Liberty General Insurance Limited
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IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

Liberty Complete Protect Group
Policy Wordings

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. **"Condition Precedent"** shall mean a policy term or condition upon which the Insurer's liability under the Policy is conditional upon

4. **"Congenital Anomaly"** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.

   a) **"Internal Congenital Anomaly"** means congenital anomaly which is not in the visible and accessible parts of the body

   b) **"External Congenital Anomaly"** means congenital anomaly which is in the visible and accessible parts of the body

5. **"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.)

6. **"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-

   i. has qualified nursing staff under its employment;

   ii. has qualified medical practitioner/s in charge;

   iii. has a fully equipped operation theatre of its own where surgical procedures are carried out;

   iv. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

7. **"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.

8. **"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.

9. **"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.

10. **"Grace period"** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

11. **"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:

    a) has qualified nursing staff under its employment round the clock;

    b) 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;

    c) has qualified medical practitioner (s) in charge round the clock;

    d) has a fully equipped operation theatre of its own where surgical procedures are carried out;

    e) maintains daily records of patients and makes these accessible to the Insurance company's authorized personnel.

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12. **"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.

13. **"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

    a) **Acute Condition** - is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

    b) **Chronic Condition** - is defined as a disease, illness or injury that has one or more of the following characteristics:

    i. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests

    ii. it needs ongoing or long-term control or relief of symptoms

    iii.it requires rehabilitations for the patient or for the patient to be specially trained to cope with it

    iv.it continues indefinitely

    v. It recurs or likely to recur.

14. **"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.

15. **"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 intensives charges.

16. **"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.

17. **"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.

18. **"Medically Necessary Treatment"** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which

    a) is required for the medical management of the illness or injury suffered by the Insured Person/s;

    b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

    c) must have been prescribed by a medical practitioner,

    d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

19. **"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.

20. **"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.

21. **"Migration"** means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

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

23. **"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.

24. **"Portability"** means the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

25. **"Pre-Existing Disease"** means any condition, ailment, injury or disease:

    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

    b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement

26. **"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.

27. **"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.

28. **"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.

ii. <u>Specific Definitions</u>

1. **"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

2. **"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;

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- Teaching hospitals of AYUSH colleges recognized by Central Council of Indian Medicine (CCIM) and Central Council of Homeopathy (CCH);
- AYUSH Hospitals as defined hereinabove.

3. **"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.

4. **"Age"** means the completed age of the Insured Person as on his last birthday.

5. **"Bank"** means a banking Company which transacts the business of banking in India.

6. **"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.

7. **"Entry age"** means the age of the Insured Person at the time of Commencement of the Policy.

8. **"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.

9. **"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.

10. **"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 3 months to 25 years. If the child above 18 years of age is financially independent, he or she shall be ineligible for coverage in the subsequent renewal.

11. **"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.

12. **"HIV"** means Human Immunodeficiency Virus

13. **"Insured"** means a Bank or Financial Institution or Group Administrator who has proposed for Insurance and on whose name the Policy is issued.

14. **"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

15. **"Insured Event"** means any event specifically mentioned as covered in the policy schedule or Certificate of insurance under each section of benefit.

16. **"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.

17. **"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.

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

19. **"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.

20. **"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.

21. **"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.

22. **"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 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.

23. **"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.

24. **"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.

25. **"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.

26. **"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.

27. **"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.

28. **"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

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Illness/undergoing the Surgical Procedure for the first time. For this policy it is limited to 30 days.

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

30. **"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.

31. **"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.

32. **"We/Us/Our/Company"** means Liberty General Insurance Limited.

33. **"You/Your/Yourself/Insured Person"** means the persons named in the Policy Schedule/Certificate of Insurance.

Part II- Scope of Cover

1. 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 or IV
2. Section V can be opted by Primary Insured Person only if Section I and/or Section II (1) and/or Section II (2) and/or Section II (3) and/or Section III, and/ or Section IV(b), benefit(s) is opted under the policy
3. Section VI can be opted by Primary Insured Person only if Section II (1) and/or Section II (2) and/or Section III, is opted under the policy
4. An Insured Person can opt for either Section V or Section VI.

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.

Optional Cover Under Section I

1. Double ICU Benefit (DIB)-Sickness: In case the Insured Person/s is/are required to be admitted in an Intensive Care Unit (ICU) for a Medically Necessary treatment (Including AYUSH Treatment) due to any Illness not traceable to accidental bodily Injury, 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 doubled and payable for every completed 24 hours in an ICU, maximum up to the number of days as mentioned in the Schedule to the Policy. If this cover is admissible, we will then not pay separately for the Daily Hospital Cash benefit or Daily Hospital Cash- Accident under Section I, (a) and (b) of the Policy.

2. Double ICU Benefit (DIB)- Only Accidents: In case the Insured Person/s is/are required to be admitted in an Intensive Care Unit (ICU) for a Medically Necessary treatment due to accidental bodily Injury and includes any Illness/sickness arising from such accidental bodily Injury sustained or contracted within the Policy Year, for a continuous period of more than the number of days as mentioned in the policy schedule, a Daily Hospital Cash Benefit or Daily Hospital Cash -Only Accidents as mentioned in the Schedule to the Policy shall be doubled and payable for every completed 24 hours in an ICU, maximum up to the number of days as mentioned in the Schedule to the Policy. If this cover is admissible, we will then not pay separately for the Daily Hospital Cash benefit or Daily Hospital Cash- Accident under Section I, (a) and (b) of the Policy.

