THE NEW INDIA ASSURANCE CO. LTD

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai – 400 001

NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY

1.0 Whereas Insured designated in the Schedule hereto has by a proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to THE NEW INDIA ASSURANCE CO. LTD. (hereinafter called the COMPANY) for the insurance herein after set forth in respect of Employees/Members (including their eligible Family Members) named in the Schedule hereto (herein after called the INSURED PERSON) and has agreed to pay premium of Rs. 14800/- as consideration for such insurance.

2.0 NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed here on the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any Illness (herein defined) or sustain any Injury (herein defined) and if such Injury shall require any such Insured Person, upon the advice of a duly qualified Medical practitioner (herein defined) or a surgeon to incur Medical Expenses/Surgery at any Hospital / Day Care Center (herein defined) in India as an Inpatient, the Company will pay to the Insured Person the amount of such expenses as good fall under different heads mentioned below, and as are Reasonably and Customarily, and Medically Necessarily incurred thereof by or on behalf of such Insured Person.

2.1 Room, Boarding Expenses as provided by the hospital including Nursing charges, not exceeding 1% of Sum Insured per day.

2.2 Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU) expenses, not exceeding 2% of the sum insured per day.

2.3 Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.

2.4 Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs & Cost of Organs and similar expenses.

2.5 Pre-hospitalization medical charges up to 30 days period.

2.6 Post-hospitalization medical charges up to 60 days period.

NOTE: SUB-LIMIT CLAUSE

1. The amounts payable under 2.3 and 2.4 shall be at the rate applicable to the entitled room category. In case of admission to a room/ICU/ICCU at rates exceeding the limits as mentioned under 2.1 and 2.2, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of room rent/ICU/ICCU charges.

2. No payment shall be made under 2.3 other than as part of the hospitalization bill.

3. However, the bills raised by Surgeon, Anesthetist directly and not included in the hospitalization bill may be reimbursed in the following manner:

a. The reasonable, customary and Medically Necessary Surgeon fee and Anesthetist fee would be reimbursed, limited to the maximum of 25% of Sum Insured. The payment shall be reimbursed provided the insured pays such fee(s) through cheque and the Surgeon / Anesthetist provides a numbered bill. Bills given on letter-head of the Surgeon, Anesthetist would not be entertained.

b. Fees paid in cash will be reimbursed up to a limit of Rs. 10,000/- only, provided the Surgeon/Anesthetist provides a numbered bill.

(N.B: Company's Liability in respect of all claims admitted during the period of insurance shall not exceed the Sum Insured per person mentioned in the schedule.)

2.7 LIMIT ON PAYMENT FOR CATARACT: Company's liability for payment of any claim relating to Cataract shall be limited to Actual or maximum of Rs.24000 (inclusive of all charges, excluding service tax), for each eye, whichever is less.

2.8 AYUSH: Expenses incurred for Ayurvedic/Homeopathic/Unani Treatment are admissible up to 25% of the sum insured provided the treatment for illness/disease and accidental injuries, is taken in a Government hospital or in any institute recognized by Government and /or accredited by Quality Council Of India / National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures.

2.9 Ambulances services – 1.0 % of the sum insured or actual, whichever is less, subject to maximum of Rs. 3000/- in case patient has to be shifted from residence to hospital for admission in Emergency Ward or ICU or from one Hospital to another Hospital by fully equipped ambulance for better medical facilities.

2.10 Hospitalization expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the insured person. The Company's liability towards expenses incurred on the donor and the insured recipient shall not exceed the sum insured of the insured person receiving the organ.

3.0 DEFINITIONS:

3.1 ACCIDENT: An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

3.2 ANY ONE ILLNESS means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

3.3 CANCELLATION: Cancellation defines the terms on which the policy contract can be terminated either by the insurer or the insured by giving sufficient notice to other which is not lower than a period of fifteen days.

3.4 CASHLESS FACILITY means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

3.5 CONDITION PRECEDENT: Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

3.6 CONGENITAL ANOMALY refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

3.6.1 CONGENITAL INTERNAL ANOMALY means a Congenital Anomaly which is not in the visible and accessible parts of the body.

3.6.2 CONGENITAL EXTERNAL ANOMALY means a Congenital Anomaly which is in the visible and accessible parts of the body

3.7 CO-PAYMENT: A co-payment is a cost-sharing requirement under a health insurance policy that provides that the insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured.

