India Group Medical Insurance Handbook 2025-2026

(Applicable to Associates on the India Payroll of Cognizant and its affiliates)

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Disclaimer

For the purposes of this handbook, the term “Associate” refers exclusively to individuals who are on the India payroll of Cognizant India Pvt. Ltd. (“Cognizant”) and its affiliates. This includes Associates across all grades, whether they are working from a Cognizant office, a client site, or remotely.

Introduction & purpose

Welcome to the Cognizant Group Medical Insurance Handbook for India. This handbook is designed to help Associates understand, access, and make the most of their medical insurance benefits.

This handbook provides clear, practical information about India medical insurance coverage, including who is eligible, what is covered, terms and conditions, and how to make claims. It aims to empower the Associate and their family to confidently navigate their health benefits and make informed decisions about their care.

Scope

The policy applies to all Associates on the payrolls of Cognizant India, its affiliates and subsidiaries. Coverage extends to enrolled dependents as defined in the policy, ensuring protection for Associates and their loved ones during medical events in India.

Policy administration

Cognizant's group medical insurance policy is administered through:

- Primary Insurer: The New India Assurance Company Limited (NIA)
- Third Party Administrator (TPA): Medi Assist Insurance TPA Private Limited (Medi Assist). A registered body engaged by the Primary Insurer for processing claims.

Annual enrollment

Associates must declare or nominate their dependents every year during the open enrollment window. There is no option for auto carry forward of dependents from previous years. It is important to review and update their dependent details annually to ensure continued coverage.

Why this handbook matters

Healthcare needs can arise unexpectedly. This handbook is Associates' go-to resource for understanding their entitlements, the process for accessing care, and the steps to take in case of hospitalization or medical emergencies. It also outlines important contacts, and where to find further support. The handbook will be updated annually to reflect any changes in coverage, process, or regulatory requirements. We've also created a Guide that summarizes what matters most in plain language, with easy navigation by role or need. For quick highlights and role-based benefit overviews, please refer to the Guide.

Associate feedback

We are committed to making this handbook as clear and helpful as possible. If Associates' have suggestions for improvement, please reach out to the HR Benefits team.

Key terms and definitions

- **Policy Year**
  A period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period.

- **Policy period:**
  Means period of one policy year. The policy period is from November 01, 2025 – October 31, 2026.
- **Enrollment window:**
  This period allows Associates to enroll dependents. Existing Associates can modify or add dependents during this time. New joiners can enroll their dependents in the policy upon joining.
- **Midterm:**
  The period between the policy start date and the policy end date.
- **Sum insured:**
  Sum Insured (Family floater basis) represents the maximum amount payable by the Insurer in respect of all claims made by one or more Insured Persons of an Associate's family during the Policy Period.
- **Coverage:**
  The extent of the sum insured provided under this policy.
- **Base policy (GMC):**
  The Base policy covers the Associate and allows the option of enrollment of up to a maximum of three (3) dependents. This policy is sponsored by Cognizant.
- **AMC (Additional Member Cover) policy:**
  Associate can add two (2) additional dependents limited to biological children, parents, parents-in-law, siblings (Differently abled dependent sibling or unmarried sister) by paying additional premium.
- **Top-up policy:**
  Associate can enhance coverage for Base cover or Base and AMC cover by paying additional premium. Top-up cover means additional Sum Insured on a floater basis available for an individual Insured/family, which can be utilised once the Base or AMC Sum Insured is exhausted. Top Up sum insured is issued as a separate policy which follows the Base and/or AMC policy terms.
- **Definition of Eligible Dependents:**
  - **Parents**: biological parents (as per regulatory guidelines), excluding stepparents and in-laws.
  - **Children**: refers to a biological or legally adopted child, unmarried, financially reliant on the insured (associate), and does not have an independent source of income. The child must be under the age of 25 to qualify as a dependent.
  - **Spouse**: legally married, not under the purview of child marriage guidelines (minimum age limit of 21 years).
  - **Differently abled dependent sibling**: brother or sister with a physical or mental disability who relies on the Associate for financial and daily support.
- **Co-pay:**
  Refers to the portion of claim that must be borne by the Associate. Co-pay shall be applicable to every admissible claim. However, no co-payment shall be applicable for Associates in cases of hospitalisation due to a workplace accident, critical illness & ailments which are capped specifically under the policy.

- **Room rent:**
  Refers to the amount charged by a hospital for bed occupancy on a per day (24 hours) basis and includes related medical expenses, such as boarding and nursing.
- **Proportionate deduction:**
  Proportionate deduction refers to the reduction in the claim amount Associates must bear if they choose a room that exceeds the eligible room rent limit, as many hospital expenses are linked to room rent.
- **Loss of pay (LOP):**
  Payment made by insurer in lieu of loss of salary with respect to any critical illness as defined in the policy.
- **Maternity expenses:**
  Expenses that are traceable to childbirth or lawful termination of pregnancy.
- **Medi Assist portal:**
  Is a web application for managing medical insurance benefits. Accessible via the One Cognizant portal, it enables seamless enrollment of dependents, guided plan selection, instant e-card access, and transparent claim tracking. Associates can locate network hospitals, estimate treatment costs, upload reimbursement documents with ease and book appointments for Master health checkup.
- **MAven app**
  Is the mobile version of the Medi Assist portal, designed to help Cognizant Associates manage their medical insurance benefits anytime, anywhere. Available on both the App Store and Play Store (search for *MAven Medi Assist*), it offers the same core functionalities as the web portal.
- **Accident:**
  A sudden, unforeseen and involuntary event caused by external, visible and violent means.
- **Age:**
  Means age of the Insured person on last birthday as on date of commencement of the policy.
- **Any one illness:**
  Means continuous period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital where treatment may have been taken.
- **Ayush treatment:**
  Refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.
- **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-authorisation approved.
- **Congenital anomaly:**
  Refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
  - **Congenital internal anomaly:**
    Means a Congenital Anomaly which is not in the visible and accessible parts of the body.
  - **Congenital external anomaly:**
    Means a Congenital Anomaly which is in the visible and accessible parts of the body.

