FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

HEALTH TOTAL
POLICY WORDINGS

CUSTOMER INFORMATION SHEET

(Description is illustrative and not exhaustive)

Sr. NO	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
1	Product Name	Health Total	
2	What am I covered for:	1) Hospitalization Medical Expenses – A minimum period of 24 Inpatient Care consecutive hours.	Sec II Benefit 1
		2) Day Care Treatment expenses- Specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.	Sec II Benefit 2
		3) Pre-hospitalisation Medical Expenses –Related medical expenses 60 days prior to hospitalisation.	Sec II Benefit 3
		4) Post-hospitalisation Medical Expenses - Related medical expenses post hospitalisation as specified in the applicable plan/Sum Insured	Sec II Benefit 4
		5) Maternity Expenses - maximum liability per pregnancy (delivery/termination) will be subject to the specified sub-limit as mentioned in the Schedule of Benefits	Sec II Benefit 5
		6) Organ Donor Expenses - Charges incurred for an organ donor's treatment for the harvesting of the organ donated.	Sec II Benefit 6
		7) Patient Care - Charges for a Qualified Nurse for the Insured Person for a period of up to 10 days immediately following the Insured Person's discharge from Hospital	Sec II Benefit 7
		8) Accidental Hospitalisation - 25% increase in balance SI	Sec II Benefit 8
		9) Accompanying Person expenses- Payment for the Accompanying Person for the hospitalized Insured Person (Dependent Child who is less than 12 years of age)	Sec II Benefit 9
		10) Road Ambulance Charges Covered	Sec II Benefit 10
		11) Emergency medical evacuation (Covered under Superior and Premiere Plan only)	Sec II Benefit 11
		12) Domiciliary Hospitalisation Expenses	Sec II Benefit 12
		13) OPD Treatment (Covered under Superior and Premiere only)	Sec II Benefit 13
		14) Child vaccination benefits (Covered under Premiere plan only)	Sec II Benefit 14
		15) Newborn Baby (Covered under Superior and Premiere only)	Sec II Benefit 15
		16) Alternative Treatment Covered	Sec II Benefit 17
		17) Medical treatment abroad (Covered for Premiere plan)	Sec II Benefit 18
		18) Wellness care	Sec II Benefit 19
		19) Death succeeding a hospitalization claim - a 10% discount in premiums on the immediate Renewal of the Policy for existing family members at the time of insured's death	Sec II Benefit 20
		20) Cumulative Bonus	Sec II Benefit 21
		21) Restoration of the Sum Insured - a Restore Sum Insured (equal to 100% of the Sum Insured) will be automatically available for the particular Policy Year on exhaustion of Sum Insured and Cumulative Bonus (if any)	Sec II Benefit 22
3	What are the major exclusions in the policy:	Any hospital admission for investigative/ diagnostic purpose.	Section III 1 (g)
		Infertility, External Congenital Anomaly and related Illness/ defect.	Section III 3 (k)
		Circumcision ,sex change treatment, Cosmetic treatment and plastic surgery	Section III
		Refractive error correction , dental treatment Surgery of any kind unless requiring Hospitalisation as a result of Injury	Section III
		Substance abuse ,self-inflicted injuries , STDs and HIV/AIDS	Section III
		Hazardous sports, War	Section III
		Any kind of service charge , surcharge ,admission fees , registration fees levied by the hospital Note: the above is a partial listing of the policy exclusions .Please refer to the policy clauses for the full listing)	Section III

CUSTOMER INFORMATION SHEET

(Description is illustrative and not exhaustive)

Sr. NO	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
4	Waiting Periods	Initial waiting period : 30days for all illnesses not applicable on renewal or for accidents) Specific waiting periods :	Section III 1 (d)
		24 months waiting period for Internal Congenital Anomalies, Cataracts, Benign Prostatic Hypertrophy, Hernia of all types, Deviated Nasal Septum, Hypertrophied Turbinate, Hydrocele, all types of sinuses, Fistulae, hemorrhoids, fissure in ano, dysfunctional uterine bleeding, Fibromyoma, Endometriosis, Hysterectomy, all internal or external tumors /cysts/nodules/polyps of any kind including breast lumps with exception of malignant tumor or growth, Surgery for prolapsed inter vertebral disc unless arising from Accident, Surgery of varicose veins and varicose ulcers, any types of gastric or duodenal ulcers, stones in the urinary and biliary systems, Surgery on ears and tonsils.	Section III 1 (b)
		48 months for Rheumatoid Arthritis, Gout, joint replacement Surgery due to degenerative condition, age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery Medically Necessary due to Injury.	Section III 1 (c)
		Any Pre-existing diseases and conditions will have a waiting period of 24 months	Section III 1 (a)
5	Payout basis	Reimbursement of covered expenses upto specified limits as, mentioned in the Schedule of benefits.	
		Fixed amount would be paid for some covers as mentioned in the Schedule of benefits.	
6	Cost Sharing	Voluntary Deductible Applicable under the Policy for all claims under Benefit 1	Section IV (7)
		a) If a Voluntary Deductible has been opted and is in force under the Policy, Our liability would be over and above the Voluntary Deductible amount for each and every claim made under Benefit 1. b) Wherever Co-payments are applicable, as per Section IV(6) of the policy clause, the same would be applied on the admissible claim amount after the application of Voluntary Deductible, if any.	
		The following Co-payments shall be applicable for claims under all Benefits other than Benefit 13:	
		a) Any Insured Person aged 60 years to 64 years, being covered for the first time in a Health Total Policy shall bear 20% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.	Section IV (6)
		b) Any Insured Person aged 65 years to 69 years, being covered for the first time in a Health Total Policy shall bear 25% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.	
		c) Any Insured Person aged 70 years to 74 years, being covered for the first time in Health Total Policy shall bear 30% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.	
		d) Any Insured Person aged 75 years and above, being covered for the first time in Health Total Policy shall bear 40% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum	
7	Renewal Conditions	a) A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the Insured Person.	Section IV (14)
		b) In case of a Renewal a grace period of 30 days is permissible and the Policy will be considered as continuous for the purpose of all waiting periods and health check-up benefits. However, We shall not provide coverage under the Policy to the Insured Persons for any Illness or Injury that occurs during the break period or for any claim which arises during the break period.	
		c) For Renewal Proposal received after completion of grace period of 30 days, all waiting periods including for health check-up, would apply afresh.	

CUSTOMER INFORMATION SHEET

(Description is illustrative and not exhaustive)

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		d) This Policy may be renewed at the expiry of the Policy Period, on payment of the Renewal premium.	
		e) Renewals will be lifelong and will not be refused or cancellation will not be invoked by Us except on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the insured.	
8	Renewal benefits	a) If no claim has been made in respect of any Benefits with the exception of any claim under Benefit 13 and the Policy is Renewed with Us without any break, We will apply a bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 50% of the Sum Insured for this Policy Year. The maximum bonus for any Policy Year will not exceed 100% of the Sum Insured of the first Policy Year.	Section II Benefit 21
		b) If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 50% of the Sum Insured in the following Policy Year. However this reduction will not reduce the Sum Insured below the base Sum Insured of the Policy.	
9	Cancellation	f) We may cancel this Policy by giving You at least 15 days written notice on the grounds of fraud, moral hazard or misrepresentation or non-cooperation.	Section IV (14)
		g) In case the Policy Period is equal to one year, You may cancel this insurance by giving Us at least 15 days written notice, and if no claim has been made then the We shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below. **Period on risk** — **Rate of premium refunded** Upto one month — 75% of annual rate Upto three months — 50% of annual rate Upto six months — 25% of annual rate Exceeding six months — Nil	
		h) In case the Policy Period exceeds one year, this Policy may be cancelled by the Insured Person at any time by giving at least 15 days written notice to Us. We will refund premium on a pro-rata basis by reference to the time period cover is provided, subject to a minimum retention of premium of 25%.	
		i) No refund of premium shall be due on cancellation if the Insured Person has made a claim under this Policy.	

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the CIS and the policy document the terms and conditions mentioned in the policy document shall prevail.

HEALTH TOTAL

This Policy has been issued to You based on the questions in Your Proposal to Us and the Disclosure to Information Norm which form a part of the Policy and on the receipt of premium due.

This Policy covers eligible Insured Persons of all ages and may continue to be renewed throughout the life of the Insured Persons.

This Policy document records the agreement between You and Us and sets out the terms, conditions and exclusions applicable under this Policy as well as the obligations of You, Us, the Insured Persons and claimants.

I. DEFINITIONS

The following words or terms shall have the meaning ascribed to them wherever they appear in this Policy, and references to the singular or to the masculine shall include references to the plural and to the female wherever the context so permits:

1. **Accident** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Alternative Treatments** mean alternative forms of treatments other than "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
3. **Any one illness** means a continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.
4. **Cashless Facility** means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.
5. **Congenital Anomaly** means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
   a) Internal Congenital Anomaly - Congenital Anomaly which is not in the visible and accessible parts of the body.
   b) External Congenital Anomaly - Congenital Anomaly which is in the visible and accessible parts of the body.
6. **Contribution** means essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured. This clause shall not apply to any Benefit offered on fixed benefit basis.
7. **Condition Precedent** means a policy term or condition upon which the insurer's liability under the policy is conditional upon.
8. **Co-payment** means a cost-sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claim amount. A Co-payment does not reduce the Sum insured.
9. **Cumulative Bonus** means any increase in the sum insured granted by the insurer without an associated increase in premium.
10. **Day Care Centre** means any institution established for Day Care Treatment of Illness and/or injuries or a medical set-up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:-
    a) has qualified nursing staff under its employment;
    b) has qualified Medical Practitioner/s in charge;
    c) has a fully equipped operation theatre of its own where Surgical Procedures are carried out;
    d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
11. **Day Care Treatment** means medical treatment and/or Surgical Procedure which is:
    a) Undertaken under general or local anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement; and
    b) Which would have otherwise required Hospitalisation of more than 24 hours.

    Treatment normally taken on an out-patient basis is not included in the scope of this definition.
12. **Diagnostic Centre** means the diagnostic centers which have been empanelled by Us as per the latest version of the schedule of diagnostic centers maintained by Us, which is available to You on request.
13. **Dependent Spouse** means Your legally married spouse as long as he/she continues to be married to You.
14. **Dependent Child** means Your child (natural or legally adopted), who is financially dependent on You and does not have his/her independent sources of income.
15. **Dependent sibling** means your brother or sister if they are unmarried and still financially dependent on You.
16. **Dependent Parents** means Your father or mother who are financially dependent on You.
17. **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.
18. **Domiciliary Hospitalisation** means medical treatment for an Illness/disease/Injury which in the normal course would

require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

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

19. **Disclosure to Information Norm**
The Policy shall be void and all premium paid hereon shall be forfeited to the Insurer, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

20. **Emergency Care** means management for a severe 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.

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

22. **Hospital** means any institution established for In-patient Care and Day Care Treatment of illness and/or injuries and which has been registered as a hospital with the local authorities, under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under:

a) has qualified nursing staff under its employment round the clock;
b) has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
c) has qualified Medical Practitioner(s) in charge round the clock;
d) has a fully equipped operation theatre of its own where Surgical Procedures are carried out; and
e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

23. **Hospitalisation** means admission in a Hospital for a minimum period of 24 Inpatient Care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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

25. **Injury** means Accidental physical bodily harm excluding Illness or disease, solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

26. **Inpatient Care** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

27. **Insured Person** means a person named in the Schedule who is covered under this Policy, for whom the insurance is proposed and the appropriate premium has been received.

28. **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 licence. The Medical Practitioner should not be the insured or close family members.

29. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

30. **Medically Necessary** means any treatment, test, medication, or stay in Hospital or part of stay in Hospital which:

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

31. **Maternity Expenses/Treatment** means expenses including:

a) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);
b) Expenses towards lawful medical termination of pregnancy during the Policy Period.

32. **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 Medical Practitioners in the same locality would have charged for the same medical treatment.

33. **Network** Provider means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a Cashless Facility.

(Please note: The Hospitals which have been empanelled by Us as Network Providers are as per the latest version of the schedule of

Hospitals maintained by Us, which is available to You on request.)

