic Surgery except to the extent that such Surgery is necessary for the repair of damage caused solely by accidental injuries, cancer or burns.
19. Treatment of xanthelesema, syringoma, acne and alopecia; circumcision unless necessary for treatment of a disease or necessitated due to an accident
20. Nuclear disaster, radioactive contamination and/or release of nuclear or atomic energy;
21. Intentional self-inflicted injuries; or any attempts of suicide while sane or insane; or deliberate exposure to exceptional danger (except in an attempt to save human life);
22. Violation or attempted violation of the law or resistance to arrest or by active participation in an act with criminal intent;
23. Participation in professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, and any other hazardous activities or sports unless agreed by special endorsement;
24. Hospitalisation where the Scheme Member is a donor for any organ transplant;
25. Aviation, gliding or any form of aerial flight other than other than on a scheduled commercial airline as a bona fide passenger (whether fare paying or not), pilot or crew member.
26. Any sickness classified as an epidemic by the Central or State government.
27. Non allopathic modes of treatment which are not approved by a medical practitioner.
28. Treatment to relieve Symptoms caused by ageing, puberty, or other natural physiological cause, such as menopause and hearing loss caused by maturing or ageing.
29. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
30. Treatment of abnormalities, deformities, or Illnesses present only because they have been passed down through the generations of the family.
31. Failure to seek or follow medical advice as recommended by a Medical Practitioner
32. Delaying of medical treatment in order to circumvent the waiting period

b. Specific Permanent Exclusions
In addition to the General Permanent Exclusions, the following shall be applicable:

1. No Critical Illness Benefit (or any variant of Critical Illness Benefit) will be payable for any of the following:
    1. The coverage shall terminate and no Benefit will be payable on diagnosis of any Critical Illness and/or hospitalization and/or treatment (availed or advised) thereof within 90 days of the commencement or date of revival of cover, whichever is later except in cases where the Critical Illness occurs as a result of an Accident (such as Major Head Trauma).Upon such termination, premium paid for Critical Illness Benefit since date of commencement of cover shall be refunded.However, no refund shall be made where coverage is called in question on the grounds as provided under sec. 45 of the Insurance Act, 1938 as amended from time to time.
    2. Critical Illness Benefit, where death occurs within 30 days of the date of diagnosis of Critical Illness
    3. Any more than one claim in respect of Critical Illness Benefit
    4. Any Pre-existing Disease

2. No Benefit shall be payable under this Master Policy in respect of any Major Cancer, Carcinoma-in-situ or Early Stage Cancer resulting directly or indirectly from or caused or contributed by (in whole or in part):
    1. Condition occurring within 180 days of risk commencement date or revival date (i.e. during the waiting period). In case of diagnosis of a Cancer contracted during the waiting period, the coverage shall terminate. Upon such termination, premium paid for Cancer Cover since date of commencement of cover shall be refunded.
    However, no refund shall be made where coverage is called in question on the grounds as provided under sec. 45 of the Insurance Act, 1938 as amended from time to time.
    2. Any Pre-existing Disease.

3. Unless expressly stated to the contrary in this Master Policy, no Benefit shall be paid for Cardiac Cover in respect of any Scheme Member if it is directly or indirectly- caused by or aggravated directly or indirectly by or arises from or is in any way attributable to any of the following:
    1. Pre-Existing Disease. Any investigation or treatment for any Illness, disorder, complication or ailment arising out of or connected with the Pre-existing Disease shall be considered part of that Pre-existing Disease. No Benefits will be payable for any condition(s) which is a direct or indirect result of any Pre-existing Disease unless Scheme Member has disclosed the same at the time of proposal or date of revival whichever is later and the company has accepted the same.
    2. The coverage shall terminate and no Benefit will be payable for diagnosis and/or hospitalization and/or treatment (availed or advised) of any disease/disorder of the heart within the waiting period.
    Upon such termination, premium paid for Cardiac Coversince risk commencement date shall be refunded.

However, no refund shall be made where coverage is called question on the grounds as provided under sec. 45 of the Insurance Act, 1938 as amended from time to time.