- **AYUSH hospital:**
  A Healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:
  - Central or State Government AYUSH Hospital or
  - Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
  - AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criteria:
    - Having at least 5 in-patient beds;
    - Having qualified AYUSH Medical Practitioner in charge round the clock;
    - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
    - Maintaining daily records of the patients and making them accessible to the insurance company's authorised representative.
- **AYUSH day care centre:**
  Means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:
  - Having qualified registered AYUSH Medical Practitioner(s) in charge;
  - Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
  - Maintaining daily records of the patients and making them accessible to the insurance company's authorised representative.
- **Day care centre:**
  A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:
  - Has qualified nursing staff under its employment;
  - Has qualified medical practitioner/s in charge;
  - Has a fully equipped operation theatre of its own where surgical procedures are carried out;
  - Maintains daily records of patients and will make these accessible to the insurance company's authorised personnel.
- **Day care treatment:**
  Refers to medical treatment or Surgery which are:
  - Undertaken under General or Local Anaesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and

- Which would have otherwise required a hospitalisation of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.

- **Dental treatment:**
  Treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery / implants.
- **Disclosure to information norm:**
  The coverage shall be void and all premiums paid thereon shall be forfeited, in the event of misrepresentation, misdescription or non-disclosure of any material fact.
- **Emergency care:**
  Means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the Insured Person's health.
- **Floater benefit:**
  Means the Sum Insured as specified for a particular Insured and the members of their family as covered under the policy and is available for any or all the members of their family for one or more claims during the tenure of the policy.
- **Hospital:**
  Means any institution established for Inpatient Care and Day Care treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1) of the said act OR complies with all minimum criteria as under:
  - Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
  - Has qualified nursing staff under its employment round the clock;
  - Has qualified medical practitioner (s) in charge round the clock;
  - Has a fully equipped operation theatre of its own where surgical procedures are carried out
  - Maintains daily records of patients and will make these accessible to the Insurance company's authorised personnel.

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

- **Hospitalisation:**
  Means admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours. (As per Annexure – II)
- **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.

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- **Injury:**
  Means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which are verified and certified by a Medical Practitioner.
- **Acute condition:**
  Means a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to their state of health immediately before suffering the disease / Illness / Injury which leads to full recovery.
- **Chronic condition:**
  Means a disease, Illness, or Injury that has one or more of the following characteristics:
  - It needs ongoing or long-term monitoring through consultations, examinations, checkups, and / or tests
  - It needs ongoing or long-term control or relief of symptoms
  - It requires rehabilitation for the patient or for the patient to be specially trained to cope with it
  - It continues indefinitely
  - It recurs or is likely to recur
- **Inpatient care (IPD):**
  Means treatment for which the Insured person has to stay in a Hospital for more than 24 hours for a covered event.
- **Intensive care unit (ICU):**
  Means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
- **ICU charges:**
  Means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.
- **Medical advice:**
  Any consultation or advice from a medical practitioner including the issue of any prescription or repeat prescription.
- **Medical expenses:**
  Means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Injury on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.
- **Medically necessary treatment:**
  Any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:
  - Is required for the medical management of the Illness or Injury suffered by the insured;
  - Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity.
  - Must have been prescribed by a medical practitioner.

- Must confirm to the professional standards widely accepted in international medical practice or by the medical community in India.

- **Medical practitioner:**
  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 their license.

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

- **Network hospital:**
  Means Hospitals enlisted by the Insurer, TPA or jointly by the Insurer and TPA to provide medical services to an Insured by a cashless facility.
- **Non-network hospital:**
  Refers to any hospital not included in the network hospital list.
- **Last working Day (LWD**)
  Refers to the final date on which an Associate is considered active on Cognizant's payroll.
- **Notification of Claim:**
  Means the process of intimating a claim to the Insurer or TPA through any of the recognized modes of communication.
- **Pre-hospitalisation medical expenses:**
  Mean Medical Expenses incurred during the period preceding the Insured Person is Hospitalised, provided that:
  - Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
  - The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.
- **Post-hospitalisation medical expenses:**
  Mean Medical Expenses incurred during the period immediately after the Insured Person is discharged from the hospital provided that:
  - Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
  - The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the insurance company.

- **Preferred provider network (PPN):**
  Means network providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for Our policyholders. The list of planned procedures is available with Insurer / TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.
- **Qualified nurse:**
  Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
- **Reasonable and Customary Charges:**
  Mean 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.

- **Sub-limit:**
  Means a cost sharing requirement under this policy in which Insurer would not be liable to pay any amount in excess of the pre-defined limit.
- **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.
- **Ailment Capping:**
  Capping for specific ailments as defined in the Table of coverages.

Eligibility & enrollment

This section details who is eligible for coverage under the Policy and how and when enrollments or changes can be made, including midterm processes.

Eligibility

- **Eligible Associates:**
  - Associates hired in India and currently in India.
  - Associates hired at an onsite geography, upon travelling to India and joining India payroll as specified in the assignment letter or associated benefits statement.

- **Eligible dependents:**
  (For detailed definitions of dependents, refer to the 'Key Terms and Definitions' section.)
  - Spouse (minimum 21 years)
  - Parents (biological parents)
  - Children (Biological child or legally adopted child) below 25 years.
  - Parents-in-law
  - Differently abled dependent sibling
  - Unmarried sister

Enrollment

- **Associates hired in India and currently in India**
  - Associates can enroll eligible dependents in the Group Medical Insurance Policy at the time of joining Cognizant.
  - At the time of joining or during the annual enrollment window, Associates may also opt and pay for Additional Member Cover (AMC), Top-up cover
  - Changes to dependent details (additions or updates) are permitted **only** during the annual Enrollment window, including those returning from onsite assignments.
  - If an Associate has an active claim registration during the enrollment window—whether as a new joiner or an existing employee—they will not be able to modify the Top-up benefit.
- **Associates hired at an onsite geography, upon travelling to India**
  - Associates hired in an onsite geography and subsequently transferred to India employment become eligible for coverage upon joining the India payroll.

- Within 14 days of arrival in India, Associates may add or update dependent details under the Base Policy—this option is available only once during the Policy Period.
- Coverage under the Base Policy for self and enrolled dependents will remain valid until the end of the Policy Period or until the Associate's stay in India ends, whichever is earlier.
- AMC with or without Top-up cover, if purchased, will remain valid for India-based dependents until the end of the Policy Period even if the Associate returns to their home country within the same period.
- If there is an active claim registration during or prior to the enrollment window after traveling to India, the Associate will not be able to modify the Top-up benefit.