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

35. **Newborn Baby** means baby born during a Policy Year and is aged between 1 day and 90 days, both days inclusive.

36. **Notification of Claim**

Notification of claim is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address/ telephone number to which it should be notified.

37. **OPD Treatment** means one in which the insured visits a clinic/Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The person is not admitted for Day Care Treatment or in-patient.

38. **Proposal** means that portion of the Policy which sets out Your/Insured Person's personal details, the type of insurance cover in force, the Policy Period and the Sum Insured.

39. **Policy** means the complete documents consisting of the Proposal, Policy wording, Schedule and endorsements and attachments if any.

40. **Policy Period** means the period starting with the commencement date mentioned in the Schedule till the end date mentioned in the Schedule.

41. **Policy Year** means every annual period within the Policy Period starting with the commencement date.

42. **Pre-hospitalization Medical Expenses** means Medical Expenses incurred immediately before the Insured Person is Hospitalised provided that:

    a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
    b) The in-patient Hospitalization claim for such Hospitalization is admissible under the Policy.

43. **Post-hospitalization Medical Expenses** means Medical Expenses incurred immediately after the Insured Person is discharged from the Hospital provided that:

    a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required; and
    b) The in-patient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

44. **Pre-existing Disease** means any condition, ailment or Injury or related condition(s) for which You /Insured Person had signs or symptoms, and/or were diagnosed and/ or received Medical Advice/treatment, within 48 months prior to inception of Your/Insured Person's first Policy issued by the insurer.

45. **Portability** means transfer by an individual health insurance policyholder (including Family cover) of the credit gained for Pre-existing Diseases and time-bound exclusions if he/she chooses to switch from one insurer to another.

46. **Pre-Natal Medical Expenses** means medical expenses incurred for the insured mother during the maternity period prior to delivery.

47. **Post-Natal Medical Expenses** means medical expenses incurred for the insured mother post the delivery.

48. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

49. **Room Rent** means the amount charged by a Hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated Medical Expenses.

50. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness/Injury involved.

51. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

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

53. **Schedule** means that portion of the Policy which sets out Your/Insured Person's personal details, the type of insurance cover in force, the period and the Sum Insured under the Policy. Any annexure or endorsement to the Schedule shall also be a part of the Schedule.

54. **Schedule of Benefits** means that portion of the Policy which sets out the three Plans of the Policy that may be opted by the Insured Person and the benefits available to You / Insured Person under each Plan in accordance with the terms of the Policy.

55. **Sum Insured** means the amount specified in the Schedule which is Our maximum, total and cumulative liability under this Policy for any and all claims arising under this Policy in a Policy Year in respect of the Insured Person(s).

56. **Subrogation** means the right of the insurer to assume the rights of the Insured Person to recover expenses paid out under the policy that may be recovered from any other source.

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

58. **Voluntary Deductible** means the Deductible You have opted

for, and is the amount stated in the Schedule, which shall be borne by the Insured Person in respect of each and every Hospitalization claim incurred in the Policy Year. Our liability to make any payment for each and every claim under the Policy is in excess of the Deductible. Each and every Hospitalization would be considered as a separate claim.

59. **We, Our** or **Us** means Future Generali India Insurance Company Limited.

60. **You** or **Your** means the policyholder shown in the Schedule who has concluded the Policy with Us.

II. SCOPE OF COVER

Insurance Plans: This Policy provides You options of 3 (three) plans namely Vital Plan, Superior Plan and Premiere Plan with each Plan having further Sum Insured options as specified in the Schedule of Benefits. The Schedule will specify the Sum Insured and the Plan which is in force for each of the Insured Persons. For a complete description of the benefits available under the applicable Plan as well as any specific limits on the amount payable under any particular benefit under the applicable Sum Insured and Plan, please refer to the "Schedule of Benefits " attached to this Policy.

Benefits: The Policy covers the Reasonable and Customary Charges incurred towards the medical treatment taken by the Insured Person during the Policy Period following an Illness or Injury that occurs during the Policy Period, subject always to the availability of the Sum Insured and any specific limits specified in the Schedule of Benefits and the terms, conditions and exclusions specified in this Policy document.

The benefits available under the Policy are listed below. The applicable Plan specified in the Schedule of Benefits will specify whether the benefit in respect of which a claim arises is in force under the applicable Plan for the Insured Person.

Benefit 1. Hospitalization Medical Expenses

We will pay the Reasonable and Customary Charges for Medical Expenses that are incurred during the Hospitalisation of the Insured Person for Medically Necessary treatment required due to an Illness or Injury sustained by the Insured Person during the Policy Period.

Benefit 2. Day Care Treatment expenses

We will pay the Reasonable and Customary Charges for Medically Necessary Day Care Treatment taken by the Insured Person on advanced technological Surgical Procedures requiring less than 24 hours of Hospitalization as listed out in Section IV(22) of the Policy.

Benefit 3. Pre-hospitalisation Medical Expenses

We will pay the Reasonable and Customary Charges for Pre-hospitalisation Medical Expenses that are incurred with respect to the Insured Person for up to 60 days immediately prior to the date of the Insured Person's admission to Hospital that is specified under the applicable Plan/Sum Insured for the Insured Person, provided that We have accepted a claim for Hospitalisation Medical Expenses under Benefit 1.

Benefit 4. Post-hospitalisation Medical Expenses

We will pay the Reasonable and Customary Charges for Post-hospitalisation Medical Expenses that are incurred with respect to the Insured Person for up to the period immediately following the Insured Person's discharge from Hospital that is specified under the applicable Plan/Sum Insured for the Insured Person, provided that We have accepted a claim for Hospitalisation Medical Expenses under Benefit 1.

Benefit 5. Maternity Expenses

We will pay the Reasonable and Customary Charges for Maternity Expenses/Treatment incurred for the Insured Person's delivery, subject to the following:

a) If the Insured Person is Your Dependent Spouse, this benefit will be applicable only if We have received at least 3 continuous annual premiums under the Health Total Insurance Policy in respect of You and Your Dependent Spouse and provided that at least 24 months of continuous coverage have elapsed from the inception of the first Health Total Policy with Us.

b) If the Insured Person is You , this benefit will be applicable only if We have received at least 5 continuous annual premiums under the Health Total Policy in respect of You and provided that at least 48 months of continuous coverage have elapsed from the inception of the first Health Total Policy with Us.

c) Our maximum liability per pregnancy (delivery/termination) will be subject to the specified sub-limit as shown in the Schedule of Benefits.

d) We will cover Reasonable and Customary Charges for Pre-natal Medical Expenses incurred on Hospitalisation for a period of 90 days immediately prior to the date of delivery and Reasonable and Customary Charges for Post-natal Medical Expenses incurred on Hospitalisation for upto a period of 45 days immediately following the date of delivery provided that this benefit is applicable only if Superior Plan or Premiere Plan are in force for the Insured Person.

e) Any expenses related to Ectopic Pregnancy (abdominal operation for extra uterine pregnancy), which is proved by submission of Ultra Sonographic Report would not be covered under this Benefit, but would be considered a claim made under Benefit 1.

Benefit 6. Organ Donor Expenses

We will pay the Reasonable and Customary Charges incurred for an organ donor's treatment for the harvesting of the organ donated provided that:

a) The organ donor is any person whose organ has been made available in accordance and in compliance with the Transplantation of Human Organs Act, 1994 and the organ donated is for the use of the Insured Person;

b) We will not pay the donor's screening expenses or pre and post hospitalisation expenses or for any other medical treatment for the donor consequent on the harvesting;

c) We have accepted claim under Benefit 1 for the Insured Person and the Insured Person has been Medically Advised to undergo an organ transplant;

d) Costs directly or indirectly associated with the acquisition of the donor's organ will not be covered.

Benefit 7. Patient Care

We will pay for the Reasonable and Customary Charges for a Qualified Nurse for the Insured Person for a period of up to 10 days immediately following the Insured Person's discharge from Hospital provided that:

a) the Insured Person is above 60 years of age;

b) the Insured Person's Hospitalisation was due to Illness or Injury sustained during the Policy Period;

c) the treating Medical Practitioner has recommended that the nursing charges are Medically Necessary;

d) We will not be liable to make payment under this Benefit in excess of the per day limits specified in the Schedule of Benefits;

e) We will not be liable to make payment under this Benefit for any Insured Person in excess of 30 days during a Policy Year.

Benefit 8. Accidental Hospitalization

We will increase the Sum Insured by 25% of the available balance of the Sum Insured (excluding the Cumulative Bonus, if any) if the Insured Person is Hospitalised during the Policy Year due to an Accident which occurred during the Policy Year provided that no increase to the Sum Insured will exceed Rs.10,00,000 and this increase to the Sum Insured will only be available for claims arising under Benefit 1.

Benefit 9. Accompanying Person

We will make payment of the amount specified in the Schedule of Benefits for each completed day of Hospitalisation for the Accompanying Person of an Insured Person provided that the Insured Person is a Dependent Child who is less than 12 years of age and the Dependent Child is undergoing Medically Necessary Hospitalisation due to an Injury or Illness that occurred during the Policy Period. We will not make payment under this Benefit in respect of an Insured Person for more than 30 days in any Policy Year.

For the purpose of this Benefit, "Accompanying Person" means the Insured Person's mother, father, grandmother or grandfather or any immediate family member of the Insured Person.

Benefit 10. Road Ambulance Charges

We will reimburse ambulance charges from home to Hospital or between Hospitals. We will reimburse payments up to a maximum of the amount specified in the Schedule of Benefits per Hospitalisation if Vital Plan is in force and actual expenses in case of Hospitalization in a Network Provider if Superior Plan or Premiere Plan are in force. In case of Hospitalization in a Non Network Provider We will reimburse upto the amount specified in the Schedule of Benefits depending on the Plan in force. We will reimburse payments under this Benefit only in respect of ambulance services of a Hospital or a registered service provider and only upon You producing the bills in original.

Benefit 11. Emergency Medical Evacuation (applicable for Superior Plan and Premiere Plan only)

We will reimburse expenses up to a maximum of 5% of the Sum Insured (excluding the Cumulative Bonus, if any) incurred in a Policy Year for the Insured Person's Medically Necessary medical evacuation in an emergency, provided that:

a) the evacuation is recommended by a Medical Practitioner who certifies that the severity of the Insured Person's Injury or Illness warrants the medical evacuation for receipt of Emergency Care.

b) It is a Condition Precedent that these expenses are authorized by Us if the evacuation is required in respect of an Insured Person's Illness and the medical evacuation is from the place of local hospitalization to any other Hospital within India.

c) For medical evacuation following an Accident during the Policy Period, We will reimburse under this Benefit expenses incurred for medical evacuation from the place where the Accidental Injury occurred or the place of local Hospitalisation immediately following the Accident to any other Hospital within India.

d) For medical evacuation following an Illness during the Policy period, We will reimburse under this Benefit expenses incurred for medical evacuation from the place of local Hospitalisation to any other Hospital within India.

e) For claims made under this Benefit, We will reimburse expenses for transportation of the Insured Person and Medical Expenses incurred during the course of evacuation provided that it is Medically Necessary that treatment is provided to the Insured Person en route.

Benefit 12. Domiciliary Hospitalisation Expenses

We will reimburse Reasonable and Customary Charges up to a maximum of 10% of the Sum Insured (excluding the Cumulative Bonus, if any) for Medical Expenses incurred on the Domiciliary Hospitalisation of the Insured Person for an Illness or Injury which occurred during a Policy Year provided that:

a) The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the Reasonable and Customary Charges of any Medically Necessary treatment for the entire period subject to other terms of the Policy;

b) Expenses incurred for pre and post Domiciliary Hospitalisation treatment will not be payable;

c) No payment will be made if the condition for which the Insured Person requires medical treatment is:

(i) Asthma, Bronchitis, Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis, cough and cold or Influenza;

(ii) Arthritis, Gout or Rheumatism;

(iii) Chronic Nephritis or Nephritic Syndrome;

(iv) Diarrhoea or any type of dysentery, including Gastroenteritis;

(v) Diabetes Mellitus or Insipidus;

(vi) Epilepsy;

(vii) Hypertension;

(viii) Psychiatric or Psychosomatic disorders of all kinds;

(ix) Pyrexia of unknown origin.