4. Unless expressly stated to the contrary in this Policy, no Benefit shall be paid for any claim under Personal Accidental Cover in respect of any Scheme Member if it is directly or indirectly- caused by, arises from or is in any way attributable to any of the following:
   i. The influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner.
   ii. Directly or indirectly arising from or consequent upon war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, terrorism, rebellion, active participation in strikes, riots or civil commotion, revolution, insurrection or military or usurped power;
   iii. Nuclear disaster, radioactive contamination and/or release of nuclear or atomic energy;
   iv. Intentional self-inflicted injuries; or any attempts of suicide while sane or insane; or deliberate exposure to exceptional danger (except in an attempt to save human life);
   v. Violation or attempted violation of the law or resistance to arrest or by active participation in an act with criminal intent;
   vi. Participation in professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, and any other hazardous activities or sports unless agreed by special endorsement;
   vii. Aviation, gliding or any form of aerial flight other than on a scheduled commercial airline as a bona fide passenger (whether fare paying or not), pilot or crew member.
   viii. Any Pre-existing disease

5. No Accidental Death Benefit will be payable if the death of Scheme Member occurs after 180 days from the date of Accident.
6. No Cancer Cover will be payable if Scheme Member does not survives for 7 days after the "full histopathological diagnosis" of the cancer, including stage and grading.
7. No Cardiac Cover will be payable where death occurs within 30 days of the date of diagnosis of conditions covered under Cardiac Cover Option.
8. Where a Scheme Member is found to be suffering from permanent or time-bound exclusions and the coverage is issued as per the Company's BAUP, the claim shall not be denied on the grounds of the said permanent or time-bound exclusions noticed at the proposal stage.

2. Claims Procedure:

All claim documents should be submitted within 60 days of the claim having occurred or after the waiting period for the particular Benefit has elapsed, whichever is later. However, we may condone the delay in claim intimation, if any, where the delay is proved to be for reasons

beyond the control of the claimant. The following should be undertaken within 60 days to register a claim under this Master Policy:

a. The following documents are required to be mandatorily submitted
   1. Duly filled and signed claim form inclusive of NEFT details in original.
   2. Cancelled personalized cheque, in original
   3. Attested copy of the first page of the bank pass book in case the cheque is not personalized.
   4. Copy of final discharge summary
   5. Copy of final Hospital bill
   6. Copies of all medical consultation reports
   7. Investigation reports in original – blood test reports, X-Rays, Ultrasounds and other radiological investigation reports
   8. Copies of operation theatre notes (wherever applicable)
   9. ID and address proof (if the claim amount is greater than Rs. 1 lakh)
   10. Disability certificate from the designated authority in your city / state
   11. Any other document or investigation report as specified in the Master Policy.

   Depending on the Benefit being claimed for, additional documents may be called.
b. On payment of all Benefit Sum Insured as provided in the COI, the coverage for the Scheme Member shall terminate.
c. All claims need to be submitted to HDFC Life at Health Claims Department, HDFC Life Insurance Company Limited, 11th Floor, LodhaExcelus, Apollo Mills Compound. N.M. Joshi Road, Mahalaxmi, Maharashtra, Mumbai – 400011.
d. A claim under the Master Policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of last necessary document.
e. Where there is a delay on the part of the Company in processing a claim for reasons other than improper identification of the Scheme Member or Nominee, the Company shall pay interest on the claim amount from the date of receipt of last necessary document to the date of payment of claim at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it (or as notified by IRDAI from time to time).
f. Where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation within 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document. In case of delay beyond stipulated 45 days the Company shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim (or as notified by IRDAI from time to time).

3. Assignment

Neither the Master Policy nor the COI can be assigned.

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 I** for reference.

5. **Issuance of Duplicate Master Policy:**
The Master Policyholder may request for a duplicate copy of the Master Policy at HDFC Life offices along with relevant documents. Additional charges may be applicable for issuance of the duplicate Master Policy. While making an application for duplicate Master Policy the Master Policyholder is required to submit a notarized original indemnity bond on stamp paper.