3.8 CONTRIBUTION: Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion.

3.9 DAY CARE TREATMENT: Day care treatment refers to medical treatment, and/or Surgical Operation 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 a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

3.10 DEDUCTIBLE: A deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.

3.11 DENTAL TREATMENT: Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

3.12 DOMICILIARY HOSPITALISATION: Domiciliary Hospitalization means medical treatment for an Illness/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

- The condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or
- The patient takes treatment at home on account of non-availability of room in a Hospital.

3.13 FLOATER BENEFIT means the Sum Insured as specified for a particular Insured and the members of his/her family as covered under the policy and is available for any or all the members of his/her family for one or more claims during the tenure of the policy.

3.14 HOSPITAL: A hospital means any institution established for Inpatient Care and Day Care treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1) of the said act OR complies with all minimum criteria as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;

- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

The term 'Hospital' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

3.14.1 HOSPITALISATION means admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours.

Anti-Rabies Vaccination	Hysterectomy
Appendectomy	Inguinal/Ventral/Umbilical/Femoral Hernia
Coronary Angiography	Lithotripsy (Kidney Stone Removal)
Coronary Angioplasty	Parenteral Chemotherapy
Dental surgery following an accident	Piles / Fistula
Dilatation & Curettage (D & C) of Cervix	Prostate
Eye surgery	Radiotherapy
Fracture / dislocation excluding hairline Fracture	Sinusitis
Gastrointestinal Tract system	Stone in Gall Bladder, Pancreas, and Bile Duct
Haemo-Dialysis	Tonsillectomy,
Hydrocele	Urinary Tract System

OR any other Surgeries / Procedures agreed by TPA/Company which require less than 24 hours hospitalization due to advancement in Medical Technology.

Note: Procedures/treatments usually done in outpatient department are not payable under the Policy even if converted as an In-patient in the Hospital for more than 24 hours.

3.14.2 Day Care Centre: A Day Care Centre means any institution established for Day Care treatment of Illness and or Injuries or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

1) has qualified nursing staff under its employment;
2) has qualified Medical Practitioner/s in charge;
3) Has a fully equipped operation theatre of its own where Surgeries are carried out;
4) Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

3.15 ID CARD means the identity card issued to the insured person by the TPA to avail cashless facility in network hospitals.

3.16 ILLNESS: Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

3.17 INJURY: Injury means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

3.18 INPATIENT CARE: Inpatient Care means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.

3.19 INSURED PERSON means You and each of the others who are covered under this Policy as shown in the Schedule.

3.20 INTENSIVE CARE UNIT (ICU): means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

3.21 MATERNITY EXPENSES: Maternity expense shall include:

a. Medical Treatment Expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalisation),
b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

3.22 MEDICAL ADVICE: Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

3.23 MEDICAL EXPENSES: Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Injury 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.

3.24 MEDICALLY NECESSARY: treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

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

3.25 MEDICAL PRACTITIONER is 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 the scope and jurisdiction of his license.

Note: The Medical Practitioner should not be the insured or close family members.

3.26 NETWORK HOSPITAL: All such Hospitals, Day Care Centers or other providers that the Insurance Company / TPA have mutually agreed with, to provide services like cashless access to policyholders. The list is available with the insurer/TPA and subject to amendment from time to time.

3.27 NON-NETWORK HOSPITAL: Any Hospital, Day Care centre or other provider that is not part of the Network.

3.28 OPD TREATMENT: OPD treatment is one in which the Insured 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 is not admitted as a Day Care or Inpatient.

3.29 PERIOD OF INSURANCE means the period for which this Policy is taken as specified in the Schedule.

3.30 PRE-EXISTING CONDITION/DISEASE: Any condition, ailment or Injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months prior to the first policy issued by the insurer.

3.31 PRE-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred immediately before the Insured Person is Hospitalized, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.32 POST-HOSPITALISATION MEDICAL EXPENSES mean Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

3.33 PORTABILITY: Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

3.34 QUALIFIED NURSE: Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

3.35 REASONABLE AND CUSTOMARY CHARGES: Reasonable 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.

3.36 RENEWAL: Renewal defines 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 all waiting periods.

3.37 ROOM RENT: Room Rent means the amount charged by a Hospital for the occupancy of a bed per day (twenty four hours) basis and shall include associated medical expenses.