Benefit 13. OPD Treatment (applicable for Superior Plan and Premiere Plan only)

We will reimburse the Reasonable and Customary Charges arising from Medical Expenses incurred on OPD Treatment for consultation, diagnostic tests and medications for prescribed drugs for the Insured Person due to an Illness, Injury or a pregnancy covered under Benefit 5 provided that diagnostic tests and medications must be prescribed by a Medical Practitioner. Our liability under this Benefit will be restricted to the following:

a) If Superior Plan is in force We shall reimburse expenses towards consultation and diagnostic tests prescribed by the Medical Practitioner.

b) If Premiere Plan is in force We shall reimburse expenses towards consultation, diagnostic tests and medications prescribed by the Medical Practitioner.

c) In case of bills for any prescribed drugs/medicines Our liability will be restricted to 80% of admissible bills.

d) In case of dental consultations and diagnostics Our liability will be restricted to 70% of admissible bills.

e) Expenses under (a) to (d) individually or in aggregate cannot exceed the Out Patient Medical Expenses limit specified in the Schedule of Benefits.

f) Only Allopathic treatment will be covered under this Benefit.

Benefit 14. Child Vaccination Benefits (applicable for Premiere Plan only)

We will cover Reasonable and Customary Charges for vaccinations of the Insured Person up to the per annum limit specified in the Schedule of Benefits provided that the Insured Person is a Dependant Child who is upto 12 years of age.

Benefit 15. Newborn Baby (applicable for Superior Plan and Premiere Plan only)

If We have accepted a maternity benefits claim under Benefit 5, then We will also:

a) Cover the Reasonable and Customary Charges for Medical Expenses towards the Medically Necessary treatment of the Insured Person's Newborn Baby while Insured Person is Hospitalised as an in-patient for delivery and cover the Newborn Baby as an Insured Person until the expiry date of the Policy Year in which the Newborn Baby is born, within the Sum Insured as applicable for the Insured Person (mother) without payment of any additional premium.

b) Cover the Reasonable and Customary Charges for vaccination expenses of the Newborn Baby upto the specified sublimit under the Schedule of Benefits for vaccinations, until the Newborn Baby completes one year of age. If the Policy ends before the Newborn Baby has completed one year, then, We will only cover such vaccinations until the Newborn Baby completes one year, and only if We have accepted the Newborn Baby as an Insured Person at the time of Renewal of the Policy and We have received the premium accordingly.

c) Include the Newborn Baby as an Insured Person under the Policy from the Policy Year immediately succeeding the Policy Year in which the Newborn Baby is born provided that We have received the premium due, to include the Newborn Baby as an Insured Person.

Benefit 16. E-Opinion in respect of an Illness or Injury

a) If an Insured Person suffers an Illness or Injury during the Policy Period in respect of which a claim has been admitted under Benefit 1, then at the Insured Person's request We will arrange a maximum of two e-opinions (in a Policy Year) from a Medical Practitioner selected by the Insured Person from Our panel. The e-opinion will be based only on the information and documentation provided to the Medical Practitioner by or on behalf of the Insured Person.

b) While claiming under this Benefit and deciding to obtain an e-opinion, each Insured Person expressly agrees that:

(i) It is entirely for the Insured Person to decide whether to obtain an E-opinion, from which Medical Practitioner in Our panel to take the e-opinion and the use (if any) to which the e-opinion so obtained is put.

(ii) We do not provide an e-opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other persons' reliance on the same, or the use to which the E-opinion is put.

(iii) We assume no responsibility for and will not be responsible for any actual or alleged errors, omissions or representations whatsoever made by any Medical Practitioner in Our Panel or in any e-opinion or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

Benefit 17. Alternative Treatment

We will reimburse Reasonable and Customary Charges for Medical Expenses incurred with respect to the Insured Person for Hospitalization under Ayurveda, Unani, Siddha or

Homeopathy provided that the Treatment has been undergone in a government Hospital or in any institute recognized by government and/or accredited by Quality Council of India/ National Accreditation Board on Health for that Alternative Treatment.

Specific Exclusions applicable to this Benefit:

a) All preventive and rejuvenation treatments (non-curative in nature) including without limitation, treatments that are not Medically Necessary are excluded.

b) Pre-hospitalisation Medical Expenses, Post-hospitalisation Medical Expenses, Day Care Treatment and outpatient Medical Expenses are excluded.

c) Any Alternative Treatment other than Ayurveda, Unani, Siddha or Homeopathy.

Benefit 18. Medical Treatment Abroad (applicable for Premiere Plan only)

a) The benefits under this Section will be available if the Insured Person has been continuously covered under Premiere Plan of Health Total Policy for a continuous period of 48 months.

b) We shall reimburse the Reasonable and Customary Charges for Medical Expenses for treatment of the Insured Person incurred outside India for the following diseases subject to the terms below:

(i) Craniotomy & Craniectomy: only as a treatment for cancers;

(ii) Lung Lobectomy that involves removal of one of the three divisions of the lungs for lung cancer;

(iii) Liver Lobectomy that involves removal of 70% of liver mass in case of liver failure;

(iv) Major organ transplant;

(v) Bone marrow transplant;

(vi) Repair of Aortic Aneurysm;

(vii) Heart valve replacement;

(viii) Coronary Artery Bypass Graft.

c) We shall cover only those Medical Expenses that would otherwise have been payable under Benefit 1. For the purpose of this Benefit, Hospital shall mean “Any institution established for Inpatient care and Day Care Treatment of Accidental Injury or Illness and which has been registered as a hospital as per the laws, rules and regulations applicable for the country where the treatment is taken.” The term ‘Hospital’ shall not include a place of rest, a place for the aged, a place for drug addicts or a place for alcoholics or a hotel, health spa or massage centre or the like.

d) Any payments under this Benefit shall always be made in India, in Indian rupees and on a reimbursement basis only. The rate of exchange as published by the Reserve Bank of India (RBI) as on the date of Hospitalisation, shall be used for conversion of foreign currency amounts into Indian rupees for payment of any claim under this Benefit. If on the date of Hospitalisation the RBI rates are not published, the rates next published by the RBI shall be considered for conversion.

e) It is a Condition Precedent that a prior written notice of at least 15 days is given to Us before the treatment described in this Benefit is taken outside India.

f) The exclusion under Section III(3)(p) of the Policy is superseded to the extent covered under this Benefit.

Benefit 19. Wellness Care

The Insured Person will be eligible for “Wellness Benefits” as per the Plan in force under the Policy. These wellness benefits will include health risk evaluation and annual health checkups as applicable for respective Plans, the updated details of which would be available on Our website. These would be conducted through Our tie up arrangements.

The annual health checkup can be conducted from 2nd year of the policy with Us ,for the insured persons who were already covered under the policy . The annual heath checkup would include tests as given below as applicable for respective plans :

Vital Plan: Complete Blood count, Urine Routine, Random Blood Sugar (maximum two insured persons per policy /per policy year irrespective of family size)

Superior Plan: Complete Blood Count, Urine Routine, Fasting blood Sugar, Post Prandial Blood Sugar, ECG, Serum Creatinine (maximum three insured persons per policy /per policy year irrespective of family size)

Premiere Plan: Complete Blood Count, Urine Routine, Fasting blood Sugar, Post Prandial Blood Sugar, ECG, Serum Creatinine (maximum four insured persons per policy/ per policy year irrespective of family size)

While availing the wellness benefits, each Insured Person expressly agrees that:

a) Annual health checkups will be provided at Our Diagnostic Centres only.

b) All decisions regarding which wellness benefit to avail and to what use to put the same to are to be solely made by the Insured Person;

c) We do not provide/assume responsibility for:

(i) the wellness benefits or make any representation as to the adequacy or accuracy of the same;

(ii) any actual or alleged errors, omissions or representations whatsoever made by any of Our wellness service providers or for any consequences of any action taken or not taken in reliance thereon by the Insured Person or any other person.

Benefit 20. Death succeeding a Hospitalization claim:

In the event of Your death following a Hospitalisation claim made under Benefit 1, We will provide a 10% discount in

premiums on the first subsequent Renewal of the Policy for Your existing family members covered under the Policy as Insured Persons at the time of Your death.

Benefit 21. Cumulative Bonus

a) If no claim has been made in respect of any Benefits with the exception of any claim under Benefit 13 and the Policy is Renewed with Us without any break, We will apply a bonus to the next Policy Year by automatically increasing the Sum Insured for the next Policy Year by 50% of the Sum Insured for this Policy Year. The maximum bonus for any Policy Year will not exceed 100% of the Sum Insured of the first Policy Year.

b) If a Cumulative Bonus has been applied and a claim is made, then in the subsequent Policy Year We will automatically decrease the Cumulative Bonus by 50% of the Sum Insured in the following Policy Year. However this reduction will not reduce the Sum Insured below the base Sum Insured of the Policy.

c) In case the Insured Person is porting a similar Policy from Us /another insurance company, portability if requested by the Insured Person, shall be applicable to the previous policy along with enhanced sum insured (base sum insured+ Cumulative Bonus) acquired under the previous policies. The premium applicable would be for the enhanced sum insured (Sum Insured + Cumulative Bonus) and if the same is not available, to the next higher Sum Insured available if requested by the Insured Person. However portability shall be applicable to the previous sum insured and the cumulative bonus.

d) In case You have opted for the 'Family Floater' option as specified in the Schedule, the Cumulative Bonus so applied will only be available to those Insured Persons who were Insured Persons in the claim free Policy Year and continue to be Insured Persons in the subsequent Policy Year.

Benefit 22. Restoration of the Sum Insured

If the Sum Insured and Cumulative Bonus (if any) is exhausted due to claims incurred and paid during the Policy Year or incurred during the Policy Year and accepted as payable, then it is agreed that a Restore Sum Insured (equal to 100% of the Sum Insured) will be automatically available for the particular Policy Year, provided that:

a) The Restore Sum Insured will be enforceable only after the Sum Insured and the Cumulative Bonus have been completely exhausted in that Policy Year;

b) The Restore Sum Insured can only be used for claims made by the Insured Person in respect of Benefits 1-4;

c) The Restore Sum Insured cannot be used for claims based on Maternity Expenses/Treatment;

d) The Restore Sum Insured can be used for only future claims made by the Insured Person and not against any claim for an Illness (including its complications) for which a claim has been paid in the current Policy Year under Benefits 1-4;

e) Only the Sum Insured (excluding Cumulative Bonus) will be considered as Restore Sum Insured;

f) The Restore Sum Insured will only be applied once for the Insured Person during a Policy Year;

g) If the Restore Sum Insured is not utilised in a Policy Year, it shall not be carried forward to any subsequent Policy Year.

If the Policy is opted by You on a 'Family Floater' basis as specified in the Schedule, then the Restore Sum Insured will only be available in respect of claims made by those Insured Persons who were Insured Persons under the Policy before the Sum Insured and Cumulative Bonus was exhausted.

III. EXCLUSIONS

1. Exclusions applicable for all Benefits other than Benefit 13

We will not pay for any expenses incurred in respect of any claims arising out of or howsoever related to any of the following (other than for a claim made under Benefit 13):

a) Benefits will not be available for any condition, Illness, or Injury or related condition(s) for which the Insured Person has been diagnosed, received medical treatment, had signs and/or symptoms, prior to inception of the Insured Person's first policy with Us, until 24 consecutive months have elapsed, after the date of inception of the first policy with Us.

This exclusion shall cease to apply if the Insured Person has maintained a health insurance policy with Us for a continuous period of full 24 months, without break from the date of the Insured Person's first health insurance policy with Us.

The period of this exclusion would stand reduced if this Policy is a continuous Renewal of an earlier similar policy of another insurer and has been ported as per the portability regulations of the Insurance Regulatory and Development Authority (IRDA).

This exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a Renewal of a health insurance policy without break in cover.

b) Without derogation from the above Section III(1)(a), the Policy will exclude any Medical Expenses incurred during the first consecutive 24 months during which the Insured Person has been covered under a health insurance policy with Us, in connection with Internal Congenital Anomalies, cataracts, Benign Prostatic Hypertrophy, hernia of all types, Deviated Nasal Septum, Hypertrophied Turbinate, Hydrocele, all types of sinuses, Fistulae, hemorrhoids, fissure in ano, dysfunctional uterine bleeding, Fibromyoma, Endometriosis, Hysterectomy, all internal or external tumors/cysts/nodules/polyps of any kind including breast lumps with exception of malignant tumor or growth, Surgery for prolapsed inter vertebral disc unless arising from Accident, Surgery of varicose veins and varicose ulcers, any types of gastric or duodenal ulcers, stones in the urinary and biliary systems, Surgery on ears and tonsils.

