

HOSPIFUND INSURANCE

PART II OF THE POLICY

1. PREAMBLE

This Policy is a contract of insurance issued by ICICI Lombard General Insurance Company Limited (hereinafter called the 'Company') to the proposer mentioned in the schedule (hereinafter called the 'Insured') to cover the

person(s) named in the schedule (hereinafter called the 'Insured Persons'). The policy is based on the statements and declaration provided in the proposal Form by the proposer and is subject to receipt of the requisite premium.

2. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specify in this Policy or related Extensions/Endorsements:

Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

i. STANDARD DEFINITIONS -

Accident means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

AYUSH Day Care Centre: AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local

authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

- i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
- ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
- iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative. (Explanation: Medical Practitioner referred in the definition of "AYUSH Hospital" and "AYUSH Day Care Centre" shall carry the same meaning as defined in the definition of "Medical Practitioner")

"Break in policy" means the period of gap that occurs at the end of the existing policy term / instalment premium due date, when the premium due for renewal on a given policy or instalment premium due is not paid on or before the premium renewal date or grace period.

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

premium is paid in instalments during the policy period.

"Migration" means a facility provided to policyholders (including all members under family cover and group policies), to transfer the credits gained for pre-existing diseases and specific waiting periods from one health insurance policy to another with the same insurer.

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

"Pre-existing disease (PED)" means any condition, ailment, injury or disease:

a. that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or for which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

"Specific waiting period/ procedure waiting period" means a period up to 24 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/treatments shall be covered provided the policy has been continuously renewed without any break.

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 is approved.

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

•**Internal Congenital Anomaly** - means Congenital Anomaly which is not in the visible and accessible parts of the body.

•**External Congenital Anomaly** - means Congenital Anomaly which is in the visible and accessible parts of the body.

Condition Precedent means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

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.

Deductible shall be applicable per year, per life or per event as stated in the Policy Schedule and specific deductible to be applied shall be as per the Policy Schedule.

Disclosure to information norm means 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.

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 impairment of the insured person's health.

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 Regulations) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR comply with all minimum criteria as under:

- has qualified nursing staff under its employment round the clock;
- has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
- 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.
- 'Hospital' includes AYUSH Hospital.

AYUSH Hospital: An 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:

- Central or State Government AYUSH Hospital; or
- Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or
- 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:
- Having at least 5 in-patient beds;

- Having qualified AYUSH Medical Practitioner in charge round the clock;

- Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

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.

Illness means a sickness or disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

- **Acute condition** is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the

person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

• **Chronic condition** A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;
- it needs ongoing or long-term control or relief of symptoms;
- it requires rehabilitation for the patient or for the patient to be specially trained to cope with it;
- it continues indefinitely;
- it recurs or is likely to recur;

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident

means which is verified and certified by a Medical Practitioner.

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 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.

Medical Advice means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.

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.

Medically Necessary Treatment means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:

Is required for the medical management of the illness or injury suffered by the insured; must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity; professional standards widely accepted in international medical practice or by the medical community in India.

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 the scope and jurisdiction of his license. The term Medical Practitioner would include physician, specialist, anesthetist and surgeon but would exclude the insured and his/her Family Member. A Family Member means an Insured's lawful spouse; children including stepchildren and children legally adopted by the Insured (below 18 years); siblings; parents; sister(s) in law, brother(s) in law; parents-in-law; legal guardian; ward; step-parents.

Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

Non-Network Provider means any hospital, day care centre or other provider that is not part of the network.

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

Renewal means the terms on which the contract of insurance can be renewed as per relevant regulatory prescriptions 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.

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.

Unproven/Experimental treatment means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven

ii. SPECIFIC DEFINITIONS -

Age means the completed years of the Insured Person on his/her last birthday as per the English calendar.

Ambulance Services means procedures that are used to provide immediate care and support to transfer the patient from the pick-up point/location to the nearest Hospital where necessary treatment/care can be initiated depending on the nature of illness or disorder, presence, severity and cause.

Alternative treatments means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Siddha and Homeopathy in the Indian context.

Claim means a demand made by You or on Your behalf for payment of Medical Expenses or any other expenses or benefits, as covered under the Policy.

Extension means an additional insurance cover available under the Policy. An Extension will be in force for the Insured Person only if the due additional premium for the Extension has been received and the Policy Schedule states that the Extension is in force.

Franchise means a minimum amount of loss that must be incurred before insurance coverage applies. Once the Deductible is met, the entire benefit amount is paid, subject to the Policy terms and conditions.

Immediate Family Member means the Insured Person's lawful spouse; children including stepchildren and children legally

adopted by the Insured Person; siblings; parents; sister(s) in law, brother(s) in law; parents-in-law; legal guardian; ward; step-parents.

Insured Event means any event specifically mentioned as covered under this policy.

Insured Person(s) means the individual(s) covered under the Policy whose name(s) is/are specifically appearing as such in the Policy Schedule.

Nominee means the person(s) nominated by You to receive the benefits under this Policy payable on Your death. For the purpose of avoidance of doubt it is clarified that if You are a minor, Your legal guardian shall appoint the Nominee.

Policy means these Policy wordings, the Policy Schedule and any applicable endorsements or Benefits attaching to or forming part thereof. The Policy contains details of the extent of cover available to the insured, what is excluded from the cover and the terms & conditions on which the Policy is issued to the insured.

Policy Period means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Schedule.

Policy Schedule means the Policy Schedule attached to and forming part of the Policy.

Policy Year means a period of twelve months beginning from the Policy Start Date 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 beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy End Date, as specified in the Policy Schedule.

Proposal and Declaration Form means any initial or subsequent declaration made by the policyholder and is deemed to be attached and which forms a part of this Policy.