3.38 SUM INSURED is the maximum amount of coverage opted for each Insured Person and shown in the Schedule.

3.39 SURGERY 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 of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

3.40 TPA: Third Party Administrators or TPA means any person who is licensed under the IRDA (Third Party Administrators - Health Services) Regulations, 2001 by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services.

3.41 UNPROVEN / EXPERIMENTAL TREATMENT: Treatment including drug experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

4.0 EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

4.1 PRE-EXISTING DISEASES/ CONDITIONS / BENEIFTS will not be available for any condition(s) as defined in the policy, until 48 months of continuous coverage have elapsed, since inception of the first policy with us.

4.2 30 DAYS EXCLUSION Any Illness other than those stated in clause 4.3 below, contracted by the insured person during first 30 days from the commencement date of the policy. This exclusion will not apply if the policy is renewed with our Company without any break. The exclusion does not also apply to treatment for any Injury.

4.3 WAITING PERIOD FOR SPECIFIED DISEASES/ALIMENTS/CONDITIONS: From the time of inception of the cover, the policy will not cover the following diseases / ailments / conditions for the duration shown below. This exclusion will be deleted after the duration shown, provided the policy has been continuously renewed with our Company without any break.

S No	Name of Disease/Ailment/Surgery not covered for	Duration
1	Any Skin disorder	Two years
2	All internal & external benign tumors, cysts, polyps of any kind, including benign breast lumps	Two years
3	Benign Ear, Nose, Throat disorders	Two years
4	Benign Prostate Hypertrophy	Two years
5	Cataract & age related eye ailments	Two years
6	Diabetes mellitus	Two years
7	Gastric/ Duodenal Ulcer	Two years
8	Gout & Rheumatism	Two years
9	Hernia of all types	Two years
10	Hydrocele	Two years
11	Hypertension	Two years
12	Hysterectomy for Menorrhagia/Fibromyoma, Myomectomy and Prolapse of uterus	Two years
13	Non Infective Arthritis	Two years
14	Piles, Fissure and Fistula in Anus	Two years
15	Pilonidal Sinus, Sinusitis and related disorders	Two years
16	Prolapse Inter Vertebral Disc unless arising from accident	Two years
17	Stone in Gall Bladder & Bile duct	Two years

18	Stones in Urinary Systems	Two years
19	Unknown Congenital internal disease/defects	Two years
20	Varicose Veins and Varicose Ulcers	Two years
21	Age related Osteoarthritis & Osteoporosis	Four years
22	Joint Replacements due to Degenerative Condition	Four years

4.4 Permanent Exclusions: Any medical expenses incurred for or arising out of:

4.4.1 War invasion, Act of foreign enemy, War like operations, Nuclear weapons, ionizing radiation, contamination by radio activity, by any nuclear fuel or nuclear waste or from the combustion of nuclear fuel.

4.4.2 Circumcision, cosmetic or aesthetic treatment, plastic surgery unless required to treat injury or illness.

4.4.3 Vaccination & Inoculation.

4.4.4 Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.

4.4.5 All types of Dental treatments except arising out of an accident.

4.4.6 Convalescence, general debility, 'Run-down' condition or rest cure, obesity treatment and its complications, congenital external disease/defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders, infertility, sterility, use of intoxicating drugs/alcohol, use of tobacco leading to cancer.

4.4.7 Bodily injury or sickness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted injury, , attempted suicide, arising out of non-adherence to medical advice.

4.4.8 Treatment of any Bodily injury sustained whilst or as a result of active participation in any hazardous sports of any kind.

4.4.9 Treatment of any bodily injury sustained whilst or as a result of participating in any criminal act.

4.4.10 Sexually transmitted diseases, any condition directly or indirectly caused due to or associated with Human T-Cell Lymphotropic Virus Type III (HTLB-III) or lymphotropathy Associated Virus (LAV) or the Mutants Derivative or Variation Deficiency syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS.

4.4.11 Diagnosis, X-Ray or Laboratory examination not consistent with or incidental to the diagnosis of positive existence and treatment of any ailment, sickness or injury, for which confinement is required at a Hospital.

4.4.12 Vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending Medical Practitioner.

4.4.13 Maternity Expenses, except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of ultra Sonographic Report and Certification by Gynecologist that it is life threatening.

4.4.14 Naturopathy Treatment. AYUSH treatment is covered.

4.4.15 Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and continuous Peritoneal Ambulatory dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition.