- **Midterm enrollment process:**

  Associates on the India payroll may update dependent details only at the time of joining or during the annual enrollment window. However, midterm inclusion is permitted in the following cases:

  - Newly Wedded Spouse
  - Newborn Child

  Process for Midterm Inclusion

  - Newly Wedded Spouse: Associates may add their spouse to the Base Policy within 45 days of marriage by raising a request via 1C AI Assistant or by emailing Medi Assist at ctsenrollment@mediassist.in.
  - Newborn Child: Associates may add their newborn child within 45 days of birth by raising a request via 1C AI Assistant or by emailing Medi Assist at ctsenrollment@mediassist.in, subject to availability of vacant slots in the Base or AMC policy. If no slots are available, one existing dependent (who has not made any claim during the current Policy Period) may be replaced in the Base Policy.
  - Under the AMC Policy, no changes to existing dependents are allowed midterm.

Coverage overview

The policy provides coverage for hospitalisation expenses, with an active line of treatment which fulfils a minimum requirement of 24 hours of hospitalisation, with time limit waiver for certain ailments (Day Care Treatments). Associates and their dependents are covered through a family floater coverage in the Base policy which is sponsored by Cognizant. Coverage is provided for new-born from the date of birth. Pre-Existing conditions are covered under the policy from day one of joining Cognizant. Associates can also avail Additional Member Cover (AMC) and/or Top-up cover based on their needs by paying premium.

Base policy

- **Eligible Dependents under Base Policy**:
  - Associates can enroll a maximum of three dependents, that includes:
    - Spouse
    - Parents
    - Children

    Notes:
    - Foster parents are not eligible for coverage.

- Adopted children can be enrolled into the policy within 45 days, once the legal adoption certificate is received.
- For detailed definition of dependents mentioned above, please see the 'Key Terms and Definitions' section.

- **Sum insured and room rent table:**

Designation	Base policy Sum insured (INR)	Maximum room rent per day (including nursing charges)	ICU room rent per day
Upto Associate	250,000	INR 7000	On Actuals
Sr. Associate & Manager	300,000	INR 7000	On Actuals
Sr. Manger and above	500,000	INR 7000	On Actuals

Note: The sum insured will remain unchanged throughout the policy period, irrespective of any promotion. Adjustments, if any, will only be made during the annual policy renewal.

Expenses covered:

- Professional fees of surgeon, Anesthetist, Medical Practitioner, Consultant, Specialist Fees
- Anaesthesia, Blood, Oxygen, Operating Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic Materials and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
- Cost of Pharmacy, Cost of Implants and Pacemaker and Cost of Diagnostics.
- Pre-hospitalisation medical charges: Up to 30 days period.
- Post-hospitalisation medical charges: Up to 60 days period.

AMC policy (Additional Member Cover)

- **Eligible dependents under AMC policy:**
  - Associates can enroll a maximum of two (2) dependents, that include:
    - Parents (as per regulatory guidelines)
    - Parents-in-law (as per regulatory guidelines)
    - Children
    - Differently abled dependent sibling
    - Unmarried sister

    Notes:
    - Foster parents are not eligible for coverage.
    - A maximum of three (3) children can be added to the Base and AMC policy.
    - Adopted children can be enrolled into the policy within 45 days once the legal adoption certificate is received.
    - Associates cannot enroll same member in both Base and AMC policy.
    - For detailed definitions of parents and children mentioned above, please see the 'Key terms and definitions' section.

- **Additional member cover (AMC) policy details**

  Associates can at the time of joining Cognizant or during the Enrollment window, may opt for an Additional Member Cover.
  - The premium for AMC must be paid by the Associate.
  - Upon opting for AMC, the Associate may choose to include a maximum of two (2) additional dependents into the policy.
  - Associates may add a newborn baby within 45 days from the date of birth, subject to availability of vacant slots. No other changes can be made to the AMC enrollment Midterm.
  - Any claim pertaining to the new member prior to enrollment / premium payment will not be admissible.

- **AMC Sum Insured options and Premium Table (per member, by age band in INR):**

AMC Sum insured (INR)	0-35	36-45	46-55	56-65	66-70	71-75	76-80	Above 80
100,000	4,963.32	5,686.66	8,590.64	18,022.38	20,199.48	23,105.82	24,554.86	27,021.06
200,000	7,769.36	8,650.82	13,059.30	29,815.30	33,343.50	37,749.62	40,399.90	44,453.20
300,000	10,001.92	10,927.04	17,411.14	37,788.56	42,415.34	48,897.08	51,675.98	56,858.54
400,000	13,133.64	14,081.18	23,659.24	48,843.98	55,022.46	64,566.30	67,398.30	74,153.80
500,000	17,454.80	18,366.94	32,522.22	63,878.36	72,211.52	86,239.36	88,925.04	97,834.04

  The premium for AMC, as indicated in the table above, includes GST. This amount is subject to revision in accordance with any changes in applicable GST rates.

- **AMC room rent and ICU limits:**

AMC Sum insured (INR)	Maximum room rent per day (including nursing charges)	ICU room rent per day
100,000	INR 4,000	On Actuals
200,000	INR 4,000	On Actuals
300,000	INR 6,000	On Actuals
400,000	INR 6,000	On Actuals
500,000	INR 6,000	On Actuals

Top-up policy

The Top-up policy allows the Associate to increase the sum insured under the Base policy as well as AMC policy. Associates can opt for Top-up at the time of joining Cognizant or during the Enrollment window.

- Top-up for AMC policy will be applicable only when the sum insured opted under AMC is INR 300,000 or above. Associates who have availed AMC with a sum insured of INR 100,000 or 200,000 are not eligible to top-up the AMC policy.
- The premium for Top-up policy must be paid by the Associate.
- Room rent is capped as per the policy (Base or AMC) of the member. Associates opting for a higher category of room will have to bear the room rent difference as well as the proportionate expenses. This will apply to both cashless and reimbursement claims. Maximum deduction under proportionate charges is limited to 10% for Base, AMC on claim admissible amount including Top-up policies as applicable.
- No changes can be made to the Top-up policy during the Midterm including increasing / decreasing the Top-up sum insured.
- There are twelve coverage options to choose from, and the premium rates below are effective November 01, 2025.