Sum Insured means the amount specified in the Policy Schedule against a Benefit or set of Benefits that represents Our maximum, total and cumulative liability for any and all claims made in respect of that Insured Person during the Policy Year under that Benefit/set of Benefits. Any Sum Insured which is not utilized in a particular Policy Year will not be carried over to any subsequent Policy Year in the Policy Period.

Third Party Administrators (TPA) means any person who is registered (Third Party Administrators - Health Services) Regulations,2016 notified by the Authority, and is engaged, for a fee or remuneration by an insurance company, for the purposes of providing health services as defined in those Regulations.

You / Your means the person named as the policyholder in the Policy Schedule and who is responsible for payment of premium.

Waiting Period means a time-bound exclusion period related to condition(s) specified in the Policy Schedule which shall be served before a claim related to such condition becomes admissible.

We/ Our / Us / Company means the ICICI Lombard General Insurance Company Limited.

3. BENEFITS COVERED UNDER THE POLICY

This Policy is a contract of insurance between the Policyholder and Us which is subject to the receipt of premium against each Benefit/Cover in respect of the Insured Persons and the terms, conditions and exclusions of this Policy. AYUSH Treatments are covered under this Policy.

BASE BENEFITS

The Policy Schedule will specify which of the following Base Benefits and Extensions are applicable and in force for the Insured Person. Claims made in respect of an Insured Person for any Base Benefit or Extension applicable to the Insured Person shall be subject to the availability of the Sum Insured for the Base Benefit/Extension, and the terms, conditions and exclusions of this Policy.

All Claims shall be made in accordance with the procedures set out in this Policy. Admitted Claims will be payable to the Insured Person or the Nominee (as applicable).

Insured can avail one or both of the base benefits. In case both the benefits are chosen, the payout in such case, will be additive of both the base benefits.

1. Hospitalization Cash Benefit: If an Insured Person

contracts an Illness or suffers an Injury due to an Accident that occurs during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, then

We will pay the daily amount specified in the Policy Schedule against this Base Benefit for each continuous and completed day of Hospitalization of the Insured Person.

This Base Benefit shall be payable subject to the following:

- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- We shall not be liable to pay the daily amount for more than the maximum number of days as specified in the Policy Schedule for each Insured Person, during the Policy Year.
- Our liability to make any payment under this Base Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Schedule, if applicable.

Illustration: If the customer opts for a Franchise of two days under this benefit and he is admitted in a hospital for one day, then this benefit shall not be triggered. However, if the customer is hospitalized for more than two days, then he shall be entitled under this benefit for all days of hospitalization (up to the sum insured). In case a Deductible of two days is opted, this benefit will only be payable for the period of Hospitalization after the first two days are completed.

- We shall not be liable to make any payment under this Base Benefit, if the Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).

If We have admitted a Claim under this Base Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Base Benefit is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

2. Accidental Hospitalization Cash Benefit: If an Insured

Person suffers an Injury due to an Accident only, that occurs during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Schedule against this Base Benefit for each continuous and completed day of Hospitalization of the Insured Person.

This Base Benefit shall be payable subject to the following:

- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- We shall not be liable to pay the daily amount for more than the maximum number of days as specified in the Policy Schedule for each Insured Person, during the Policy Year.
- Our liability to make any payment under this Base Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Schedule, if applicable.

Illustration: If the customer opts for a Franchise of two days under this benefit and he is admitted in a hospital for one day, then this benefit shall not be triggered. However, if the customer is hospitalized for more than two days, then he shall be entitled under this benefit for all days of hospitalization (up to the sum insured). In case a Deductible of two days is opted, this benefit will only be payable for the period of Hospitalization after the first two days are completed.

- We shall not be liable to make any payment under this Base Benefit, if the Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).
- If We have admitted a Claim under this

Base Benefit, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Base Benefit is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

EXTENSIONS TO THE BASE BENEFIT

The following extensions to the base benefits) can be availed by paying additional premium. The Payout in case of these extension benefits will be additive.

1. Intensive Care Cash Benefit: If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized in an Intensive Care Unit, then We will pay the daily amount specified in the Policy Schedule against this Extension for each continuous and completed day of confinement of the Insured Person in the Intensive Care Unit.

This Extension shall be payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same Illness/Injury in respect of which the Insured Person was Hospitalized in the Intensive Care Unit.
- The Hospitalization in the Intensive Care Unit is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- We shall not be liable to pay the daily amount for more than the maximum number of days

specified in the Policy Schedule for each Insured Person, during the Policy Year.

- Our liability to make any payment under this Extension Benefit shall be in excess of the per event Deductible or per event Franchise stated in the Policy Schedule, if applicable. However, the Deductible/Franchise will not apply to the extent of days in respect of which the Insured Person has already been admitted in the Hospital in a non- ICU room.

Illustration: If the customer opts for a Franchise of two days under this benefit and he is admitted in a hospital for one day, then this benefit shall not be triggered. However, if the customer is hospitalized for more than two days, then he shall be entitled under this benefit for all days of hospitalization (up to the sum insured). In case a Deductible of two days is opted, this benefit will only be payable for the period of Hospitalization after the first two days are completed.

- We shall not be liable to make any payment under this Extension, if the Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).
- If We have admitted a Claim under this Extension then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

2. Cancer Hospitalization Cash Benefit: If an Insured Person contracts 'Cancer of Specified Severity' during the Policy Period and which solely and directly

requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Schedule against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Cancer of Specified Severity.