6. **Age Admitted**
The Company has calculated the Premiums under the Master Policy on the basis of the age of the Scheme Member as declared in the Proposal. In case proof of age of the Scheme Member has not been provided with the Proposal, the Master Policyholder will be required to furnish such proof of age as is acceptable to us and have the age admitted. In the event the age so admitted ("Correct Age") during the Cover Term is found to be different from the age declared in the Proposal, without prejudice to our rights and remedies including those under the Insurance Act, 1938, as amended from time to time we shall take one of the following actions
(i) If eligible, and if the Correct Age is found to be higher, the Benefit payable under this Master Policy, Rider, if any, shall be after deduction of such difference of Premium (i.e. difference in Premium paid based on age declared in the Proposal and Premium based on the Correct Age) along with interest thereon. In such cases, before calculating the amount of Benefit payable, the Scheme Member shall be subject to re-underwriting and the Sum Insured shall be subject to eligibility as per underwriting norms and the Premium to be deducted shall be calculated proportionately on such Sum Insured payable. If the Correct Age is found to be lower, excess Premiums without any interest shall be refunded.
(ii) If ineligible for the Scheme basis the Correct Age, the Insurance cover for the Scheme Member shall be void-ab-initio and the total Premiums paid shall be refunded without interest after deducting all applicable charges like medical, Stamp Duty, risk etc.

7. **Withdrawal of Product**
This product may be withdrawn by the Company in the future. Any withdrawal will only be done after obtaining prior approval from the IRDAI. The options available to the Master Policyholder on such withdrawal of the Product will be as per approval granted by IRDAI and may include the option to shift to a similar product available with us at that time.

8. **Alterations:**
New Scheme Members can be admitted for Insurance under the Master Policy during the Policy Year at any well-defined date and existing Scheme Members can leave the Master Policy.

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 II** for reference.

10. **Taxes**

a. Indirect Taxes
Taxes and levies as applicable shall be levied. Any taxes, statutory levy becoming applicable in future may become payable by the Master Policyholder by any method including by levy of an additional monetary amount in addition to Premium and or charges.

b. Direct Taxes
Tax will be deducted at the applicable rate from the payments made under the Master Policy, as per the prevailing provisions of the Income Tax Act, 1961.

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

(1) This Master Policy is subject to-
(i) The Insurance Act, 1938 as amended from time to time,
(ii) Amendments, modifications (including re-enactment) as may be made from time to time, and
(iii) 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 Master Policy provisions / terms and conditions in accordance with changes in applicable regulations or Laws and where required, with IRDAI's approval.

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

13. Notices:
Any notice, direction or instruction given to us, under the Master Policy, shall be in writing and delivered by hand, post, facsimile or from registered electronic mail ID to:

HDFC Life Insurance Company Limited, 11th Floor, LodhaExcelus, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400011.

Registered Office: LodhaExcelus, 13th Floor, Apollo Mills Compound, N.M. Joshi Marg, Mahalaxmi, Mumbai - 400011.
E-mail: groupoperations@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 Master Policy, shall be in writing and delivered by hand, post, courier, facsimile or registered electronic 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.

14. General:

(1) Any information needed to administer the Master 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 provisions if it becomes impossible or impractical to observe or execute them.

(4) The Master Policyholder will be responsible and liable for making payment, including payment of Benefits, in the appropriate form to the Scheme Member(s) or to his/her nominee or to another scheme as transfer value as applicable.

(5) The Insurer can check/inspect/audit, at any time, if the Benefits are being paid to the correct person as and when due.

Part G
Grievance Redressal Mechanism

1. Complaint Resolution Process

(i) The customer can contact us on the below mentioned address or at any of our branches in case of any complaint/ grievance:
Grievance Redressal Officer
HDFC Life Insurance Company Limited
11th Floor, LodhaExcelus, Apollo Mills Compound,
N. M. Joshi Marg, Mahalaxmi, Mumbai, Maharashtra - 400011
Tel: 022-67516666, Helpline number: 18602679999 (Local charges apply)
E-mail: service@hdfclife.com
Our senior citizen customers can now avail of a privileged service to have their query/grievance addressed by simply giving a missed call on 8000006607 from their registered phone number. One of our specialists will call back to assist further.

(ii) All grievances (Service and sales) received by the Company will be responded to within the prescribed regulatory Turn Around Time (TAT) of 15 days.

(iii) Written request or email from the registered email id is mandatory.

(iv) If required, we will investigate the complaints by taking inputs from the customer over the telephone or through personal meetings.

(v) We will issue an acknowledgement letter to the customer within 3 working days of the receipt of complaint.

(vi) The acknowledgement that is sent to the customer has the details of the complaint number, the Policy number and the Grievance Redressal Officer's name who will be handling the complaint of the customer.

(vii) If the customer's complaint is addressed within 3 days, the resolution communication will also act as the acknowledgment of the complaint.

(viii) The final letter of resolution will offer redressal or rejection of the complaint along with the appropriate reason for the same.

(ix) In case the customer 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.