Top-up policy premium table:

#	Top-up Sum insured (INR)	Premium (INR) Base Policy Only	Premium (INR) Base + AMC Policy
1	100,000	5,580.22	7,811.60
2	200,000	6,974.98	9,765.68
3	300,000	9,765.68	12,556.38
4	400,000	12,669.66	15,993.72
5	500,000	19,514.84	24,289.12
6	600,000	25,464.40	30,559.64
7	700,000	30,559.64	34,376.94
8	800,000	34,924.46	39,286.92
9	900,000	42,092.96	47,354.58
10	1,000,000	46,774.02	52,617.38
11	1,500,000	79,750.30	89,713.04
12	2,000,000	1,06,335.70	1,19,616.60

The premium for Top-up policy, as indicated in the table above, includes GST charges. This amount is subject to revision in accordance with any changes in applicable GST rates.

The AMC policy and the Top-up policy, if selected, will expire at the end of each policy period. Associates are required to renew and pay for AMC and Top-up benefits annually during the enrollment window via the Medi Assist app if they wish to continue their coverage for the following year.

Validity of AMC & top-up covers:

Category	AMC validity period	Top-up validity period
Associates hired in India and currently in India	Active on India Payroll: Valid till the end of the Policy Period. Separation: Valid till the Last Working Day (LWD). Travel on global assignment: Till the end of the Policy Period.	Active on India Payroll: Valid till the end of the Policy Period. Separation: Valid till the LWD. Travel on global assignment: Till the end of the Policy Period.
Onsite hires on assignment in India at the time of renewal or during the Policy Period	Active on India Payroll: Valid till the end of the Policy Period. Separation: Valid till the LWD. Travel back to parent location or other countries: Till the end of the Policy Period.	Active on India Payroll: Valid till the end of the Policy Period. Separation: Valid till the LWD. Travel back to parent or other countries: Till their stay in India Payroll.

Co-pay

- A Co-pay of 10% shall be applicable on the admissible claim amount for the hospitalisation (including Pre and Post Hospitalisation) of the Associate, spouse and children
- A Co-pay of 15% shall be applicable on the admissible claim amount for the hospitalisation (including Pre and Post Hospitalisation) of the Associates' dependent parents, parents-in-law and siblings
- No Co-pay for hospitalisation resulting in death of the Associate.
- No Co-pay for hospitalisation due to critical illness for Associate only.

Claimant	Applicable Co-pay	Illustrative claim amount	Co-pay Calculation	Co-pay
Associate, Spouse, Children	10% of the admissible claim amount	INR 90,000	INR (10% x (90,000))	INR 9,000
Parents, Parents-in-law, Siblings	15% of the admissible claim amount	INR 90,000	INR (15% x (90,000))	INR 13,500

Proportionate Deductions

- Room rent is capped as per the policy (Base or AMC) of the member. If an Associate opts for a room category exceeding the cap, they must bear the room rent difference and proportionate expenses on all other charges. This applies to both cashless and reimbursement claims

- Proportionate deductions apply to charges for the surgeon, assistant surgeon, operation theater, anesthetist, investigations, and any other charges that may vary as per room category.
- The maximum deduction under proportionate charges is limited to 10% of the admissible claim amount across Base, AMC, and Top-up policies.
- Proportionate deductions are calculated using the weighted average method

Pre & post hospitalization expenses

These are medical expenses that are incidental to hospitalisation. Pre-hospitalisation expenses refer to the expenses that are incurred for a period of 30 days before the date of hospitalisation and post hospitalisation expenses refer to the expenses incurred for a period of 60 days from the date of discharge.

- For example, while expenses incurred on a routine (medical) scan are not covered under the policy, expenses incurred on such scans leading to the diagnosis of an included ailment and to subsequent hospitalisation for its treatment, will be covered.
- While routine consultation fee paid to the medical practitioner is not covered under the policy, should such consultation result in the diagnosis of an included ailment and to subsequent hospitalisation for its treatment, the expenses incurred will be covered.

In simple terms, any medical expenses incurred 30 days before the hospitalisation which is related to the ailment diagnosed will be covered under pre-hospitalisation. Similarly, after discharge any medical expenses incurred for 60 days will be covered as post hospitalisation expenses.

Table of coverages

Pre-Existing Disease	Waived
Specific waiting period	Waived.
First 30 days waiting period	Waived.
Maternity Benefit	Normal delivery - INR 50,000. Caesarean Section - INR 75,000. Applicable for treatments of Associates and spouses in the Base policy. Maternity benefit with baby expenses covered within maternity limit. No cap for Maternity complications leading to life threating condition. Max of two living children covered. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization), except ectopic pregnancy. Covers expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period
9 month waiting period for maternity	Waived.
Pre- and post-natal expenses	Covered within Maternity Sub-limit. Not covered unless admitted in Hospital and treatment is taken there.
Newborn baby cover	Newborn Baby covered as a separate life covered for full Sum Insured.