For the purpose of this Extension, Cancer of Specified Severity means-

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

The following are excluded -

- All tumors which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 and CIN-3.
- Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- Chronic lymphocytic leukaemia less than RAI stage 3;
- Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification;
- All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count

of less than or equal to 5/50 HPFs;

This Extension shall be payable subject to the following:

- i. We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
- ii. The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- iii. Our liability to make any payment under this Extension shall be in excess of the per event Deductible / per event Franchise stated in the Policy Schedule, if applicable.
- iv. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule for each Insured Person during the Policy Year.
- v. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule.
- vi. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

3. **Brain & Stroke Hospitalization Cash Benefit:** If an Insured Person contracts any of the Brain Ailment or Stroke listed below during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily

amount, specified in the Policy Schedule against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of the Brain Ailment or Stroke. For the purpose of this Extension, Brain Ailment and Stroke shall mean the following:

• 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 like CT Scan or MRI.

• This brain tumor must result in at least one of the

following and must be confirmed by the relevant medical specialist

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

The following conditions are excluded:

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

• 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:
- Transient ischemic attacks (TIA)
- Traumatic injury of the brain
- Vascular disease affecting only the eye or optic nerve or vestibular functions.

• 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.

• MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

Motor neuron disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

• MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

- The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following: Investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis; and
- There must be current clinical impairment of

motor or sensory function, which must have persisted for a continuous period of at least 6 months.

Other causes of neurological damage such as SLE are excluded .

- **MAJOR HEAD TRAUMA**

- Accidental head injury resulting in permanent

Neurological deficit to be assessed no sooner than

3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, 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.

- The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this Benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

- The Activities of Daily Living are:

- Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

- Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;

- Mobility: the ability to move indoors from room to room on level surfaces;

- Toileting: the ability to use the lavatory or

otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

- Feeding: the ability to feed oneself once food has been prepared and made available.

The following are excluded:

I. Spinal cord injury.

This Extension shall be payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

- The Hospitalization is for a Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

- Our liability to make any payment under this Extension Benefit shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule, if applicable. We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule for each Insured Person during the Policy Year.

- We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

4. Organ Transplant Hospitalization

Cash Benefit: If an Insured Person undergoes Organ Transplant during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized for the procedure for transplantation, then We will pay the daily amount specified in the Policy Schedule against this Extension for each continuous and completed day of Hospitalization of the Insured Person for transplantation of the organ.

For the purpose of this Extension, Organ Transplant shall mean the following:

The actual undergoing of transplant of:

- a. One of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end stage failure of the relevant organ;
- b. 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:

- a. Other stem cell transplants;
- b. Where only islets of langerhans are transplanted. This Extension shall be payable subject to the following:
 - We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
 - The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
 - We shall not be liable to make any payment under this Extension in respect of any organ transplantation that is not carried out in accordance with the Transplantation of Human Organs Act 1994, as amended.
 - Our liability to make any payment under this

Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule, if applicable.

- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule for each Insured Person during the Policy Year.

We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule, unless due to an Accident.

- If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

5. Heart Ailment Hospitalization Cash Benefit

Cash Benefit: If an Insured Person contracts any of the Heart Ailments listed below during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Schedule against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of that Heart Ailment.

For the purpose of this Extension, Heart Ailments mean the following:

I. MYOCARDIAL INFARCTION (First Heart Attack of specific severity)

i. 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:

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

The following are excluded:

- 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.

II. OPEN CHEST CABG

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

The following are excluded:

Angioplasty and/or any other intra-arterial procedures

III. 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.

IV. ANGIOPLASTY

i. Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

ii. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

iii. Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

v. PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION

i. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Cauterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

ii. The NYHA Classification of Cardiac Impairment are as follows:

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.

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

This Extension shall be payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner. Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule.
- If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall

be paid directly to the Insured Person/Nominee.

6. Fracture & Burns Cash Benefit: If an Insured Person suffers a Fracture and/or Second Degree Burns and/or Third Degree Burns during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, then

We will pay the daily amount specified in the Policy Schedule against this Extension for each continuous and completed day of Hospitalization of the Insured Person for treatment of

that Fracture, Second Degree Burns or Third Degree Burns.

For the purpose of this Extension the following definitions will apply:

Fracture means a medical condition in which there is a damage in the continuity of the bone. A bone fracture may be the result of high force impact or stress, or a minimal trauma Injury as a result of certain medical conditions that weaken the bone, such as Osteoporosis, bone cancer, or osteogenesis imperfect, where the fracture is then properly termed a pathologic fracture.

Second Degree (partial thickness) Burns means burns which involves the epidermis and part of the dermis layer of skin. Third Degree (full thickness) Burns means burns which affects and destroys the epidermis and the dermis.

This Extension shall be payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.

- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise as stated in the Policy Schedule, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless such Fracture is due to an Accident).

If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured

Person/Nominee.

7. Day Care Treatment Cash Benefit: If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Policy Period and which solely and directly requires the Insured Person to undergo a Day Care Treatment during the Policy Period We will pay the per event amount specified in the Policy Schedule against this Extension.

For the purpose of this Extension, Day Care Treatment and Day Care Centre may be

defined as under:

Day Care Treatment means medical treatment, and/or surgical procedure which is:

- Undertaken under general or local anesthesia in a hospital or day care centre in less than 24 hours because of technological advancements 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.

Day Care Centre means any institution established for day care treatment of illness and/or injuries or a medical setup with 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 criterion as under -

- i. has qualified nursing staff under its employment;
- ii. has qualified medical practitioner/s in charge;
- iii. has 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.

This Extension shall be payable subject to the following:

i. The Day Care Treatment is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

ii. We shall not be liable to pay the event amount for more than 5 times for each Insured Person during the Policy Year.

We shall not be liable to make any payment under this Extension, if the Day Care Treatment was taken prior to the commencement of the

Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).

iii. If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Base Benefit directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

8. Convalescence Benefit: If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Policy Period and which solely and directly requires the Insured

Person to be Hospitalized for a continuous period of at least 10 consecutive days, then We will pay the event amount specified in the Policy Schedule against this Extension towards convalescence of the Insured Person. This Extension is payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization. If a Claim is not admitted under the Base Benefit in respect of the Insured Person for the same period of Hospitalization, then no Claim will be admitted under this Extension even if the period of Hospitalization of the Insured Person exceeds 10 days.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.