3. Family Floater Cover: A Policy where the Insured Person(s) in a family are insured under a single Sum Insured under Section I. This Section Sum Insured represents the maximum liability for any and all claims made by the Insured Person(s) covered under this Family Floater during the Policy Year.

Primary Insured Person means the first Insured Person with other members insured under the Policy being treated as secondary members to this Policy. The secondary member/s shall mean his/her lawful spouse &/or two dependent child/children.

4. Deductible: It is a cost sharing requirement under this section that provides that the company will not be liable for a specified number of days in case of hospitalization which will apply before any benefits are payable by the company. There are 3 deductible options which the company plans to provide which is 1 day or 2 days or 3 days. A discount in rate would be applicable as per the deductible opted.

5. Day Care Procedure Cash (DCP): In case of Hospitalization of the Insured Person(s) for a Medically Necessary treatment as an inpatient for less than 24 hours in a Hospital or day care center for any of the below listed Procedures, then We will pay Day care Procedure Cash as mentioned in the Schedule to this Policy, for each procedure undertaken, limited to the maximum number of days as mentioned in the Schedule to the Policy.

Covered Day Care Procedures:

Sr. No	Microsurgical operations on the middle ear
1	Stapedotomy
2	Stapedectomy
3	Revision of a stapedectomy
4	Other operations on the auditory ossicles
5	Myringoplasty (Type -I Tympanoplasty)
6	Tympanoplasty (closure of an eardrum perforation/reconstruction of the auditory ossicles)
7	Revision of a tympanoplasty
8	Other microsurgical operations on the middle ear
	Other operations on the middle & internal ear
9	Myringotomy

Sr. No	Operations on the tonsils & adenoids
71	Transoral incision and drainage of a pharyngeal abscess
72	Tonsillectomy without adenoidectomy
73	Tonsillectomy with adenoidectomy
74	Excision and destruction of a lingual tonsil
75	Other operations on the tonsils and adenoids
76	Trauma surgery and orthopaedics
77	Incision on bone, septic and aseptic
78	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
79	Suture and other operations on tendons and tendon sheath
80	Reduction of dislocation under GA

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10	Removal of a tympanic drain
11	Incision of the mastoid process and middle ear
12	Mastoidectomy
13	Reconstruction of the middle ear
14	Other excisions of the middle and inner ear
15	Fenestration of the inner ear
16	Revision of a fenestration of the inner ear
17	Incision (opening) and destruction (elimination) of the inner ear
18	Other operations on the middle and inner ear
	Operations on the nose & the nasal sinuses
19	Excision and destruction of diseased tissue of the nose
20	Operations on the turbinates (nasal concha)
21	Other operations on the nose
22	Nasal sinus aspiration
	Operations on the eyes
23	Incision of tear glands
24	Other operations on the tear ducts
25	Incision of diseased eyelids
26	Excision and destruction of diseased tissue of the eyelid
27	Operations on the canthus and epicanthus
28	Corrective surgery for entropion and ectropion
29	Corrective surgery for blepharoptosis
30	Removal of a foreign body from the conjunctiva
31	Removal of a foreign body from the cornea
32	Incision of the cornea
33	Operations for pterygium
34	Other operations on the cornea
35	Removal of a foreign body from the lens of the eye
36	Removal of a foreign body from the posterior chamber of the eye
37	Removal of a foreign body from the orbit and eyeball
38	Operation of cataract
	Operations on the skin & subcutaneous tissues
39	Incision of a pilonidal sinus
40	Other incisions of the skin and subcutaneous tissues
41	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
42	Local excision of diseased tissue of the skin and subcutaneous tissues
43	Other excisions of the skin and subcutaneous tissues
44	Simple restoration of surface continuity of the skin and subcutaneous tissues
45	Free skin transplantation, donor site
46	Free skin transplantation, recipient site
47	Revision of skin plasty
48	Other restoration and reconstruction of the skin and subcutaneous tissues
49	Chemosurgery to the skin
50	Destruction of diseased tissue in the skin and subcutaneous tissues
	Operations on the tongue
51	Incision, excision and destruction of diseased tissue of the tongue
52	Partial glossectomy
53	Glossectomy
54	Reconstruction of the tongue
55	Other operations on the tongue
81	Arthroscopic knee aspiration
	Operations on the digestive tract
82	Incision and excision of tissue in the perianal region
83	Surgical treatment of anal fistulas
84	Surgical treatment of haemorrhoids
85	Division of the anal sphincter (sphincterotomy)
86	Other operations on the anus
87	Ultrasound guided aspirations
88	Sclerotherapy
	Operations on the female sexual organs
89	Incision of the ovary
90	Insufflation of the Fallopian tubes
91	Other operations on the Fallopian tube
92	Dilatation of the cervical canal
93	Conisation of the uterine cervix
94	Other operations on the uterine cervix
95	Incision of the uterus (hysterotomy)
96	Therapeutic curettage
97	Culdotomy
98	Incision of the vagina
99	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
100	Incision of the vulva
101	Operations on Bartholin's glands (cyst)
92	Dilatation of the cervical canal
93	Conisation of the uterine cervix
94	Other operations on the uterine cervix
95	Incision of the uterus (hysterotomy)
96	Therapeutic curettage
97	Culdotomy
98	Incision of the vagina
99	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
100	Incision of the vulva
101	Operations on Bartholin's glands (cyst)
	Operations on the prostate & seminal vesicles
102	Incision of the prostate
103	Transurethral excision and destruction of prostate tissue
104	Transurethral and percutaneous destruction of prostate tissue
105	Open surgical excision and destruction of prostate tissue
106	Radical prostatovesiculectomy
107	Other excision and destruction of prostate tissue
108	Operations on the seminal vesicles
109	Incision and excision of periprostatic tissue
110	Other operations on the prostate
	Operations on the scrotum & tunica vaginalis testis
111	Incision of the scrotum and tunica vaginalis testis
112	Operation on a testicular hydrocele
113	Excision and destruction of diseased scrotal tissue
114	Plastic reconstruction of the scrotum and tunica vaginalis testis
115	Other operations on the scrotum and tunica vaginalis testis
	Operations on the testes
116	Incision of the testes