Co-pay	Co-payment of 10% will be applicable on the admissible claim amount for Associates, Spouses and Dependent Children only. Co-payment of 15% will be applicable on the admissible claim amount for all other members covered under the policy. No Co-pay for ailments which are capped specifically under the policy. No Co-pay applicable for Associates for hospitalization due to workplace accident & Critical illness.
Ambulance charges	1% of the Base policy Sum insured or actual, whichever is lower, subject to a maximum of INR 2,000, per person per Hospitalization.
Pre-hospitalization expenses	Covered upto 30 days prior to hospitalization.
Post hospitalization expenses	Covered upto 60 days post hospitalization.
Lasik power correction	Covered for eye power > = +/- 5. Admissible only if either cylindrical or spherical power is ±5 (not combined). For AMC dependents, covered for eye power > = +/- 7.5
Cyber knife Treatment / Stem Cell Transplantation	50% Co-pay applicable.
Total Knee Replacement treatment	Maximum of INR 2,00,000 per knee and INR 3,00,000 per bilateral replacement (both knees) in a single Hospitalization
Cancer Benefit	If an Associate is diagnosed with cancer and the claim is admissible under this policy, INR 1,00,000 will be paid as Cancer Benefit in addition to the admissible claim amount.
Hysterectomy treatments	INR 75,000 per claim.
Cochlear Implant	Covered up to 50% of Base policy Sum Insured.
Ayurvedic Treatment	Covered if treatment for illness or injury is taken in a government hospital or any institute recognized by the government.
Day Care procedures	Covered for the procedures as per Annexure II and any inpatient treatments that do not require 24-hour hospitalization due to technological advancements.
Loss of Pay (Only under Base policy for Associate)	Weekly compensation of INR 10,000 while the Associate is on Loss of Pay, up to a maximum of INR 5,00,000 till the end of the policy period.
Treatment of infertility	Maximum of INR 40,000 for Associate or spouse if there are no living children. Cost must be incurred in a hospital; 24-hour clause does not apply. Once utilized, no payment will be made in subsequent years for that Associate and spouse. If both Associate and spouse are employed at Cognizant, expenses can be claimed separately up to the total limit..
Proportionate Clause	Maximum deduction restricted to 10% for Base, AMC, and Top-up policies.

Cataract Surgery	Limit of liability for payment of any claim relating to Cataract shall not exceed INR 35,000 for each eye.
Outpatient expenses for children with disability	Outpatient Expenses for Children with Disability: Maximum INR 5,000 per child per year, regardless of date of birth. This is additional to Base Policy Sum Insured.
Air ambulance cover	Maximum INR 1,00,000 per incident. Applicable only in emergencies for critical ailments listed in the policy and where no hospitals are available within 75 km. This is in addition to Base Policy Sum Insured.
OPD expenses for suspected head / skull injury (Only under Base Plan for Associate)	Expenses incurred for any suspected head / skull injury needing imaging tests such as CT scan and MRI or any tests undertaken for the injury will be paid up to INR 5000 per case only for Associates. Applicable only for Trauma cases of OPD and not for tests taken at time of hospitalization. This payment is within Sum Insured.
No deduction for any hospitalization resulting in death of Associate	For any hospitalization resulting in death of Associate, no deduction shall apply which are normally applied otherwise. However maximum amount payable will be Sum Insured limit. This clause will apply only when the death of the Associate is due to an admissible claim.
Cost of drugs for Associate suffering from Tuberculosis.	Reimbursed up to INR 7000 per Associate. Applicable only for Associates. This is additional to Sum Insured
Bariatric surgery	Covered only for Associates with BMI exceeding 35
Critical Illness Benefit (excluding cancer) (Only under Base Plan for Associate)	INR 25,000 paid as a one-time benefit for Associates diagnosed with a critical illness for the first time during the policy period. Paid as a reimbursement claim upon discharge, once the first critical illness claim is settled under the policy.
Oral Chemotherapy	Covered up to 50% of the Base policy Sum insured for Associates and 10% of the Base/AMC policy Sum insured for Dependents. The list of admissible drugs & their regimen as per the annexure (Available in the policy clause).
Genetic Disorder	Covered unto the available Sum insured including Top-up policy. Applicable for all members.
Diseases directly linked to excess smoking and alcohol consumption	Covered upto the available Sum insured including Top-up policy. Applicable only for Associates.
Cover for LGBT	Applicable for Associate and their partner.
Gender realignment surgery	Covered up to sub-limits mentioned in the Gender Transition Benefits section. Applicable only to Associates.
Coverage For Deceased Associate's Dependents	In case of Associate's demise during the policy period, dependents will remain covered until policy expiry. Only cashless claims allowed. Only newborn baby can be added for the deceased Associate during the policy period.
Failure Suicidal Attempt	Covered only for Associates.

Psychiatric Ailments	Only inpatient treatment covered. Applicable only for Associates. For Dependents – Limit restricted to 25% of Base policy Sum insured
Impairment of Intellectual Faculties	Limit restricted to 5% of Base policy Sum insured, maximum INR 25,000 per policy period, when arising during treatment for a covered illness under an admissible claim.
Artificial Life Maintenance	Limit restricted to 10% of Base policy Sum Insured, maximum 15 days per policy period, for life support in case of a vegetative state certified by the treating doctor. Expenses must relate to an admissible claim
Puberty & Menopause Disorders	Covered only on IPD basis with a sub-limit of 25% of Base policy Sum Insured.
Behavioral & Neuro Developmental Disorders	Covered only on IPD basis with a sub-limit of 25% of Base policy Sum Insured.
Palliative Chemotherapy	Applicable to all members (Associates & Dependents) For Associates - Covered up to Base policy Sum Insured. For Dependents – Limit restricted to 50% of available balance Base policy Sum Insured. Top Up policy if any will not be considered for Palliative Chemo.
Midterm inclusion of Associate's dependents	Allowed only for newlywed spouses, and newborns.
Basis of premium computation for midterm additions & deletions.	Pro rata basis.
Age limit	No Age Limit restriction. However minimum age of a spouse shall not be less than 21 years.
Congenital Internal Diseases	Covered.
Congenital External Diseases	Covered. The list of congenital external ailments which are covered under the policy is as per the list attached.
Special Coverage for SAARS - COVID 19 Swine flu H1N1	Domiciliary and outpatient treatment including home quarantine for COVID-19 positive cases Limit: Up to INR 25,000per event AYUSH Treatment: Covered if referred by government authorities or authorized doctors. Maximum limit: INR 25,000 per case Non-Medical Expenses: Payable up to a maximum of INR 1,00,000 per claim or INR 2,00,000 per family. Applicable for Base / Base + AMC policies
General Health Checkup	Cognizant-sponsored Master Health Checkup (MHC) for Associates available once per policy year. List of age, gender-specific tests included in the MHC package is available on the Medi Assist portal → All Services → Wellness → Master Health checkup, or scroll down to "Explore the wellness section" on the home page. Dependents can avail the age, gender-specific package at discounted rates.