- We shall not be liable to pay the event amount for

more than 5 times specified in the Policy Schedule for each Insured Person during the Policy Year.

- We shall be liable to pay the Benefit amount under this extension, only once per hospitalization event.
- We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).

• If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance

written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are

able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

9. Ambulance Cover Benefit: If an Insured Person contracts an Illness or suffers an Injury that occurs due to an Accident during the Policy Period and that Illness or Injury solely and directly requires the Insured Person to be transported to a Hospital for Medically Necessary Treatment, We will pay the event amount specified against this Extension in the Policy Schedule in respect of any Ambulance Services used for transportation of the Insured Person from the site of the Accident/Illness to the nearest Hospital or from the site of first treatment to a higher centre of care.

This Extension shall be payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
- The transportation in case of movement from the site of first treatment to a centre of higher care is recommended in writing by the treating Medical Practitioner.
- We shall not be liable to pay the event amount for more than 5 times for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).

10. Child Care Cash Benefit: If an Insured Person contracts an Illness or suffers an Injury due to an Accident that occurs during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified against this Extension for the purpose of providing care to the Insured Person's Dependent Child/Children.

For the purpose of this Extension, Dependent Child/Children means:

Child/Children (including step child/children) of the Insured Person up to the age of 18 years who are dependent on the Insured Person for maintenance and financial support.

This Extension shall be payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating

Medical Practitioner.

- Our liability under this Extension shall not increase if the Insured Person has more than one Dependent Child.
- We shall not be liable to make any payment under this Extension if the Insured Person has no Dependent Children on the date of the Insured Event giving rise to the Claim under this Extension.
- Our liability to make any payment under this Extension shall be in excess of the per event Deductible/Franchise as stated in the Policy Schedule, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule for each Insured Person during the Policy Year.

11. We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).

12. Hospital Attendant Cash Benefit: If an Insured Person contracts an Illness or suffers an Injury due to Accident during the Policy Period and which solely and directly requires the Insured Person to be Hospitalized, then We will pay the daily amount specified in the Policy Schedule against this Extension in respect of each continuous and completed day of Hospitalization of the Insured Person which requires a Hospital Attendant to be present.

For the purpose of this Extension, Hospital Attendant means the Insured Person's family member / relative / acquaintance / any other registered third party service

provider who would be available to take care of the Insured Person during his/ her Hospitalization.

This Extension shall be payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- Our liability to make any payment under this Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule, if applicable.
- We shall not be liable to pay the daily amount for more than the maximum number of days specified in the Policy Schedule for each Insured Person during the Policy Year.
- We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).
- If We have admitted a Claim under this Extension, then on the Insured Person/Nominee's advance written request, We may pay the amount due under this Extension directly to the Hospital where the Insured Person was treated, provided that We are able to offer Cashless Facility at that Hospital. If the payment due under this Extension is more than the amount payable to the Hospital, then the balance amount shall be paid directly to the Insured Person/Nominee.

13. Compassionate Visit Cash Benefit:

If an Insured Person contracts an Illness or suffers an Injury that occurs during the Policy Period that Illness or Injury solely and directly requires the Insured Person to be Hospitalized for at least 3 continuous days at a location outside the Insured Person's city of residence, We will pay

the event amount specified against this Extension in the Policy Schedule towards the expenses incurred on the travel of the Insured Person's Immediate Family Member(s) to the place of Hospitalization.

For the purpose of this Extension, Immediate Family Member means:

The Insured Person's lawful spouse; children including stepchildren and children legally adopted by the Insured Person; siblings; parents; sister(s) in law, brother(s) in law; parents-in-law; legal guardian; ward; step-parents. This Extension shall be payable subject to the following:

- We have accepted a Claim under the Base Benefit in respect of that Insured Person for the same period of Hospitalization.
- The Hospitalization is for Medically Necessary Treatment and is commenced and continued on the written advice of the treating Medical Practitioner.
- The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence.
- The Medical Practitioner treating the Insured Person recommends in writing the personal attendance of an Immediate Family Member.
- The Insured Person has not been Hospitalized for any planned treatment or Surgery.
- Our liability to make any payment under this

Extension shall be in excess of the per event Deductible/per event Franchise stated in the Policy Schedule, if applicable.

- We shall not be liable to pay the event amount for more than 5 times for each Insured Person within the Policy Year.
- We shall be liable to pay the Benefit amount under this extension, only once per Hospitalization event.
- Our liability under this Extension shall not increase if more than one Immediate Family Member of the Insured Person travels to the Insured Person's place of Hospitalization.
- We shall not be liable to make payment of the event amount under this Extension more than once for any period of Hospitalization of the Insured Person.
- We shall not be liable to make any payment under this Extension, if Hospitalization commenced prior to the commencement of the Policy Period or within the Waiting Period specified in the Policy Schedule (unless due to an Accident).

5. EXCLUSIONS

We shall not be liable to make any payment for any Claim under this Policy in respect of an Insured Person, directly or indirectly for, caused by, arising from or in any way attributable to any of the following:

i. STANDARD EXCLUSIONS -

• Pre-existing Diseases (Code - Excl 01)

- i. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with insurer.
- ii. In case of enhancement of sum insured the

exclusion shall apply afresh to the extent of sum insured increase.

If the Insured Person is continuously covered without any break as defined under the portability, then waiting period for the same would be reduced to the extent of prior coverage

iii. Coverage under the policy after the expiry of 24 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

• 30 day waiting period (Code - Excl 03) -

i. 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.

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

iii. The within referred waiting period shall be applicable to the enhanced sum insured in the event of granting higher sum insured subsequently

• Specified disease/procedure waiting period - Two Years Exclusions (Code - Excl 02) -

- Expenses related to the treatment of the below listed

Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.