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	Operations on the salivary glands & salivary ducts
56	Incision and lancing of a salivary gland and a salivary duct
57	Excision of diseased tissue of a salivary gland and a salivary duct
58	Resection of a salivary gland
59	Reconstruction of a salivary gland and a salivary duct
60	Other operations on the salivary glands and salivary ducts
	Other operations on the mouth & face
61	External incision and drainage in the region of the mouth, jaw and face
62	Incision of the hard and soft palate
63	Excision and destruction of diseased hard and soft palate
64	Incision, excision and destruction in the mouth
65	Plastic surgery to the floor of the mouth
66	Palatoplasty
67	Other operations in the mouth
	Operations on the breast
68	Incision of the breast
69	Operations on the nipple
	Operations on the urinary system
70	Cystoscopical removal of stones

117	Excision and destruction of diseased tissue of the testes
118	Unilateral orchidectomy
119	Bilateral orchidectomy
120	Orchidopexy
121	Abdominal exploration in cryptorchidism
122	Surgical repositioning of an abdominal testis
123	Reconstruction of the testis
124	Implantation, exchange and removal of a testicular prosthesis
125	Other operations on the testis
	Operations on the spermatic cord, epididymis und ductus deferens
126	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
127	Excision in the area of the epididymis
128	Epididymectomy
129	Reconstruction of the spermatic cord
130	Reconstruction of the ductus deferens and epididymis
131	Other operations on the spermatic cord, epididymis and ductus deferens
	Operations on the penis
132	Operations on the foreskin
133	Local excision and destruction of diseased tissue of the penis
134	Amputation of the penis
135	Plastic reconstruction of the penis
136	Other operations on the penis
	Other Operations
137	Lithotripsy
138	Coronary angiography
139	Haemodialysis
140	Radiotherapy for Cancer
141	Cancer Chemotherapy

6. Waiting Period Waiver

In consideration of additional premium received by the Company and realization thereof from the Insured/ Insured Person following standard waiting periods applicable under this Section of the policy can be waived for all Insured Person(s) covered under the policy.

6 (1). 30 Days Waiting Period and/or

6 (2). 90 Days Waiting Period and/or

6 (3). First Year Waiting Period and/or

6 (4). Two Year Waiting Period and/or

6 (5). Pre-Existing Disease Waiting Period

Waiting Period Under Section I - Daily Hospital Cash Benefit

1. 30 days Waiting Period:

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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**

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 12 /24 /48 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

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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: Coronory 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) Four Year (48 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 48 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.

a. 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.

Specific Exclusions under Section I - Daily Hospital Cash Benefit

(In addition to General Exclusion)

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**
   i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
   ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
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. EECP & Chelation Therapy, Rotational Field Quantum Magnetic Resonance (RFQMR) or Cytotron therapy.

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 **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 /2 /3 or 4) and Optional Cover as per his insurance needs:

Coverage
1. Accidental Death Only
2. Permanent Total Disablement Only
3. Permanent Partial Disablement Only
4. Temporary Total Disablement Only

Table of Benefits:

1. Accidental Death: If an Insured Person suffers an Accident during the Policy Period and this is the sole and direct cause of his 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.

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 Permanent Total Disability in one of the ways detailed in the table below, We will pay the percentage of the Section Sum Insured shown in the table

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.

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%

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Permanent Partial Disability Means:

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.

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 the Accident this is the sole and direct cause of his Permanent Partial Disability in one of the ways detailed in the table below, then We will pay the percentage of the Section Sum Insured shown in the table.

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.

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 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.

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.

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, then We will pay a weekly benefit, 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.

Optional Cover Under Section II : Personal Accident Benefit

a. Child Education Support:

If the Insured Person suffers an Accident during the Policy Period for which a valid claim has been admitted for Accidental Death or Permanent Total Disability, We will make payment towards child education support of the Insured Person(s)' dependent child /children maximum for two dependent children to the extent of the sum insured mentioned against this benefit.

In case of one child, the benefit payable would be the maximum Sum Insured as specified under this extension and in the case of more than one child, the benefit will be equally divided between maximum two dependent children.

"Dependent Child" refers to a child (natural or legally adopted) below 25 years of age, who is pursuing an educational course as a fulltime student in an Educational Institution.