Sub-limit & policy clause

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

- No payment shall be made under policy other than as part of the hospitalization bill.
- However, the bills raised by the Surgeon, Anesthetist directly and not included in the hospitalization bill may be reimbursed in the following manner:
  - The reasonable, customary and Medically Necessary Surgeon fee and Anesthetist fee would be reimbursed. The payment shall be reimbursed provided the insured pays such fee(s) through cheque and the Surgeon / Anesthetist provides a numbered bill. Bills given on letterhead of the Surgeon, Anesthetist would not be entertained.

(Note: Insurer's liability in respect of all claims admitted during the Policy Period shall not exceed the Sum Insured on a Floater basis, the limit shall apply to the Floater Sum Insured and not to per person.)

- **Limit on payment for cataract:** insurer's liability for payment of any claim relating to Cataract shall be limited to Actual or maximum of INR 35,000 (inclusive of all charges), for each eye, whichever is less. (Irrespective of any lens either unifocal or multifocal).
- **Ayush**: Expenses incurred for Ayurvedic / Homeopathic / Unani Treatment are admissible up to 100% of the sum insured provided the treatment for Illness and accidental injuries, is taken in AYUSH Hospital (Government Hospital or in any institute recognized by Government and /or accredited by Quality Council Of India / National Accreditation Board on Health, excluding centers for spas, massage and health rejuvenation procedures).
- **Ambulances services** – 1.0 % of the sum insured or actual, whichever is less, subject to maximum of INR 2,000 in case patient has to be shifted from residence to hospital for admission in Emergency Ward or ICU or from one Hospital to another Hospital by fully equipped ambulance for better medical facilities.
- **Hospitalization expenses** (excluding cost of organ) incurred on the donor during the course of organ transplant to the insured person. The Insurer's liability towards expenses incurred on the donor and the insured recipient shall not exceed the sum insured of the insured person receiving the organ.
- **Impairment of persons' intellectual faculties** by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Base policy Sum Insured, maximum upto INR 25,000 per policy period, subject to it arising during treatment of covered illness for an admissible claim. This amount shall be part of the Sum Insured.
- **Artificial life maintenance**, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Base policy Sum Insured and for a maximum of 15 days per policy period following admission for covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract). Such expenses shall be payable if required in conjunction to an admissible claim and shall be within the Sum insured

- **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders:** Insurer indemnify the Hospital, or the Insured the Medical Expenses (including Pre and Post Hospitalization Expenses) related to following and they are covered with a sub-limit up to 25% of Base policy Sum Insured per policy period.

  The below covers are subject to the patient simultaneously exhibiting the following traits and requiring Hospitalization as per the treating Psychiatrist's advice:

  - Major Depressive Disorder- when the patient is aggressive or violent.
  - Acute psychotic conditions – aggressive / violent behavior or hallucinations, incoherent talking or agitation.
  - Schizophrenia - esp. Psychotic episodes.
  - Bipolar disorder - manic phase.
  - Treatment of any Injury due to Suicidality shall not be covered.

  Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

  Any kind of psychological counselling, cognitive / family / group / behavior / palliative therapy or other kinds of psychotherapy for which Hospitalization is not necessary shall not be covered.

- **Puberty and menopause related disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure. This cover will have a sub-limit of up to 25% of Base policy Sum Insured per policy period.
- **Age related macular degeneration (ARMD):** coverage only for Intravitreal Injections and anti – VEGF medication. This cover will have a sub-limit of 10% of Base policy Sum Insured, maximum up to INR 75,000 per policy period. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.
- **Behavioral and neuro developmental disorders:** Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure. This cover will have a sub-limit of 25% of Sum Insured per policy period. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.
- **Maternity benefit**: The maximum benefit allowed under this policy will be up to INR 50,000 for normal delivery or INR 75,000 for caesarian section. No cap for Maternity complications leading to life threating condition and abdominal operation for extra uterine pregnancy (Ectopic/Tubular Pregnancy), which is proved by submission of ultra–Sonographic Report and certification by gynecologist that it is life threatening.
  - Special conditions applicable to Maternity expenses benefit extension: These Benefits are admissible only if the expenses are incurred in Hospital as inpatients in India.
  - Claim in respect of delivery for only first two children and / or surgeries associated therewith will be considered in respect of any one Insured Person covered under the Policy or any renewal thereof. Those Insured Persons who already have two or more living children will not be eligible for this benefit.
  - Expenses incurred in connection with voluntary medical termination of pregnancy during the first 12 weeks from the date of conception are not covered.

    - Pre-natal and post-natal expenses are not covered unless admitted in Hospital and treatment is taken there
    - Maternity Expenses can be claimed by both the associate and the spouse separately up to the total individual limit, if both are working in Cognizant. However, the Associates cannot duplicate expenses for the claim.
- **Infertility**: The coverage and limits as mentioned in the Table of coverages will be covered, subject to maximum of INR 40,000, for Associate or spouse if there are no living children. Cost needs to be incurred in a hospital, however 24-hour clause does not apply. Once utilized, there will be no payment in subsequent years for that Associate and spouse. If both Associate and spouse are working in Cognizant, expenses can be claimed under both the associate and spouse separately up to the total individual sub-limit.
- **Newborn baby:** "Newborn Baby" stands covered from day one, provided the Associate enrolls the child in the portal within 45 days from the date of birth.
- **Hysterectomy** - For Hysterectomy treatments there will be a cost cap of INR 75,000 per claim
- **Stem cell treatment:** Stem Cell Treatment is covered, subject to 50% Co-pay clause.
- **Lasik surgery:** Lasik surgery stands covered in the policy. Lasik Surgery covered for eye power >= (+/-) 5. Admissible only if the eye power is +/-5 for either cylindrical power or spherical power and not combined. For AMC dependents, Lasik surgery is admissible only if the eye power is +/-7.5
- **Terrorism:** "Injury arising out of terrorism" stands covered the policy.
- **Cyber knife surgery:** Cyber Knife surgery will be covered in the policy. The limits will be as mentioned in the Table of coverages, subject to 50% Co-pay clause.
- **Chemotherapy:** Cost of oral chemotherapy will be payable under the policy. Covered up to 50% of the Base policy Sum insured for Associates and 10% of the Base/AMC policy Sum insured for Dependents. The list of admissible drugs & their regimen will be as follows:
    - Altretamine
    - All trans retinoic acid (atra)
    - Busulfan
    - Bexarotene
    - Capacitabine
    - Cyclophosphamide
    - Chlorambucil
    - Etoposide
    - Hydroxyurea
    - Leucovorin
    - Lomustine
    - Melphalan
    - Mecaptopurine (6-mp)
    - Mesna
    - Methotrexate
    - Mitotane
    - Procarbazine
    - Temozolamide
    - Topotecan
    - Thioguanine (6-tg)
- **Palliative chemotherapy:**

