

Liberty Complete Protect Group Policy Policy Wordings (UIN –LIBHLGP25002V032425)

Conditions precedent to the contract

Liberty General Insurance Limited (hereinafter called the “Company”) will provide insurance cover to the Person/person(s) (hereinafter called the “Insured”) upon acceptance of the **Proposal** made, subject to the terms and conditions of the Policy and agreed premium paid within such time, before commencement of the risk under the proposal or within such period, as may be prescribed under the provisions of the Insurance Act, 1938, for the policy period stated in the **Schedule** or during any further period for which the Company may accept payment for the renewal or extension of this Policy.

This Policy records the agreement between the Company (We) and the Insured (You) and sets Insured (You) in the proposal form and the declaration signed by Insured (You) forms the basis of this contract.

The Policy, the Schedule and any Extension shall be read together and any word or expression to which a specific meaning has been attached in any part of this Policy or of Schedule shall bear such meaning whenever it may appear.

Part I - Definitions

The words or expressions defined below have specific meanings ascribed to them wherever they appear in this Policy. For purposes of this Policy, please note that references to the singular or masculine include references to the plural or to the female respectively.

I. Standard Definitions

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **AYUSH Hospital** is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by *AYUSH Medical Practitioner(s)* comprising of any of the following:
 - a. Central or State Government AYUSH Hospital; or
 - b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
 - c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered *AYUSH Medical Practitioner* and must comply with all the following criterion:
 - I. Having at least 5 in-patient beds;
 - II. Having qualified *AYUSH Medical Practitioner* in charge round the clock;
 - III. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
 - IV. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.
3. **Benign Brain Tumor** means 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.
 - a. 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.
 - b. The following conditions are excluded:
 - i. Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

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4. **Blindness** means total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident
- The Blindness is evidenced by:
 - corrected visual acuity being 3/60 or less in both eyes or;
 - 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.
5. **Break-in Policy** means the period of gap that occurs at the end of the existing policy term/installment premium due date, when the premium due for renewal on a given policy or installment premium due is not paid on or before the premium renewal date or grace period.
6. **Cancer of Specified Severity** means 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 –
- 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.
 - Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
 - Malignant melanoma that has not caused invasion beyond the epidermis;
 - 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
 - All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
 - Chronic lymphocytic leukemia less than RAI stage 3
 - Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
 - 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;
 - All tumors in the presence of HIV infection
7. **Coma of Specified Severity** means 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:
- No response to external stimuli continuously for at least 96 hours;
 - Life support measures are necessary to sustain life; and
 - 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 from alcohol or drug abuse is excluded.
8. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the Policy is conditional upon
9. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
- Internal Congenital Anomaly** means **congenital anomaly** which is not in the visible and accessible parts of the body

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- b) **External Congenital Anomaly** means **congenital anomaly** which is in the visible and accessible parts of the body
10. **Deafness** means 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.
11. **Disclosure to Information Norm** - The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
- (Explanation: Material facts for the purpose of this policy shall mean all relevant information sought by the company in the proposal for and other connected documents to enable it to make informed decision in the context of underwriting the risk.)**
12. **Day Care Centre** means any institution established for day care treatment of illness and /or injuries or a medical set up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under-
- has qualified nursing staff under its employment;
 - has qualified medical practitioner/s in charge;
 - has a fully equipped operation theatre of its own where surgical procedures are carried out;
 - maintains daily records of patients and will make these accessible to the insurance company's authorized personnel
13. **Day care Procedure/Treatment** refers to medical treatment, and/or surgical procedure which is undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hours because of technological advancement, and which would have otherwise required hospitalization of more than 24 hours.
- Treatment normally taken on an out-patient basis is not included in the scope of this definition.
14. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.
15. **Emergency Care** Emergency care means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term of the insured person's health.
16. **End-Stage Liver Failure** means Permanent and irreversible failure of liver function that has resulted in all three of the following:
- Permanent jaundice; and
 - Ascites; and
 - Hepatic encephalopathy.
- Liver failure secondary to drug or alcohol abuse is excluded.
17. **End-Stage Lung Failure** means end stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
- FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
 - Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
 - Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO₂ < 55mmHg); and
 - Dyspnea at rest.

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18. **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.
19. **Hospital** means any institution established for in- patient care and day care treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under 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:
- has qualified nursing staff under its employment round the clock;
 - has at least 10 inpatient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
 - has qualified medical practitioner (s) in charge round the clock;
 - has a fully equipped operation theatre of its own where surgical procedures are carried out;
 - maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.
20. **Hospitalization** means admission in a Hospital for a minimum period of 24 consecutive In-patient Care hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.
21. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifest itself during the policy period and requires medical treatment
- 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.
 - Chronic Condition** - is defined as a disease, illness or injury that has one or more of the following characteristics:
 - it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
 - it needs ongoing or long-term control or relief of symptoms
 - it requires rehabilitations for the patient or for the patient to be specially trained to cope with it
 - it continues indefinitely
 - It recurs or likely to recur.
22. **Intensive Care Unit** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in ordinary and other wards.
23. **ICU (Intensive Care Unit) Charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
24. **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 registered Medical Practitioner

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25. **In-patient Care** means treatment for which the insured person has to stay in a Hospital for more than 24 Hours for a covered event.
26. **Kidney Failure Requiring Regular Dialysis** means 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.
27. **Loss of Speech** means total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.
All psychiatric related causes are excluded.
28. **Loss of Limbs** means 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.
29. **Major Head Trauma** means;
- I. 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, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.
- II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word permanent shall mean beyond the scope of recovery with current medical knowledge and technology.
- III. The Activities of Daily Living are:
- 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;
 - Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
 - Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
 - Mobility: the ability to move indoors from room to room on level surfaces;
 - Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
 - Feeding: the ability to feed oneself once food has been prepared and made available.
- IV. The following are excluded:
- Spinal cord injury;
30. **Major Organ / Bone Marrow Transplant** means
The actual undergoing of a transplant of:
- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
 - 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:
- Other stem-cell transplants
 - Where only islets of langerhans are transplanted

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31. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which
- is required for the medical management of the illness or injury suffered by the Insured Person/s;
 - must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
 - must have been prescribed by a medical practitioner,
 - must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
32. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. The term Medical Practitioner would include physician, specialist, anesthetist and surgeon but would exclude the Insured Person/s and his/her Immediate Family. Immediate Family would comprise of spouse, children, brother(s), sister(s), parent(s), parents in law (s), brother In Law(s), sister In Law(s), uncle(s), aunt(s), grandparents, great-grandparents, grandchildren, great-grandchildren, cousins, adopted children and step-parents/step-children, of the Insured Person.
33. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
34. **Migration** means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.
35. **Motor Neuron Disease with Permanent Symptoms** means a motor neuron disease diagnosed by a specialist medical practitioner (Neurologist) 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.
36. **Multiple Sclerosis With Persisting Symptoms** means the the unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
- investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
 - 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 and HIV are excluded.
37. **Myocardial Infarction (First Heart Attack of Specified Severity)**
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:
- A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
 - New characteristic electrocardiogram changes
 - Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

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- 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.

 38. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.

 39. **Open Chest CABG / Coronary Artery Bypass Surgery**
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.

 40. **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.

 41. **Outpatient treatment (OPD)** is one in which the Insured Person visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured Person/s is not admitted as a day care or in-patient.

 42. **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.

 43. **Portability** means a facility provided to the health insurance policyholders (including all members under family cover), to transfer the credits gained for, pre-existing diseases and specific waiting periods from one insurer to another insurer.

 44. **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.

 45. **Primary (Idiopathic) Pulmonary Hypertension**
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 Catheterization. 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.

The NYHA Classification of Cardiac Impairment are as follows:

- i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

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- ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.
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.
46. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
47. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
48. **Specific waiting period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.
49. **Stroke Resulting In Permanent Symptoms** means 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.
50. **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.
51. **Subrogation** shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.
52. **Third-Degree Burns (Major 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.

i. **Specific Definitions**

1. **Activities of Daily Living means,**
- 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.

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2. **Age** means the completed age of the Insured Person as on his last birthday.
3. **AIDS** means Acquired Immune Deficiency Syndrome, a condition characterised by a combination of signs and symptoms, caused by Human Immunodeficiency Virus, which attacks and weakens the body's immune system making the HIV-positive person susceptible to life threatening conditions or other conditions
4. **Angioplasty (for Option II: Heart Protect)**
- 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).
 - Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.
 - Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.
5. **Alzheimer's Disease**
- Alzheimer's disease is a progressive degenerative illness of the brain, characterized by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes.
- The Unequivocal diagnosis of Alzheimer's disease (presenile dementia) before age 60 that has to be confirmed by a specialist Medical Practitioner (Neurologist) and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT Scan, MRI, PET of the brain).
- The disease must also result in a permanent inability to perform independently three or more Activities of Daily Living or must result in need of supervision and the permanent presence of care staff due to the disease.
- These conditions must be medically documented for at least 90 days.
- The following conditions are however not covered:
- a) non-organic diseases such as neurosis and psychiatric illnesses;
 - b) alcohol related brain damage; and
 - c) any other type of irreversible organic disorder/dementia.
6. **Apallic Syndrome**
- A persistent vegetative state in which patients with severe brain damage (universal necrosis of the brain cortex with the brainstem remaining intact), are in a state of partial arousal rather than true awareness. The Diagnosis must be confirmed by a Specialist Medical Practitioner (Neurologist) and condition must be documented for at least 30 days.
7. **Aplastic Anemia**
- A Chronic persistent bone marrow failure which results in total aplasia of the bone marrow and requires treatment with at least one of the following:
- a) Regular blood product transfusion
 - b) Marrow stimulating agents
 - c) Immunosuppressive agents
 - d) Bone marrow transplantation
- The diagnosis and suggested line of treatment must be confirmed by a Haematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by two out of the following three values:
- e) Absolute Neutrophil count of 500 per cubic millimetre or less;
 - f) Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
 - g) Platelet count of 20,000 per cubic millimetre or less.

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8. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under 'Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
Provided that the hospitalization is not for evaluation and/or investigation purpose only and treatment is availed in India and provided the treatment has undergone in:
- Government hospital or in any institute recognized by government and/or accredited by Quality Council of India or National Accreditation Board on Health;
 - Teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH);
 - AYUSH Hospitals as defined hereinabove.
9. **Bank** means a banking Company which transacts the business of banking in India.
10. **Balloon Valvotomy or Valvuloplasty (for Option II: Heart Protect)**
- The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a consultant Cardiologist where the procedure is performed totally via intravascular catheter based techniques.
 - The diagnosis of heart valve abnormality must be supported by cardiac catheterization or Echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist.
 - The following are excluded: o Procedures done for treatment of Congenital Heart Disease
11. **Brain Surgery**
The actual undergoing of surgery to the brain under general anesthesia during which a craniotomy is performed. The procedure must be considered necessary by a qualified specialist.
- The following are excluded:
Minimally invasive treatment where no surgical incision is performed to expose the target, irradiation by gamma knife or endovascular neuroradiological interventions, embolizations, thrombolysis and stereotactic biopsy are excluded. Burr hole Surgery or Brain surgery as a result of an accident are also excluded.
12. **Carcinoma in-Situ (for Option II: Cancer Protect)**
Carcinoma-in-situ means 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 carcinoma is included
 - xii) Nasopharynx
- For this 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.
13. **Cardiomyopathy**

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

The following conditions are excluded:

Cardiomyopathy secondary to alcohol or drug abuse.

All other forms of heart disease, heart enlargement and myocarditis.

14. **Carotid Artery Surgery (for Option II: Heart Protect)**

- The actual undergoing of surgery to the Carotid Artery to treat carotid artery stenosis of fifty percent (50%) and above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria below must be met:

- o Either:

Actual undergoing of endarterectomy to alleviate the symptoms; or

Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and

- The Diagnosis and medical necessity of the treatment must be confirmed by a Registered Medical Practitioner who is a specialist in the relevant field.

- Endarterectomy of blood vessels other than the carotid artery is specifically excluded.

15. **Creutzfeldt-Jakob Disease (CJD)**

A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist) based on clinical assessment, EEG and imaging. There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.

Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

16. **Complete discharge** means any payment made to the insured person or his/her nominee or his/her representative or assignee as the case may be, for any benefit under the policy shall be a valid discharge.