The period of this exclusion would stand reduced if this Policy is a continuous Renewal of an earlier similar policy of another insurer and has been ported as per the portability regulations of the IRDA. The period of exclusion would stand reduced by the period of continuous existence of the earlier policy with another insurer of which this Policy is a Renewal.

This exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a Renewal of a health insurance policy without break in cover.

c) Without derogation from the above Section III(1)(a), the Policy will exclude any Medical Expenses incurred during the first consecutive 48 months during which the Insured Person has been covered under a health insurance policy with Us in connection with Organ transplant, Rheumatoid Arthritis, Gout, joint replacement Surgery due to degenerative condition, age related Osteoarthritis and Osteoporosis unless such joint replacement Surgery is Medically Necessary due to Injury.

The period of this exclusion would stand reduced if this Policy is a continuous Renewal of an earlier similar policy of another insurer and has been ported as per the portability regulations of the IRDA.

This exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a Renewal of a health insurance policy without break in cover.

d) Medical Expenses incurred for any Illness diagnosed or diagnosable within 30 days, of the commencement of the Policy Period except those incurred as a result of Injury. The exclusion would not apply if this Policy is a continuous Renewal of an earlier similar policy of a different insurer and has been ported as per the portability regulations of the IRDA.

This exclusion shall apply only to the extent of the amount by which the limit of indemnity has been increased if the Policy is a Renewal of a health insurance policy without break in cover.

e) Outpatient diagnostic, medical and Surgical Procedures or treatments.

f) Dental Treatment or Surgery of any kind unless requiring Hospitalisation as a result of Injury.

g) Charges incurred at a Hospital primarily for diagnostic, X-ray or laboratory examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, for which confinement is required at a Hospital.

h) A Medical Practitioner's home visit charges during pre and post Hospitalization period and attendant nursing charges, except to the extent covered under Benefit 7.

2. Exclusions for OPD Treatment claims under Benefit 13

We will not pay for any expenses incurred in respect of any claims made under Benefit 13, arising out of or howsoever related to any of the following:

a) Any expenses in excess of the maximum amount payable under the outpatient medical expenses limit specified in the Schedule of Benefits.

b) Cost of an Annual Health Check-up.

c) Any expenses for OPD Treatment including dental expenses in case of Vital Plan.

d) Any expenses for prescribed medications in case of Superior Plan.

e) Any expenses for consultation, diagnostics, medications which are not duly supported with medical documents from the Medical Practitioner mentioning:

(i) Diagnosis;

(ii) Referral for diagnostic test;

(iii) Prescription for medications.

f) Costs incurred on all methods of treatment except Allopathic.

3. General Exclusions applicable for all Benefits

We will not pay for any expenses incurred in respect of any claims made under the Policy, arising out of or howsoever related to any of the following:

a) Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not).

b) Circumcision, unless necessary for treatment of an Illness not excluded hereunder or as may be necessitated due to an Accident.

c) Vaccination/inoculation (except as post bite treatment) except to the extent covered under Benefits 14 and 15.

d) Cosmetic treatments (for change of life or cosmetic or aesthetic treatment of any description), plastic surgery other than as may be necessitated due to an Accident or as a part of any Illness, refractive error corrective procedures, experimental, investigational or Unproven/Experimental Treatment, devices and pharmacological regimens of any description.

e) Charges incurred in connection with cost of spectacles and contact lenses, hearing aids, durable medical equipment (including but not limited to cost of instrument used in the treatment of Sleep Apnea Syndrome (C.P.A.P), Continuous Peritoneal Ambulatory Dialysis (C.P.A.D) and oxygen concentrator for asthmatic condition, wheel chair, crutches, artificial limbs, belts, braces, stocking, Glucometer and the like), namely that equipment used externally for the human body which can withstand repeated use; is not designed to be disposable; is used to serve a medical purpose, such cost of all appliances/devices whether for diagnosis or treatment after discharge from the Hospital.

f) The treatment of obesity (including morbid obesity) and other weight control programs, services and supplies.

g) Expenses incurred towards treatment of Illness or Injury

arising out of alcohol use/misuse or abuse of alcohol, narcotic substance or drugs (whether prescribed or not).

h) Convalescence, general debility, ''Run-down" condition or rest cure, venereal disease or intentional self-injury.

i) In-Vitro Fertilization (IVF), Gamete Intra Fallopian Transfer (GIFT) procedures, and Zygote Intra Fallopian Transfer (ZIFT) procedures, and any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation; voluntary medical termination of pregnancy; any treatment related to infertility, impotence and sterilization.

j) All expenses arising out of any condition directly or indirectly caused to or associated with Human T-Cell Lymph Tropic Virus Type III (HTLB-III) or Lymphadenopathy Associated Virus (LAV) or Human Immunodeficiency Virus or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS. This exclusion stands deleted in Premiere Plan except under Section III(2).

k) External Congenital Anomaly and related Illness/ defect.

l) Vitamins, tonics, nutritional supplements unless forming part of the treatment for Injury or Illness as certified by the attending Medical Practitioner.

m) Injury or Illness directly or indirectly caused by or contributed to by nuclear weapons/materials.

n) Genetic disorders and stem cell implantation/Surgery/storage.

o) Any treatment required arising from Insured Person's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing unless specifically agreed by Us.

p) Any treatment received in convalescent home, rehabilitation centre, convalescent hospital, health hydro, nature care clinic or similar establishments.

q) Non-prescribed drugs and medical supplies, hormone replacement therapy, sex change or treatment which results from or is in any way related to sex change.

r) Treatment for any mental illness or psychiatric illness.

s) Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.

t) Standard list of excluded items attached as Annexure 1 to this Policy.

IV. CONDITIONS

1. Insured Persons

The following persons shall be eligible to be Insured Persons under the Policy:

a) For Vital Plan: You, Your Dependent Spouse, Your Dependent Children and Your Dependent Parents;

b) For Superior Plan & Premiere Plan: You, Your Dependent Spouse, Your Dependent Children or non-dependent children, Your Dependent Parents or non-dependent parents, Your Dependent Siblings, Your daughter in law, Your son in law, Your parents in law, Your grandparents and Your grandchildren.

Only those persons named as Insured Persons in the Schedule shall be covered under this Policy. A person may be added as an Insured Person during the Policy Period after his/her application has been accepted by Us, an additional premium has been received and Our agreement to extend cover has been indicated by Us issuing an endorsement confirming the addition of such person as an Insured Person.

2. Communications

a) Any communications, notifications or declarations meant for Us must be in writing and delivered to Our address specified in the Schedule.

b) Any communication meant for You will be sent by Us to Your address shown in the Schedule. You must notify Us immediately of any change in Your address.

c) Our agents are not authorized to receive communications, notices or declarations on Our behalf.

3. Cost Of Pre-Insurance Medical Examination

We will reimburse 100% of the cost of any pre-insurance medical examination conducted at our empanelled diagnostic center, once the Proposal is accepted and the Policy is issued for that Insured Person.

4. Claims Procedures

If the Insured Person meets with any Injury or suffer an Illness that may result in a claim under the Policy, then as a Condition Precedent to Our liability, the following must be complied with:

a) Cashless Facility is only available at a Network Provider. In order to avail Cashless Facility, the following procedure must be followed:

(i) For availing cashless at a Network Provider, We must be called at Our call centre and a request for pre-authorisation must be made by way of the written form prescribed by Us.

(ii) After considering the request and obtaining any further information or documentation that We have sought, We may, if satisfied, send the Network Provider an authorisation letter. The authorisation letter, the ID card issued to the Insured Person along with this Policy and any other information or documentation that We have specified must be produced to the Network Provider identified in the pre-authorisation letter at the time of the Insured Person's admission to the Hospital.

(iii) If the above procedure is followed, the Insured Person will not be required to directly pay for those Medical Expenses to the Network Provider that We are liable to indemnify under

this Policy. The original bills and evidence of treatment in respect of the same shall be left with the Network Provider. Pre-authorisation does not guarantee that all costs and expenses that are incurred will be covered. We reserve the right to review each claim for Medical Expenses incurred and accordingly coverage will be determined according to the terms, conditions and exclusions of this Policy. All other costs and expenses that are not covered under this Policy must be settled directly with the Network Provider and We shall have no liability in this regard.

b) If a pre-authorisation request is denied by Us or if treatment is taken in a Hospital other than a Network Provider or if You/ Insured Person does not wish to avail of the Cashless Facility, then:

(i) We must be given Notification of Claim in writing immediately and in any event within 48 hours of the commencement of the Illness or Injury. The Insured Person must immediately consult a Medical Practitioner and follow the advice and treatment that he/she recommends.

(ii) The Insured Person must take reasonable steps or measures in good faith to minimise the quantum of any claim that may be made under this Policy.

(iii) The Insured Person must submit to examination by Our medical advisors if We ask, the cost for which will be borne by Us.

(iv) We must be given promptly, and in any event within 15 days of the Insured Person's discharge from a Hospital, the documentation including written details of the quantum of any claim along with all original supporting documentation, including but not limited to the following, and other information We ask for to investigate the claim for Our obligation to make payment for it:

a. The claim form specified by Us duly completed and signed by the claimant or a family member;

b. first consultation letter;

c. first prescription from the Medical Practitioner;

d. original vouchers;

e. original Hospital bills giving a detailed break up of all expense heads mentioned in the bill;

f. Money receipt duly signed with a revenue stamp;

g. birth/death certificate (as applicable);

h. the original Hospital discharge card;

i. all original laboratory and diagnostic test Reports such as X-Ray, E.C.G, USG, MRI Scan, Haemogram, etc;

j. If medicines have been purchased in cash and if this has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner and the supporting medicine bill from the chemist;

k. If diagnostic or radiology tests have been paid for in cash and it has not been reflected in the Hospital bill, please enclose a prescription from the Medical Practitioner advising the tests, the actual test reports and the bill from the diagnostic centre for the tests.

c) In the event of Your/Insured Person's death, You/Insured Person's nominee/legal heir claiming on his/her behalf must inform Us in writing immediately and send Us a copy of the post mortem report (if any) within 14 days.

d) If We are not given notice/documentation within the time frames set out above, then We may accept the claim notice/ documentation if it is demonstrated to Us that the delay was for reasons beyond the control of the claimant.

5. Basis Of Claims Payment

a) Claims related to Pre-existing Diseases:

We shall indemnify upto 50% of the admissible claim amount in respect of a claim arising from any Pre-existing Diseases that are specifically listed in the Schedule where the claim arises during the third year of continuous Renewal with Us of the Policy for the same Sum Insured and Plan. We shall indemnify upto 100% of the admissible claim amount in respect of a claim arising from any Pre-existing Diseases that are specifically listed in the Schedule from the fourth year of continuous Renewal with Us of the Policy for the same Sum Insured and Plan. The above clause is applied subject to portability regulations .

b) Claims related to Surgery for cataracts:

Our obligation to make payment in respect of Surgery for cataracts (after the expiry of the two years period referred to in Section III(1)(b) above), shall be restricted to 10% of the Sum Insured for each eye, and a maximum of Rs.1,00,000/- per eye.

c) Claims related to Any One Illness:

All claims relating to Any One Illness shall be deemed to be part of the same original claim.

d) Claims for Day Care Treatment:

The Day Care Treatments listed are subject to the exclusions, terms and conditions of the Policy and will not be treated as independent coverage under the Policy.

e) Claims between 2 Policy Year

If the claim event falls within two Policy Years, the claims shall be paid taking into consideration the available Sum Insured in the two Policy Year, including the Deductibles for each Policy Year. Such eligible claim amount to be payable shall be reduced to the extent of premium to be received for the Renewal/due date of premium of the Health Total Policy, if not received earlier.