- Documents required in case of claim:
  - Proof of number of dependent child /children viz. Ration card
  - Age proof of the dependent child /children
  - Proof of education and payment of fee

b. Accidental Medical Expenses:

If an Insured Person suffers an Accident during the Policy Period requiring immediate medical treatment following such accident, we will reimburse Reasonable and Customary Charges for Medical Expenses that are incurred towards treatment of such person to the extent of limit/s mentioned in the schedule forming part of the policy, provided a valid claim has been admitted in respect of any of the accident benefit(s) defined in the Table of Benefits.

Specific Exclusions Under Accidental Medical Expenses (In addition to General Exclusion)

a) Any treatment for an existing disability from a previous accident.
b) Vaccination and inoculation of any kind unless forming part of treatment for injury due to an accident as prescribed by the Medical Practitioner.
c) Vitamins and tonics unless forming part of treatment for injury due to an accident as prescribed by the Medical Practitioner.
d) Dietary supplements and substances that can be purchased without prescription, including Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure
e) Any treatment received outside India if accidental injury happened within India
f) Costs incurred on all methods of treatment except Allopathic.
g) Naturopathy treatment.
h) Loss caused directly or indirectly, wholly or partly by Bacterial infections (except pyogenic infections which shall occur through an accident) or any other kind of disease

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i) Medical or surgical treatment except as may be necessary solely as a result of injury;

Documents required in case of claim:

- Copy of document of hospitalization/medical treatment
- Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization/medical treatment
- Bills and receipts towards medical expenses.
- Copy of the test reports
- Hospital / Nursing Home Medical Records, when required for verification of claims

c. Transportation of Mortal Remains:

In the event of We, making payment for a claim for Accidental Death, we will indemnify towards

i. Expenses incurred for transportation of the mortal remains from the place of death to Your city of residence/residential place as mentioned in the Policy Schedule provided the place of death is not less than 100 kms from Your normal place of residence.

ii. Our liability to make payment will be actuals or up to the maximum amount as mentioned in the Policy Schedule whichever is lower.

Documents required in case of claim:

- Bills and receipt towards cost of transportation of the mortal remains to the place of residence/hospital and/or cremation/burial ground.

d.Performance of Funeral Ceremony:

In the event of We, making payment for a claim for Accidental Death, we will indemnify towards

i. Expenses incurred for preparation for burial or cremation service of mortal remains

ii. Our liability to make payment will be actuals or up to the maximum amount as mentioned in the Policy Schedule whichever is lower.

Documents required in case of claim:

- Bills and receipt towards expenses relevant to funeral ceremony.

e. Ambulance Hiring Charges

Following an Accident, if it is necessary to immediately transfer the Insured Person to the nearest Hospital / Nursing Home by an ambulance offered by a healthcare or an ambulance service provider, then We shall reimburse the actual expenses of the transfer using the shortest route or up to a maximum amount as specified in the Policy Schedule subject to a valid claim admitted under the Accident benefit(s) covers provided under the Policy.

Documents required in case of claim:

-Bills and receipt towards cost of ambulance services

f. Modification of Vehicle/Residence

If the Insured Person suffers an Accident during the Policy Period for which a valid claim has been admitted under Permanent Total Disability or Permanent Partial Disability and, we will reimburse the reasonable expenses incurred to modify Insured Person's residential accommodation and/or vehicle within India and as certified by a Doctor to be necessary, up to the limit as specified in the Policy Schedule.

Special Exclusions: Any modifications or alterations not compliant with the Motor Vehicle Act and Construction of residential houses laws applicable in the respective city / State of India.

Documents required in case of claim:

- Permanent Total Disability / Permanent Partial Disability related documents
- Bills and receipts towards vehicle or residence modifications

g. Permanent Total Disability (Enhanced)

Notwithstanding anything contrary to the terms & conditions under the Permanent Disability benefit cover of the Policy and in consideration of the extra premium charged, it is hereby agreed and declared that, If the Insured Person suffers from an accidental injury during the Policy Period and within 12 (twelve) Calendar months from the date of Accident and this is the sole and direct cause of Permanent Total Disability in one of the ways detailed in the table below, we will pay the percentage of the Section Sum Insured shown in the table:

Permanent Total Disability - Table of Benefits Loss of	Option 1 % of CSI	Option 2 % of CSI	Option 3 % of CSI
Limbs (both hands or both feet or one hand and one foot)	125%	150%	200%
Loss of a Limb and an eye	125%	150%	200%
Complete and irrecoverable loss of sight of both eye	125%	150%	200%
Complete and irrecoverable loss of speech & hearing of both ears	125%	150%	200%

For 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

Specific Exclusions under Section II - Personal Accident Benefit

(In addition to General Exclusion)

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 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

Secton III : Critical Illness Benefit

While this Policy is in force, the Company shall provide the benefit in one lump sum 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 as defined under Covered Critical Illness herein below and if all of the following conditions are satisfied.