17. **Death Due to Accident** means if an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his/her death within twelve calendar months from the date of the Accident, then We will pay the Section Sum Insured as mentioned in the Policy Schedule and the benefit and relevant extensions shall cease to exist.

18. **Disappearance** means if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months/ as opted in policy schedule, following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such Insured Member was known to have been travelling as a fare paying passenger or in any event arising as a result of Act of God Perils during the Policy Period, where it is reasonable to believe that such Insured Member has died as a result of an Accidental Injury.

19. **Encephalitis**

It is a severe inflammation of brain tissue, resulting in permanent neurological deficit lasting for a minimum period of 30 days. This must be certified by a Specialist Medical Practitioner (Neurologist). The permanent deficit must result in an inability to perform at least three 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.

20. **Early-Stage Cancers (for Option II: Cancer Protect)**

Early Stage Cancer shall mean first ever diagnosis with the presence of one of the following malignant conditions:

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- i) Any malignant tumor of the thyroid, positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue, which is histologically classified as T1N0M0 according to the TNM classification system, or another equivalent classification
- ii) Prostate tumor should be histologically described as TNM Classification T1a or T1b or T1c are of another equivalent classification.
- iii) Chronic lymphocytic leukemia classified as RAI Stage I or II;
- iv) Hodgkin's lymphoma Stage I by the Cotswold's classification staging system.
- v) All tumors of the urinary bladder histologically classified as T1N0M0 (TNM Classification)
- vi) Basal cell and squamous skin cancer that has spread to distant organs beyond the skin
The Diagnosis must be based on histopathological features and confirmed by a specialist consultant (Oncologist).
Pre-malignant lesions and conditions, unless listed above, are excluded.

21. **Entry age** means the age of the Insured Person at the time of Commencement of the Policy.
22. **Endorsement** means written evidence of change to the Policy including but not limited to increase or decrease in the period, extent and nature of the cover agreed by Us in writing.
23. **EMI or EMI Amount** means the fixed payment amount required to repay the principal amount of Loan and Interest by the Insured Person at a specified date each calendar month, as set forth in the amortization chart referred to in the Loan agreement (or any amendments thereto) between the Bank/Financial Institution and the Insured Person prior to the date of occurrence of the Insured Event under this Policy. For the purpose of avoidance of doubt, it is clarified that any monthly payments that are overdue and unpaid by the Insured Person prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured Person.
24. **Family** means, the family that consists of the proposer and any one or more of the family members as mentioned below -
Legally wedded spouse, Dependent children (i.e. natural or legally adopted) between the age 1 day to 25 years provided the policy provide cover for Dependent children. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewal.
25. **Financial Institution** shall have the same meaning assigned to the term under section 45 I of the Reserve Bank of India Act, 1934 and shall include a Non-Banking Financial Company as defined under section 45 I of the Reserve Bank of India Act, 1934.
26. **Fulminant Viral Hepatitis**
A sub-massive to massive necrosis of the liver by a Hepatitis virus, leading precipitously to liver failure where the following criteria are met:
Rapid decrease in liver size associated with necrosis involving entire lobules;
Rapid degeneration of liver enzymes;
Deepening jaundice; and
Hepatic encephalopathy
Hepatitis infection or carrier status alone, does not meet the diagnostic criteria.
27. **Goodpasture's Syndrome**
Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for a continuous period of at least 30 days. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist).
28. **HIV** means Human Immunodeficiency Virus
29. **Implantable Cardioverter Defibrillator (for Option II: Heart Protect)**

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- Actual undergoing of insertion of an implantable cardiac defibrillator to correct serious cardiac arrhythmia which cannot be treated via other methods or the insertion of permanent cardiac defibrillator to correct sudden loss of heart function with cessation of blood circulation around the body resulting in unconsciousness
 - Insertion of Cardiac Defibrillator means surgical implantation of either Implantable Cardioverter Defibrillator (ICD), or Cardiac Resynchronization Therapy with Defibrillator (CRT-D)
 - The insertion of a permanent Cardioverter-Defibrillator (ICD) must be certified to be absolutely necessary by a specialist in the relevant field.
 - Cardiac arrest secondary to alcohol or drug misuse will be excluded.
30. **Implantation of Pacemaker of Heart (for Option II: Heart Protect)**
- Actual undergoing of Insertion of a permanent cardiac pacemaker to correct 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 arrest secondary to alcohol or drug misuse will be excluded.
31. **Income (monthly)** means fix gross monthly salary excluding all variables, special allowances, employer contribution towards Provident Fund & gratuity, reimbursements and perks.
32. **Infective Endocarditis (for Option II: Heart Protect)**
- Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:
Positive result of the blood culture proving presence of the infectious organism(s)
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
Infective Endocarditis and the severity of valvular impairment are confirmed by a consultant cardiologist.
33. **Insured** means a Bank or Financial Institution or Group Administrator who has proposed for Insurance and on whose name the Policy is issued.
34. **Insured Person/ Beneficiary** means the person(s) named in the Schedule to the Policy, and for whom the insurance is also proposed, and appropriate premium paid
35. **Insured Event** means any event specifically mentioned as covered in the policy schedule or Certificate of insurance under each section of benefit.
36. **Leave without Pay/Loss of Pay means** a period of leave from employment with an Employer during which the Insured Person is not entitled to receive payment of Salary from the Employer.
37. **Loan** means the sum of money lent at interest or otherwise to the Insured Person/s by any Bank/Financial Institution as identified by the Loan Account Number referred in the policy schedule.
38. **Loss of Limbs** means 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.
39. **Medullary Cystic Disease**
A progressive hereditary disease of the kidneys characterized by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anemia, polyuria and renal loss of sodium, progressing to chronic renal failure.
The diagnosis must be supported by renal biopsy.
40. **Minimally Invasive Surgery of Aorta (for Option II: Heart Protect)**

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- 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 with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.
- Procedures done for treatment of Congenital heart disease are excluded.

41. **Multiple System Atrophy**

A diagnosis of multiple system atrophy by a Specialist Medical Practitioner (Neurologist). There must be evidence of permanent clinical impairment for a minimum period of 30 days of either:
motor function with associated rigidity of movement; or
The ability to coordinate muscle movement; or
Bladder control and postural hypotension.

42. **Muscular Dystrophy**

Muscular Dystrophy is a group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be made by a consultant neurologist, and confirmed with the appropriate laboratory, biochemical, histological, and electromyographic evidence.

The disease must result in the permanent inability of the insured person to perform (whether aided or unaided) at least three (3) of the six (6) Activities of Daily Living.

43. **Nominee** means the person named in the Proposal or Schedule to whom the benefits under the Policy is nominated by the Insured Person.

44. **Parkinson's Disease**

The unequivocal diagnosis of idiopathic Parkinson's Disease by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

- i. The disease cannot be controlled with medication; and
- ii. There are objective signs of progressive deterioration; and
- iii. There is an inability of the Life Assured to perform (whether aided or unaided) at least three of the five Activities of Daily Living for a continuous period of at least 6 months:

Drug-induced or toxic causes of Parkinsonism are excluded.

45. **Pericardiectomy (for Option II: Heart Protect)**

- The undergoing of a pericardiectomy 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. Other procedures on the pericardium including pericardial biopsies, and pericardial drainage procedures by needle aspiration are excluded.

- The actual undergoing of pericardiectomy secondary to chronic constrictive pericarditis.

- The following are specifically excluded:
 - o Chronic constrictive pericarditis related to alcohol or drug abuse or HIV
 - o Acute pericarditis due to any reason

46. **Pneumonectomy**

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the Insured person.

The following conditions are excluded:

Removal of a lobe of the lungs (lobectomy)

Lung resection or incision

47. **Policy** means this document of Policy describing the terms and conditions of this contract of insurance including the Company's covering letter to the Insured /Insured Person if any, the Schedule attached to and forming part of this Policy, the Insured's Proposal form and any applicable endorsement attaching to and forming part thereof either at inception or during the period of insurance.

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48. **Policy Period** means the period between the inception date and the expiry date as specified in the Schedule to this Policy or the cancellation of this insurance, whichever is earlier.
49. **Policy Year** means a period of twelve months beginning from the date of commencement of the Policy Period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the Policy Period, as mentioned in the schedule
50. **Principal Outstanding** means the principal amount of the Loan outstanding as on the date of occurrence of Insured Event less the portion of principal component included in the EMIs payable but not paid from the date of the loan agreement till the date of the Insured Event/s. For the purpose of avoidance of doubt, it is clarified that any EMIs that are overdue and unpaid to the Bank or NBFC prior to the occurrence of the Insured Event will not be considered for the purpose of this Policy and shall be deemed as paid by the Insured Person/s.
51. **Progressive Supranuclear Palsy**
A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days.
52. **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 following conditions are excluded:
- Localised scleroderma (linear scleroderma or morphea);
 - Eosinophilic fascitis; and
 - CREST syndrome
53. **Proposal and Declaration Form** means any initial or subsequent declaration made by the Insured/ Insured Person/s and is deemed to be attached and forming part of this Policy.
54. **Pulmonary Artery Graft Surgery**
The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.
- The following conditions are excluded:
- Pulmonary artery graft surgery necessitated as a result of CABG
 - Pulmonary artery graft surgery necessitated as a result of Post trauma
55. **Pulmonary-Renal Syndrome**
Diagnosis of pulmonary renal syndrome, in which a combination of diffuse alveolar hemorrhage (DAH) and a rapid progressive glomerulonephritis (RPGN) occurs.
56. **Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the Insured/ Insured Persons, the Sum Insured, the period, Coverage and the limits to which benefits under the Policy are subject to.
57. **Severe Rheumatoid Arthritis**
The unequivocal diagnosis of Rheumatoid Arthritis must be made by a certified medical consultant based on clinically accepted criteria with all of the following criteria are met:
- There must be imaging evidence of erosions with widespread joint destruction in three or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet.
 - There must also be typical rheumatoid joint deformities.
 - Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
 - Permanent inability to perform at least two (2) Activities of Daily Living
 - The foregoing conditions have been present for at least six (6) months.

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- vi. Elevated levels of Creactive protein (CRP), or erythrocyte sedimentation rate (ESR)

Degenerative osteoarthritis and all other forms of arthritis are excluded.

There must be history of treatment or current treatment with disease-modifying anti-rheumatic drugs, or DMARDs. Non-steroidal anti-inflammatory drugs such as acetylsalicylic acid are not considered a DMARD drug under this definition.

58. **Section Sum Insured** means and denotes the amount of cover available to the Insured Person/s under each section opted, subject to the terms and conditions of this Policy and as stated in the Table of Benefits of the Schedule wherever applicable, which is the maximum liability of the Company under this Policy

59. **Sum Insured** means and denotes the amount of cover available to the Insured Person/s subject to the terms and conditions of this Policy and as stated in the Table of Benefits of the Schedule, wherever applicable, which is the maximum liability of the Company under this Policy.

60. **Surgery to Aorta / Aorta Graft Surgery**

The actual undergoing of major surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. Undergoing of a laparotomy or thoracotomy to repair or correct an aneurysm, narrowing, obstruction or dissection of the aortic artery.

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

Surgery performed using only minimally invasive or intra-arterial techniques such as percutaneous endovascular aneurysm repairs are excluded. Angioplasty and all other intra-arterial, catheter-based techniques, keyhole or laser procedures are excluded.

61. **Survival Period** is the period after an insured event that you have to survive before a claim becomes valid following the first diagnosis of the Critical Illness/undergoing the Surgical Procedure for the first time. For this policy it is limited to 30 days.

62. **Systemic Lupus Erythematosus**

Systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V lupus nephritis, established by renal biopsy, and in accordance with the World Health Organization (WHO) classification). A diagnosis of systemic lupus erythematosus by a Rheumatologist resulting in either of the following:

- i. Permanent neurological deficit with persisting clinical symptoms for a continuous period of 30 days; or
- ii. The permanent impairment of kidney function tests as follows; Glomerular Filtration Rate (GFR) below 30 ml/min.
- iii. Other forms, discoid lupus, and those forms with only haematological and joint involvement are however not excluded.

The WHO lupus classification is as follows:

Class I: Minimal change – Negative, normal urine.