- In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.

- If any of the specified disease/procedure falls under the waiting period specified for pre-existing diseases, then the longer of the two waiting periods shall apply.
- The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated, then waiting period for the same would be reduced to the extent of prior coverage.
- List of specific disease/procedures -
- Deviated Nasal Septum, CSOM-Chronic Suppurative Otitis Media
- Stapedectomy, Mastoidectomy, any treatment for conditions related to tonsils, adenoids, sinuses, turbinates/concha
- Fibroids (fibromyoma), Endometriosis, Uterine Prolapse, Polycysic Ovarian Syndrome(PCOS)
- Dilatation and curettage (D&C), Myomectomy,
- Hysterectomy
- Arthritis, Gout and Rheumatism, Intervertebral disc disorders , Arthroscopy, Spinal and Vertebral Disorders including diagnosis as low back ache, Surgeries for joint replacements Stones in gall bladder and biliary system; Cholecystitis, Fissure/fistula in anus, hemorrhoids, pilonidal sinus, piles, Esophageal Varices and Gastric Varices,Gastritis,
- Duodenitis & Pancreatitis
- Gastric and Duodenal ulcers, Gastro Esophageal Reflux Disorder (GERD)/Acid Peptic Disease, Ulcerative colitis, Crohn's disease, Irritable Bowel Syndrome,
- Inflammatory Bowel disease
- All forms of cirrhosis, rectal prolapse, Perineal Abscesses, Perianal Abscesses
- Cholecystectomy, Endoscopy

- Stones in urinary system, all prostate diseases, chronic renal failure or end stage renal failure or chronic kidney disease, dialysis
- Dysfunctional uterine bleeding, pelvic inflammatory diseases, stress incontinence,
- Hydrocele, varicocele/ rectocele/spermatocele
- Cataract, Glaucoma, Diseases of the vitreous and retina
- Unless malignant, all internal/ external tumors, cysts, nodules, polyps, sinus, fistula, adenoma, lumps including teratoma, breast lumps, dermoid cyst, ovarian cyst, desmoid tumour, umbilical granuloma, mucous cyst of lip/cheek
- Diseases related to thyroid
- All skin ailments
- Ulcers of any kind (whether internal or external) including decubitus ulcers
- Varicose veins and varicose ulcers
- All hernias

- Cosmetic or plastic surgery (Code - Excl 08) - Expenses for cosmetic or plastic surgery or any treatmentto change appearance unless for reconstruction following an Accident, Burn(s) 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.
- Refractive Error (Code - Excl 15) - Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.
- Obesity/Weight Control (Code - Excl 06) - Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
 1. Surgery to be conducted is upon the advice of the Doctor
 2. The surgery/Procedure conducted should be

supported by clinical protocols

3. The member has to be 18 years of age or older and

4. Body Mass Index (BMI); greater than or equal to 40 or

a. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy

ii. Coronary heart disease

iii. Severe Sleep Apnea

iv. Uncontrolled Type2 Diabetes

- Rest Cure, rehabilitation and respite care (Code - Excl 05) - 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 such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

II. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

- Change of Gender Treatments (Code - Excl 07) - Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

- Breach of Law (Code - Excl 10) - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent

- Treatment for, Alcoholism, drug or substance abuse or any addictive condition and

consequences thereof. (Code - Excl 12)

- Investigation & Evaluation (Code - Excl04) -

- a. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded;

- b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

- Unproven Treatments (Code - Excl 16) - 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.

- Hazardous or Adventure Sport (Code - Excl 09) - Expenses related to any treatment necessitated due to participation as a professional 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.

- Sterility and Infertility (Code - Excl 17) - Expenses related to Sterility and infertility.

This includes:

- i. Any type of contraception, sterilization
- ii. Assisted Reproduction services including artificial insemination and
- iii. advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI Gestational Surrogacy
- iv. Reversal of sterilization.

- Excluded Providers (Code - Excl 11) - Expenses incurred towards treatment in any hospital or by an Medical

Practitioner or any other provider specifically excluded by the Insurer and disclosed in its

website/notified to the

policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

- Maternity (Code - Excl 18) -

- 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;

- Treatments received in health 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 - Excl 13)

- Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. (Code - Excl 14)

ii. SPECIFIC EXCLUSIONS -

- Any dental treatment or dental surgery of any kind unless necessitated due to an Accident or specifically covered and specified in the Policy Schedule/Policy Schedule.
- Vaccination and inoculation of any kind.
- Any alternative treatments not covered under AYUSH as instituted in a government

hospital or any institutes

recognised by the government and/or accredited by Quality Council of India / National Accreditation Board of Health.

- Any treatment received outside India unless specifically covered and specified in the Policy Schedule.
- Circumcision unless necessary for treatment of an underlying illness.
- Hormone replacement therapy.
- Alopecia, baldness, wigs, or toupees and hair fall treatment.
- Routine medical, eye and ear examinations unless specifically covered and specified in the Policy Schedule.
- Any medical examination or diagnostics or Hospitalization for the purpose of employment or travel.
- Treatment of general debility, sterility, venereal disease.
- Intentional self Injury, suicide or attempt to suicide.
- First Degree Burns where First Degree (superficial) Burns are those which affects only the epidermis, or outer layer of skin.
- Any External Congenital Anomalies unless specifically covered and specified in the Policy Schedule.
- Any sexually transmitted diseases..
- Treatment by a Family Member and self-medication or any treatment that is not scientifically recognized.
- Illness or Injury whilst performing duties as a serving member of a military or a police force or any other forces of similar nature.
- Expenses related to donor screening related

to donation of an organ(s).

