Ensure you are covered against 19 Critical Illnesses

HDFC Life

Group Critical Illness Plus Rider

A non linked non-participating health group pure risk rider
Benefit on diagnosis of any of the 19 listed Critical Illnesses

Illnesses always come unexpectedly and adversely affect life and financial situation. Have you ever considered the financial impact on your life if you were to suffer from a critical illness? Being absent from work during recovery or in worst case being forced to quit work will definitely impact your income and coping up with the high medical expenses will wipe out your savings.
HDFC Life Group Critical Illness Plus Rider financially protects your members and their family by providing a lump sum benefit on diagnosis of any of the 19 listed critical illnesses (Annexure 1) which can be used to cover the expenses associated with illness. This rider can only be added at inception or renewal of the base policy.

HDFC Life Group Critical Illness Rider at a glance

Parameters	Limit
Minimum entry age (last birthday)	18 years
Maximum entry age (last birthday)	74 years
Maximum maturity age (last birthday)	75 years
Policy term	Annual, Half –yearly, Quarterly and Monthly
Premium payment mode	10,000 per member
Minimum Sum Assured	Employer-Employee schemes:10 Other than Employer – Employee schemes: 50

What are the benefits under this rider?

This rider provides a Rider Sum Assured as lump sum benefit to the member, on diagnosis of any of the 19 critical illnesses mentioned below.

Illnesses covered
Cancer of specified severity
Open Chest CABG Myocardial
Infarction
Kidney Failure requiring regular dialysis
Major Organ Transplant (as recipient)
Stroke resulting in Permanent symptoms Apallic
Apallic Syndrome
Benign Brain Tumour
Coma of specified severity
End Stage Liver Failure
End Stage Lung Failure
Open Heart Replacement or repair of heart valves
Loss of Limbs
Loss of Independent Existence
Blindness
Third Degree Burns
Major Head Trauma
Permanent Paralysis of limbs
Surgery of Aorta

Definitions of the covered conditions are given below in Annexure 1.
At the time of policy-inception, the Master Policyholder must choose one of the two available benefit options:

1. **Additional CI Benefit:** On diagnosis of any of the 19 listed critical illnesses a lump sum benefit equal to the Rider Sum Assured shall bepayable, provided the member survives for a period of 30 days following diagnosis of the critical illness. On payment of the Rider Sum Assured, the benefits under the base plan still continue. The rider benefits shall cease once the Rider Sum Assured has been paid out or on completion of the rider term, whichever is earlier.
2. **Accelerated CI Benefit:** On diagnosis of any of the 19 listed critical illnesses, the Sum Assured payable under the base plan, to the extent of the Rider Sum Assured, is accelerated and paid out as a lump sum. The Sum Assured payable on death under the base plan will be reduced by the extent of Rider Sum Assured already paid to that member. The rider benefits shall cease once the Rider Sum Assured has been paid out or on completion of the rider term, whichever is earlier.

Which products can this Rider be offered with?
HDFC Life Group Critical Illness Plus Rider will be available with HDFC Life Group Term Insurance (UIN: 101N005V08) and HDFC Life Group Term Life (UIN: 10101N169V03)
What about the premium payment?
The premium payment term is 1 year. Frequency of premium payment for the rider will be same as that of the base plan.

New members can join the policy during the year as per the schemerules. Members joining during the scheme policy year and opting for the rider will be charged the rider premium proportionate to the duration, the member is covered during the policy year. Any applicable taxes, duties or surcharges will also be charged. For members leaving the scheme during the policy year, a proportionate refund of the rider premium, after deducting any applicable levies & taxes would be made.

Where appropriate, we may permit individual members at scheme level to be covered under this rider for 1 year from their scheme joining date. In the event where the Master Policyholder has collected/deducted the premium but has failed to pay the premium to the insurer due to administrative delays within the grace period, the insurer will be responsible for any valid claims.

Is there any survival period before the claim?
In case Additional CI Benefit option is chosen the critical illness benefit will be paid only if the member survives for a period of 30 days post diagnosis of the critical illness. This exclusion does not apply to Accelerated CI Benefit option.