Class II: Mesangial – Moderate proteinuria, active sediment.

Class III: Focal Segmental – Proteinuria, active sediment.

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

Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

63. **Table of Benefits** means the Table of Benefits specified under the Accident Benefits section of this Policy.

64. **Vector-borne Diseases** are a group of globally distributed and rapidly spreading serious diseases that are caused by vectors. These vectors are organism transmitting pathogens and parasites from one infected organism to another.

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65. **Waiting Period** means the period during which no benefits are payable under the cover. Such waiting period starts from the date of first inception of the policy.
66. **War** means war, whether declared or not or any warlike activities, including use of the military force by any sovereign nations to achieve economic, geographic, nationalistic, political racial religious or other ends.
67. **We/Us/Our/Company** means Liberty General Insurance Limited.
68. **You/Your/Yourself/Insured Person** means the insured persons named in the Policy Schedule/Certificate of Insurance.

Part II– Scope of Cover

This Policy offers selection of cover as per your need by providing options to choose from either of the cover as mentioned below under Section I, II, III, IV, V, VI, VII and VIII

Section I: Daily Hospital Cash Benefit

- a. **Daily Hospital Cash Benefit (DHC) - Illness / Injury** : In case of Hospitalization of the Insured Person/s for a Medically Necessary treatment (including AYUSH Treatment) due to any Illness or accidental bodily Injury sustained or contracted within the Policy Year, for a continuous period of more than the number of days as mentioned in policy schedule, a daily Hospital cash benefit as mentioned in the Schedule to the Policy, shall be payable for every completed 24 hours of Hospitalization, maximum up to the number of days as mentioned in the Schedule to the Policy (inclusive of both ICU & Non-ICU stay) with a maximum period of benefit during the Policy Year as per plan Opted

This benefit is available in Single Event Per Year and Multiple Event Per Year Option as opted and mentioned in the Policy Schedule or Certificate of Insurance.

OR

- b. **Daily Hospital Cash (DHC) - Only Accidents**: In case of Hospitalization of the Insured Person/s due to accidental bodily Injury and/or any Illness/sickness arising due to consequences of accidental bodily Injury sustained or contracted during the Policy Year, for a continuous period of more than the number of days as mentioned in policy schedule, a Daily Hospital Cash – Only Accidents as mentioned in the Schedule to the Policy shall be payable, for every completed 24 hours of Hospitalization, maximum up to the number of days as mentioned in the Schedule to the Policy (inclusive of both ICU & Non-ICU stay) with a maximum period of benefit during the Policy Year as per plan Opted

This benefit is available in Single Event Per Year and Multiple Event Per Year Option as opted and mentioned in the Policy Schedule or Certificate of Insurance.

Specific Condition applicable to Section I (Hospital Cash Benefit)

The cover as described under this Section, for specific Insured Person/s, shall terminate for that Policy Year in the event of complete utilization of the maximum number of coverage day opted, by one/or more claim as the case may be in respect of that Insured Person/s becoming admissible and accepted by the Company under this Section and the Company admitting liability against this Section I for that Insured Person/s.

Section II: Personal Accident Benefit

This section of the policy if opted provides compensation to the Insured Person, his or her nominee or legal representatives, as the case may be, the sum or sums as set forth in the Tables of Benefits below, subject to the

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Section Sum Insured being the maximum liability of the Company towards injury, solely and directly from accident and resulting in death or disability within 12 (twelve) calendar months of occurrence of such injury. The compensation under more than one benefit for same period of disability shall not exceed the **Section Sum Insured**.

The policy allows the Insured Person to choose any one or all the listed benefit coverage (1 and or 2 and or 3 and or 4) and Optional Cover as per his or her insurance needs:

Coverage

1. Accidental Death:

We will pay the Section Sum Insured as mentioned in the Policy Schedule / Certificate of Insurance in case of Accidental Death / Disappearance / Drowning of the Insured Person as the case may be, when the nominee or the legal heir provides a legally binding indemnity bond or any other document as required by Us which guarantees, that, if at any time, after the payment of the Accidental death benefit, it is discovered that the Insured Person is still alive, all payments shall be repaid in full to Us.

The total liability for payment of compensation for an Insured Person under the above Accidental Death benefits – Death due to Accident/ Disappearance Cover/ Drowning Cover in aggregate shall not exceed the amount mentioned as Section Sum Insured against each Insured Person in Policy Schedule. On payment of the Section Sum Insured as referred for all the above benefits, such benefits and relevant extensions shall cease to exist.

- a) The Company will pay, the Section Sum Insured less any other amount paid/payable under: Permanent Total Disability and Permanent Partial Disability and Temporary Total Disability section of this Policy.
- b) Once a Claim has been accepted and 100% Section Sum Insured has been paid then this Coverage shall immediately and automatically cease in respect of that Insured Person.

2. **Permanent Total Disability:** If an Insured Person suffers from an accidental injury during the Policy Period and within twelve calendar months from the date of Accident, which is the sole and direct cause of his/her Permanent Total Disability in one of the ways listed below, we will pay the percentage of the Section Sum Insured as shown in table of benefit listed below:

Table of Benefit –(I)

Permanent Total Disability – Table of Benefits	
Loss of	% of CSI
Limbs (both hands or both feet or one hand and one foot)	100%
Loss of a Limb and an eye	100%
Complete and irrecoverable loss of sight of both eye	100%
Complete and irrecoverable loss of speech & hearing of both ears	100%

In this benefit

- i. Limb means a hand at or above the wrist or a foot above the ankle.
- ii. Loss of Limb means physical separation of a limb above the wrist or ankle respectively

In case of physical severance of Limbs, waiting period of 12 months shall not be applicable and the claim would be payable immediately subject to admission of claim as per the Policy terms and conditions and submission of all necessary documents / information and any other additional information required for the settlement of the claim.

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The compensation under more than one event as stated above, for same period of disability shall not exceed the Section Sum Insured stated under this cover.

The total liability for payment of compensation for an Insured Person under Accident benefit(s) in aggregate shall not exceed the amount mentioned as Section Sum Insured against each Insured Person in Policy Schedule. On payment of the section Sum Insured as referred for all the above benefits, such benefits and relevant extensions shall cease to exist.

3. **Permanent Partial Disability:** If an Insured Person suffers from an accidental injury during the Policy Period and within twelve calendar months from the date of Accident, which is the sole and direct cause of his/her Permanent Partial Disability in one of the ways listed in the table of benefit listed below, we will pay the percentage of the Section Sum Insured as listed in the table below:

Table of Benefit –(II)

Permanent Partial Disability – Table of Benefits	
Loss of	% of CSI
Each arm at the shoulder joint	70%
Each arm to a point above elbow joint	65%
Each arm below elbow joint	60%
Each hand at the wrist	55%
Each thumb	20%
Each index finger	10%
Each other finger	5%
Each leg above center of the femur	70%
Each leg up to a point below the femur	65%
Each leg to a point below the knee	50%
Each leg up to the center of tibia	45%
Each foot at the ankle.	40%
Each big toe	5%
Each other toe	2%
Each eye	50%
Hearing in each ear	30%
Sense of smell	10%
Sense of taste	5%
Any other Permanent Partial Disability	Percentage as assessed by Registered medical practitioner

The total liability for payment of compensation for an Insured Person under Accident benefit(s) in aggregate shall not exceed the amount mentioned as Sum Insured against each Insured Person in Policy Schedule. On payment of the Sum Insured as referred for all the above benefits, such benefits and relevant extensions shall cease to exist.

In case of multiple claims under Permanent Partial Disability arising due to multiple events during the Policy Period, the total claim payable amount shall not exceed the Section Sum Insured stated under this cover.

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4. Temporary Total Disability: If an Insured Person suffers an accidental injury during the Policy Period which is the sole and direct cause of a Temporary Total Disability which completely prevents him/her from performing each and every duty pertaining to his/her employment or occupation of any description whatsoever, we will pay a weekly benefit amount as mentioned in the Policy Schedule / Certificate of Insurance, provided that:

- The temporary total disability is certified by the treating Doctor, and
- Our maximum liability to make payment will be limited to the amount per week and disability period not exceeding 104 weeks from the date of accident as opted and stated in the Schedule of this Policy towards this benefit.

The total liability for payment of compensation for an Insured Person under Accident benefit(s) in aggregate shall not exceed the amount mentioned as Section Sum Insured against each Insured Person named in the Policy Schedule. On payment of the Sum Insured as referred for all the above benefits, such benefits and relevant extensions shall cease to exist.

Specific Condition applicable to Section II (Personal Accident Benefit)

- a) The cover as described under this Section, for specific Insured Person/s, shall terminate in the event of claim exhausting the liability under this section in respect of that Insured Person/s becoming admissible and accepted by the Company under this Section and the Company admitting liability against Section II for the Insured Person/s
- b) The compensation under more than one benefit for same period of disability shall not exceed the Section II Sum Insured mentioned in the Policy Schedule/Certificate of Insurance
- c) The geographical scope of this benefit will be worldwide; however the claims shall be settled in India in Indian rupees

Section III: Critical Illness Benefit

While this Policy is in force, the Company shall provide the benefit in one lump sum or percentage of Sum Insured as stated in the Schedule to this Policy subject to the provisions, conditions and limitations contained herein or which may be endorsed hereinafter if the Insured Person is diagnosed to be suffering from or undergoing for the first time any of the listed surgical procedure for Covered Critical Illness as per the plan opted by the Insured Person subject to fulfillment of below conditions:

- (a) The Insured Person experiences a Critical Illness specifically listed and defined in this Policy; and
- (b) The Critical Illness experienced by the Insured Person is the first incidence of that Critical Illness; and
- (c) Any illness, medical event or surgical procedure as specifically defined which was first diagnosed more than 90 days after the commencement of first Policy Period; and
- (d) The Insured person survives the illness by 30 days or more, from the date of diagnosis.
- (e) Critical Illness coverage is available for Individual Insured Person and up to the Sum Insured as specified in the Schedule to this Policy.

Covered Critical Illness:

A “Critical Illness” shall mean any one of the following critical illness and it is subject to fulfillment of all conditions as defined above of this benefit and as applicable particularly to each Critical Illness as per plan opted and mentioned in Policy Schedule / Certificate of Insurance.

For list of Critical Illness and Plans available refer annexure B
Option-I and Option-II

Insured has option to choose any one or more than 1 plan as per his requirement.

In case of minor illness under Option-II our liability shall be limited to the percentage of Sum Insured as agreed and mentioned in the Policy Schedule / Certificate of Insurance.

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Specific Condition applicable to Section III (Critical Illness Benefit)

- a) The cover as described under this Section, for specific Insured Person/s, shall terminate in the event of one claim in respect of that Insured Person/s becoming admissible and accepted by the Company under this Section and the Company admitting liability against Section III for the Insured Person/s.
- b) The geographical scope of this benefit will be worldwide; however the claims shall be settled in India in Indian rupees

Section IV: Vector Borne Diseases Benefit

a. In-patient Hospitalization Benefit

This is a mandatory cover under this Section.

We will pay the Section Sum Insured for the Policy Year in the manner as specified in the Policy Schedule or Certificate of Insurance to an Insured Person due to medically necessary Hospitalization of an Insured Person due to;

1. Plan A - Dengue Fever
2. Plan B – Malaria
3. Plan C - Other Vector Borne Diseases listed below
 - a. Chikungunya
 - b. Japanese Encephalitis
 - c. Kala-azar
 - d. Lymphatic Filariasis
 - e. Zika Virus

which is/are covered as specified in the Policy Schedule or Certificate of Insurance and contracted during the Policy Year and as defined and opted under the Policy subject to waiting Period as specified in the Policy Schedule.

b. Double Vector Borne Diseases Benefit

We will pay the Section Sum Insured against this Benefit as specified in the Policy Schedule/Certificate of Insurance if the insured person is diagnosed and/or hospitalized for the 2nd time for the same Vector Borne disease for which the claim was admissible in Section 4(a) provided the 2nd diagnosis and/or hospitalisation is within 7 days from the date of discharge of 1st hospitalisation and with the severity as defined below.