6. Co-Payments Applicable under the Policy

The following Co-payments shall be applicable for claims under all Benefits other than Benefit 13:

a) Any Insured Person aged 60 years to 64 years, being covered for the first time in a Health Total Policy shall bear 20% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

b) Any Insured Person aged 65 years to 69 years, being covered for the first time in a Health Total Policy shall bear 25% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

c) Any Insured Person aged 70 years to 74 years, being covered for the first time in Health Total Policy shall bear 30% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

d) Any Insured Person aged 75 years and above, being covered for the first time in Health Total Policy shall bear 40% of each and every admissible claim and Our liability, if any, shall only be in excess of that sum.

7. Voluntary Deductible Applicable under the Policy for all claims under Benefit 1

a) If a Voluntary Deductible has been opted and is in force under the Policy, Our liability would be over and above the Voluntary Deductible amount for each and every claim made under Benefit 1.

b) Wherever Co-payments are applicable, as per Section IV(6) above, the same would be applied on the admissible claim amount after the application of Voluntary Deductible, if any.

8. Policy Currency

We shall make payment in Indian rupees and in India only.

9. Reimbursement Claims

For reimbursement claims, the payment will be made to You/ Insured Person. In the event of Your/Insured Person's death, We will pay the nominee (as named in the Schedule) and in case the nominee is deceased or untraceable, payment to Your/Insured Person's legal heir who holds a succession certificate or indemnity bond to that effect, whichever is available and where discharge shall be treated as full and final discharge of Our liability under the Policy.

10. Settlement of Claims

Our Medical Practitioners will scrutinize the claims and flag the claim as settled/rejected/pending within the period of 30 days of the receipt of the last necessary documents specified in Section IV(4) above.

a) In case of 'pending' claims We will ask for submission of incomplete documents.

b) 'Rejected' claims will be informed to the Insured Person in writing with reason for rejection.

c) In the cases of delay in the payment of a 'settled' claim beyond the period of 30 days of the receipt of the last documents specified in Section IV(4) above, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year.

11. Fraud

If You/Insured Person or Your nominee/legal heir or any person acting on Your/their behalf makes or progresses any claim knowing it to be false or fraudulent in any way, then this Policy will be void and all claims or payments due and the premium paid shall be forfeited.

12. Contribution

a) If You or any of the Insured Persons covered under the Health Total Policy hold two or more policies from one or more insurers to indemnify medical treatment costs, We will not apply the contribution clause, and You will have the right to require a settlement of the claim in terms of any of the policies You or the Insured Persons hold with any insurer.

b) In all such cases if You/Insured Person covered choose to claim under this Policy then We shall settle the claim without insisting on the Contribution clause being applied as long as the claim is within the limits of and according to the terms of the Health Total Policy.

c) If the amount claimed under this Policy exceeds the Sum Insured after considering the Deductibles or Co-payment, then You/Insured Person shall have the right to choose other concurrent insurers by whom the claim can be settled. In such cases, We will settle the claim with applying the Contribution clause.

d) The Contribution clause shall not be applied to any fixed benefits payable under this Policy.

13. Portability

a) All health insurance policies are portable.

b) Portability if requested by the Insured Person, shall be applicable to the previous sum insured and the Cumulative Bonus acquired under the previous policies. The premium applicable would be for the enhanced sum insured (Sum Insured + Cumulative Bonus) and if the same is not available, to the next higher Sum Insured available if requested by the Insured Person.

c) This clause does not alter the annual character of this insurance policy or Our right to decline to renew or to cancel the Policy.

d) Portability will be granted to policyholders of a similar health indemnity policy of Us/another insurer to Health Total Policy as per portability guidelines of the IRDA.

e) Portability will be granted subject to the policyholder desirous of porting his policy to Health Total Policy applying to Us at least 45 days before the premium renewal date of his/her existing policy.

f) We will not be liable to offer portability if policyholder fails to approach us at least 45 days before the premium renewal date.

g) Where the outcome of acceptance of portability is still awaited

from Us on the date of Renewal the existing policyholder should extend his existing policy with the existing insurer on a short period basis as per the portability guidelines of the IRDA.

h) Portability will be allowed for all individual health insurance policies issued by non-life insurance companies including family floater policies.

i) Portability will be applicable for waiting periods under Benefit 1 to 4 except maternity benefit.

j) Policyholders should initiate action to approach another insurer, to take advantage of portability, well before the Renewal date to avoid any break in the policy coverage due to delays in acceptance of the proposal by the other insurer.

14. Renewal & cancellation

a) A health insurance policy shall ordinarily be renewable except on grounds of fraud, moral hazard or misrepresentation or non-cooperation by the Insured Person.

b) In case of a Renewal a grace period of 30 days is permissible and the Policy will be considered as continuous for the purpose of all waiting periods and health check-up benefits. However, We shall not provide coverage under the Policy to the Insured Persons for any Illness or Injury that occurs during the break period or for any claim which arises during the break period.

c) For Renewal Proposal received after completion of grace period of 30 days, all waiting periods including for health check-up, would apply afresh.

d) This Policy may be renewed at the expiry of the Policy Period on payment of the Renewal premium.

e) Renewals will be lifelong and will not be refused or cancellation will not be invoked by Us except on grounds of mis-representation, fraud, non-disclosure of material facts or non-cooperation of the insured.

f) We may cancel this Policy by giving You at least 15 days written notice on the grounds of fraud, moral hazard or misrepresentation or non-cooperation.

g) In case the Policy Period is equal to one year, You may cancel this insurance by giving Us at least 15 days written notice, and if no claim has been made then the We shall refund premium on short term rates for the unexpired Policy Period as per the rates detailed below.

Period on risk	Rate of premium refunded
Upto one month	75% of annual rate
Upto three months	50% of annual rate
Upto six months	25% of annual rate
Exceeding six months	Nil

h) In case the Policy Period exceeds one year, this Policy may be cancelled by the Insured Person at any time by giving at least 15 days written notice to Us. We will refund premium on a pro-rata basis by reference to the time period cover is provided, subject to a minimum retention of premium of 25%.

i) No refund of premium shall be due on cancellation if the Insured Person has made a claim under this Policy.

j) There will be no loading on premium for adverse claims experience.

k) The brochure/ prospectus mentions the premiums as per the age slabs/ Sum Insured and the same would be charged as per the completed age at every Renewal. The premiums as shown in the brochure/ prospectus are subject to revision as and when approved by the IRDA. However such revised premiums would be applicable only from subsequent Renewals and with due notice whenever implemented.

15. Dispute Resolution

Any and all disputes or differences under or in relation to this Policy shall be subject to the exclusive jurisdiction of the Indian Courts and subject to Indian law.

16. Subrogation

You and any claimant under this Policy shall do whatever is necessary to enable Us to enforce any rights and remedies or obtain relief from other parties to which We would become entitled or Subrogated upon Us paying for or making good any loss under this Policy whether such acts and things shall be or become necessary or required before or after Your indemnification by Us. This provision shall not apply to any fixed benefits payable under the Policy

17. Territorial Limits and Law

a) Except as provided in Benefit 18, We shall cover only treatment and investigations covered in terms of this Policy that is taken during the Policy Period and takes place anywhere in the territory of India.

b) The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Indian law.

c) The Policy constitutes the complete contract of insurance between Us and You/Insured Person. No change or alteration shall be valid or effective unless approved in writing by Us, which approval shall be evidenced by an endorsement on the Schedule.

18. Free Look Period

a) You will be allowed a period of 15 days from the date of receipt of the Policy document to review the terms and conditions of the Policy and to return the same if not acceptable.

b) If no claim has been made during the free look period, You shall be entitled to:

i) A refund of the premium paid less any expenses incurred by Us on medical examination of the Insured Persons and the stamp duty charges;

(ii) Where the risk has already commenced and the option of return of the policy is exercised by You, a deduction

towards the proportionate risk premium for period on cover or;

iii) Where only a part of the risk has commenced, such proportionate risk premium commensurate with the risk covered during such period.

19. Revision/Modification Of Product

There is a possibility of revision/modification of terms, conditions, coverages and/or premiums of this product at any time in future, with the appropriate approval from the IRDA. In such an event of revision/modification of the product, intimation shall given to You at least 3 months prior to the date such revision/modification of the Policy comes into the effect.

20. Withdrawal of Policy

There is a possibility of withdrawal of this product at any time in future with appropriate approval from the IRDA, as We reserve Our right to do so with intimation of 3 months prior to the withdrawal of this product. In such an event of withdrawal of this product, at the time of Your seeking Renewal of this Policy, You can choose, among Our available similar and closely similar health insurance products. Upon Your so choosing Our new product, You will be charged the premium as per Our underwriting policy for such chosen new product, as approved by the IRDA. Provided however, if You do not respond to Our intimation regarding the withdrawal of the product under which this Policy is issued, then this Policy shall be withdrawn and shall not be available to You for Renewal on the Renewal date and accordingly upon Your seeking Renewal of this Policy, You shall have to take a Policy under available new products of Ours subject to Your paying the Premium as per Our Underwriting Policy for such available new product chosen by You and also subject to Portability condition.

21. Policy Period

The minimum Policy Period offered under this product is one year, and the maximum Policy Period is three years.

22. Day Care List

In addition to day care list as set out below We shall also cover any other Surgeries/procedures agreed to be covered by Us which require less than 24 hours Hospitalization.

1. Suturing - CLW - under LA or GA.
2. Surgical debridement of wound.
3. Therapeutic Ascitic Tapping.
4. Therapeutic Pleural Tapping.
5. Therapeutic Joint Aspiration.
6. Aspiration of an internal abscess under ultrasound guidance.
7. Aspiration of Hematoma.
8. Incision and Drainage
9. Endoscopic Foreign Body Removal - Trachea /pharynx-l arynx/bronchus.
10. Endoscopic Foreign Body Removal -Oesophagus/ stomach/rectum.
11. True Cut Biopsy – Breast/liver/Kidney-Lymph Node/ Pleura/lung/muscle
12. Biopsy/nerve biopsy/synovial biopsy/Bone Trephine Biopsy/Pericardial Biopsy.
13. Endoscopic ligation/banding.
14. Sclerotherapy
15. Dilatation of digestive tract strictures.
16. Endoscopic ultrasonography and biopsy.
17. Nissen fundoplication for Hiatus Hernia/Gastro esophageal reflux disease.
18. Endoscopic placement/removal of stents.
19. Endoscopic Gastrostomy.
20. Replacement of Gastrostomy tube.
21. Endoscopic Polypectomy.
22. Endoscopic decompression of colon.
23. Therapeutic ERCP.
24. Brochoscopic treatment of bleeding lesion.
25. Brochoscopic treatment of fistula/stenting.
26. Bronchoalveolar lavage & biopsy.
27. Tonsillectomy without Adenoidectomy.
28. Tonsillectomy with Adenoidectomy.
29. Excision and destruction of lingual tonsil.
30. Foreign body removal from nose.
31. Myringotomy.
32. Myringotomy with Grommet insertion.
33. Myringoplasty/Tympanoplasty.
34. Antral wash under LA.
35. Quinsy drainage.
36. Direct Laryngoscopy with or without biopsy.
37. Reduction of nasal fracture.
38. Mastoidectomy.
39. Removal of tympanic drain.
40. Reconstruction of middle ear.
41. Incision of mastoid process & middle ear.
42. Excision of nose granuloma.
43. Blood transfusion for recipient.
44. Therapeutic Phlebotomy
45. Haemodialysis/Peritoneal Dialysis.
46. Chemotherapy.
47. Radiotherapy.
48. Coronary Angioplasty (PTCA).
49. Pericardiocentesis.
50. Insertion of filter in inferior vena cava.
51. Insertion of gel foam in artery or vein.
52. Carotid angioplasty.
53. Renal angioplasty.
54. Tumor embolisation.
55. TIPS procedure for portal hypertension.
56. Endoscopic Drainage of Pseudopancreatic cyst.
57. Lithotripsy.
58. PCNS (Percutaneous Nephrostomy).
59. PCNL (Percutaneous Nephrolithotomy).
60. Suprapubiccytostomy.
61. Transurethral resection of bladder tumor.
62. Hydrocele Surgery.
63. Epididymectomy.