Applicable for all members (Associate & Dependents)
  - For Associates- up-to full Sum insured
  - For Dependents - Limit restricted to 50% of available balance Base policy sum insured.
  - Top Up policy if any will not be considered for Palliative chemotherapy.
- **Genetic diseases or disorders**: Covered within the available balance sum insured. Covered for all member.
- **Congenital internal diseases:** Congenital internal diseases covered as per the policy terms.
- **Congenital external diseases:** Congenital external diseases will be covered in the policy. List of congenital external ailments which are covered under the policy :
- Congenital external diseases covered under Base/AMC and Top-up policy
  - Face, Neck & Head
    - Cleft Lip
    - Cleft Palate
    - Congenital Thyroid Cyst.
    - Obstructive Hydrocephalus.
  - ENT:
    - Microtia/Anotia
    - Cup & Bat Ears
  - Eye
    - Congenital Cataract
    - Ptosis
    - Entropion
    - Strabismus diagnosed within 3-6 months of birth
  - Genitourinary System
    - Testicular Torsion
    - Varicocele
    - Orchidopexy
    - Undescended Testis
    - Hypospadias (INR 50,000 maximum)
  - Orthopedics:
    - Crowe Grade III & IV of Congenital Hip Dysplasia
    - Congenital Kyphosis
    - Knee Dislocation
    - Congenital Talipes Equinovarus (Club Foot)
    - Congenital muscular torticollis
    - Pes Cavus
    - Syndactyly
    - Pectus excavatum
  - Neurological:
    - Spina Bifida
    - Meningocele
    - Craniosynostosis
  - Dermatological:
    - Hamartoma Excision
    - Hemangioma Excision

    - Congenital Dermal Sinus
- **Total knee replacement treatment**, subject to maximum of INR 2,00,000/- per knee and INR 3,00,000 per bilateral replacement (both knees) in single Hospitalization.
- **Cancer benefit**: If during the period of Insurance any Associate discovers that they are suffering from Cancer which results in a claim admissible under this Policy, INR 1,00,000 would be paid as Cancer Benefit along with the admissible claim amount. Cancer Benefit is payable only once in the lifetime of each Associate and is not applicable to those Associates for whom it is a Pre-Existing Disease. Any payment under this clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.

  Cancer for the purpose of Cancer Benefit shall mean the presence of one of the following malignant conditions:
  A malignant tumor, characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma & sarcoma:
  - Prostate tumor which are histologically described as TNM classification T1a or T1b or T1c are of another equivalent or lesser classification.
  - Chronic lymphocytic leukemia classified as RAI stage I or II
  - Basal cell and squamous carcinoma that has spread to distant organs.
  - Hodgkin's lymphoma.
  - Carcinoma in situ of breasts, ovary, colon rectum, penis, testis, lung liver stomach and esophagus urinary tract nasopharynx.

  The following conditions are excluded:

  - Any skin cancer other than invasive malignant melanoma.
  - Papillary micro-carcinoma of the thyroid less than 1 cm in diameter.
  - Chronic lymphocytic leukemia less than RAI stage 3.
  - Micro carcinoma of the bladder.
  - Cervical dysplasia.
  - All tumors in the presence of HIV infection.
- **Loss of pay (LOP) benefit:** If during the Policy period an Associate is discovered:
  - To have been suffering from any Critical Illness/ accident on or after the commencement of the insurance policy and
  - Has undergone a Hospitalisation thereafter during the policy period and
  - Has exhausted all leave to their credit as a result of such Critical Illness/ accident and
  - Is suffering from loss of pay

  then Insurer will pay weekly compensation of INR 10,000 as long the Associate is suffering from Loss of Pay but not exceeding INR Five Lakhs in respect of any Associate.

  The above benefit shall also be applicable to the Associate who has been suffering from critical illness/ accident & hospitalized thereafter before the currency of the policy and has exhausted all their leaves to their credit as a result of such critical illness/accidents and is suffering from loss of pay triggering on or after the commencement of the policy.

  Accidents for the purpose of Loss of Pay means 'any bodily injury resulting solely and directly from accident caused by external, violent and visible means that necessitates medical or

surgical intervention and that results in an Associate or associate totally disabled from engaging in any employment or occupation of any description for more than 3 weeks certified by a Medical Practitioner.

The following are the nature of critical injury admissible for LOP benefit.

Nature of injury	Admissibility for LOP claim
Burns	Only if the person become unconscious admitted in hospital or requires resuscitation.
Fracture	Fracture of Spine, head & Bone excl hairline, fracture to fingers, toes or broken nose.
Dislocation	Dislocation of Hip, Knee & Shoulder, elbow.
Amputation	Amputation excl loss of fleshy tip, nail or tooth of finger.
Other Injury	Crush injury, Eye injury resulting in either permanent or temporary loss of sight.
and any other cases to be agreed by Insurer.	

- **Critical illness benefit:** During the Policy period any Associate discovers for the first time that they are suffering from Critical Illness (excluding Cancer) as defined below, which results in a claim admissible under this Policy, INR 25,000 would be paid as Critical illness Benefit along with the admissible claim amount. Critical illness Benefit is payable only once in the lifetime of each Associate and is not applicable to those Associates for whom it is a pre-existing disease. Any payment under this clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.
- **Critical illness:** Critical Illness is defined (as per IRDA Guideline) as first-time occurrence of the following:
  - Cancer of specified severity
  - First heart attack of specified severity
  - Open Chest - CABG
  - Open heart replacement or repair of heart valves
  - Coma of specified severity
  - Kidney failure requiring regular dialysis
  - Stroke resulting in permanent symptoms
  - Major organ / Bone marrow transplant
  - Permanent paralysis of limbs
  - Motor neuron disease with permanent symptoms
  - Multiple sclerosis with persisting symptoms
  - Accident*

  *Accident means any bodily injury resulting solely and directly from accident, caused by external, violent and visible means that necessitates medical or surgical intervention or that results in disability, or disrupts engaging in any employment or occupation of any description for more than three weeks certified by a medical practitioner.