Plans are as follow-

1) Plan A - Dengue Fever

Dengue Shock Syndrome is a complication of Dengue haemorrhagic fever which is a potentially fatal complication of dengue causing an

- i. enlarged liver with shock (a sudden drop in blood pressure),
- ii. irregular breathing,
- iii. dilated pupils
- iv. circulatory system failure
- v. damage to the lymphatic system
- vi. Encephalopathy presenting with dengue encephalitis associated with development of seizures and altered sensorium.

2) Plan B – Malaria

- i. Cerebral malaria affects the brain, which can cause brain to swell, sometimes leading to permanent brain damage altered mental status, or multiple seizures with P falciparum in the blood
- ii. Other severe complications like
 - o Liver failure and Hepatic Toxicity

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- Shock – a sudden drop in blood pressure,
- ARDS (acute respiratory distress syndrome)
- Acute Renal Failure
- Swelling and Rapture of Spleen

3) **Plan C - Other Vector Borne Diseases listed below**

- i. Chikungunya - Severe complications such as liver failure, myocarditis/pericarditis, encephalitis, pneumonia, renal failure, and pancreatitis
- ii. Japanese Encephalitis - Underlying injury to the brain, leading to memory loss and personality behaviour changes and epilepsy.
- iii. Kala-azar – Visceral leishmaniasis – Causing damage to Liver, spleen, and septicaemia
- iv. Lymphatic Filariasis – Payable only once in a lifetime The most common symptom of elephantiasis is swelling of body parts. The swelling tends to happen in the below most common
 - a. legs
 - b. genitals
 - c. breasts
 - d. arms
- v. Zika Virus - Neurologic complications in adults and children, including Guillain-Barré syndrome, neuropathy and myelitis

Coverage

1. Dengue Fever

Subject to Limit of Benefits, the Company shall pay the benefit as specified in the Policy Schedule in the event of the Insured Person(s), as the case may be being hospitalized during the Policy Year, with the diagnosis of Dengue which is confirmed by Medical Practitioner along with laboratory examinations results countersigned by a Pathologist/microbiologist indicating –

1. Immunoglobulins /Polymerase Chain Reaction (PCR) test showing positive results for Dengue
2. Concurrent to the above, the final diagnosis should be confirmed as Dengue Fever

2. Malaria

The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Person being hospitalized during the Policy Year, with the diagnosis of Malaria which is confirmed by a medical practitioner with confirmatory tests indicating presence of Plasmodium falciparum/ vivax/ malaria in the his/her blood by laboratory examination countersigned by a pathologist/microbiologist in peripheral blood smear or positive rapid diagnostic test (antigen detection test).

3. Lymphatic Filariasis

(Payable only once in lifetime)

The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Person being hospitalized during the Policy Year, with the diagnosis of Filariasis commonly known as elephantiasis, and same must be confirmed by a Medical Practitioner with laboratory examination with presence of microfilariae in a blood smear by microscopic examination and along with any two of the following Clear and visible manifestation of the disease:

1. lymphoedema,
2. elephantiasis and
3. scrotal swelling
4. Concurrent to the above three conditions the final diagnosis should be confirmed as Filariasis

Note-

1. If the Insured Person is already infected with Filariasis prior to first Policy inception, then this benefit will not be extended for lifetime
2. Once the Section Sum Insured for the policy year is paid for any Insured Person, no other claim for this condition shall be paid to the Insured Person in his/her entire lifetime.

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4. Kala Azar

The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Person being hospitalized during the Policy Year, with the diagnosis of Visceral Leishmaniosis, also known as kala-azar which is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver and anemia and same must be confirmed by a Medical Practitioner by parasite demonstration in bone marrow/spleen/lymph node aspiration or in culture medium as the confirmatory diagnosis or positive serological tests for kala azar indicating presence of this disease.

5. Chikungunya

The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Person being hospitalized during the Policy Year, with the diagnosis of Chikungunya which is characterized by an abrupt onset of fever with Joint pain. Other common signs and symptoms include muscle pain, headache, nausea, fatigue and rash and same must be confirmed by a Medical Practitioner and by Serological tests, such as enzyme-linked immunosorbent assays (ELISA), confirming the presence of IgM and IgG anti-chikungunya antibodies.

6. Japanese Encephalitis

The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Person being hospitalized during the Policy Year, with the diagnosis of Japanese Encephalitis which is characterized by rapid onset of high fever, headache, neck stiffness, disorientation, coma, seizures, spastic paralysis and same must be confirmed by a Medical Practitioner by positive serological test for Japanese Encephalitis by immunoglobulin M (IgM) antibody capture ELISA (MAC ELISA) for serum and cerebrospinal fluid (CSF).

7. Zika Virus

The Company shall pay the benefit as specified in the Policy Schedule in the event of Insured Person being hospitalized during the Policy Year, with the diagnosis of Zika virus disease which have symptoms like mild fever, skin rash, conjunctivitis, muscle and joint pain, malaise or headache and same must be confirmed by a registered medical practitioner by plaque-reduction neutralization testing (PRNT). PRNT is performed by CDC or a CDC-designated confirmatory testing laboratory to confirm presumed positive, equivocal, or inconclusive IgM results.

Specific Condition applicable to Section IV (Vector Borne diseases Benefit)

If we pay the claim for any of the listed vector borne diseases as per plan opted under Section IV(a) the cover under this section of Policy shall cease for the named Insured Person, as the case may be for that Policy Year. However, in case of multiyear policy, the sum insured shall get reinstated automatically for the next Policy Year.

Section V: EMI Protector Benefit

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, general exclusions stated in the Policy, to pay once during the Policy Period, on occurrence of the Insured Event as stated below under this Section and as per the Benefit Section opted and stated in the Policy Schedule/Certificate of Insurance, in relation to the Insured Person, the number of EMI Amount(s) as specified in the Policy Schedule/Certificate of Insurance, falling due in respect of the Loan (Loan account number as stated in Certificate of Insurance) after the commencement of the Insured Event as per the Benefit Section opted and stated in the Policy Schedule/Certificate of Insurance till the expiry of Policy Period, subject to a maximum of Section Sum Insured as stated under Schedule to this Policy / Certificate of Insurance for the Insured Person mentioned in the Policy.

However, if the Section Sum Insured opted is less than the Loan Amount, then the EMI payable will be in proportion to the Section Sum Insured opted and will not be the actual EMI corresponding to the Loan amount. In any case, the EMI payable cannot exceed the actual EMI. The benefit under this Section is available only for the Loan taken in the name of the Insured Person within India.

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Insured Event: For the purposes of this Section and the determination of the Company's liability under it, Insured Event in relation to the Insured Person, shall mean –

- a) **In-patient Hospitalization Benefit:** We shall pay the number of EMIs as specified in the Policy Schedule/Certificate of Insurance due to Illness/ Injury or Accident only as opted, for every completed continuous hospitalization exceeding the number of days mentioned in the Policy Schedule/Certificate of Insurance.

Explanation

1. Exceeds minimum no of days mentioned in Policy Schedule / Certificate of Insurance in single continuous hospitalisation – Benefit amount opted
 2. Exceeds 2 times the minimum no of days mentioned in Policy Schedule / Certificate of Insurance in single continuous hospitalisation - 2 times of benefit amount
 3. Exceeds 3 times the minimum no of days mentioned in Policy Schedule / Certificate of Insurance in single continuous hospitalisation - 3 times of benefit amount
- b) In case the continuous hospitalization exceeds the number of days opted, the company shall pay the number of EMIs as stated in the Policy Schedule / Certificate of Insurance, subject to the Policy terms and conditions.
- c) **Personal Accident Benefit:** We shall pay the number of EMIs as specified in the Policy Schedule/Certificate of Insurance or Actuals whichever is less, subject to the Policy terms and conditions, in case of Accidental Death and/or Permanent Total Disability and / or Permanent Partial Disability of the Insured Person.
- d) **Critical Illness Benefit:** We shall pay the number of EMIs as specified in the Policy Schedule/Certificate of Insurance or Actuals whichever is less, subject to the Policy terms and conditions, in case the Insured Person is diagnosed to be suffering from or undergoing for the first time any of the listed surgical procedure as opted and as defined under Covered Critical Illness herein below and if all of the following conditions are satisfied.
- i. The Insured Person experiences a Critical Illness specifically listed and defined in this Policy; and
 - ii. The Critical Illness experienced by the Insured Person is the first incidence of that Critical Illness; and
 - iii. Any illness, medical event or surgical procedure as specifically defined below which was first diagnosed more than 90 days after the commencement of first Policy Period; and
 - iv. The Insured person survives the illness by 30 days or more, from the date of diagnosis.
 - v. Critical Illness coverage is available for Individual Insured Person and up to the Sum Insured as specified in the Schedule to this Policy.

***Listed Critical Illnesses as opted (for admissibility of Claim under Section V):** A “Critical Illness” shall mean any one of the following critical illness and it is subject to fulfillment of all conditions as defined above of this benefit and as applicable particularly to each Critical Illness as per plan opted and mentioned in Policy Schedule / Certificate of Insurance.

For list of Critical Illness and Plans available refer annexure B
Option-I and Option-II

- e) **Vector Borne Disease Benefit:** We shall pay the number of EMIs as specified in the Policy Schedule/Certificate of Insurance or Actuals whichever is less, subject to the Policy terms and conditions, due to medically necessary Hospitalization of the Insured Person due to:
1. Plan A - Dengue Fever
 2. Plan B – Malaria
 3. Plan C - Other Vector Borne Diseases listed below
 - a. Chikungunya

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- b. Japanese Encephalitis
- c. Kala-azar
- d. Lymphatic Filariasis
- e. Zika Virus

which is/are covered as specified in the Policy Schedule or Certificate of Insurance and contracted during the Policy Year and as defined and opted under the Policy subject to waiting Period as specified in the Policy Schedule.

Specific Condition Applicable to Section V

1. The cover as described under this Section, for Insured Person, shall terminate in the event of one claim in respect of that Insured Person becoming admissible and accepted by the Company under this Section.
2. The geographical scope of this benefit will be worldwide; however the claims shall be settled in India in Indian rupees

Section VI: Loan Protector Benefit

We shall pay once during the Policy Period, the Principal Outstanding Loan Amount falling due in respect of the Loan (Loan account number as stated in Certificate of Insurance) after the commencement of the Insured Event as per the Benefit Section opted and stated in the Policy Schedule/Certificate of Insurance, till the expiry of Policy Period, subject to a maximum of the Section Sum Insured as stated under the Schedule to this Policy/Certificate of Insurance for the Insured Person mentioned in the Policy, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, general exclusions stated in the Policy.

However, if the Section Sum Insured opted is less than the Loan Amount, then the Principal Outstanding Loan Amount payable will be in proportion to the Section Sum Insured opted and will not be the actual Loan amount corresponding to the Loan account. In any case, the Principal Outstanding Loan Amount payable cannot exceed the actual outstanding amount.

Insured Event: For the purposes of this Section and the determination of the Company's liability under it, Insured Event in relation to the Insured Person, shall mean –

- a) **Personal Accident Benefit:** We shall pay the Principal Outstanding Loan Amount falling due in respect of the Loan (Loan account number as stated in Certificate of Insurance) subject to a maximum of the Section Sum Insured or Percentage of Sum Insured as stated under the Schedule to this Policy/Certificate of Insurance, in case of Accidental Death and/or Permanent Total Disability and / or Permanent Partial Disability of the Insured Person, subject to the Policy terms and conditions.

* Permanent Total Disability - Our liability shall be limited to the percentage of Sum Insured mentioned in the Table of Benefit (I) of Section II

*Permanent Partial Disability – Our liability shall be limited to the percentage of Sum Insured mentioned in the Table of Benefit (II) of Section II

- b) **Critical Illness Benefit:** We shall pay the Principal Outstanding Loan Amount falling due in respect of the Loan (Loan account number as stated in Certificate of Insurance) subject to a maximum of the Section Sum Insured as stated under the Schedule to this Policy schedule/Certificate of Insurance, subject to the Policy terms and conditions, in case the Insured Person is diagnosed to be suffering from or undergoing for the first time any of the listed surgical procedure as defined under Covered Critical Illness herein below and if all of the following conditions are satisfied.
 - i. The Insured Person experiences a Critical Illness specifically listed and defined in this Policy; and
 - ii. The Critical Illness experienced by the Insured Person is the first incidence of that Critical Illness; and
 - iii. Any illness, medical event or surgical procedure as specifically defined below which was first diagnosed more than 90 days after the commencement of first Policy Period; and
 - iv. The Insured person survives the illness by 30 days or more, from the date of diagnosis.