4.4.16 Genetic disorders and stem cell implantation / surgery.

4.4.17 Domiciliary Hospitalization.

4.4.18 Treatment taken outside India.

4.4.19 Experimental Treatment, Unproven treatment.

4.4.20 Change of treatment from one system to another unless recommended by the consultant / hospital under whom the treatment is taken.

4.4.21 Any expenses relating to cost of items detailed in Annexure I.

4.4.22 Service charges or any other charges levied by hospital, except registration/admission charges.

4.4.23 Treatment for Age Related Macular Degeneration (ARMD) , treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

5.0 CONDITIONS:

5.1 COMMUNICATION: Every notice or communication to be given or made under this policy shall be delivered in writing at the address as shown in the Schedule.

5.2 PREMIUM PAYMENT: The premium payable under this policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorized official of the Company.

5.3 NOTICE OF CLAIM: Preliminary notice of claim with particulars relating to Policy Number, name of insured person in respect of whom claim is to be made, nature of illness/injury and Name and Address of the attending Medical Practitioner/Hospital/Nursing Home should be given to the Company/TPA within 7 days from the date of hospitalization in respect of reimbursement claims.

Final claim along with hospital receipted original Bills/Cash memos**,** claim form and documents as listed in the claim form below should be submitted to the Policy issuing Office/TPA not later than 30 days of discharge from the hospital. The insured may also be required to give the Company/TPA such additional information and assistance as the Company/TPA may require in dealing with the claim.

a. Bill, Receipt and Discharge certificate / card from the Hospital.
b. Cash Memos from the Hospitals(s) / Chemists(s), supported by proper prescriptions.

c. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests / pathological.
d. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.

e. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.

f. Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.

Waiver: Waiver of period of intimation may be considered in extreme cases of hardships where it is proved to the satisfaction of the Company/TPA that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit. This waiver cannot be claimed as a matter of right.

5.4 PHYSICAL EXAMINATION: Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or Disease requiring Hospitalization when and as often as the same may reasonably be required on behalf of the Company.

5.5 The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.

5.6 CONTRIBUTION: If two or more policies are taken by Insured Person during a period from one or more insurers to indemnify treatment costs, Company shall not apply the contribution clause, but the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies.

1. In all such cases Company shall be obliged to settle the claim without insisting on the contribution clause as long as the claim is within the limits of and according to the terms of the policy.

2. If the amount to be claimed exceeds the Sum Insured under a single policy after considering the deductibles or co-pay, the Insured Person shall have the right to choose insurers by whom the claim to be settled. In such cases, the insurer may settle the claim with contribution clause.

3. Except in benefit policies, in cases where Insured Person have policies from more than one insurer to cover the same risk on indemnity basis, Insured Person shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the policy.

Note: Insured Personmust disclose such other insurance at the time of making a claim under this Policy.

5.7 CANCELLATION CLAUSE: The policy may be renewed by mutual consent. The company shall not however be bound to give notice that it is due for renewal and the Company may at any time cancel this Policy by sending the insured 30 days' notice by registered letter at the Insured's last known address and in such event the Company shall refund to the Insured a pro-rata premium for unexpired Period of Insurance. The Company shall, however, remain liable for any claim which arose prior to the date of cancellation.

The Insured may at any time cancel this policy and in such event the Company shall allow refund of premium at Company's short period rate only (table given here below) provided no claim has occurred up to the date of cancellation.

PERIOD OF RISK	RATE OF PREMIUM TO BE CHARGED
Up to one month	1/4th of the annual rate
Up to three months	½ of the annual rate
Up to six months	3/4th of the annual rate
Exceeding six months	Full annual rate

5.8 **DISCLAIMER OF CLAIM:** If the Company shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.9 All medical/surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

7.1 **MATERNITY EXPENSES BENEFIT EXTENSION (OPTIONAL COVER):** This is an optional cover which can be obtained on payment of 10% of the total basic premium for all the Insured Persons under the Policy Total basic premium means the total premium computed before applying Group Discount and / or High Claim Ratio Loading, Low Claim Discount and special discount in lieu of agency commission.

7.2 Option for maternity Benefits has to be exercised at the inception of the policy period and no refund is allowable in case of Insured's cancellation of this option during currency of the policy.

7.3 The maximum benefit allowable under this clause will be upto as agreed of the Sum Insured opted by the member of the group whichever is lower.