- Treatment taken from persons not registered as Medical Practitioners under respective medical councils.
- Domiciliary Hospitalization.
- Engaging in professional sports unless specifically covered and specified in the Policy Schedule.
- War, invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion.
- Nuclear weapon materials or ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission or nuclear fusion.
- Whilst mounting or dismounting into an aircraft or flying or taking part in aerial activities (including airline crew or cabin crew) except as a fare-paying passenger in a regular scheduled airline or air charter company.
- Treatment of any sexual problem including but not limited to impotence and Erectile Dysfunction irrespective of the cause; Venereal diseases or any sexually transmitted diseases.
- Hospitalization primarily for evaluative and diagnostic purpose for which no active line of treatment/ treatment which is possible in outpatient department is given; Admission only for Holter monitoring/Sleep study.

CLAIM DOCUMENTS AND PROCEDURE

- On the occurrence of an Insured Event which may give rise to a claim under the Policy, We shall be provided with the following necessary and mandatory information and documentation specified in relation to the Base Benefit/Extension being claimed within 30 days of the occurrence of the Insured Event:
 - 1. Claim form duly completed and signed by the claimant/Insured Person. The claim form can be downloaded from our website www.icicilombard.com
 - 2. Indoor case papers from the Hospital mentioning the diagnosis, date and time of admission and discharge, past medical and surgical history with duration.
 - 3. Hospital discharge summary filled and attested by Hospital.
 - 4. First Information Report (F.I.R.) copy & Spot Panchanama / medico-legal case papers - notarized/ attested by a gazetted officer in case of an Injury.
 - 5. Payment receipt in case an Ambulance Service has been availed, if applicable.
 - 6. KYC Documents of the Insured Person and claimant.
 - 7. Age proof of child in case of Child Care Cash Benefit.
 - 8. Travel Declaration by the Immediate Family Member in case of Compassionate Visit Cash Benefit.
 - 9. Account details for Electronic Fund Transfer (EFT mandate form and cancelled cheque).
 - 10. Any other document as required by Us to investigate the claim or Our obligation to make payment for it

CLAIM ADMINISTRATION APPLICABLE TO THIS POLICY

1. The fulfillment of the terms and conditions of this Policy (including payment of premium by

the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the procedures and requirements in relation to claims, shall be Conditions Precedent to Our liability under this Policy.

2. We shall be under no obligation to make any payment under this Policy unless We have received all premium payments in full and on time in respect of the Insured Person's cover under the Policy and all payments have been realised.

3. On occurrence of an any event that may give rise to a Claim under this Policy, You shall-

i. Notify Us immediately on toll free number 1800 2666 or on our website www.icicilombard.com or also in writing at Our address as specified on policy schedule.

ii. Along with the completed and signed Claim form, provide all the relevant documents in support of Your Claim within 15 days.

iii. Wherever details pertaining to happening of Claim are conveyed by you to Us after reasonable period, You shall provide the reasons of such delay to Us.

4. All claims documentation specified within the relevant Section of the Policy for the Base Benefit/Extension being claimed must be submitted in full. The final decision to waive the requirement for any specified claim documents rests with Us.

5. If any Claim is not made within 15 days of the Insured Event, then We will condone such delay on merits only where the delay has been proved to be for reasons beyond the claimant's control.

6. We/Our representatives must be given all reasonable co-operation in investigating the Claim in order to assess Our liability and quantum in respect of such Claim. If requested by Us and at Our cost, the Insured Person must

submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's Injury/Illness and treatment and to investigate the facts surrounding the Claim.

7. Our medical or other representative shall be allowed to examine the Insured Person on the occurrence of any alleged Injury or disablement when and as often as the same may reasonably be required on behalf of Us. Such evidence as We may require from time to time shall be furnished within a period of 15 days.

8. The directions, advice and guidance of the treating Medical Practitioner shall be followed by the Insured Person.

9. All Claims will be investigated (as required) and settled in accordance with the applicable regulatory guidelines, and any rejections if done, would be provided with proper reasons by Us within 15 days of claim along with claim form and required documents

10. The admissible Claim amount will be calculated post applicability of Deductible, Co-pay, Sub-limit if any and as specifically defined in Policy Schedule.

11. You/the Insured Person must take all reasonable steps or measures to minimize the quantum of any Claim that may be covered under the Policy. If so requested by Us, the Insured Person will have to undergo a medical examination from Our nominated Medical Practitioner, as and when We consider reasonable and necessary to obtain an independent opinion for the purpose of processing any Claim. The cost of such examination will be borne by Us

12. Any notice or declaration for Your attention shall be deemed served if sent by Us to You at Your latest known address.

13. Any payment due to You under this Policy shall be paid to You by Us. However, We also reserve Our right to pay the Claim directly to the Hospital or to the Nominee (as named in the Policy Schedule)..

14. We shall have no liability under this Policy, once the Sum Insured, as stated in the Policy Schedule, is exhausted by You.

15. For any payment to be made by Us under any Claim arising under this Policy, We shall make the payment in India and in Indian rupees only.

Claim falling in 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 Deductible or Franchise applicable for each Policy Period. Such eligible claim amount to be payable to the Insured Person shall be reduced to the extent of premium to be received for the Renewal/due date of premium of the health insurance Policy, if not received earlier.

TERMS OF RENEWAL

a. The Policy may be renewed except on grounds of established fraud or non-disclosure or misrepresentation and in such event the Renewal premium should be paid to Us on or before the date of expiry of the Policy and in no case later than the Grace Period of 30 days from the expiry of the Policy. We will not be liable to pay for any Claim arising out of an Injury or Accident or Illness or Hospitalization that occurred during the Grace Period.

b. You shall on tendering any premium for the Renewal of this Policy give notice in writing to Us of any Illness, physical defect or infirmity with which any of the Insured Person(s) have

become affected since the payment of the expiring Policy start date.