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- v. Critical Illness coverage is available for Individual Insured Person and up to the Sum Insured as specified in the Schedule to this Policy.

***Listed Critical Illnesses as opted (for admissibility of Claim under Section VI):** A “Critical Illness” shall mean any one of the following critical illness and it is subject to fulfillment of all conditions as defined above of this benefit and as applicable particularly to each Critical Illness as per plan opted and mentioned in Policy Schedule / Certificate of Insurance.

For list of Critical Illness and Plans refer annexure B Option-I and Option-II

Specific Condition Applicable to Section VI

1. The cover as described under this Section, for Insured Person, shall terminate in the event of one claim in respect of that Insured Person becoming admissible and accepted by the Company under this Section.
2. The geographical scope of this benefit will be worldwide; however the claims shall be settled in India in Indian rupees

Section VII: Infectious Diseases Benefit

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, General Exclusions stated in this Policy, to pay the Sum Insured in relation to the Insured person as stated against this Section under Policy Schedule and Certificate of Insurance on the occurrence of an Insured Event as stated below, under this part of Section VII.

For the purposes of this Section and the determination of the Company’s liability under it, the Insured Event in relation to the Insured person, shall mean **any one of the below** as opted by the Insured Person and specified in the Policy Schedule / Certificate of Insurance –

- 1) First diagnosis of (or first medical advice or treatment in relation to) illness or medical event, with respect to the Insured Person
- OR
- 2) Medically necessary In-patient Hospitalization for minimum 24 hours of an Insured Person due to illness or medical event

which is/are covered as specified in the Policy Schedule or Certificate of Insurance and contracted during the Policy Year and as defined and opted under the Policy subject to waiting Period as specified in the Policy Schedule.

Following are the sets of various infectious diseases for which coverage is available under this Section. Set/Sets as opted by Insured Person and as specified in Policy schedule/Certificate of Insurance are covered.

Set A: Infectious Diseases.		Set B: HIV Infection	Set C: Covid Infection
Typhoid	Ebola	HIV	Covid -19
Hepatitis A, D & E	Swine Influenza Virus, H1N1 Virus		
Amoebiasis	SARS, MERS		
Leptospirosis	Mucormycosis		
Cholera	Diphtheria		
Nipah Virus	Tuberculosis		

Coverage Type for Infectious diseases:

- a) Common SI for opted sets:

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Sum insured limit for this Section will be applicable for all the sets opted. Therefore, if a claim becomes payable for any of the covered infectious disease, the coverage under this section shall be terminated for remaining policy period. In case of multiyear policy, the Sum Insured shall get reinstated automatically for the next Policy Year.

*If we pay the claim for any of the listed Diseases as per the plan opted under Section VII the cover under this section of Policy shall cease for the named Insured Person, as the case may be for that Policy Year. However, in case of multiyear policy, the sum insured shall get reinstated automatically for the next Policy Year.

b) Separate SI for opted sets:

Sum insured limit for covered sets of infectious diseases will be applicable separately for each of the sets opted. Therefore, if a claim becomes payable for any of the covered infectious disease the coverage under the set to which such disease belongs, shall be terminated for remaining policy period. Coverage will be available for remaining opted set(s), if any, of this Section.

*In case of multiyear policy, the sum insured shall get reinstated automatically for the next Policy Year.

The Insured Event under this Section and the conditions applicable to this Section are more particularly defined below:

Set A: Infectious Diseases

1) **Typhoid**

Typhoid or Typhoid fever is an acute infectious disease caused by the bacterium Salmonella Typhi. The illness is characterized by prolonged fever, headache, nausea, loss of appetite, and constipation or sometimes diarrhoea. The diagnosis should be confirmed by isolation of bacteria through blood culture or by analysing blood, stool or urine sample. The diagnostic tests reports must be countersigned by qualified MD pathologist.

2) **Hepatitis A, D & E**

Acute viral hepatitis caused by Hepatitis virus A, D or E, characterized by symptoms such as jaundice (yellowing of the skin and eyes), dark urine, extreme fatigue, nausea, vomiting and abdominal pain Or Chronic hepatitis caused by Hepatitis B or C virus. Diagnosis of such viral hepatitis must be established by clinical symptoms, physical examination by Medical Practitioner and blood tests. Hepatitis caused by other infections, by secondary result of medication, drugs, toxins and alcohol; and autoimmune hepatitis is excluded. Hepatitis B and Hepatitis C are excluded.

3) **Amoebiasis**

Amoebiasis is an infection caused by Entamoeba Histolytica causing both intestinal and extraintestinal symptoms leading to the complications like Amoebic liver abscess.

4) **Leptospirosis**

Leptospirosis is a bacterial infection that affects that spreads from contact of unhealed break or injured skin with contaminated water or soil resulting in the complications like Kidney and Liver failure, Sepsis.

5) **Cholera**

An infectious disease caused by infection with the bacteria Vibrio cholerae and characterized by intense vomiting and profuse watery diarrhea and that rapidly leads to dehydration. Clinical symptoms must be certified by treating Medical Practitioner. Diagnosis must be established by pathological tests for identification of bacteria in stool sample.

6) **Nipah Virus**

Nipah Virus is caused by virus through Bats leading to drowsiness, disorientation and respiratory distress leading to the complications like Inflammation and irreversible damage to brain. Diagnosis of this disease must be confirmed by testing for antibodies using an enzyme-linked immunosorbent assay (ELISA).

7) **Ebola**

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Ebola virus disease is a deadly disease which spreads from few animals like Monkeys, Bats etc., through body fluids and mucus membranes leading to Fever, severe body ache, rashes and diarrhoea leading to the complications like Septic shock and death. Clinical symptoms must be certified by treating Medical Practitioner. Diagnosis must be established by pathological tests like Polymerase chain reaction (PCR).

8) **Swine Influenza Virus, H1N1 Virus**

A rapidly contagious infection transmitted from animals and spread through droplet circulation leading to fever, cough and severe respiratory symptoms leading to the complications like Pneumonia leading to Respiratory arrest, Lung fibrosis, renal failure, septic shock and death. Diagnosis must be established by clinical signs and symptoms and laboratory test like Polymerase chain reaction (PCR).

9) **SARS, MERS**

A rapidly contagious infection caused by a virus from Coronavirus Family, transmitted from animals and spread through droplet circulation leading to fever, cough, mild to severe respiratory symptoms leading to the Complications like Pneumonia leading to Respiratory failure, cardiorespiratory arrest, Lung fibrosis, renal failure, septic shock and death. Diagnosis must be established by clinical signs and symptoms and laboratory test rRT-PCR.

10) **Mucormycosis**

Mucormycosis is a type of fungal infection. It's relatively rare, but also very serious. Formally known as zygomycosis, this infection tends to occur most often if you have weakened immunity from an illness or health condition. It may lead to Brain infection, Paralysis, Pneumonia, Seizures and death. Diagnosis must be established by clinical signs and symptoms and laboratory test like analysis of biological specimens from clinically involved sites, direct examination & fungal culture.

11) **Diphtheria**

Diphtheria is an upper respiratory tract infection which spreads through touch and droplets starts with thick coating of throat, swelling of glands in neck and fever. Resulting to Respiratory failure, Paralysis, Myocarditis or Polyneuropathy. Diagnosis of diphtheria must be confirmed by culture of the organism from the specimen and by demonstrating toxin production using an immunoprecipitation reaction (the modified Elek test).

12) **Tuberculosis**

Tuberculosis or TB is a contagious infection caused by the bacterium Mycobacterium tuberculosis which usually attacks the lungs. It can also spread to other parts of the body, like the brain and spine. Tubercles (tiny lumps) are a characteristic finding in TB. Other symptoms of TB include chronic cough with blood containing mucus, fever, night sweats and weight loss. Diagnosis must be evidenced by AFB smear test and by culturing Mycobacterium tuberculosis organisms from a specimen taken from the patient (most often sputum, but may also include pus, CSF, biopsied tissue, etc.). All diagnostic test result reports must be duly signed by qualified MD pathologist. For the purpose of this policy coverage, only the active cases of Tuberculosis are covered. Tuberculosis secondary to infections like HIV or due to immunosuppressive drugs are excluded.

Set B: HIV Infection

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

Set C: Covid Infection

Covid-19 means coronavirus disease as defined by the World Health Organization (WHO) and caused by the virus SARS-CoV2. The positive diagnosis of Covid shall be from a government authorized diagnostic centre.

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Section VIII: Income Protection Cover

The Company hereby agrees, subject to the terms, conditions and exclusions applicable to this Section and the terms, conditions, general exclusions stated in the Policy, to pay once during the Policy Period, in relation to the Insured Person, after Insured Person has completely utilized the Sick / Casual / Privileged / Paid leaves paid from the time the Insured Person goes on Leave of Absence (without pay) till her/his return to employment (with pay) or till end of maximum number of weeks specified in Policy Schedule / Certificate of Insurance whichever is earlier, arising due to below mentioned insured event:

- a) **Loss of Income Due to Accident-** If the Insured Person suffers from an accidental injury during the Policy Period and within twelve calendar months from the date of Accident, which is the sole and direct cause of his Permanent Total Disability and / or Permanent Partial Disability and / or Temporary Total Disability of the Insured Person
OR
- b) **Loss of Income Due to Listed Critical Illness-** During the policy period if the Insured Person is being diagnosed to be suffering from or undergoing for the first time any of the listed surgical procedure as defined under Covered Critical Illness herein below and if all the following conditions are satisfied.
- The Insured Person experiences a Critical Illness specifically listed and defined in this Policy; and
 - The Critical Illness experienced by the Insured Person is the first incidence of that Critical Illness; and
 - Any illness, medical event or surgical procedure as specifically defined below which was first diagnosed more than 90 days after the commencement of first Policy Period; and
 - The Insured person survives the illness by 30 days or more, from the date of diagnosis.
 - Critical Illness coverage is available for Individual Insured Person and up to the Sum Insured as specified in the Schedule to this Policy.

***Listed Critical Illnesses (for admissibility of Claim under Section VIII):** A “Critical Illness” shall mean any one of the following critical illness and it is subject to fulfillment of all conditions as defined above of this benefit and as applicable particularly to each Critical Illness as per plan opted and mentioned in Policy Schedule / Certificate of Insurance.

For list of Critical Illness and Plans available refer annexure B
Option-I and Option-II

Specific Condition Applicable to Section VIII

- The cover as described under this Section, for Insured Person, shall terminate in the event of one claim in respect of that Insured Person becoming admissible and accepted by the Company under this Section.
- The geographical scope of this benefit will be worldwide; however the claims shall be settled in India in Indian rupees

Part III – Applicable Waiting Periods.

Waiting Period Applicable to Section I – Daily Hospital Cash Benefit, Section V - EMI Protector Benefit (a) and Section VII – Infectious Diseases Benefit, Optional Cover -Surgical Benefit Cover, Joint Hospitalization Cover and Convalescence Benefit Cover, unless specifically waived off and mentioned in the Policy Schedule / Certificate Of Insurance,

- 30 days Waiting Period: Code Excl03**
 - Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
 - This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

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- c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.
2. **90 days Waiting Period:** Expenses related to the treatment of Critical illness(s) within 90 days from the first policy commencement date shall be excluded except claims arising due to accidental bodily Injury requiring hospitalization, provided the same are covered
3. **Specified disease/procedure waiting period- Code- Excl02**
- Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 /24 /36 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
 - In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
 - If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
 - The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
 - If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
 - List of specific diseases/procedures

i) First Year (12 months) Waiting Period:

During the first Year of operation of this insurance cover, expenses on treatment of the following diseases are not payable: Cataract, Benign Prostatic Hypertrophy, Hernia, Hydrocele, Fistula in anus, piles, Sinusitis and related disorders, Fissure, Gastric and Duodenal ulcers, gout and rheumatism; internal tumors, cysts, nodules, polyps including breast lumps (each of any kind unless malignant); Hysterectomy/ myomectomy for menorrhagia or fibromyoma or prolapse of uterus, polycystic ovarian diseases; skin tumors unless malignant, benign ear, nose and throat (ENT) disorders and surgeries (including but not limited to adenoidectomy, mastoidectomy, tonsillectomy and tympanoplasty); dilatation and curettage (D&C); & Congenital Internal Diseases.

ii) Two Year (24 months) Waiting Period:

During the first two Years of the operation of this insurance cover, the expenses on treatment of following diseases are not payable: Calculus diseases of Gall bladder and Urogenital system, Hypertension and Diabetes and related complications, Joint Replacement due to Degenerative condition, Surgery for prolapsed inter vertebral disc unless arising from accident, Age related Osteoarthritis and Osteoporosis, Spondylosis / Spondylitis, Surgery of varicose veins and varicose ulcers.