(x) 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	Designation	Response Time
1st Level	Associate Vice President – Customer Relations	10 working days
2nd Level (for response not received from Level 1)	Sr. Vice President – Customer Relations	7 working days

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

(xi) If you are not satisfied with the response or do not receive a response from us within 15 days, you may approach the Grievance Cell of IRDAI on the following contact details:

- IRDAI Grievance Call Centre (IGCC) TOLL FREE NO: 155255 / 18004254732
- Email ID: complaints@irda.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,
  Consumer Affairs Department - Grievance Redressal Cell
  Insurance Regulatory and Development Authority of India
  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 below. You are requested to refer to the IRDAI website at "www.irdai.gov.in" for the updated details.

a. 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@ecoi.co.in	Gujarat , Dadra & Nagar Haveli, Daman and Diu
BHOPAL	Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh & Chhattisgarh

BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa
BENGALURU	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.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 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , Chandigarh
CHENNAI	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, AnnaSalai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry)
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura

	Email: bimalokpal.guwahati@ecoi.co.in	
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 - 67504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanamand part of Territory of Pondicherry
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM	Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe – a part of Pondicherry
KOLKATA	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands
LUCKNOW	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh :Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur,

		Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar
MUMBAI	Office of the Insurance Ombudsman, 3rd Floor, Jeevan SevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
NOIDA	Office of the Insurance Ombudsman, BhagwanSahaiPalace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun,

		Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
PATNA	Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in.	Bihar, Jharkhand
PUNE	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

b. 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 (C) provided herein below.

c. 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 Company rejecting the representation is received; orafter receipt of decision of the Company which is not to the satisfaction of the complainant;

ii. 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.

Annexure I

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 II

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. the date of commencement of risk or c. the date of Revival of policy or d. the date of rider to the policy whichever is later.

(2) On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from a. the date of issuance of policy or b. the date of commencement of risk or c. the date of Revival of policy or d. the date of rider to the policy whichever is later.
For this, the insurer should communicate in writing to the insured or legal representative or nominee or assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.

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

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

(5) No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / 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, 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 - List of Surgeries

CATEGORY 1

Sr No	Surgery	Sr No	Surgery
1	Surgery of the Aorta	9	Bone Marrow transplant (as recipient)
2	CABG (two or more coronary arteries) via open thoracotomy	10	Repair of Cerebral or Spinal Arterio-Venous Malformations or aneurysms
3	Prosthetic replacement of Heart Valve	11	Craniotomy for malignant Cerebral tumors
4	Heart/Heart-Lung Transplant	12	Pineal Gland excision
5	Lung Transplantation	13	Pituitary Gland excision
6	Liver Transplantation	14	Excision of esophagus and stomach
7	Renal transplant (recipient)	15	Abdominal-Perineal Pull Through Resection of rectum with Colo-Anal Anastomosis
8	Proximal Aortic Aneurysmal repair by coronary artery transplantation		

CATEGORY 2

Sr No	Surgery	Sr No	Surgery
16	Pericardiotomy / Pericardectomy	37	Total Laryngectomy
17	Permanent pacemaker Implantation in heart	38	Excision of Diaphragmatic tumors
18	Mitral valve repair	39	Total Esophagectomy
19	Aortic valve repair	40	Total Gastrectomy
20	Tricuspid valve repair	41	Complete excision of adrenal glands
21	Pulmonary valve repair	42	Total thyroidectomy
22	Major Excision and grafting of Lymphedema	43	Complete excision of Parathyroid gland
23	Splenectomy	44	Total ear amputation with reconstruction
24	Craniotomy for non malignant space occupying lesions	45	Trans mastoid removal cholesteatoma with extended Mastoidectomy
25	Operations on Subarachnoid space of brain	46	Major Nasal Reconstruction due to Traumatic lesions
26	Craniotomy- Surgery on meninges of Brain	47	Wide excision and Major reconstruction of malignant Oro-pharyngeal tumors
27	Other operations on the meninges of the Brain	48	Partial Resection of Liver
28	Micro vascular decompression of cranial nerves/nervectomy	49	Partial Pancreatectomy