64. Orchidectomy.
65. Herniorrhaphy.
66. Hernioplasty.
67. Incision and excision of tissue in the perianal region.
68. Surgical treatment of anal fistula.
69. Surgical treatment of hemorrhoids.
70. Sphincterotomy/Fissurectomy.
71. Laparoscopic Appendicectomy.
72. Laparoscopic Cholecystectomy.
73. TURP (Resection Prostate).
74. Varicose vein stripping or ligation.
75. Excision of dupuytren's contracture.
76. Carpal tunnel decompression.
77. Excision of granuloma.
78. Arthroscopic therapy.
79. Surgery for ligament tear.
80. Surgery for meniscus tear.
81. Surgery for hemoarthrosis/pyoarthrosis.
82. Removal of fracture pins/nails.
83. Removal of metal wire.
84. Incision of bone, septic and aseptic.
85. Closed reduction on fracture, luxation or epiphyseolysis with osetosynthesis.
86. Suture and other operations on tendons and tendon sheath.
87. Reduction of dislocation under GA.
88. Cataract Surgery.
89. Excision of lachrymal cyst.
90. Excision of pterigium.
91. Glaucoma Surgery.
92. Surgery for retinal detachment.
93. Chalazion removal (Eye).
94. Incision of lachrymal glands.
95. Incision of diseased eye lids.
96. Excision of eye lid granuloma.
97. Operation on canthus and epicanthus.
98. Corrective Surgery for entropion and ectropion
99. Corrective Surgery for blepharoptosis.
100. Foreign body removal from conjunctiva.
101. Foreign body removal from cornea.
102. Incision of cornea.
103. Foreign body removal from lens of the eye.
104. Foreign body removal from posterior chamber of eye.
105. Foreign body removal from orbit and eye ball.
106. Excision of breast lump/Fibro Adenoma.
107. Operations on the nipple.
108. Incision/drainage of breast abscess.
109. Incision of pilonidal sinus.
110. Local excision of diseased tissue of skin and subcutaneous tissue.
111. Simple restoration of surface continuity of the skin and subcutaneous tissue.
112. Free skin transportation, donor site.
113. Free skin transportation recipient site.
114. Revision of skin plasty.
115. Destruction of the diseases tissue of the skin and subcutaneous tissue.
116. Incision, excision, destruction of the diseased tissue of the tongue.
117. Glossectomy.
118. Reconstruction of the tongue.
119. Incision and lancing of the salivary gland and a salivary duct.
120. Resection of a salivary duct.
121. Reconstruction of a salivary gland and a salivary duct.
122. External incision and drainage in the region of the mouth, jaw and face.
123. Incision of hard and soft palate.
124. Excision and destruction of the diseased hard and soft palate.
125. Incision, excision and destruction in the mouth.
126. Surgery to the floor of mouth.
127. Palatoplasty.
128. Transoral incision and drainage of pharyngeal abscess.
129. Dilatation and curettage.
130. Myomectomies.
131. Simple Oophorectomies.

Note: The standard exclusions and waiting periods are applicable to all of the above procedures depending on the medical condition/disease under treatment. Only 24 hours Hospitalization is not mandatory.

23. Special Conditions Applicable for Policies Issued With Premium Payment on Instalment Basis.

If You have opted for a Policy Period of more than one year and for payment of premium on an instalment basis, as specified in the Schedule, the following conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy):

1. In case of any Hospitalization claim, an amount equivalent to the balance of the instalment premiums payable in the Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person.

2. If the claim amount is lesser than the balance premium payable, then no claims would be payable till the applicable premium is recovered. This provision will not apply to claims arising under Benefit 13.

3. Relaxation period for the policies with installment option would be as under:

Instalment Option	Relaxation for payment of premium
Annual	15 days
Half yearly	15 days
Quarterly	15 days
Monthly	15 days

4. In case of instalment premiums not received within the relaxation period the Policy will get cancelled and a fresh policy with all waiting periods applicable would be issued.

Schedule Of Benefits									
		Vital Plan			Superior Plan			Premiere Plan	
Eligibility	Sum Insured (in ₹)	3 lakhs	5 lakhs	10 lakhs	15 lakhs	20 lakhs	25 lakhs	50 lakhs	1 crore
	Minimum age at entry	1 day	1 day	1 day	1 day	1 day	1 day	1 day	1 day
	Maximum age at entry	None	None	None	None	None	None	None	None
	Maximum renewal age	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long	Life Long
	Individual SI / family floater SI options	Both	Both	Both	Both	Both	Both	Both	Both
	Family definition	S+Sp+2C+2P (1+5)	S+Sp+2C+2P (1+5)	S+Sp+2C+2P (1+5)	Extended family up to 15 members	Extended family up to 15 members	Extended family up to 15 members	Extended family up to 15 members	Extended family up to 15 members
Hospitalisation Benefits	Hospitalisation	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI	Up to SI
	Day care treatment	√	√	√	√	√	√	√	√
	Pre-hospitalisation	60 days	60 days	60 days	60 days	60 days	60 days	60 days	60 days
	Post-hospitalisation	90 days	90 days	90 days	120 days	120 days	120 days	180 days	180 days
	Restoration of SI	√	√	√	√	√	√	√	√
	Cumulative bonus - 50% for every claim-free year to max 100%	√	√	√	√	√	√	√	√
	Maternity benefit - normal delivery (in ₹)	15,000	20,000	25,000	30,000	40,000	40,000	50,000	50,000
	Maternity benefit - LSCS (caesarian) (in ₹)	25,000	35,000	45,000	50,000	60,000	60,000	1,00,000	1,00,000
	Pre-natal hospitalisation (within maternity limits)	×	×	×	90 days	90 days	90 days	90 days	90 days
	Post-natal hospitalisation (within maternity limits)	×	×	×	45 days	45 days	45 days	45 days	45 days
	Organ donor expenses	√	√	√	√	√	√	√	√
	New born baby benefits: Automatic cover within mother's / floater Sum Insured up to expiry date of policy	×	×	×	√	√	√	√	√
	New born baby benefits: Reasonable vaccination benefits up to 1 year of age (in ₹)	×	×	×	Max 3,500	Max 3,500	Max 3,500	Max 5,000	Max 5,000
	Patient care (above 60 years) - per day benefit up to max (in ₹)	350/day	350/day	350/day	500/day	500/day	500/day	1,000/day	1,000/day
	Patient care (above 60 year) - maximum	10 days per Hospitalisation and 30 days per policy year							
	Accidental hospitalisation - 25% increase subject to maximum of ₹10 lakh	√	√	√	√	√	√	√	√
	Accompanying person (up to 12 years) ₹500 /day to maximum of 30 days	√	√	√	√	√	√	√	√
	Domiciliary hospitalisation expenses - maximum up to 10% of SI	√	√	√	√	√	√	√	√
	Alternative treatments Ayurveda / Unani / Sidha / Homeopathy - reimbursement	√	√	√	√	√	√	√	√
Medical Treatment Abroad	Medical treatment abroad	×	×	×	×	×	×	√	√
	Medical treatment abroad - waiting period							4 years	4 years
Road Ambulance	Road ambulance charges - network hospitals (in ₹)	1,500	1,500	1,500	Actuals	Actuals	Actuals	Actuals	Actuals
	Road ambulance charges - non network hospitals (reimbursement up to a maximum) (in ₹)	1,500	1,500	1,500	2,000	2,000	2,000	5,000	5,000

Schedule Of Benefits									
		Vital Plan			Superior Plan			Premiere Plan	
Emergency Medical Evacuation	Emergency medical evacuation - 5% of SI (reimbursement up to a maximum)	×	×	×	√	√	√	√	√
E-Opinion	E-Opinion for illness / injury (maximum 2 per policy year)	√	√	√	√	√	√	√	√
**Out-patient Medical Expenses	Out-patient consultations and diagnostics (reimbursement up to a maximum (in ₹)	×	×	×	3,000 for Individual option/ 10,000 for floater option	3,000 for Individual option/ 10,000 for floater option	3,000 for Individual option/ 10,000 for floater option	10,000 for Individual option /20,000 for floater option	10,000 for Individual option /20,000 for floater option
	Prescribed medicines (reimbursement up to a maximum)	×	×	×	×	×	×		
Child Vaccination Benefits	Child vaccination benefits (reimbursement up to a maximum)	×	×	×	×	×	×	Up to 12 years of age (₹5,000 per annum)	Up to 12 years of age (₹5,000 per annum)
Wellness Benefits	Wellness including medical tests at designated centres	√	√	√	√	√	√	√	√
One Time Discount	One time renewal discount-subsequent to death of proposer	10%	10%	10%	10%	10%	10%	10%	10%
Family Discount	Family Discount 10% (Individual SI Policies)	√	√	√	√	√	√	√	√
Voluntary Deductible	Discount in lieu of voluntary deductible	√	√	√	√	√	√	√	√
Waiting Periods	Pre-existing disease								
	Compulsory waiting period	2 years	2 years	2 years	2 years	2 years	2 years	2 years	2 years
	Pre-existing disease - max liability 3rd year onwards	50%	50%	50%	50%	50%	50%	50%	50%
	Pre-existing disease - 4th Year onwards	100%	100%	100%	100%	100%	100%	100%	100%
	General waiting periods								
	30-day - fresh proposals excluding accidental hospitalisation	√	√	√	√	√	√	√	√
	2-year waiting period for listed conditions	√	√	√	√	√	√	√	√
	4-year waiting period - joint replacement and organ transplant	√	√	√	√	√	√	√	√
Compulsory Co-pay	20% co-payment where entry age is from 60 year to 64 years	√	√	√	√	√	√	√	√
	25% co-payment where entry age is from 65 year to 69 years	√	√	√	√	√	√	√	√
	30% co-payment where entry age is from 70 year to 74 years	√	√	√	√	√	√	√	√
	40% co-payment where entry age is 75 years and above	√	√	√	√	√	√	√	√

** Out-patient medical expenses. (Applicable for Superior and Premiere Plan)
In case of bills for any prescribed drugs/medicines, our liability will be restricted to 80% of admissible bills.
In case of dental consultations and diagnostics, our liability will be restricted to 70% of admissible bills.
* All benefits are given within the base Sum Insured except Accidental Hospitalisation.
SI : Sum insured, S: Self, Sp: Spouse, C: Child, P: Parent

ANNEXURE 1: NON PAYABLE ITEMS		
Sr. No.	Expense Head	Special Remarks
1	Hair Removal Cream	Not Payable
2	Baby Charges (Unless Specified/Indicated)	Not Payable
3	Baby Food	Not Payable
4	Baby Utilities Charges	Not Payable
5	Baby Set	Not Payable
6	Baby Bottles	Not Payable
7	Brush	Not Payable
8	Cozy Towel	Not Payable
9	Hand Wash	Not Payable
10	Moisturizer Paste Brush	Not Payable
11	Powder	Not Payable
12	Razor	Not Payable
13	Shoe Cover	Not Payable
14	Beauty Services	Not Payable
15	Belts/ Braces	Essential and may be paid specifically for cases who have undergone Surgery of thoracic or lumbar spine.
16	Buds	Not Payable
17	Barber Charges	Not Payable
18	Caps	Not Payable
19	Cold Pack / Hot Pack	Not Payable
20	Carry Bags	Not Payable
21	Cradle Charges	Not Payable
22	Comb	Not Payable
23	Disposables Razors Charges	Payable for Site Preparations
24	EauDeCologne / Room Fresheners	Not Payable
25	Eye Pad	Not Payable
26	Eye Shield	Not Payable
27	Email / Internet Charges	Not Payable
28	Food Charges (Other Than Patient's Diet Provided By Hospital)	Not Payable
29	Foot Cover	Not Payable
30	Gown	Not Payable
31	Leggings	Essential in bariatric and varicose vein Surgery and should be considered for these conditions where Surgery itself is Payable.
32	Laundry Charges	Not Payable
33	Mineral Water	Not Payable
34	Oil Charges	Not Payable
35	Sanitary Pad	Not Payable
36	Slippers	Not Payable
37	Telephone Charges	Not Payable
38	Tissue Paper	Not Payable
39	Tooth Paste	Not Payable
40	Tooth Brush	Not Payable
41	Guest Services	Not Payable
42	Bed Pan	Not Payable
43	Bed Under Pad Charges	Not Payable
44	Camera Cover	Not Payable
45	Cliniplast	Not Payable
46	Crepe Bandage	Not Payable
47	Curapore	Not Payable
48	Diaper Of Any Type	Not Payable
49	DVD, CD Charges	Not Payable unless CD is specifically sought by Insurer
50	Eyelet Collar	Not Payable
51	Face Mask	Not Payable
52	Flexi Mask	Not Payable
53	Gauze Soft	Not Payable
54	Gauze	Not Payable