Diabetes & related complications including but not limited to: Diabetic Retinopathy, Diabetic Nephropathy, Diabetic Foot/Wound, Diabetic Angiopathy, Diabetic Neuropathy, Hypo/Hyperglycemic Shocks.

Hypertension & related complications including but not limited to: Coronary Artery Disease, Cerebrovascular Accident, Hypertensive Nephropathy, Internal Bleed/Haemorrhages.

Treatment related to Anxiety (F06, F40-41), Conduct & Mood disorders (F34, F38-39, F92-93, F98), Personality disorders (F60-61, F93) and stress (F43)*

If these diseases/disorders are pre-existing at the time of proposal or subsequently found to be pre-existing, then Pre-Existing Condition Exclusion (“e” below) shall be applicable.

iii) Three Year (36 months) Waiting Period:

Treatment of Bipolar (F31), Delirium (F05), Dementia (F00-F03), Depression (F30,F32,F33), Hyperkinetic (F90), Mental retardation (F70-79), Schizophrenia (F20-29), including its

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complications will be covered post 36 continuous months of this Policy with us. The Waiting Period shall apply unless expressly stated to the contrary elsewhere in this Policy.*

* The illnesses/diseases mentioned with the coding in the bracket such as F06, F40 are as per the 'International Classification of Diseases (ICD's). ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion.

4. Pre- Existing Diseases: Code- Excl01

- a. Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
- b. In case of enhancement of sum insured the exclusion shall apply afresh top the extent of sum insured increase
- c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- d. Coverage under the policy after expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of proposal and accepted by Insurer.

Waiting Period applicable to Section III – Critical Illness Benefit, Section V-EMI Protector Benefit ©, Section VI – Loan Protector Benefit (b) and Section VIII – Income Protection (b) Benefit, unless specifically waived off and mentioned in the Policy Schedule / Certificate Of Insurance

1. **90 days Waiting Period:** A waiting period of 90 days from the commencement date of the first Policy will apply to Critical Illness (es) contracted other than accidental bodily Injury requiring Hospitalization

2. Pre-Existing Diseases: Code- Excl01

- a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.
- b) In case of enhancement of sum insured the exclusion shall apply afresh top the extent of sum insured increase
- c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.
- d) Coverage under the policy after expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

3. Specified disease/procedure waiting period- Code- Excl02

- a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 /36 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- f) List of specific diseases/procedures

1. Two Year (24 months) Waiting Period:

Treatment related to Anxiety (F06, F40-41), Conduct & Mood disorders (F34, F38-39, F92-93, F98), Personality disorders (F60-61, F93) and stress (F43)*

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If these diseases/disorders are pre-existing at the time of proposal or subsequently found to be pre-existing, exclusion below shall be applicable.

2. **Three Year (36 months) Waiting Period:**

Treatment of Bipolar (F31), Delirium (F05), Dementia (F00-F03), Depression (F30,F32,F33), Hyperkinetic (F90), Mental retardation (F70-79), Schizophrenia (F20-29), including its complications will be covered post 36 continuous months of this Policy with us. The Waiting Period shall apply unless expressly stated to the contrary elsewhere in this Policy.*

* The illnesses/diseases mentioned with the coding in the bracket such as F06, F40 are as per the International Classification of Diseases (ICD's). ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive, hierarchical fashion.

4. **Survival Period:**

A claim for an insured condition becomes valid and payable if the Insured Person survive for 30 days after the insured condition.

Waiting Period under Section IV - Vector Borne Diseases Benefit and Section V – EMI Protector Benefit (d), unless specifically waived off and mentioned in the Policy Schedule / Certificate Of Insurance

1. **30 days Waiting Period: Code Excl03**

- Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

2. If the Policy is opted after occurrence of any of the listed vector borne diseases, 60 days waiting period shall be applicable for the specific ailment from date of previous admission. However,

- Single Year Policy - Once a benefit is paid under this section during the Policy Period and the Named Insured Person renews the Policy, in such scenario for the renewal Policy, 60 days waiting period from date of previous admission would apply for the specific ailment of which a claim has been paid.
- Multi-Year Policy - Once a benefit is paid under this section during the Policy Year and the policy is continued for the next policy year in case of long term policy, in such scenario 60 days waiting period from date of previous admission would apply for the specific ailment of which a claim has been paid.

3. If the Policy is renewed post 60 days from the date of admission of the previously paid claim for the named Insured Persons, then a fresh waiting period of 15 days shall apply for all listed vector borne diseases.

Part IV – Section Specific Exclusions (In addition to General Exclusions)

Specific Exclusions applicable to Section I – Daily Hospital Cash Benefit, Section V EMI Protector Benefit (a) as per benefit cover opted, unless specifically waived off and mentioned in the Policy Schedule / Certificate Of Insurance

We will not make any payment for any claim in respect of any Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary elsewhere in this Policy:

1. **Maternity: Code Excl18**

- Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

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- ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
2. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident
3. Any OPD treatment
4. Treatment received outside India
5. Charges incurred at Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury for which Inpatient Care/Day Care Treatment is required
6. Any charges incurred to procure any medical certificate, treatment or Illness related documents pertaining to any period of Hospitalization or Illness.
7. Alopecia, wigs and/or toupee and all hair or hair fall treatment and products
8. EECF & Chelation Therapy, Rotational Field Quantum Magnetic Resonance (RFQMR) or Cytotron therapy.

Specific Exclusions applicable to Section II – Personal Accident Benefit, Section V-EMI Protector Benefit (b), Section VI-Loan Protector Benefit (a) and VIII-Income Protection Benefit (a) as per benefit cover opted.

The Company shall not be liable under this Policy for –

1. Death or disability resulting directly or indirectly caused by, contributed to or aggravated or prolonged by childbirth or from pregnancy excluding ectopic pregnancy.
2. Any pre-existing condition/ disability / accidental injury except where the proximate cause of injury is accident.
3. Any claim arising out of Insured Person(s) serving in any branch of the Military or Armed Forces of any country during war or warlike operations.
4. We shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

Specific Exclusion applicable to Section III – Critical Illness Benefit, Section V-EMI Protector Benefit (c), Section VI-Loan Protector Benefit (b) and VIII-Income Protection Benefit (b) as per benefit cover opted, unless specifically waived off and mentioned in the Policy Schedule / Certificate Of Insurance.

The Company shall not be liable to make any payment under this Policy in connection with or in respect of any Insured Event, as stated in this Section, occurred or suffered before the commencement of Period of Insurance or arising within the first 90 days of the commencement of the Period of Insurance.

1. If the Insured Person does not submit a medical certificate from the Doctor evidencing diagnosis of Illness or Injury or occurrence of the medical event or the undergoing of the medical / surgical procedure in relation to the claim of the particular insured Person.
2. Any Critical Illness arising out of use, abuse or consequence or influence of any substance (substances that are abused like illegal drugs, opioids, marijuana etc) intoxicant, drug, alcohol or hallucinogen.
3. Any illness which is not a part of the listed Critical Illness, as mentioned under Section III of the Policy and/or not opted by the Insured/Insured Person/s.

Specific Exclusion applicable to Section IV - Vector Borne Diseases Benefit and Section V- EMI Protector Benefit (d) as per benefit cover opted, unless specifically waived off and mentioned in the Policy Schedule / Certificate Of Insurance.

We will not make any payment for any claim in respect of the Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy;

- 1) Pre-existing Lymphatic Filariasis at the time of taking the policy is excluded for lifetime
- 2) Any OPD Treatment
- 3) Any Treatment taken for any illness other than for vector borne diseases as listed in Section IV
- 4) Admission to hospital for less than 24 hours
- 5) Diagnosis and treatment outside India.

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Specific Exclusion applicable to Section VIII - Infectious Diseases Benefit , unless specifically waived off and mentioned in the Policy Schedule / Certificate Of Insurance

We will not make any payment for any claim in respect of the Insured Person directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary in this Policy

1. Any Treatment taken for any illness other than for infectious diseases as listed in Section VII.
2. Diagnosis and treatment outside India.
3. If the Insured does not submit a medical certificate from the Medical Practitioner evidencing diagnosis of Illness or Injury or occurrence of the medical event or the undergoing of the medical / surgical procedure in relation to the claim of the particular Insured Person.
4. Any treatment/surgery for change of sex or any cosmetic surgery or treatment/surgery /complications/illness arising as a consequence thereof.
5. Treatment by a family member and self-medication or any treatment that is not scientifically recognized.

Part V - General Exclusions applicable to all sections

We will not make any payment for any claim in respect of any Insured Person/s directly or indirectly for, caused by, arising from or in any way attributable to any of the following unless expressly stated to the contrary elsewhere in this Policy:

1) **Rest Cure, rehabilitation and respite care: Code- Excl05**

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment, this also includes:

- (i) Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled person
- (ii) Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

2) **Obesity /Weight Control: Code-Excl06**

Expenses related to the surgical treatment of obesity that does not full fill all the below condition

- (i) Surgery to be conducted is upon the advice of the doctor
- (ii) The Surgery/procedures conducted should be supported by clinical protocols
- (iii) The member has to be 18 years of age or older and
- (iv) Body Mass Index (BMI)
 - (1) Greater than or equals to 40 or
 - (2) Greater than or equals to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
 - (a) Obesity related cardiomyopathy
 - (b) Coronary Heart disease
 - (c) Severe Sleep Apnea
 - (d) Uncontrolled Type2 Diabetes

3) **Change of Gender Treatments: Code-Excl07**

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

4) **Cosmetic or Plastic Surgery: Code-Excl08**

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

5) **Hazardous and Adventure Sports: Code-Excl09**

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

6) **Breach of Law: Code-Excl10**

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

- 7) Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code-Excl12**
- 8) Treatments received in health spas, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code-Excl13**
- 9) **Unproven Treatments: Code-Excl16**
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- 10) **Sterility and Infertility: Code-Excl17**
Expenses related to sterility and infertility. This includes:
 - a) Any type of contraception, sterilization
 - b) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
 - c) Gestational Surrogacy
 - d) Reversal of sterilization

II. Other Exclusions

- 1) Treatment taken from anyone who is not registered as Medical Practitioners under respective Medical Councils or from a Medical Practitioner who is practicing outside the discipline for which he is licensed, or the treatment is undertaken from an immediate family member or any kind of self-medication.
- 2) Congenital external diseases, defects or anomalies.
- 3) Birth control procedures and hormone replacement therapy.
- 4) War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.
- 5) Dental care or surgery except as occasioned by Accidental Injury and requiring hospitalization.
- 6) Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
 - (i) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
 - (ii) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
 - (iii) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
- 7) Any expenses incurred on Domiciliary Hospitalization and OPD treatment
- 8) Any claim of the Insured Person

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- i) from intentional self-injury, suicide or attempted suicide
 - ii) whilst under the influence of liquor or drugs or other intoxicants except where the insured person is not directly responsible for the injury / accident though under influence of intoxication.
 - iii) as a result of active participation in any violent labour disturbance, riot or civil commotion or public disorder
 - iv) driving any vehicle without a valid driving licence
 - v) whilst engaging as a driver, co-driver or passenger of a vehicle engaging in speed contest or racing of any kind or participating in a trail run.
- 9) Any loss whilst flying or taking part in aerial activities (including cabin crew) except as a fare-paying passenger in a regular Scheduled airline or Air Charter Company.

Fare paying passenger includes person travelling through some concession or benefit in terms of valid boarding pass / voucher

Expenses for treatment directly arising from or consequence upon any insured person participating in an actual or attempted felony, riot, crime, misdemeanor or civil commotion.