If the diagnosis is made within the policy term, however the survival period crosses the end point of rider term then a valid claim arising as a result of such a diagnosis shall be considered. The claim is required to be intimated to us along with all necessary claim documents within a period of 60 days from the date of diagnosis.

Is there any waiting period?
Waiting period of 90 days applies from the date of the scheme member first being covered for a group critical illness benefit with any insurer (assuming an unbroken period of cover). If the cover period is broken then the 90 days period applies from the date critical illness cover re-commences in respect of the scheme member. No benefit will be payable if the claim has occurred during the waiting period.

Is there any death benefit?
There is no death benefit payable under this rider.

Is there any maturity benefit?
There is no maturity benefit available under this rider.

What is the grace period?
Grace period will be as per the base plan to which this rider is attached.

Can the rider be surrendered?
In case of surrender of the policy by the policyholder before the completion of the rider term, an amount equal to the rider premium for the unexpired term of the discontinuing members, less appropriate deduction for expenses, commission and taxes and levies as applicable would be payable.

What if premiums are discontinued?
In case the rider premium payment is discontinued during the premium paying term, the rider will lapse and no benefits will be payable under the rider.

What is not covered under this policy?
We shall not be liable to pay any benefit indicated in the policy schedule if the critical illness is caused directly or indirectly by the following:

- Any of the critical illness conditions where death occurs within 30 days of the diagnosis, in case of Additional CI Benefit option.
- Any sickness related condition manifesting itself within 90 days of the date of the scheme member first being covered for a group critical illness benefit with any insurer (assuming an unbroken period of cover#). If the cover period is broken then the 90 days period applies from the date, critical illness cover re-commences in respect of the scheme member.
- Intentionally self-inflicted injury or attempted suicide, irrespective of mental condition.
- Alcohol or solvent abuse, or voluntarily (without the prescription of a medical practitioner^) taking or using any drug, medication or sedative unless it is an "over the counter" drug, medication or sedative taken according to package directions.
- Taking part in any act of a criminal nature with criminal intent
- Any Pre-existing medical condition* as defined below.
- HIV or AIDS
- Failure to seek medical or follow medical advice (as recommended by a Medical Practitioner^)
- Radioactive contamination due to nuclear accident.

#The "broken period of cover" refers to the period where a member is not covered by any group critical illness scheme. The waiting period exclusion shall be waived off for members (e.g. employees of a firm) to the extent of duration of waiting period already served in a similar scheme (e.g. Employer employee critical illness cover with another insurer).

Pre-existing condition is:

Means any condition, ailment, injury or disease:

1. 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
2. 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.

What are other terms & conditions?

i) **Cancellation of Rider:** The Master Policyholder may choose to cancel the rider without the cancellation of the base policy by discontinuing rider premium payment. On cancellation, rider shall terminate and base policy shall continue.

ii) **Cancellation in the Free-look Period:**

By Master Policy Holder:

1) In case, the Master Policyholder, is 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) whether received electronically or otherwise.
2) Irrespective of the reasons mentioned, the Master 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.

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 Certificate of Insurance) whether received electronically or otherwise.
(2) Irrespective of the reasons mentioned, the Member shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the proposer and stamp duty charges.

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

- If rider is cancelled with the base policy, we shall refund the total (rider + base) Premium paid, subject to deduction of the proportionate risk Premium for the period on cover and the expenses incurred for medical examination (if any) and stamp duty, (if any). A rider once cancelled shall not be revived, reinstated or restored at any point of time and a new proposal will have to be made for a new Policy.
- If rider is cancelled independently of the base policy, then the rider premium will be returned after adjusting proportionate rider risk premium for the period of cover and the expenses incurred for medical examination (if any) and stamp duty (if any).
- The rider will be cancelled automatically if the base policy to which it is attached is cancelled in the free-look period

iii) **Alterations:** Rider term and Sum Assured cannot be altered. The premium payment frequency of the rider can be changed if the premium payment frequency on the base product is changed. The premium payment frequency of the rider cannot be changed independently from the base policy.