- c. There will be life-long renewal without any age restriction for the cover.
- d. The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy.

Sum Insured Enhancement: You can enhance Your sum insured under the policy only upon renewal, subject to underwriter's approval. If the policy is renewed for an enhanced sum insured, then fresh waiting period will be applicable to the enhanced limit from the effective date of such enhancement.

POLICY RELATED TERMS AND CONDITIONS

- Please inform us immediately of any change in the address, occupation, state of health, or of any other changes affecting the Insured Person (or his Nominee/ legal heir, as the case may be)
- Any change in policy terms and conditions including but not limited to Sum Insured and/or coverage shall not be permitted within the Policy Period.
- Chooses to pay the premium in instalments then he/she shall not be able to change the frequency of payments within the Policy Period.
- In case the customer has opted for renewal the policy shall be Renewed with the same policy terms & conditions including but not limited to the Sum Insured, coverage, premium paying terms and Claim payment terms and policy terms and conditions.
- We shall make payment to assignee as the case may be or in the absence of assignee to the Insured Person or the Insured Person's nominee. If there is no assignee or nominee and the Insured

Person is incapacitated or deceased, We will pay to the Insured Person's heir, executor or validly appointed legal representative. Any payment We make in this manner will be a complete and final discharge of Our liability towards the Claim.

- The scope of the cover shall be within geographical boundaries on India unless specified otherwise.

PART III OF THE POLICY SCHEDULE GENERAL TERMS AND CLAUSES -

a. STANDARD GENERAL TERMS AND CLAUSES

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.

("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. Condition Precedent to Admission of Liability

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

3. Complete Discharge

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

4. 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 and the premium paid shall be forfeited.

□ Any amount already paid against claims made under this policy but which are found fraudulent later

shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

□ For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other pa(y) acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- he suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- the active concealment of a fact by the insured person having knowledge or belief of the fact;
- any other act fitted to deceive; and
- 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 misstatement of or suppression of material fact are within the knowledge of the insurer

5. Cancellation/ Termination

The policyholder may cancel this policy by giving 7days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below

i) Refund Grid applicable to Policies having Policy Period lesser than or equal to one year:

PERIOD ON RISK	RATE OF PREMIUM REFUNDED
Up to 1 month*	75% of premium
Up to 3 months	50% of premium
Up to 6 months	25% of premium
Exceeding six months	NIL

* Not applicable for policies with freeloook period; Premium refund for cancellations during the freeloook period will be provided as per the Free look clause

ii) Refund Grid Applicable to policies having Policy Period greater than 1year

Time of cancellation	Policy duration		
	One year	Two Years	Three Years
Within 1 month*	80%	80%	80%
From 1 month to 3 months	60%	70%	70%
From 3 months to 6 months	40%	60%	65%
From 6 months to 9 months	20%	50%	60%
From 9 months to 12 months	0%	40%	55 %

From 12 months to 15 months	NA	30%	45 %
From 15 months to 18 months	NA	20%	40 %
From 18 months to 21 months	NA	10%	35 %
From 21 months to 24 months	NA	0 %	25 %
From 24 months to 27 months	NA	NA	20 %
From 27 months to 30 months	NA	NA	10 %
From 30 months to 33 months	NA	NA	5%
From 33 months to 36 months	NA	NA	0%

Not applicable for policies with freeloook period; Premium refund for cancellations during the freeloook period will be provided as per the Free look clause

For any cancellation initiated by the company, refund shall be done on a pro rata basis.

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.

b) The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, established

fraud by the insured person by giving 7 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

6. Migration

In case of migration of this policy with the Company, the insured can transfer the credits gained to the extent of the Sum Insured and benefits available in the previous policy to the migrated policy. The Company may underwrite the proposal in case of migration, if the insured is not continuously covered for 36 months. For Detailed Guidelines on migration, kindly refer the link https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

7. Portability:

- The insured is entitled to transfer the credits gained to the extent of the sum insured and the benefits available in the previous policy, subject to the underwriting policy of the Company
- The Company shall decide and communicate on the proposal upon receipt of information from Existing insurer within prescribed timelines .
- This benefit is not applicable for enhanced sum insured.

8. Withdrawal of Policy

- i. 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.
- ii. 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 periods per regulatory prescriptions, provided the policy has been maintained without a break.

9. Moratorium After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the Company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

10. Premium Payment in Instalments

If the insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the policy)

The grace period for payment of the premium for all types of insurance policies shall be: fifteen days where premium payment mode is monthly and thirty days in all other cases. Provided the company shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

The insured person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated grace Period.

No interest will be charged If the instalment premium is not paid on due date.

In case of instalment premium due not received within the grace period, the policy will get cancelled.

In the event of a claim, all subsequent premium instalments shall immediately become due and payable.

The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

11. Possibility of Revision of Terms of the Policy including the Premium Rates

The Company, , may revise or modify the terms of the policy including the premium rates.

12. Free look period

Every insured of new health insurance policies, except for those policies with tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy. If the insured cancels the policy within free look period then the insured shall be entitled to a refund of the premium paid subject only to a deduction of a proportionate risk premium for the period of cover and the expenses, if any, incurred by the insurer on medical examination of the insured and stamp duty charges.

13. Redressal of Grievance In case of any grievance the insured person may contact the Company through Website: www.icicilombard.com Toll free: 1800 2666 Email: customersupport@icicilombard.com

ICICI Lombard General Insurance Co. Ltd.
Ground floor- Interface 11, Sixth floor- Interface 16 Office no 601 & 602, New linking Road, Malad (West), Mumbai – 400064

There is an interactive voice response (IVR) facility for senior citizens' grievance redressal for easy and faster resolution

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance. For branch details, please visit
<https://www.icicilombard.com/docs/default-source/policy-wordings-product-brochure/final-gro-mapping.pdf>.