7.4 Special conditions applicable to Maternity Expenses Benefit Extension:

1. These Benefits are admissible only if the expenses are incurred in Hospital as inpatients in India.
2. A waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarian section or abdominal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery miscarriage or abortion induced by accident or other medical emergency.
3. Claim in respect of delivery for only first two children and / or surgeries associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who are already having two or more living children will not be eligible for this benefit.
4. Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.
5. Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there

Note: When Group Policy is extended to include Maternity Expenses Benefit, the exclusion 4.13 of the policy stands deleted.

8.0 **CASHLESS SERVICE THROUGH TPAS:** Claims in respect of Cashless access services will be through the agreed list of network of hospital and is subject to pre-admission authorization. The TPA shall, upon getting the related medical information from the insured person /network provider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the hospital mentioning the sum guaranteed as payable also the ailment for which the person is seeking to be admitted as a patient. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details as required by the TPA. The TPA will make it clear to the insured

person that denial of Cashless Access is in no way construed to be denial of treatment. The insured person may obtain the treatment as per his /her treating Medical Practitioners medical advice and later on submit the full claim papers to the TPA for reimbursement.

9.0 FRAUD, MISREPRESENTATION, CONCEALMENT: The policy shall be null and void and no benefits shall be payable in the event of misrepresentation, misdescription or nondisclosure of any material fact/particulars if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his/her behalf.

10.0 RENEWAL CLAUSE: The Company sends renewal notice as a matter of courtesy. If the insured does not receive the renewal notice it will not amount to any deficiency of service.

The Company shall not be responsible or liable for non-renewal of the policy due to non-receipt /delayed receipt of renewal notice or due to any other reason whatsoever.

We shall be entitled to decline renewal if:

a) Any fraud, moral hazard/misrepresentation or suppression by You or any one acting on Your behalf is found either in obtaining insurance or subsequently in relation thereto, or non-cooperation of the Insured Person, or

b) We have discontinued issue of the Policy, in which event You shall however have the option for renewal under any similar Policy being issued by Us; provided however, benefits payable shall be subject to the terms contained in such other Policy, or

c) You fail to remit Premium for renewal before expiry of the Period of Insurance. We may accept renewal of the Policy if it is effected within thirty days (grace period) of the expiry of the Period of Insurance. On such acceptance of renewal, we, however shall not be liable for any claim arising out of Illness contracted or Injury sustained or Hospitalization commencing in the interim period after expiry of the earlier Policy and prior to date of commencement of subsequent Policy.

11.0 MEDICAL EXPENSES FOLLOWING UNDER TWO POLICY PERIODS: If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available sum insured in the two policy periods, including the deductibles for each policy period. Such eligible claim amount to be payable to the insured shall be reduced to the extent of premium to be received for the renewal/due date of premium of health insurance policy, if not received earlier.

12.0 REPUDIATION OF CLAIM: A claim, which is not covered under the Policy conditions, can be rejected. All the documents submitted to TPA shall be electronically collected by Us for settlement and denial of the claims by the appropriate authority.

With Our prior approval Communication of repudiation shall be sent to You, explicitly mentioning the grounds for repudiation, through Our TPA.

13.0 PROTECTION OF POLICY HOLDERS' INTEREST: This policy is subject to IRDA (Protection of Policyholders' Interest) Regulation, 2002

14.0 GRIEVANCE REDRESSAL: In the event of Insured has any grievance relating to the insurance, Insured Person may contact any of the Grievance Cells at Regional Offices of the Company or Office of the Insurance Ombudsman under the jurisdiction of which the Policy Issuing Office falls. The contact details of the office of the Insurance Ombudsman are provided in the Annexure II.

15.0 PAYMENT OF CLAIM: The insurer shall settle the claim, including rejection, within thirty days of the receipt of the last necessary document.

On receipt of the duly completed documents either from the insured or Hospital the claim shall be processed as per the conditions of the policy. Upon acceptance of claim by the insured for settlement, the insurer or their representative (TPA) shall transfer the funds within seven working days. In case of any extra ordinary delay, such claims shall be paid by the insurer or their representative (TPA) with a penal interest at a rate which is 2% above the bank rate at the beginning of the financial year in which the claim is reviewed

All admissible claims shall be payable in Indian Currency only.

16.0 ARBITRATION: If we admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration.

The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

No reference to Arbitration shall be made unless We have Admitted our liability for a claim in writing.

If a claim is declined and within 12 calendar months from such disclaimer any suit or proceeding is not filed then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.