iv) **Surrender:** In case of surrender of the policy before the completion of the rider term, an amount equal to the premium for the unexpired term of the discontinuing members, less appropriate deduction for expenses, commission and taxes, as applicable, shall be payable.
V) **Lapse:** No benefits shall be payable in case of Lapse.

vi) **Revival:** Applicable as per the terms and condition of revival of the base policy.

vii) **Nomination:** Sec 39 of Insurance Act 1938 as amended from time to time

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 member of policyholder may appoint any person to receive the money secured by the policy in the event of member'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) 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.
9) 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), Bill 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.

viii) **Assignment and Transfer:** Section 38 of the Insurance Act 1938, as amended from time to time

1) This policy may be transferred/assigned, wholly or in part, with or without consideration.
2) An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer.
3) The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made.
4) The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness.
5) The transfer or assignment shall not be operative as against an Insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorized agents have been delivered to the Insurer.
6) Fee to be paid for assignment or transfer can be specified by the Authority through Regulations.
7) On receipt of notice with fee, the Insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice.
8) The Insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is (a) not bonafide or (b) not in the interest of the policyholder or (c) not in public interest or (d) is for the purpose of trading of the insurance policy.
9) In case of refusal to act upon the endorsement by the Insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the Insurer.

Section C (Nomination) and D (Assignment or Transfer) are simplified versions prepared for general information only and hence are not comprehensive. For full texts of these sections please refer to Section 39 and Section 38 respectively of the Insurance Act, 1938 as amended by the Insurance Laws (Amendment) Act, 2015.

ix) **Prohibition of Rebates:** In accordance with Section 41 of the Insurance Act, 1938 as amended from time to time:Section 41 of the Insurance Act, 1938, as amended from time to time:

1. No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commis- sion payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer. Provided that acceptance by an insurance agent of commission in connection with a policy of life insurance taken out by himself on his own life shall not be deemed to be acceptance of a rebate of premium within the meaning of this sub-section if at the time of such acceptance the insurance agent satisfies the prescribed conditions establishing that he is a bona fide insurance agent employed by the insurer.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten Lakh rupees.

x) **Non-Disclosure:** Section 45 of the Insurance Act, 1938 as amended from time to time:

1. No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e., from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later.
2. A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud: Provided that the insurer

insurer shall have to commu- nicate in writing to the insured or the legal representatives or nominees or asignees of the insured the grounds and materials on which such decision is based.

3. Notwithstanding anything contained in sub-section (2), no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer: Provided that in case of fraud, the on us of disproving lies upon the beneficiaries, in case the policyholder is not alive.
4. A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued:Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees or assignees of the insured the grounds and materials on which such decision to repudiate the policy of life insurance is based: Provided further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees or assignees of the insured within a period of ninety days from the date of such repudiation.
5. Nothing in this section shall prevent the insurer from calling 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 that the age of the life insured was incorrectly stated in the proposal.
6. In case of fraud or misstatement including non-disclosure of any material facts, the Policy shall be cancelled immediately and the Surrender Value shall be payable, subject to the fraud or misstatement being established in accordance with Section 45 of the Insurance Act, 1938, as amended from time to time.
7. This is not a comprehensive list of amendments of Insurance Laws (Amendment) Ordinance,2014 and only a simplified version prepared for general information. Policy Holders are advised to refer to Original Ordinance Gazette Notification dated December 26 , 2014 for complete and accurate details.

xi) **Indirect & Direct Taxes**

Indirect Taxes

Taxes and levies as applicable will be charged and are payable by you by any method including by levy of an additional monetary amount in addition to premium and/or charges.