(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 below 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 defined below-

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Option A	Option B	Option C
1. Cancer of Specified Severity	1. Alzheimer's Disease	1. Alzheimer's Disease
2. Kidney Failure Requiring Regular Dialysis	2. Benign Brain Tumor	2. Apallic Syndrome
3. Open Chest CABG	3. Cancer of Specified Severity	3. Aplastic Anemia
4. Major Organ / Bone Marrow Transplant	4. Coma of Specified Severity	4. Bacterial Meningitis
5. Multiple Sclerosis with Persisting Symptoms	5. Deafness	5. Benign Brain Tumor
6. Myocardial Infraction (First Heart Attack of Specified Severity)	6. End Stage Liver Failure	6. Blindness
7. Permanent Paralysis of Limbs	7. Kidney Failure Requiring Regular Dialysis	7. Brain Surgery
8. Stroke Resulting In Permanent Symptoms	8. Loss of Speech	8. Cancer of Specified Severity
9. Surgery to Aorta / Aorta Graft Surgery	9. Major Organ / Bone Marrow Transplant	9. Cardiomyopathy
	10. Medullary Cystic Disease	10. Coma of Specified Severity
	11. Motor Neuron Disease with Permanent Symptoms	11. Creutzfeldt-Jakob Disease (CJD)
	12. Multiple Sclerosis with Persisting Symptoms	12. Deafness
	13. Muscular Dystrophy	13. Encephalitis
	14. Myocardial Infraction (First Heart Attack of Specified Severity)	14. End-Stage Liver Failure
	15. Open Chest CABG	15. End-Stage Lung Failure
	16. Open Heart Replacement or Repair of Heart Valves	16. Fulminant Viral Hepatitis
	17. Parkinson's Disease	17. Goodpasture's Syndrome
	18. Permanent Paralysis of Limbs	18. Kidney Failure Requiring Regular Dialysis
	19. Pneumonectomy	19. Loss of Speech
	20. Primary (Idiopathic) Pulmonary Hypertension	20. Loss of Limbs
	21. Pulmonary Artery Graft Surgery	21. Major Head Trauma
	22. Stroke Resulting In Permanent Symptoms	22. Major Organ / Bone Marrow Transplant
	23. Surgery to Aorta / Aorta Graft Surgery	23. Medullary Cystic Disease
	24. Systemic Lupus Erythematosus	24. Motor Neuron Disease with Permanent Symptoms
	25. Third-Degree Burns (Major Burns)	25. Multiple Sclerosis with Persisting Symptoms
		26. Multiple System Atrophy
		27. Muscular Dystrophy
		28. Myocardial Infarction (First Heart Attack of Specified Severity)
		29. Open Chest CABG / Coronary Artery Bypass Surgery
		30. Open Heart Replacement or Repair of Heart Valves
		31. Parkinson's Disease
		32. Permanent Paralysis of Limbs
		33. Pneumonectomy
		34. Primary (Idiopathic) Pulmonary Hypertension
		35. Progressive Supranuclear Palsy
		36. Progressive Scleroderma
		37. Pulmonary Artery Graft Surgery
		38. Pulmonary-Renal Syndrome
		39. Severe Rheumatoid Arthritis
		40. Stroke Resulting in Permanent Symptoms
		41. Surgery to Aorta / Aorta Graft Surgery
		42. Systemic Lupus Erythematosus
		43. Third-Degree Burns (Major Burns)

Descriptions of Critical Illnesses / Insured Conditions

i. <u>Standard Definitions</u>

1. Benign Brain Tumor

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

a. This brain tumor must result in at least one of the following and must be confirmed by the Neurologist.
   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.

2. Blindness

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

a. The Blindness is evidenced by:
   i. corrected visual acuity being 3/60 or less in both eyes or;
   ii. the field of vision being less than 10 degrees in both eyes.
b. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

3. Cancer of Specified Severity

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

The following are excluded -

I. All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.
ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
iii. Malignant melanoma that has not caused invasion beyond the epidermis;
iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

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vi. Chronic lymphocytic leukemia less than RAI stage 3
vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,
viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
ix. All tumors in the presence of HIV infection

4. Coma of Specified Severity
A state of unconsciousness with no reaction or response to external stimuli or internal needs.

This diagnosis must be supported by evidence of all of the following:
i. No response to external stimuli continuously for at least 96 hours;
ii. Life support measures are necessary to sustain life; and
iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.
The condition has to be confirmed by a specialist medical practitioner
Coma resulting from alcohol or drug abuse is excluded.

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

6. End-Stage Liver Failure
Permanent and irreversible failure of liver function that has resulted in all three of the following:
i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.
Liver failure secondary to drug or alcohol abuse is excluded.

7. End-Stage Lung Failure
End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:
i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
iv. Dyspnea at rest.

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

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

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

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

IV. The following are excluded:
i. Spinal cord injury;

12. Major Organ / Bone Marrow Transplant
The actual undergoing of a transplant of:
i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:
i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

13. Motor Neuron Disease with Permanent Symptoms
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.

14. Multiple Sclerosis With Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i) investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii) there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.
Other causes of neurological damage such as SLE and HIV are excluded.

15. 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:

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

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

16. 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.

17. 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.

18. Permanent Paralysis of Limbs

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

19. 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 Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

The NYHA Classification of Cardiac Impairment are as follows:

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

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.

20. Stroke Resulting In Permanent Symptoms

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

The following are excluded:

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

21. 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.

ii. Specific Definitions

1. 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.

2. 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.

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3. 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.

4. Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit lasting for a minimum period of 30 days. It should result in a permanent 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

a. This diagnosis must be confirmed by
   i. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
   ii. A consultant neurologist certifying the diagnosis of bacterial meningitis.

5. 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:

o 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.

6. Cardiomyopathy

A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist). There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least Class 3 of the New York Heart Association 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:

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

7. 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.

i. Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.
ii. Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

8. 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.

9. 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:

i. Rapid decrease in liver size associated with necrosis involving entire lobules;
ii. Rapid degeneration of liver enzymes;
iii. Deepening jaundice; and
iv. Hepatic encephalopathy

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

10. 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).

11. 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.

12. 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:

i. motor function with associated rigidity of movement; or
ii. The ability to coordinate muscle movement; or
iii. Bladder control and postural hypotension.

13. 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.

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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".

14. 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.

15. 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:

i. Removal of a lobe of the lungs (lobectomy)
ii. Lung resection or incision

16. 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.

17. 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:

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

18. 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:

i. Pulmonary artery graft surgery necessitated as a result of CABG
ii. Pulmonary artery graft surgery necessitated as a result of Post trauma

19. Pulmonary-Renal Syndrome

Diagnosis of pulmonary renal syndrome, in which a combination of diffuse alveolar hemorrhage (DAH) and a rapid progressive glomerulonephritis (RPGN) occurs.

20. 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:

i. 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.
ii. There must also be typical rheumatoid joint deformities.
iii. Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;
iv. Permanent inability to perform at least two (2) "Activities of Daily Living"
v. The foregoing conditions have been present for at least six (6) months.
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.

21. 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 laporotomy 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.

22. 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:

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

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Optional Cover under Section III - Critical Illness Benefit

1. Option to Waive 30-Day Survival Period: If you specify that you would like to opt this cover for waiving the Survival Period from the date of diagnosis, We will apply an additional pricing to the premium payable. If you opt for this Optional feature, and you submit a duly filled claim form along with specified documents, a claim can be valid and payable without completion of the Survival Period.

2. Waiting Period Waiver
In consideration of additional premium received by the Company and realization thereof from the Insured/ Insured Person following standard waiting periods applicable under this Section of the policy can be waived for all Insured Person(s) covered under the policy.
2(1). 90 Days Waiting Period and/or
2(2). Two Year Waiting Period and/or
2(3). Pre-Existing Disease Waiting Period

Waiting Period under Section III - Critical Illness Benefit

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 /48 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)*
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. Four Year (48 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 48 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.

Specific Exclusion under Section III - Critical Illness Benefit
(In addition to General Exclusion)

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 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;
I) Plan A - Dengue Fever
ii) Plan B - Malaria
iii) Plan C - Other Vector Borne Diseases:
a. Chikungunya
b. Japanese Encephalitis
c. Kala-azar
d. Lymphatic Filariasis
e. Zika Virus

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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.

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
   - o Shock - a sudden drop in blood pressure,
   - o ARDS (acute respiratory distress syndrome)
   - o Acute Renal Failure
   - o 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 myeliti

Optional Cover under Section IV - Vector Borne Diseases Benefit

1. Waiting Period Waiver

In consideration of additional premium received by the Company and realization thereof from the Insured/ Insured Person, following standard waiting periods applicable under this Section of the policy can be waived for all Insured Person(s) covered under the policy.

1(1). 30 Days Waiting Period and/or

1(2). 60 Days Waiting Period

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. Decreasing platelet levels- less than 100,000 cells/mm3; and
2. Immunoglobulins /Polymerase Chain Reaction (PCR) test showing positive results for Dengue
3. Concurrent to the above two conditions 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.

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.

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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 is 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)

a) If We pay the claim for any of the listed vector borne diseases under Section IV(a) then this 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) The cover as described under Section IV(b), 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

Waiting Period under Section IV - Vector Borne Diseases Benefit

1. 30 days Waiting Period: Code Excl03

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

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,

a. 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.

b. 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.

Specific Exclusion under Section IV - Vector Borne Diseases Benefit

(In addition to General Exclusion)

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.

Section V: EMI Protector Benefit

Coverage under this Benefit Section is available only to the Primary Insured Person named in the Certificate of Insurance, if Section I and/or Section II (1) and/or Section II (2) and/or Section II (3) and/or Section III and/or Section IV(b), is opted under the Policy. This benefit section is not available if only TTD benefit is opted under Section II and if only Inpatient Hospitalization is opted under Section IV.

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 Primary 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 Primary 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 Primary Insured Person within India.

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

a) For Section I (Daily Hospital Cash Benefit)

o In case of an admissible claim under Section I and Hospitalization + Recovery /Bed Rest as prescribed by treating doctor exceeds the number of days mentioned below, in such case We shall pay the number of EMI as applicable below. In any case the monthly EMI payable shall not exceed the actual monthly EMI

- Greater than 21 days - 1 EMI will be payable
- Greater than 45 days - 2 EMI will be payable
- Greater than 70 days - 3 EMI will be payable

b) For Section II (Personal Accident Benefit)

o If a claim is admissible under Section II as per the Table of Benefits, under sub-sections AD/PTD/PPD, as opted, then 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.

c) For Section III (Critical Illness Benefit)

o If a claim is admissible under Section III then 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.

d) For Section IV (Vector Born Disease Benefit)

o If a claim is admissible under Section IV (b), then We shall pay the number of EMIs as specified in the Policy Schedule/Certificate of Insurance or Actuals whichever is

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less, subject to the Policy terms and conditions.