If Insured person is not satisfied with the redressal of grievance ,insured person may contact the grievance redressal officer at the details provided in the below link:

<https://www.icicilombard.com/grievancedres sal.com>

If Insured person is not satisfied with the redressal of grievance, the insured person may also approach Insurance Regulatory and Development Authority of India (IRDAI) through the Bima Bharosa Portal - <https://bimabharosa.irdai.gov.in/> or IRDA Grievance Call Centre(IGCC) at their toll free no. 1800 4254 732 / 155255

Insured may also approach Insurance Ombudsman, subject to vested jurisdiction, for the redressal of grievance. Details of Insurance Ombudsman offices are available at IRDAI website: www.irdai.gov.in, or on the Company's website at www.icicilombard.com or on <https://www.cioins.co.in/>

Office of the Insurance Ombudsman	Area of Jurisdiction
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AHMEDABAD Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, AHMEDABAD – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.	BHUBANESWAR Insurance Ombudsman Office of the Insurance Ombudsman, 62, Forest park, Bhubaneswar – 751 009. Tel.: 0674 - 2596461 /2596455 Email: bimalokpal.bhubaneswar @cioins.co.in	Odisha
BENGALURU Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N- 19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@ci oins.co.in	Karnataka	CHANDIGARH Insurance Ombudsman Office Of The Insurance Ombudsman, Jeevan Deep Building SCO 20-27, Ground Floor Sector- 17 A, Chandigarh – 160 017. Tel.: 0172 - 4646394 / 2706468 Email: bimalokpal.chandigarh@ci oins.co.in	Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgar h), Himachal Pradesh, Union Territories of Jammu & Kashmir,La dakh & Chandigarh .
BHOPAL Insurance Ombudsman Office of the Insurance Ombudsman, 1st floor,"Jeevan Shikha", 60-B,Hoshangabad Road, Opp. Gayatri Mandir, Bhopal – 462 011. Tel.: 0755 - 2769201 / 2769202 Email: bimalokpal.bhopal@cioins .co.in	Madhya Pradesh, Chhattisgar h.	CHENNAI Insurance Ombudsman Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24333678 Email: bimalokpal.chennai@cioin s.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).

DELHI Insurance Ombudsman Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23237539 Email: bimalokpal.delhi@cioins.co.in	Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.	JAIPUR Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141- 2740363/2740798 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan
GUWAHATI Insurance Ombudsman Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	KOCHI Insurance Ombudsman Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash,LIC Building, Opp to Maharaja's College Ground,M.G.Road, Kochi - 682 011. Tel.: 0484 - 2358759 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry .
HYDERABAD Insurance Ombudsman Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka- Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Email: bimalokpal.hyderabad@cioins.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry .	KOLKATA Insurance Ombudsman Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 7th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124341 Email: bimalokpal.kolkata@cioins.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
		LUCKNOW Insurance Ombudsman Office of the Insurance	Districts of Uttar Pradesh :

Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in	Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Brahmaich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajganj, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur,	MUMBAI Insurance Ombudsman Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in	Chandauli, Ballia, Sidharathnagar.
		NOIDA Insurance Ombudsman Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandsheh ar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad , Muzaffarnagar, Oraiyya, Pilibhit, Etawah,

	Farrukhabad, Firozbad, Gautam Buddh Nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiram Nagar, Saharanpur.	THANE Shri Umesh Sinha Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West) Thane - 400604 Email: bimalokpal.thane@cioins.co.in	Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.
PATNA Insurance Ombudsman Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna 800 001. Tel.: 0612-2547068 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.	Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://ligms.irda.gov.in/ The updated details of Insurance Ombudsman are also available on IRDA website: www.irdaindia.org , on the website of Executive Council of Insurers(ECOI): Our website www.icicilombard.com or from any of Our offices or https://www.cioins.co.in/Ombudsman	
PUNE Insurance Ombudsman 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.: 020-24471175 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Areas of Navi Mumbai and Thane (excluding Mumbai Metropolitan Region).	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.

SPECIFIC TERMS & CLAUSES

1. Material Change

The Insured Person shall immediately notify Us in writing of any material change in the risk and cause at his own expense such additional precautions to be taken as circumstances may require to ensure safe operation, trade or business practices thereby containing the circumstances that may give rise to the Claim and We may, adjust the scope of cover and / or premium, if necessary, accordingly.

2. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant particulars and shall allow Us to inspect such record.

3. Notice of Charge

of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but the payment by Us to the Insured Person, Nominee, assignee or his legal heirs of any amount under the Policy shall in all cases be an effectual discharge to Us.

4. Overriding effect of Part II of the Schedule

The terms and conditions contained herein and in Part II of the Schedule to this Policy shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Schedule to this Policy, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in Part II of the

Schedule to this Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

5. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be adjudicated or interpreted in accordance with Indian Laws and only competent Indian courts shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be

determined or adjudicated in accordance with the law and practice of such Court.

6. Notices

Any notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to: In case of the Insured Person, at the address specified in the Policy Schedule.

In case of Us:

ICICI Lombard General Insurance Company Limited, ICICI Lombard House,
414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi,
Mumbai 400 025

Notice and instructions will be deemed served 7 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

7. Customer Service

If at any time the Insured Person (or his Nominee/ legal heir, as the case may be) requires any clarification or assistance, they may contact Our offices at the address specified below, during normal business hours.
ICICI Lombard General Insurance Company Limited ICICI Lombard House

414, Veer Savarkar Marg, Siddhi Vinayak
Temple, Prabhadevi,
Mumbai 400025.

OTHER TERMS AND CONDITIONS

1: Premium Instalment Clause

We will accept payment of the premium applicable taxes, charges, cess etc. in monthly/quarterly/semi-annual/annual instalments as specified in the Policy Schedule provided that the Policyholder continues to perform and observe all their obligations hereunder.