ANNEXURE 1: NON PAYABLE ITEMS		
55	Hand Holder	Not Payable
56	Hansaplast / Adhesive Bandages	Not Payable
57	Infant Food	Not Payable
58	Slings	Reasonable costs for one sling in case of upper arm fractures should be considered
59	Weight Control Programs/ Supplies/ Services	Not Payable
60	Cost Of Spectacles / Contact Lenses / Hearing Aids	Not Payable
61	Dental Treatment Expenses That Do Not Require Hospitalisation	Not Payable
62	Hormone Replacement Therapy	Not Payable
63	Home Visit Charges	Not Payable
64	Infertility / Subfertility / Assisted Conception Procedure	Not Payable
65	Obesity (Including Morbid Obesity)	Not Payable
66	Psychiatric & Psychosomatic Disorders	Not Payable
67	Corrective Surgery For Refractive Error	Not Payable
68	Treatment Of Sexually Transmitted Diseases	Not Payable
69	Donor Screening Charges	Not Payable
70	Admission / Registration Charges	Not Payable
71	Hospitalisation For Evaluation / Diagnostic Purpose	Not Payable
72	Expenses For Investigation / Treatment Irrelevant To The Disease For Which Admitted Or Diagnosed	Not Payable
73	Any Expenses When The Patient Is Diagnosed With Retro Virus + Or Suffering From HIV / AIDS Etc Is Detected / Directly Or Indirectly	Not Payable
74	Stem Cell Implantation / Surgery And Storage	Not Payable except Bone Marrow Transplantation where covered by policy
75	Ward And Theatre Booking Charges	Payable under OT Charges, not Payable separately
76	Arthroscopy & Endoscopy Instruments	Rental charged by the Hospital Payable. Purchase of instruments not Payable
77	Microscope Cover Payable Under OT	Payable under OT Charges, not Payable separately
78	Surgical Blades, Harmonic Scalpel, Shaver	Payable under OT Charges, not Payable separately
79	Surgical Drill	Payable under OT Charges, not Payable separately
80	Eye Kit	Payable under OT Charges, not Payable separately
81	Eye Drape	Payable under OT Charges, not Payable separately
82	X Ray Film	Payable under radiology charges, not as consumable
83	Sputum Cup	Payable under investigation charges, not as consumable
84	Boyles Apparatus Charges	Payable under OT Charges, not Payable separately
85	Blood Grouping And Cross Matching Of Donors Samples	Not Payable, part of cost of blood
86	Antiseptic Or Disinfectant Lotions	Not Payable, part of dressing charges
87	Band Aids, Bandages, Sterile Injections, Needles, Syringes	Not Payable, part of dressing charges
88	Cotton	Not Payable, part of dressing charges
89	Cotton Bandage	Not Payable, part of dressing charges
90	Micropore / Surgical Tape	Not Payable, part of dressing charges
91	Blade	Not Payable
92	Apron	Not Payable, part of hospital services/disposable linen to be part of OT/ICU Charges
93	Torniquet	Not Payable
94	Orthobundle, Gynaec Bundle	Not Payable, part of dressing charges
95	Urine Container	Not Payable
96	Luxury Tax	Actual tax levied by government is Payable. Part of charge for room sub limits
97	HVAC	Not Payable, part of room charge
98	Housekeeping Charges	Not Payable, part of room charge
99	Service Charges Where Nursing Charge Also Charged	Not Payable, part of room charge
100	Television & Air Conditioner Charges	Not Payable, part of room charge
101	Surcharges	Not Payable, part of room charge
102	Attendant Charges	Not Payable, part of room charge
103	IM IV Injection Charges	Not Payable, part of nursing charges
104	Clean Sheet	Not Payable, part of laundry/housekeeping
105	Extra Diet Of Patient (Other Than That Which Forms Part Of Bed Charge)	Patient diet provided by Hospital is Payable

ANNEXURE 1: NON PAYABLE ITEMS		
106	Blanket / Warmer Blanket	Not Payable, part of room charge
107	Admission Kit	Not Payable
108	Birth Certificate	Not Payable
109	Blood Reservation Charges And Ante Natal Booking Charges	Not Payable
110	Certificate Charges	Not Payable
111	Courier Charges	Not Payable
112	Conveyance Charges	Not Payable
113	Diabetic Chart Charges	Not Payable
114	Documentation Charges / Administrative Expenses	Not Payable
115	Discharge Procedure Charges	Not Payable
116	Daily Chart Charges	Not Payable
117	Entrance Pass / Visitors Pass Charges	Not Payable
118	Expenses Related To Prescription On Discharge	Not Payable. To be claimed by patient under Post-Hospitalisation Medical Expenses, if admissible
119	File Opening Charges	Not Payable
120	Incidental Expenses / Misc. Charges (Not Explained)	Not Payable
121	Medical Certificate	Not Payable
122	Maintenance Charges	Not Payable
123	Medical Records	Not Payable
124	Preparation Charges	Not Payable
125	Photocopies Charges	Not Payable
126	Patient Identification Band / Name Tag	Not Payable
127	Washing Charges	Not Payable
128	Medicine Box	Not Payable
129	Mortuary Charges	Payable upto 24 Hours, shifting charges not Payable
130	Medico Legal Case Charges (MLC Charges)	Not Payable
131	External Durable Devices	Not Payable
132	Walking Aids Charges	Not Payable
133	Bipap Machine	Not Payable
134	Commode	Not Payable
135	CPAP / CAPD Equipments	Not Payable
136	Infusion Pump - Cost	Not Payable
137	Oxygen Cylinder (For Usage Outside The Hospital)	Not Payable
138	Pulse Oxymeter Charges	Not Payable
139	Spacer	Not Payable
140	Spirometer	Not Payable
141	Sp02 Probe	Not Payable
142	Nebulizer Kit	Not Payable
143	Steam Inhaler	Not Payable
144	Arm Sling	Not Payable
145	Thermometer	Not Payable
146	Cervical Collar	Not Payable
147	Splint	Not Payable
148	Diabetic Foot Wear	Not Payable
149	Knee Braces (Long / Short / Hinged)	Not Payable
150	Knee Immobilizer / Shoulder Immobilizer	Not Payable
151	Lumbosacral Belt	Essential and may be paid specifically for cases who have undergone Surgery of lumbar spine
152	Nimbus Bed Or Water Or Air Bed Charges Payable For Any ICU	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs.200/- day
153	Ambulance Collar	Not Payable
154	Ambulance Equipment	Not Payable
155	Microshield	Not Payable
156	Abdominal Binder	Essential and should be paid in post Surgery patients of major abdominal Surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
157	Betadine \ Hydrogen Peroxide \ Spirit \ Disinfectants Etc.	May be Payable when prescribed for patient, not Payable for Hospital use in OT or ward or for dressings in Hospital

ANNEXURE 1: NON PAYABLE ITEMS		
158	Private Nurses Charges - Special Nursing Charges	Post-Hospitalisation nursing charges not Payable
159	Nutrition Planning Charges - Dietician Charges / Diet Charges	Not Payable
160	Sugar Free Tablets	Payable. Sugar free variants of admissible medicines are not excluded
161	Creams Powders Lotions	Toiletries are not Payable, only prescribed medical pharmaceuticals Payable
162	Digestion Gels	Payable when prescribed
163	ECG Electrodes Upto 5 Electrodes	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and atleast one set every second day must be Payable
164	Gloves	Sterilized gloves Payable. Unsterilized gloves not Payable
165	HIV Kit	Payable for pre operative screening
166	Listerine / Antiseptic Mouthwash	Payable when prescribed
167	Lozenges	Payable when prescribed
168	Mouth Paint	Payable when prescribed
169	Nebulisation Kit	If used during Hospitalisation is Payable if reasonable
170	Novarapid	Payable when prescribed
171	Volini Gel / Analgesic Gel	Payable when prescribed
172	Zytee Gel	Payable when prescribed
173	Vaccination Charges	Routine vaccination not Payable. Post Bite Vaccination Payable
174	AHD	Not Payable. Part of Hospital's own internal cost
175	Alcohol Swabs	Not Payable. Part of Hospital's own internal cost
176	Scrub Solution / Sterillium	Not Payable. Part of Hospital's own internal cost
177	Vaccine Charges For Baby	Not Payable
178	Aesthetic Treatment/Surgery	Not Payable
179	TPA Charges	Not Payable
180	Visco Belt Charges	Not Payable
181	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]	Not Payable
182	Examination Gloves	Not Payable
183	Kidney Tray	Not Payable
184	Mask	Not Payable
185	Ounce Glass	Not Payable
186	Outstation Consultant's / Surgeon's Fees	Not Payable, except for telemedicine consultations where covered by Policy
187	Oxygen Mask	Not Payable
188	Paper Gloves	Not Payable
189	Pelvic Traction Belt	Not Payable
190	Referral Medical Practitioner's Fees	Not Payable
191	Accu Check (Glucometery/ Strips)	Not Payable pre Hospitalisation or post Hospitalisation/Reports and charts required
192	Pan Can	Not Payable
193	Sofnet	Not Payable
194	Trolly Cover	Not Payable
195	Urometer, Urine Jug	Not Payable
196	Ambulance	Ambulance from home to Hospital or inter Hospital shifts is Payable/RTA as specific requirement is Payable
197	Tegaderm / Vasofix Safety	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
198	Urine Bag	Payable where Medically Necessary till a reasonable cost, maximum 1 per 24 hrs
199	Softovac	Not Payable
200	Stockings	Essential for case like CABG etc. where it should be paid

In case of any claims, contact:

Claims Department
Future Generali Health (FGH)
Future Generali India Insurance Co. Ltd.

Office No. 3, 3rd Floor, “A” Building , G - O - Square
S. No. 249 & 250, Aundh Hinjewadi Link Road, Wakad, Pune - 411 057.
Toll Free Number: 1800 103 8889
Toll Free Fax : 1800 103 9998
Email: fgh@futuregenerali.in

GRIEVANCE REDRESSAL PROCEDURES

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Dear Customer,

At **Future Generali** we are committed to provide **"Exceptional Customer-Experience"** that you remember and return to fondly. We encourage you to read your policy & schedule carefully. We want to make sure the plan is working for you and welcome your feedback.

What Constitutes a Grievance?

A "Grievance/Complaint" is defined as any communication that expresses dissatisfaction about an action or lack of action, about the standard service/deficiency of service from Future Generali or its intermediary or asks for remedial action.

If you have a complaint or grievance you may reach us through the following avenues:

	**Help - Lines**	**1800-220-233 / 1860-500-3333 / 022-67837800**		**Email**	Fgcare@futuregenerali.in
				**Website**	www.futuregenerali.in
	**GRO at each Branch**	Walk-in to any of our branches and request to meet the **Grievance Redressal Officer (GRO).**			

What can I expect after logging a Grievance?

We will acknowledge receipt of your concern within 3 - business days.
Within 2 - weeks of receiving your grievance, we shall revert to you the final resolution.
We shall regard the complaint as closed if we do not receive a reply within 8 weeks from the date of receipt of response.

What do I do, if I am unhappy with the Resolution?

You can write directly to our Customer Service Cell at our Head office:	**Customer Service Cell**	**Customer Service Cell, Future Generali India Insurance Company Ltd.** Corporate & Registered Office:- 6th Floor, Tower 3, Indiabulls Finance Center, Senapati Bapat Marg, Elphinstone Road, Mumbai – 400013 Please send your complaint in writing. You can use the complaint form, annexed with your policy. Kindly quote your policy number in all communication with us. This will help us to deal with the matter faster.

How do I Escalate?