Direct Taxes

Tax will be deducted at the applicable rate from the payments made under the policy, as per the provisions of the Income-tax Act, 1961.

xii) Grievance Redressal Process

You can contact us at any of the below touchpoints in case of any concern:
Helpline number: 022-68446530 (Call Charges apply) | NRI Helpline number +91 89166 94100 (Call Charges apply) | E-mail Address: service@hdfclife.com | nriservice@hdfclife.com (For NRI customers only)

You can let us know of your concerns/grievances through any of below options:

- Option 1: Written letter duly signed by the policyholder at any HDFC Life Branch. There is a Grievance Redressal Officer at the respective branch to address the customer's complaint.
  To know more about branch address and timing's you can visit this link: https://www.hdfclife.com/contact-us#BranchLocator . Please note, branches are closed on Sundays, national holidays and region-specific public holidays.
- Option 2: Write to us from your registered email ID at service@hdfclife.com.
- Option 3: Visit us at our website https://www.hdfclife.com/customer-service/grievance-redressal
  You may refer to the escalation matrix in case there is no response to a grievance within the prescribed timelines.
  If you are still not satisfied with our response, you may approach the Insurance Ombudsman located in your region. For more information on our Grievance Redressal Mechanism and the detailed

address of the Insurance Ombudsman, please refer Part G of the policy document given to you

Definitions & Exclusions of Critical Illnesses:

1) Cancer of Specified Severity

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

The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

ix. All tumors in the presence of HIV infection.

2) 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 asternotomy (cutting through the breast bone) or minimally invasive keyholecoronary artery bypass procedures. The diagnosis must be supported by acoronary angiography and the realization of surgery has to be confirmed by acardiologist.

The following are excluded:

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

3) Myocardial Infarction

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

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

ii. New characteristic electrocardiogram changes

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

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 overtischemic heart disease OR following an intra-arterial cardiac procedurel.

4) Kidney Failure Requiring Regular Dialysis

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

5) Major Organ Transplant (as recipient)

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 ofa 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

6) Stroke Resulting in Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

7) Apallic Syndrome

Universal necrosis of the brain cortex with the brainstem remaining intact. Diagnosis must be confirmed by a neurologist acceptable to the Company and the condition must be documented for at least one month.

8) Benign Brain Tumour

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

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

The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

9) Coma of specified Severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. No response to external stimuli continuously for at least 96 hours;
ii. Life support measures are necessary to sustain life; and
iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

10) End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three ofthe following:

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.
iv. Liver failure secondary to drug or alcohol abuse is excluded.

11) 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 pressure of 55mmHg or less ($PaO2 < 55mmHg$); and
iv. Dyspnea at rest.

12) **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 beconfirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/- valvuloplasty are excluded.

13) **Loss of Independent Existence**

Confirmation by a consultant physician acceptable to the Company of the loss of independent existence due to illness or trauma, which has lasted for a minimum period of 6 months and results in a permanent inability to perform at least three (3) of the Activities of Daily Living (either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons). For the purpose of this benefit, the word "permanent", shall mean beyond the hope of recovery with current medical knowledge and technology.

14) **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.

15) **Blindness**

Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident. The Blindness is evidenced by:

i. Corrected visual acuity being 3/60 or less in both eyes or ;
ii. The field of vision being less than 10 degrees in both eyes.

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

16) **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.

17) **Major Head Trauma**

Accidental head injury resulting in permanent Neurological deficit to be assessedno sooner than 3 months from the date of the accident. This diagnosis must besupported by unequivocal findings on Magnetic Resonance Imaging.

Computerized Tomography, or other reliable imaging techniques. The accidentmust be caused solely and directly by accidental, violent, external and visiblemeans and 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 ofmechanical equipment, special devices or other aids and adaptations in use fordisabled persons. For the purpose of this benefit, the word "permanent" shallmean 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 intoand out of the bath or shower) or wash satisfacto- rily by other means;
ii. Dressing: the ability to put on, take off, secure and unfasten all garmentsand, as appropriate, any braces, artificial limbs or other surgicalappliances;
iii. Transferring: the ability to move from a bed to an upright chair orwheelchair 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 andbladder functions so as to maintain a satisfactory level of personalhygiene;
vi. Feeding: the ability to feed oneself once food has been prepared andmade available.

The following are excluded:

i. Spinal cord injury;

18) Permanent Paralysis Of Limbs

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

19) Surgery of Aorta

The actual undergoing of surgery (including key-hole type) for a disease or injury of the aorta needing excision and surgical replacement of the diseased part of the aorta with a graft.
The term "aorta" means the thoracic and abdominal aorta but not its branches. Stent-grafting is not covered.

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