- 10) Any claim caused by or contributed to or arising from-
- i) Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel and for the purpose hereof, combustion shall include any self-sustaining process of nuclear fission; or
 - ii) Nuclear weapons material

Part VI - General Terms & Conditions

I. Standard General Terms and Conditions

1. Complete Discharge

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

2. Condition Precedent to Admission of Liability

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

3. Disclosure of information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis-description or non-disclosure of any material fact by the policyholder

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

4. Material Change / Change of Occupation

The Insured/ Insured Person shall immediately notify the Company in writing of any material change in the risk or change in business or occupation during the currency of the Policy and the Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

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

5. Multiple Policies ((if applicable))

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a) Indemnity based policies : In case of multiple policies held by Insured person, insured person has a choice to file claim settlement under any policy. if insured person chooses to file such claim under policy held with with the Company, then same shall be treated as the primary Insurer. In case the available coverage under the said policy is less than the admissible claim amount, then we, Liberty General Insurance as primary Insurer shall seek the details of other available policies of the Insured and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the Insured.

b) Benefit based Policies:

On occurrence of the insured event, the policyholders can claim from all Insurers under all policies.

6. Fraud

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

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all person(s), who has made the particular claim, who shall be jointly and severally liable for such repayment to the Company.

For the purpose of this clause, the expression "fraud" means any or all of the following acts wilfully committed by the Insured Person or by his agent or intermediary, with intent to deceive the insurer or to induce the insurer to issue an insurance Policy:

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

The Company shall not repudiate the claim and/or forfeit the policy benefits on the ground of fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer.

7. Premium Payment in Installments (if applicable)

If the insured person has opted for payment of premium on an installment basis i.e. Half Yearly, Quarterly or Monthly as mentioned in the certificate of insurance, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the policy). This facility needs to be opted before inception of the policy and opting ECS/SI payment mode.

- i. The grace period of fifteen days (where premium is paid in monthly installments) and thirty days (where premium is paid in quarterly/half-yearly/annual installments) is available on the premium due date, is available to the policyholder to pay the premium.
- ii. If the premium is paid in instalments during the policy period, coverage will be available for the grace period also.
- iii. If the policy is renewed during grace period, all the credits (Sum Insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
- v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
- vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
- vii. The company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Installment Frequency	% of Annual Premium
Half Yearly	51%
Quarterly	26%

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The total premium applicable for a yearly or long-term policy tenure shall be collected by us not later than first year of the policy.	Monthly	8.75%
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Please review the installment payment terms on the right, which apply to standard premiums.

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

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

9. Cancellation (if applicable)

(i) The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall

- a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period.
- b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

(ii) The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

10. Migration (if applicable)

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30days before policy renewal date as per IRDA Guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDA Guidelines on Migration.

11. Portability (if applicable)

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 30 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

12. Moratorium Period (if applicable)

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the insurer on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

Note :The accrued credits gained under the ported and migrated policies shall be counted for the purpose of calculating the Moratorium period.

13. Nomination

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

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14. Free look period (if applicable)

The insured person shall be allowed free look period of 30 days from date of receipt of the policy document 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. The Free Look Period shall be applicable only for new individual health insurance policies, except for those policies with tenure of less than a year and not on renewals.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to -

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

15. Renewal of Policy (if applicable)

The policy shall ordinarily be renewable except on grounds of established fraud or non-disclosure or misrepresentation by the insured person.

- i. The Company shall give notice for renewal at least 30 days prior to expiry of the policy.
- ii. Renewal of a health insurance policy shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

10. Notice

Every notice and communication to the Company required by this Policy shall be in writing and be addressed to the registered office of the Company. In case the Policy is sold via voice log the notice to the Company may be placed via same mode.

11. Withdrawal of Product

In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.

Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

II. Specific General Terms and Conditions

1. Observance of Terms and Conditions

The due observance and fulfillment of the terms, conditions and endorsements of this Policy insofar as they relate to anything to be done or complied with by the Insured/Insured Person/s shall be a condition precedent to any liability of the Company to make any payment under this Policy.

2. Notice of charge

The Company shall not be bound to take notice or be affected by any notice of any trust, charge, lien, or other dealing with or relating to this Policy, but the payment by the Company to the Insured /Insured Person, his/her nominees or legal representatives, as the case may be, of any compensation or benefit under the Policy shall in all cases be an effectual discharge to the Company.

3. Assignment

You can assign this policy under intimation to Us. Assignment of a policy shall be in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time .

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1) An assignment of a policy of insurance, wholly or in part, whether with or without consideration, may be made only by an endorsement upon the policy itself or by a separate instrument, signed in either case by the assignor or his duly authorised agent and attested by at least one witness, specifically setting forth the fact of assignment and the reasons thereof, the antecedents of the assignee and the terms on which the assignment is made.

(2) An insurer may, accept the assignment, or decline to act upon any endorsement made under sub-section (1), where it has sufficient reason to believe that such assignment is not bona fide or is not in the interest of the Insured Person or in public interest or is for the purpose of trading of insurance policy.

(3) The insurer shall, before refusing to act upon the endorsement, record in writing the reasons for such refusal and communicate the same to the Insured Person not later than thirty days from the date of the Insured Person giving notice of such assignment.

(4) Any person aggrieved by the decision of an insurer to decline to act upon such assignment may within a period of thirty days from the date of receipt of the communication from the insurer containing reasons for such refusal, prefer a claim to the Authority.

(5) Subject to the provisions in sub-section (2), the assignment shall be complete and effectual upon the execution of such endorsement or instrument duly attested but except, where the assignment is in favour of the insurer, shall not be operative as against an insurer, and shall not confer upon the assignee, or his legal representative, any right to sue for the amount of such policy or the moneys secured thereby until a notice in writing of the assignment and either the said endorsement or instrument itself or a copy thereof certified to be correct by both assignor and assignee or their duly authorised agents have been delivered to the insurer: Provided that where the insurer maintains one or more places of business in India, such notice shall be delivered only at the place where the policy is being serviced.

(6) The date on which the notice referred to in sub-section (5) is delivered to the insurer shall regulate the priority of all claims under the assignment as between persons interested in the policy; and where there is more than one instrument of assignment the priority of the claims under such instruments shall be governed by the order in which the notices referred to in sub-section (5) are delivered: Provided that if any dispute as to priority of payment arises as between assignees, the dispute shall be referred to the Authority.

(7) Upon the receipt of the notice referred to in sub-section (5), the insurer shall record the fact of such assignment together with the date thereof and the name of the assignee and shall, on the request of the person by whom the notice was given, or of the assignee, on payment of such fee as may be specified by the regulations, grant a written acknowledgement of the receipt of such notice; and any such acknowledgement shall be conclusive evidence against the insurer that he has duly received the notice to which such acknowledgment relates.

(8) Subject to the terms and conditions of the assignment, the insurer shall, from the date of the receipt of the notice referred to in sub-section (5), recognise the assignee named in the notice as the absolute assignee entitled to benefit under the policy, and such person shall be subject to all liabilities and equities to which the assignor was subject at the date of the assignment and may institute any proceedings in relation to the policy, obtain a loan under the policy or surrender the policy without obtaining the consent of the assignor or making him a party to such proceedings. Explanation. Except where the endorsement referred to in sub-section (1) expressly indicates that the assignment is conditional in terms of subsection (10) hereunder, every assignment shall be deemed to be an absolute assignment and the assignee shall be deemed to be the absolute assignee.

(9) Notwithstanding any law or custom having the force of law to the contrary, an assignment in favour of a person made upon the condition that —

(a) the proceeds under the policy shall become payable to the Insured Person or the nominee or nominees in the event of either the assignee predeceasing the insured Person; or

(b) the Insured Person surviving the term of the policy, shall be valid: Provided that a conditional assignee shall not be entitled to obtain a loan on the policy or surrender a policy.

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(10) In the case of the partial assignment of a policy of insurance under sub-section (1), the liability of the insurer shall be limited to the amount secured by partial assignment and such insured person shall not be entitled to further assign the residual amount payable under the same policy.

4. Special Provisions

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

5. Currency for Payment

All claims shall be payable in India and in Indian Rupees only.

6. Subrogation

In the event of payment under this Policy, the Company shall be subrogated to all the Insured /Insured Person's rights of recovery thereof against any person or organization, and the Insured/Insured Person shall execute and deliver instruments and papers necessary to secure such rights. The Insured/Insured Person and any claimant under this Policy shall at the expense of the Company do and concur in doing and permit to be done, all such acts and things as may be necessary or required by the Company, before or after Insured /Insured Person's indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company shall be or would become entitled or subrogated. This clause applies only to coverage under the indemnity section of the policy and does not apply to benefit sections.

7. Policy Disputes

The parties to this Policy expressly agree that the laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy. Any dispute concerning the interpretation of the terms and conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian law. Each party agrees to be subject to the executive jurisdiction of the appropriate Courts in Mumbai and to comply with all requirements as necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

8. Arbitration

If any dispute or difference shall arise as to the quantum to be paid under this Policy (liability being otherwise admitted) such difference shall independently of all other questions be referred to the decision of a sole arbitrator to be appointed in writing by the parties thereto or if they cannot agree upon a single arbitrator within 30 days of any party invoking arbitration, the same shall be referred to a panel of three arbitrators, comprising of two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and the arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996 or any subsequent amendment thereto.

It is clearly agreed and understood that no dispute or difference shall be referred to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of this Policy.

It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon this Policy that the award by such arbitrator/arbitrators of the amount of the loss or damage shall be first obtained. The seat of Arbitration shall be Mumbai

Part VII: Conditions when a Claim arises

1. Notification of Claim

It is a condition precedent to our liability hereunder that written notice of claim must be given by the Insured Person/Nominee/Legal Heir, as applicable, to the Company within 15 days after an actual or potential loss begins or as soon as is reasonably possible and, in any event, not later than 30 days after an actual or potential loss begins.

Claim Intimation for Hospital Cash Benefit / Vector Borne Diseases.

You shall intimate the Claims to us within 2 days hospitalization or diagnosis of Vector Borne Diseases as the case may be or as specified in the policy schedule through any available mode of communication as specified in the Policy, Health Card or our Website

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However, the Company may condone the delay on merits of the claim subject to getting satisfied that the delay in notification was due to reasons beyond the control of the Insured Person/Nominee/Legal Heir.

2. Time for Filing Claim Documents

Completed Claim Forms and written evidence of loss must be furnished to us within 30 days after the date of such accident. Failure to furnish such evidence within the time required shall not invalidate nor reduce any claim if the Insured Person/Nominee/Legal Heir can satisfy the company that it was not reasonably possible for the Insured Person/Nominee/Legal Heir to give proof / documents within such time.

The above time limit will not apply to claims pending action or arbitration.

3. Claim Procedure

It is a condition precedent to the Company's liability that upon the discovery or happening of any loss that may give rise to a claim under this Policy, the Insured Person/Nominee/Legal Heir, as applicable, shall undertake the following:

The claim has to be intimated to the Company directly or through the group administrator.

The following information should be furnished by the Insured Person/s while intimating a claim:

1. Insured Person's contact numbers
2. Policy Number
3. Location, Date and Time of Loss
4. Whether Police authorities has been informed (in case of Road/Rail Accident claim)
5. Name of the Insured Person(s) named in the Policy schedule/Certificate of Insurance availing treatment,
6. Nature of disease/illness/injury,
7. Name and address of the attending Medical Practitioner/Hospital
8. Date and time of event if applicable
9. Date of admission

Claims Processing and Settlement

- i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.
- ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.
- iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle the claim within 45 days from the date of receipt of last necessary document.
- iv. 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.

Bank rate shall mean the rate fixed by Reserve Bank of India at the beginning of the financial year in which claim have fallen due.

Claims processing and settlement will be as per relevant provisions of applicable Circulars and Regulations issued by IRDAI from time to time.

Proof satisfactory to the Company shall be furnished on all matters upon which a claim is based. Any Medical Officer or other representative of the Company shall be allowed to examine the Insured/Insured Person on the occasion of any alleged injury or disability when and so often as the same may reasonably be required on behalf of the Company. Such evidence as the Company may from time to time require shall be furnished within the space of fourteen days after demand in writing.

No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal and/ or Legal Hair can claim or sue us under this Policy.