While we constantly endeavor to promptly register, acknowledge & resolve your grievance, if you feel that you are experiencing difficulty in registering your complaint, you may register your complaint through the **IRDA (Insurance Regulatory and Development Authority). CALL CENTER: TOLL FREE NUMBER (155255).**

REGISTER YOUR COMPLAINT ONLINE AT: HTTP://WWW.IGMS.IRDA.GOV.IN/

Insurance Ombudsman:

If you are still not satisfied with the resolution to the complaint as provided by our **GRO,** you may approach the Insurance Ombudsman for a review. The Insurance Ombudsman is an organization that addresses grievances that are not settled to your satisfaction. You may reach the nearest insurance ombudsman office. The list of Insurance Ombudsmen offices is as mentioned below.

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD	Insurance Ombudsman Office of the Insurance Ombudsman 2nd Floor, Ambica House, Nr. C.U.Shah College, 5, Navyug Colony, Ashram Road, **AHMEDABAD - 380 014** Tel: 079-27545441/27546139 Fax: 079-27546142 **E-mail: bimalokpal.ahmedabad@gbic.co.in**	Gujarat, UT of Dadra & Nagar Haveli, Daman and Diu
BENGALURU	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Mangal Bldg., 2nd Floor, Behind Canara Mutual Bldgs., No.4, Residency Road, **Bengaluru – 560 025.** Tel.: 080 - 22222049 **E-mail: bimalokpal.bengaluru@gbic.co.in**	Karnataka
BHOPAL	Insurance Ombudsman Office of the Insurance Ombudsman Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, **BHOPAL - 462 023** Tel: 0755-2569201/9202 Fax: 0755-2769203 **E-mail: bimalokpalbhopal@airtelmail.in**	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Insurance Ombudsman Office of the Insurance Ombudsman 62, Forest Park, **BHUBANESHWAR - 751 009** Tel: 0674-2596455/2596003 Fax: 0674-2596429 **E-mail: bimalokpal.bhubaneswar@gbic.co.in**	Orissa
CHANDIGARH	Insurance Ombudsman Office of the Insurance Ombudsman S.C.O. No.101 - 103, 2nd Floor, Batra Building, Sector 17-D, **CHANDIGARH - 160 017** Tel: 0172-2706468/2705861 Fax: 0172-2708274 **E-mail: bimalokpal.chandigarh@gbic.co.in**	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, UT of Chandigarh
CHENNAI	Insurance Ombudsman Office of the Insurance Ombudsman Fatima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, **CHENNAI - 600 018** Tel:044-24333668 /5284 Fax: 044-24333664 **E-mail: bimalokpal.chennai@gbic.co.in**	Tamilnadu, UT- Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
DELHI	Insurance Ombudsman Office of the Insurance Ombudsman 2/2 A, Universal Insurance Bldg. Asaf Ali Road, **NEW DELHI - 110 002** Tel: 011-23237539/23232481 Fax: 011-23230858 **E-mail: bimalokpal.delhi@gbic.co.in**	Delhi
GUWAHATI	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Nivesh, 5th floor Nr. Panbazar Overbridge, S.S. Road, **GUWAHATI - 781 001** Tel:0361-2132204/5 Fax: 0361-2732937 **E-mail: bimalokpal.guwahati@gbic.co.in**	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
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: 040-65504123/23312122 Fax: 040-23376599 **E-mail: bimalokpal.hyderabad@gbic.co.in**	Andhra Pradesh, Telangana and UT of Yanam - a part of UT of Pondicherry
JAIPUR	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, **Jaipur - 302 005.** Tel : 0141-2740363 **E-mail: bimalokpal.jaipur@gbic.co.in**	Rajasthan
ERNAKULAM	Insurance Ombudsman Office of the Insurance Ombudsman 2nd Floor, CC 27/2603, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, **ERNAKULAM - 682 015** Tel: 0484-2358759/2359338 Fax: 0484-2359336 **E-mail: bimalokpal.ernakulam@gbic.co.in**	Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry
KOLKATA	Insurance Ombudsman Office of the Insurance Ombudsman 4th Floor, Hindusthan Bldg., Annexe, 4, C.R.Avenue, **KOLKATA - 700 072** Tel: 033-22124346 / (40) Fax: 033-22124341 **E-mail : bimalokpal.kolkata@gbic.co.in**	West Bengal, Sikkim and UT of Andeman & Nicobar Islands
LUCKNOW	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Bhawan, Phase 2, 6th Floor, Nawal Kishore Road, Hazratganj, **LUCKNOW - 226 001** Tel: 0522 -2231331/30 Fax: 0522-2231310 **E-mail: bimalokpal.lucknow@gbic.co.in**	Districts of U.P:- Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar

Office of the Ombudsman	Contact Details	Areas of Jurisdiction
MUMBAI	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Seva Annexe, 3rd Floor, S.V.Road, Santacruz (W), **MUMBAI - 400 054** Tel: 022-26106928/26106552 Fax: 022-26106052 **E-mail: bimalokpal.mumbai@gbic.co.in**	Goa and Mumbai Metropolitan Region excluding Areas of Navi Mumbai & Thane
Noida	Insurance Ombudsman Office of the Insurance Ombudsman	Uttaranchal and the following Districts of U.P:- Agra, Aligarh, Bagpet, Bareilly, Bijnor, Budaun, Bulandshehar, Etah , Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozabad, Gauta bodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur
Patna	Insurance Ombudsman Office of the Insurance Ombudsman	Bihar and Jharkhand
Pune	Insurance Ombudsman Office of the Insurance Ombudsman Jeevan Darshan Bldg., 2nd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan **Peth, Pune – 411 030**. Tel: 020-32341320 **E-mail: bimalokpal.pune@gbic.co.in**	Maharashtra, Area of Navi Mumbai and Thane but excluding Mumbai Metropolitan Region

The updated details of Insurance Ombudsman are available on IRDA website: HYPERLINK “http://www.irda.gov.in/”www.irda.gov.in, on the website of General Insurance Council: HYPERLINK “http://www.generalinsurancecouncil.org.in/”www.generalinsurancecouncil.org.in, our website HYPERLINK “http://www.futuregenerali.in/” or from any of our offices.

Future Generali India Insurance Company Limited
Future Generali India Insurance Company Limited (IRDAI Regn. No.: 132) (CIN: U66030MH2006PLC165287) Regd. and Corp. Office: Indiabulls Finance Centre, Tower 3, 6th Floor, Senapati Bapat Marg, Elphinstone Road (W), Mumbai - 400013.
Fax: 022-4097 6900 I Email: fgcare@futuregenerali.in.
Future Group’s and Generali Group’s liability is restricted to the extent of their shareholding in Future Generali India Insurance Company Limited.
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Form for Request / Complaint / Feedback / Appreciation

I want to submit the below:

REQUEST: ---------- COMPLAINT: ----------

SUGGESTION / FEEDBACK: ---------- APPRECIATION: ----------

POLICY TYPE

MOTOR: ---------- HEALTH: ----------

PERSONAL ACCIDENT: ---------- OTHER: ----------

POLICY DETAILS

POLICY NO: ---------- CLAIM NO: ----------

COVER NOTE: ---------- HEALTH CARD: ----------

EXISTING SERVICE REQUEST: ----------

CUSTOMER NAME: ----------

ADDRESS: ----------

CITY: ---------- PIN CODE: ----------

TEL NO: ---------- MOBILE NO: ----------

Detailed description: ----------

---------- ----------

Customer's Signature Date

You may submit the form to the Nearest Branch Office or mail it to our Customer Service Cell at: **Customer Service Cell**

Future Generali India Insurance Company Ltd.
Corporate & Registered Office: - 6th Floor, Tower 3, Indiabulls Finance Centre, Senapati Bapat Marg, Elphinstone Road, Mumbai – 400013

Care Lines: 1800-220-233 / 1860-500-3333 / 022-6783 7800 **Email:** fgcare@futuregenerali.in Website: www.futuregenerali.in

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Office Use Only: Service / Case: ----------

Comments : ----------

Health Insurance Claim Form

ALL FIELDS IN THIS FORM ARE MANDATORY AND THE CLAIM WILL BE NOT BE PROCESSED IF ANY OF THE DETAILS ARE MISSING

Claim Number (For FGH Use Only)	

POLICY / INSURED DETAILS

Policy No :	Health Card No. of Patient	
Policy Start Date	Policy End Date	Date of Joining the Policy
Corporate Name :	(Only for Group Policies) Employee ID	

PERSONAL DETAILS OF EMPLOYEE/PROPOSER

1	Name of the Employee / Individual:
2	E-Mail address of the Employee/Individual:
3	Mobile No:
4	Permanent Account Number (PAN):

CLAIMANT / PATIENT DETAILS

1	Name of the Patient:	
2	Relationship with the Employee / Proposer ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Others _____	
3	Date of Birth of Claimant: _____ Age _____ Years Gender ☐ Male ☐ Female	
4	Residential Address	

CLAIM DETAILS

Total Claimed Amount: ₹							

Claimed Amount in Words: Rupees (₹)_____

1. Diagnosis _____	Enclosure Check List :
2. Admission Date: _____ __Discharge Date : _____	1. Original Discharge Summary containing all relevant details
3. Name of Treating Doctor: _____	2. All Original Bills and their Receipts
4. Mobile No. of Treating Doctor: _____	3. Copies of all Reports & prescriptions
5. Name of Family Physician: _____	4. First Prescription / Consultation Letter from your Doctor.
6. Mobile No. of Family Physician: _____	5. Original Money Receipt duly signed with a Revenue Stamp.
	6. Copy of Proposer/Employee Photo ID Proof & Address Proof

CONSENT REQUIREMENT FOR ACCESS TO TREATMENT PAPERS / INDOOR CASE SHEETS / MEDICAL RECORDS / INVESTIGATOR VISIT

I hereby authorize Future Generali India Insurance or any agency / individual authorized by them to obtain copies or review in person all my medical records including but not limited to admission notes, treatment sheets, indoor case papers, investigation reports, prescriptions and all other documents present in the hospital case file. Details related to my past hospitalisations in your hospital can also be provided / shown to Future Generali or its authorized representatives. I agree that all information provided above by me in the claim documents is true and that if I have provided any false or untrue information, my right to claim the reimbursement of expenses shall be absolutely forfeited.

Name of Patient / Relative: _____

Relationship with Patient: _____

Signature of Patient / Relative: _____

Date: DD_/_MM_/_YYYY

Please attach this form in Original to the hospital bill and other claim documents. Separate claim form required for each claim. PLEASE ENCLOSE A PHOTOCOPY OF THE FUTURE GENERALI HEALTH ID CARD.

AUTHORIZATION FOR TRANSFER OF CLAIM AMOUNT BY NATIONAL ELECTRONIC FUND TRANSFER

Name as per Bank Account														
Bank Name														
Branch Name & Address														
Branch Phone No.														
Branch MICR Code														
Branch IFSC Code for NEFT														
(Please attach a Photocopy of a cheque or a blank cheque of your bank duly cancelled for ensuring accuracy of the bank name, branch name, account number & name of account holder printed)														
Account Type (Please Tick)	Savings			Current			Cash / Credit							
Account No. (as appearing in Cheque Book)														
HR Authorization & Stamp					Bank Authorization & Stamp									

Date from which the mandate should be effective: _____

I hereby declare that the particulars given above are correct and complete and request you to remit any amount due to me, if any to the aforesaid bank account. I herewith further declare that if any transaction is delayed or not effected at all or is wrongly credited to any other account for reasons of incomplete or incorrect information as provided above, I shall not hold Future Generali India Insurance Company Ltd ("Company") or any of its directors, employees or agents responsible for the same. I also declare that the remittance of any dues to the aforesaid bank account shall be considered as full and valid discharge of its obligations by the company. I also undertake to advise any change in the particulars of my bank account to facilitate updation of records for the purpose of credit of any amount due, through NEFT.

Name of Employee / Proposer: _____ Signature of Employee / Proposer: _____

Policy No. _____ Claimant Name: _____ Date: _____

FEEDBACK AND SUGGESTIONS

We thank you for choosing Future Generali as your Insurance provider. We always strive to ensure that our service levels exceed our customer's expectations. In the spirit of this endeavour, we will greatly appreciate your valuable inputs and feedback. Kindly provide your feedback on your experience with Future Generali and any suggestions for improving our services. We value your time and promise to evaluate your suggestions for improvement of our service.