29	Pneumenectomy	50	Replantation of upper limb
30	Diaphragmatic/Hiatus Hernia Repair	51	Replantation of lower limb
31	Thoracotoplasty	52	Major reconstructive oro-maxillafacial Surgery due to trauma or burns and not for cosmetic purpose
32	Open Lobectomy of Lung	53	Osteotomy including segmental resection with bone grafting for Mandibular and maxillary lesions
33	Open excision of benign mediastinal lesions	54	Hysterectomy for malignant conditions
34	Partial Extirpation of Bronchus	55	Radical prostatovesiculectomy
35	Partial Pharyngectomy	56	Penile replantation for post traumatic amputation
36	Total Pharyngectomy	57	Radical Mastectomy

CATEGORY 3

Sr No	Surgery	Sr No	Surgery
58	Angioplasty with stent implantation (two or more coronary arteries must be stented)	87	Prosthetic replacement of head of femur using cement
59	Major vein repair with or without grafting for traumatic & nontraumatic lesions	88	Prosthetic replacement of head of femur not using cement
60	Craniotomy for Drainage of Extradural, subdural or intracerebral space	89	Other prosthetic replacement of head of femur
61	Entrapment syndrome- decompression Surgery	90	Prosthetic replacement of head of humerus using cement
62	Unilateral or Bilateral sympathectomy	91	Prosthetic replacement of head of humerus not using cement
63	Peripheral nerve Graft	92	Other prosthetic replacement of head of humerus
64	Free Fascia Graft for Facial Nerve Paralysis	93	Prosthetic replacement/articulation/other bone using cement
65	Excision of deep seated peripheral nerve tumor	94	Prosthetic replacement/articulation/other bone not using cement
66	Multiple Microsurgical Repair of digital nerve	95	Other prosthetic replacement of articulation of other bone
67	Pleurectomy or Pleural decortication	96	Prosthetic interposition reconstruction of joint
68	Tracheal reconstruction for various lesion	97	Other interposition reconstruction of joint
69	Resection and Anastomosis of any part of digestive tract	98	Excision reconstruction of joint

70	Open Surgery for treatment of Peptic Ulcer	99	Other reconstruction of joint
71	Partial excision of adrenal glands	100	Implantation of prosthesis for limb
72	Subtotal/Partial Thyroidectomy	101	Amputation of arm
73	Partial excision of Parathyroid gland	102	Amputation of leg
74	Labyrinthotmy for various lesions	103	Fracture fixation- Spine
75	Total Glossectomy	104	Elevation, Exploration and Fixation of fractured Zygoma
76	Orbit Tumor Exenteration /Flap reconstruction	105	Total nephrectomy(Not as transplant donor)
77	Cholecystectomy /Choledochotomy for various Gall bladder lesions	106	Partial Nephrectomy
78	Total hip replacement(With Cement)	107	Open extirpation of lesion of kidney
79	Total hip replacement(Without Cement)	108	Excision of ureter
80	Total hip replacement- Others	109	Total excision of bladder
81	Total Knee replacement(With Cement)	110	Kidney Injury repair
82	Total Knee replacement(With Cement)	111	Pyloplasty / Ureterocalcycostomy for pelvic ureteric junction obstruction
83	Total Knee replacement- Others	112	Penile Amputation repair
84	Total prosthetic replacement of other joint using cement	113	Excision of vagina
85	Total prosthetic replacement of other joint not using cement	114	Unilateral or Bilateral excision of adnexa of uterus
86	Other total prosthetic replacement of other joint	115	Operations on frontal sinus

CATEGORY 4

Sr No	Surgery	Sr No	Surgery
116	Therapeutic Burr Hole on skull-Drainage of Extra-Dural, intra-Dural or intracerebral space	128	Urinary diversion
117	Artificial opening into stomach	129	Replantation of ureter
118	Oral Leukoplakia- Wide excision	130	Unilateral or Bilateral excision of testes
119	Corneal or Retinal Repair for Traumatic eye injuries	131	Other operations on Scrotum and tunica vaginalis testis
120	Penetrating injuries of the eye or repair of ruptured globe	132	Reconstruction of the testis
121	Amputation of hand	133	Open surgical excision and destruction of prostate tissue
122	Amputation of foot	134	Extirpation of lesion of vulva
123	Therapeutic knee Arthroscopy	135	Excision of vulva

124	Replantation of finger following traumatic amputation	136	Operations on maxillary antrum using sublabial approach
125	Surgical Drainage and Curettage for osteomyelitis	137	Simple Mastectomy
126	Partial excision of bladder	138	TIPS procedure for portal Hypertension
127	Therapeutic ureteroscopic operations on ureter		