Specific Condition Applicable to Section V

The cover as described under this Section, for Primary 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

Exclusion under Section V - EMI Protector Benefit

Section Specific exclusion and General Exclusions are applicable as per Benefit Section opted and mentioned under the Schedule to the Policy or Certificate of Insurance.

Section VI: Loan Protector Benefit

Coverage under this Benefit Section is available only to the Primary Insured Person named in the Certificate of Insurance, if Section II (1) and/or Section II (2) and/or Section III, is opted under the Policy.

In case of admissible claims under Section II (1) Accidental Death and/or Section II (2) Permanent Total Disability and/or Section III Critical Illness Benefit, in relation to the Primary Insured Person, 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 Primary 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.

Specific Condition Applicable to Section VI

The cover as described under this Section, for Primary Insured Person, shall terminate in the event of one claim in respect of that Primary Insured Person becoming admissible and accepted by the Company under this Section

Exclusion under Section VI - Loan Protector Benefit

Section Specific exclusion and General Exclusions are applicable as per Benefit Section opted and mentioned under the Schedule to the Policy or Certificate of Insurance.

I. Standard Exclusions

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

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 heath hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code-Excl13**

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. Specific 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
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 IV - General Terms & Conditions

I. Standard General Terms and Conditions

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

2. 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.

3. 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.

4. Premium Payment in Installments
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

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Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
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IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

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. Grace Period of 15 days would be given to pay the instalment premium due for the policy.
ii. During such grace period, coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
iii. The insured person will get the accrued continuity benefit in respect of the "Waiting Periods" in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace period, the policy will get cancelled.
vi. In 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.
viii. in case the claim amount is less than the balance premium installment, no claim will be payable till the balance premium installment is recovered.

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.

Installment Frequency	% of Annual Premium
Half Yearly	51%
Quarterly	26%
Monthly	8.75%

Please review the installment payment terms on the right, which apply to standard premiums.

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

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

6. Cancellation

The Company may cancel the Policy at any time on grounds of misrepresenation, 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 misrepresenation ,non-disclosure of material facts or fraud.

The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

One time premium paid					
Cancellation period	**1 Year Policy**	**2 Year Policy**	**3 Year Policy**	**4 Year Policy**	**5 Year Policy**
Up to 1 Month	75.00%	87.50%	87.50%	87.50%	87.50%
Up to 3 Months	50.00%	75.00%	75.00%	80.00%	80.00%
Up to 6 Months	25.00%	62.50%	70.00%	75.00%	75.00%
Up to 9 Months	NIL	50.00%	60.00%	70.00%	70.00%
Up to 12 Months	NIL	42.00%	55.00%	65.00%	65.00%
Up to 15 Months	NIL	25.00%	50.00%	60.00%	60.00%
Up to 18 Months	NIL	12.50%	40.00%	55.00%	55.00%
Up to 24 Months	NIL	NIL	25.00%	45.00%	50.00%
Up to 30 Months	NIL	NIL	15.00%	30.00%	40.00%
Up to 36 Months	NIL	NIL	NIL	20.00%	30.00%
Up to 42 Months	NIL	NIL	NIL	10.00%	25.00%
Up to 48 Months	NIL	NIL	NIL	NIL	15.00%
Up to 54 Months	NIL	NIL	NIL	NIL	8.00%
Up to 60 Months	NIL	NIL	NIL	NIL	NIL

Cancellation period	Installment premium														
	1 Year Policy			2 Year Policy			3 Year Policy			4 Year Policy			5 Year Policy		
	Monthly	Quarterly	Half-Yearly	Monthly	Quarterly	Half-Yearly	Monthly	Quarterly	Half-Yearly	Monthly	Quarterly	Half-Yearly	Monthly	Quarterly	Half-Yearly
Up to 1 Month	NIL	NIL	20%	NIL	NIL	25%	NIL	10%	35%	NIL	10%	35%	10%	10%	35%
Up to 3 Months	NIL	NIL	NIL	NIL	NIL	25%	NIL	10%	30%	10%	10%	30%	10%	10%	30%
Up to 6 Months	NIL	NIL	NIL	10%	10%	10%	20%	20%	25%	20%	20%	25%	25%	25%	25%
Up to 9 Months	NIL	NIL	NIL	20%	25%	30%	30%	30%	45%	35%	35%	50%	35%	35%	55%
Up to 12 Months	NIL	NIL	NIL	35%	40%	40%	35%	35%	40%	50%	50%	50%	50%	50%	50%
Up to 15 Months	NIL	NIL	NIL	NIL	NIL	NIL	30%	30%	30%	45%	45%	45%	50%	50%	50%
Up to 18 Months	NIL	NIL	NIL	NIL	NIL	NIL	30%	30%	30%	40%	40%	40%	40%	40%	40%
Up to 24 Months	NIL	NIL	NIL	NIL	NIL	NIL	20%	20%	20%	30%	30%	30%	35%	35%	35%
Up to 30 Months	NIL	NIL	NIL	NIL	NIL	NIL	10%	10%	10%	20%	20%	20%	30%	30%	30%
Up to 36 Months	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	15%	15%	15%	25%	25%	25%