Section I: Daily Hospital Cash:

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1. Duly Filled and signed claim form;
2. Copy of discharge summary/ Final bill/ investigation reports.
3. Photo ID proof of the insured member whose name the payment is to be done.
4. Address proof of the insured member whose name the payment is to be done.
5. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done
6. Indoor case papers from hospital.

Section II: Personal Accident benefit

A. Accidental Death

1. Duly filled and signed claim form.
2. FIR / MLC from police authorities.
3. Driving License of the Insured Person in case death or injury because of Road Traffic accident and the Insured Person was driving the vehicle involved.
4. Death Certificate issued by competent Authorities.
5. Death Summary from the Hospital Authorities if death is confirmed by the Hospital.
6. Post Mortem Report if conducted (Viscera report may asked in case chemical analysis preserved)
7. Inquest / Panchnama Report.
8. Letter from HR stating the attendance closure to the incident in case if employee for Group policies.
9. Indemnity Bond / Succession Certificate/ Legal Heir Certificate.
10. Latest Photograph of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
11. Photo ID proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
12. Address proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
13. NEFT mandate form filled by beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done
14. Outstanding Loan Statement

B. PTD/PPD Claim Check List:

- a. Duly filled and signed claim form
- b. FIR / Medico Legal Case (MLC) report from police authorities.
- c. Driving License of the Insured Person in case of injury because of Road Traffic accident and the Insured Person was driving the vehicle involved.
- d. Medical Certificate from the attending Medical Practitioner for the injury indicating the extent of disability.
- e. Hospital / Nursing Home Medical Records.
- f. Radiological / X Ray report relevant to the disability.
- g. Photographs of the insured showing affected area.
- h. Photo ID proof of the deceased / Insured Person in whose name the payment is to be done.
- i. Address proof of the deceased / Insured Person in whose name the payment is to be done.
- j. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done.
- k. Disability Certificate from Civil Surgeon in PPD & PTD Claim.

C. TTD Claim Check List

1. Duly filled and signed claim form
2. FIR / MLC from police authorities.
3. Driving License of the Insured Person in case of injury because of Road Traffic accident and the Insured Person was driving the vehicle involved.
4. Medical fitness certificate from the Treating consultant indicating duration of rest medically advised
5. Hospital / Nursing Home Medical Records.
6. Radiological / X Ray report relevant to the disability.
7. Leave certificate from HR (for salaried people) if employee for Group policies.
8. Salary certificate / income proof if employee for Group policies.

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9. Photo ID proof of the deceased / Insured Person in whose name the payment is to be done.
10. Address proof of the deceased / Insured Person in whose name the payment is to be done.
11. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done.

Section III: Critical Illness Benefit:

1. Dully filled & signed claim form
2. Investigation reports, Histological report or Scan/ X Ray Plates, etc. as applicable confirming diagnosis of the indicated Critical Illness
3. All Documents prior and after, related to the diagnosis of indicated critical illness
4. Medical certificate from the certified Physician confirming the diagnosis of Indicated critical illness
5. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done

Section IV: Vector Borne Diseases Benefit

A. In-patient Hospitalization Benefit

1. Duly Filled and signed claim form;
2. Copy of discharge summary/ Final bill/ investigation reports.
3. Photo ID proof of the insured member whose name the payment is to be done.
4. Address proof of the insured member whose name the payment is to be done.
5. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done
6. Indoor case papers from hospital.

B. Double Vector Borne Diseases Benefit:

1. Duly filled and signed claim form.
2. Copy of discharge summary/ Final bill/ investigation reports
3. Indoor case papers from hospital
4. Latest Photograph of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
5. Photo ID proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
6. Address proof of the beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done.
7. NEFT mandate form filled by beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done

Section V & VI: EMI Protector and Loan Protector Benefit:

1. Duly completed claim form
2. Certificate if applicable from the Bank stating the amortization schedule, the EMI Amounts, Principal Outstanding, etc.
3. Photo Id & Address Proof of insured member
4. NEFT mandate form filled by beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done
5. Documents Pertaining to the cover opted.
 - i. In Patient Hospitalisation Benefit – as mentioned in Section I-Daily Hospital Cash Benefit
 - ii. Personal Accident Benefit – as mentioned in Section II – Personal Accident Benefit
 - iii. Critical Illness Benefit – as mentioned in Section III – Critical Illness Benefit
 - iv. Vector Borne Diseases Benefit – as mentioned in Section IV – Vector Borne Diseases Benefit

Section VII: Infectious Diseases Benefit: (as applicable)

1. Duly Filled and signed claim form;
2. Copy of discharge summary/ Final bill/ investigation reports.
3. Photo ID proof of the insured member whose name the payment is to be done.
4. Address proof of the insured member whose name the payment is to be done.

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5. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done
6. Indoor case papers from hospital.

Section VIII: Income Protection Benefit: (as applicable)

1. Duly Filled and signed claim form;
2. List of documents as mentioned in Section III Critical Illness Benefit, for Loss of Income Due to Critical Illness (as per plan opted)
3. List of documents as mentioned in Section II Personal Accident Benefit, for Loss of Income Due to Personal Accident (as per cover opted)
4. Leave Certificate from Employer confirming loss of pay

Optional Cover

Surgical Benefit Cover / Maternity Benefit Cover / Double Maternity Benefit Cover / Joint Hospitalization Cover / Convalescence Benefit

- Copy of document of hospitalization/medical treatment
- Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization/medical treatment
- Discharge Summary

We may call for additional documents/ information as relevant and necessary for processing of the claim.

In case you are covered under multiple policies which provide fixed benefits, on the occurrence of the insured condition, We shall make the claim payments as per terms and conditions of this policy, independent of payments received by You under other similar policies

No person other than the Insured /Insured Person(s) and/ or nominees named in the proposal and/ or Legal Hair can claim or sue us under this Policy.

In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, the Company shall accept properly verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.

Part VIII - Grievance Redressal Procedure

Grievance—In case of any grievance relating to servicing the Policy, the Insured Person may contact the Company through Website: www.libertyinsurance.in

Toll free:1800166584

Email: care@libertyinsurance.in

Courier: Unit 1501&1502, 15th Floor, Tower 2, One International Center, Senapati Bapat Marg, Prabhadevi, Mumbai – 400013

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at gro@libertyinsurance.in

For grievance redressal mechanism and details of grievance office of the Company, kindly refer the link - <https://www.libertyinsurance.in/customer-support/grievance-redressal>

Senior Citizens can email us at: seniorcitizen@libertyinsurance.in

Grievance may also be lodged at IRDAI Integrated Grievance Management System - <https://igms.irda.gov.in/>

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Insurance Ombudsman –If the insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance. The contact details of the Insurance Ombudsman offices have been provided as Annexure-A

Insurance is the subject matter of solicitation Annexure A

The contact details of the **Insurance Ombudsman** offices are as below –

Areas of Jurisdiction	Office of the Insurance Ombudsman
Gujarat, Dadra & Nagar Haveli, Daman and Diu.	Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in
Karnataka	Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in
Madhya Pradesh and Chhattisgarh	Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in
Orissa	Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 / 2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in
Punjab, Haryana(excluding Gurugram, Faridabad, Sonapat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.	Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in
Tamil Nadu, Tamil Nadu Puducherry Town and Karaikal (which are part of Puducherry).	Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in
Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonapat & Bahadurgarh.	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in

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Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.	Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in
Rajasthan	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in
Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	Office Of The Insurance Ombudsman LIC Of India, 10Th Floor, 'Jeevan Prakash', Divisional Office, M G Road, Ernakulam Kochi – 682011 Tel.: - 0484-2358759/2359338 Fax:- 0484-2359336 Email: bimalokpal.ernakulam@cioins.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in
Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, 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.	Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.	Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in
State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanoorj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur,	Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in

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Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	
Bihar, Jharkhand.	Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in

Critical Illness Plan (Annexure B)
Option-I

Plan Name		Plan-A	Plan-B	Plan-C	Plan- D	Plan- E	Plan- F
Sr.No	No of Critical Illness Covered	9	25	43	16	18	34
1	Alzheimer's Disease		Y	Y	Y		Y
2	Apallic Syndrome			Y		Y	Y
3	Aplastic Anemia			Y		Y	Y
4	Bacterial Meningitis			Y		Y	Y
5	Benign Brain Tumor		Y	Y	Y		Y
6	Blindness			Y		Y	Y
7	Brain Surgery			Y		Y	Y
8	Cancer of Specified Severity	Y	Y	Y			
9	Cardiomyopathy			Y		Y	Y
10	Coma of Specified Severity		Y	Y	Y		Y
11	Creutzfeldt-Jakob Disease (CJD)			Y		Y	Y
12	Deafness			Y		Y	Y
13	Encephalitis			Y		Y	Y
14	End-Stage Liver Failure		Y	Y	Y		Y
15	End-Stage Lung Failure			Y		Y	Y
16	Fulminant Viral Hepatitis			Y		Y	Y
17	Goodpasture's Syndrome			Y		Y	Y
18	Kidney Failure Requiring Regular Dialysis	Y	Y	Y			
19	Loss of Speech		Y	Y	Y		Y
20	Loss of Limbs		Y	Y	Y		Y
21	Major Head Trauma			Y		Y	Y
22	Major Organ / Bone Marrow Transplant	Y	Y	Y			
23	Medullary Cystic Disease		Y	Y	Y		Y
24	Motor Neuron Disease with Permanent Symptoms		Y	Y	Y		Y
25	Multiple Sclerosis with Persisting Symptoms	Y	Y	Y			
26	Multiple System Atrophy			Y		Y	Y
27	Muscular Dystrophy		Y	Y	Y		Y
28	Myocardial Infarction (First Heart Attack of Specified Severity)	Y	Y	Y			
29	Open Chest CABG / Coronary Artery Bypass Surgery	Y	Y	Y			
30	Open Heart Replacement or Repair of Heart Valves		Y	Y	Y		Y
31	Parkinson's Disease		Y	Y	Y		Y
32	Permanent Paralysis of Limbs	Y	Y	Y			
33	Pneumonectomy		Y	Y	Y		Y
34	Primary (Idiopathic) Pulmonary Hypertension		Y	Y	Y		Y
35	Progressive Supranuclear Palsy			Y		Y	Y
36	Progressive Scleroderma			Y		Y	Y

37	Pulmonary Artery Graft Surgery		Y	Y	Y		Y
38	Pulmonary-Renal Syndrome			Y		Y	Y
39	Severe Rheumatoid Arthritis			Y		Y	Y
40	Stroke Resulting in Permanent Symptoms	Y	Y	Y			
41	Surgery to Aorta / Aorta Graft Surgery	Y	Y	Y			
42	Systemic Lupus Erythematosus		Y	Y	Y		Y
43	Third-Degree Burns (Major Burns)		Y	Y	Y		Y

Option-II

Brain Protect	Heart Protect	Cancer Protect	RenLiv Protect
Apallic Syndrome	Cardiomyopathy	Cancer of Specified Severity	End-Stage Liver Failure
Motor Neuron Disease with Permanent Symptoms	Heart Transplant		Kidney Failure Requiring Regular Dialysis
Multiple Sclerosis with Persisting Symptoms	Myocardial Infarction (First Heart Attack of Specified Severity)		Kidney / Liver Transplant
Permanent Paralysis of Limbs	Open Chest CABG / Coronary Artery Bypass Surgery		Medullary Cystic Disease
Progressive Supranuclear Palsy	Open Heart Replacement or Repair of Heart Valves		Pulmonary-Renal Syndrome
Stroke Resulting in Permanent Symptoms	Primary (Idiopathic) Pulmonary Hypertension		
Encephalitis	Pulmonary Artery Graft Surgery		
Bacterial Meningitis	Surgery to Aorta / Aorta Graft Surgery		
Benign Brain Tumor			
Brain Surgery			
Coma of Specified Severity			
Creutzfeldt-Jakob Disease (CJD)			
Minor Illness - % of SI as mentioned in Policy Schedule / Certificate of Insurance is payable			
Angioplasty		Early-Stage Cancers	
Balloon Valvotomy or Valvuloplasty		Carcinoma in-Situ	
Carotid Artery Surgery			
Implantable Cardioverter Defibrillator			
Implantation of Pacemaker of Heart			
Infective Endocarditis			
Minimally Invasive Surgery of Aorta			
Pericardiectomy			