Liberty Complete Protect Group
Policy Wordings

Up to 42 Months	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	10%	10%	10%	20%	20%	20%
Up to 48 Months	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	10%	10%	10%
Up to 54 Months	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	5%	5%	5%
Up to 60 Months	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL

7. Migration
The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company by applying for migration of the policy atleast 30days before policy renewal date as per extant Guidelines related to 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, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:
i. The waiting periods as specified above for applicable sections shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous sum insured and accrued bonus/multiplier benefit (as part of the base sum insured), migration benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Migration, kindly refer the link https://www.libertyinsurance.in/

8. Portability
The Insured Person will have the option to port the Policy to other insurers by applying to such other insurer by applying to such other insurer to port the entire policy along with al the members of the family, if any atleast 45 days before but not earlier that 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 plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:
i. The waiting periods as specified above for applicable sections shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.
For Detailed Guidelines on Portability, kindly refer the link https://www.libertyinsurance.in/

9. 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.

10. Renewal of Policy
The Policy shall ordinarily be renewable except on the grounds of fraud, moral hazard or misrepresentation by the Insured/Insured Person.
i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
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 the continuity of benefits without break in policy. Coverage is not available during grace period.
v. No loading shall apply on renewals based on individual claims experience

11. 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.

10. 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 .
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.
(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

Conditions when a Claim arises

9. 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
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.

10. 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.

11. 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 Company's Policy issuing office or any other office of the Company at the nearest regional offices or through agents in writing.

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

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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 Protection of Policy Holder's Interest, Regulation 2017 as amended 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:

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.
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.

Optional Cover Under Section II Personal Accident Benefit

A. Child Education Support:

1. Proof of number of dependent child /children viz. Ration card
2. Age proof of the dependent child /children
3. Proof of education and payment of fee

B. Accidental Medical Expenses

1. Copy of document of hospitalization/medical treatment
2. Certificate from treating doctor about the diagnosis and line of treatment given during hospitalization/medical treatment
3. Bills and receipts towards medical expenses.
4. Copy of the test reports
5. Hospital / Nursing Home Medical Records, when required for verification of claims.

C. Transportation of Mortal Remains:

1. Bills and receipt towards cost of transportation of the mortal remains to the place of residence/hospital and/or cremation/burial ground.
2. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done

D. Performance of Funeral Ceremony

1. Bills and receipt towards expenses relevant to funeral ceremony
2. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done

Liberty General Insurance Limited
10th Floor, Tower A, Peninsula Business Park,
Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

E. Ambulance Hiring Charges
1. Bills and receipt towards cost of ambulance services
2. NEFT mandate form filled by deceased / Insured Person in whose name the payment is to be done

F. Modification of Vehicle/Residence
1. Permanent Total Disability / Permanent Partial Disability related documents
2. Bills and receipts towards vehicle or residence modifications

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. Certificate from the employer of the Insured Person confirming the termination, dismissal temporary suspension or retrenchment from employment of the Insured person furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured Person with the reasons for the same. In case of temporary suspension the period of suspension should also be mentioned in such certificate.
4. Any other document as may be required by the Company.
5. Photo Id & Address Proof of insured member
6. NEFT mandate form filled by beneficiary / Insured Person / Legal Heirs in whose name the payment is to be done

We may call for additional documents/ information as relevant to 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 polices

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 V - 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: 10th floor, Tower A, Peninsula Business Park, Lower Parel, 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/

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

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Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

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Annexure B

Insurance is the subject matter of solicitation

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	**AHMEDABAD** Office of the Insurance Ombudsman, 2nd floor, Ambica House, Near C.U. Shah College, 5, Navyug Colony, Ashram Road, Ahmedabad - 380 014. Tel.: 079 - 27546150 / 27546139 Fax: 079 - 27546142 Email: bimalokpal.ahmedabad@ecoi.co.in
Karnataka.	**BENGALURU** Office of the Insurance Ombudsman, JeevanSoudhaBuilding,PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ecoi.co.in
Madhya Pradesh Chattisgarh.	**BHOPAL** Office of the Insurance Ombudsman, JanakVihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in
Orissa	**BHUBANESHWAR** Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar - 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in
Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandigarh.	**CHANDIGARH** Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in
Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).	**CHENNAI** Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI - 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@ecoi.co.in
Delhi.	**DELHI** Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in
Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**GUWAHATI** Office of the Insurance Ombudsman, JeevanNivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205 Fax: 0361 - 2732937 Email: bimalokpal.guwahati@ecoi.co.in

Areas of Jurisdiction	Office of the Insurance Ombudsman
Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.	**HYDERABAD** Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in
Rajasthan.	**JAIPUR** Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: Bimalokpal.jaipur@ecoi.co.in
Kerala , UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry	**ERNAKULAM** Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in
West Bengal, Sikkim, Andaman & Nicobar Islands.	**KOLKATA** Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in
Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	**LUCKNOW** Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in
Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane	**MUMBAI** Office of the Insurance Ombudsman, 3rd Floor, Jeevan SevaAnnexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in

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IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

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State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.	**NOIDA** Office of the Insurance Ombudsman, BhagwanSahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@ecoi.co.in
Bihar, Jharkhand, Saharanpur.	**PATNA** Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in
Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.	**PUNE** Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in

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