  Note: Accidents under the purview of workplace or notional extension of workplace will only be excluded for copay, rest all accidents will be subjected to copay as per the policy terms and conditions.

- **Accident benefit:** Expenses incurred for any suspected head / skull injury needing imaging tests such as CT scan and MRI or any tests undertaken for the injury will be paid upto INR 5000 per case only for Associates. Applicable only for Trauma cases and not for tests taken at time of hospitalization. This payment is within Sum Insured
- **Disability:** For children with disability, outpatient expenses subject to a maximum INR 5000 per child per year regardless of baby's date of birth will be paid. It is not necessary that the expense be related to the disability. This is additional to Sum Insured
- **Air ambulance:** cover in emergency cases not exceeding INR1,00,000 per incident. Only in case of emergency for critical ailments listed in the policy and where there are no hospitals in the vicinity of 75Kms. This is in addition to the Sum Insured.
- **Death:** For any hospitalization resulting in death of an Associate, no deduction shall apply which are normally applied otherwise. However, the maximum amount payable will be Sum Insured limit. This clause will apply only when the death of the Associate is due to an admissible claim.
- **Tuberculosis:** For Associates suffering from Tuberculosis, cost of drugs will be reimbursed upto INR 7000 per Associate. Applicable only for Associates. This is additional to Sum Insured.
- **Bariatric surgery:** with BMI exceeding 35 - applicable only for Associates.
- **Diseases directly linked to excess smoking and alcohol consumption:** Covered within the available balance sum insured. Coverage applicable only to Associates.
- **Gender realignment surgery:** Congenital internal Diseases will be covered in the policy within the available sub-limits mentioned below in the Gender transition benefits section. Coverage applicable only to Associates.
- **Gender transition benefits:**
    - Associates can declare their gender transition and will be eligible for medical benefits as per policy terms.
    - Base policy covers gender transition surgeries for the Associates (eligibility below):
        - Surgery for Hysterectomy (removal of uterus) covered up to INR 75,000
        - Surgery for Mastectomy (removal of breast) covered up to INR 75,000
        - Genital Surgery (Male to Female) covered up to INR 75,000
        - Hormonal Treatment forming part of the Pre and Post Hospitalization associated with any of the above surgeries will be covered and shall be capped at a maximum of INR 25,000.
    - All the above coverages are restricted to availability of sum insured under Base Policy. Top up cover availed, if any, will not be applicable for this benefit.
    - Associates may utilise their available leave balance for the surgeries specified above, subject to approval from the HCM supervisor.
    - Associates must furnish Self-Declaration and Notarized Affidavit for gender transition.
    - Associate can declare and cover same sex partner (domestic partner), with respect to coverage guidelines. Associates can write to HRBenefitsIndia@cognizant.com.
        - Medical coverage for same sex partner (domestic partner) will be based on their current gender orientation.
        - Associates should furnish the following documents:
            - Self-Declaration Form
            - ID proof of the domestic partner declared.

        - Proof of living at the same residential address (any of the below).
            - Governmental proofs like Voters ID, Driving License, Passport.
            - Proofs like rental / lease agreement/ utility bill.
            - Notarized Affidavit.
    - Any change to the domestic partner declaration during active Policy Period is restricted.
    - Medical coverage is limited to treatment taken in India where medical units are registered under Medical Association/National Accreditation Board for health & Health Care providers (NABH).

- **Covid coverage (SAARS - Covid 19 Swine flu H1N1):**
    - Domiciliary and outpatient treatment including home quarantine for COVID- 19 positive cases limit of/up to INR 25000 per case.
    - AYUSH treatment covered if referred by Govt. authorities or authorized doctors and to a maximum limit of INR 25000 per case.
    - Non-medical expenses payable to a max cap of INR 100,000 per claim or INR 200,000 per family.

Coverage for modern treatments or procedures

The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

#	Treatment or Procedure	Limit (Per Policy Period)
1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Up to 20% of Base policy Sum Insured subject to Maximum INR 2 Lakh
2	Balloon Sinuplasty.	Up to 20% of Base policy Sum Insured subject to Maximum INR 2 Lakh
3	Deep Brain stimulation.	Up to 50% of Base policy Sum Insured subject to Maximum INR 5 Lakh
4	Immunotherapy - Monoclonal Antibody to be given as injection.	For cancer-related claims: Coverage up to 100% of the Base/AMC and Top-up Sum Insured. For other claims: Coverage up to 25% of the Base/AMC Sum Insured, subject to a maximum of INR 2 lakh.
5	Intravitreal injections.	Up to 10% of Base/AMC and Top-up Sum Insured subject to Maximum INR 75,000.
6	Robotic surgeries.	Up to 50% of Base policy Sum Insured subject to Maximum INR 5 Lakh.
7	Stereotactic radio surgeries.	Up to 50% of Base policy Sum Insured subject to Maximum INR 3 Lakh.
8	Bronchial Thermoplasty.	Upto 50% of Base policy Sum Insured subject to Maximum INR 2.5 Lakh.
9	Vaporization of the prostrate (Green laser treatment or holmium laser treatment).	Up to 50% of Base policy Sum Insured subject to Maximum INR 2.5 Lakh.

10	IONM - (Intra Operative Neuro Monitoring).	Up to 10% of Base policy Sum Insured subject to Maximum INR 50,000.

Permanent exclusions under the policy

The insurer shall not be liable to make any payment under this policy in respect of any medical expenses incurred for or arising out of:

- **Investigation & evaluation:**
  - Expenses related to any admission primarily for diagnostics and evaluation purposes.
  - Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

  However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which etiology is unknown is not excluded. It is covered with a Sub-Limit of up to 10% of Sum Insured per policy period.
- **Rest cure, rehabilitation and respite care:** Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
  - Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
  - Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

  However, expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a maximum period of 14 days in a policy period.
- **Obesity/ weight control:** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
  - Surgery to be conducted is upon the advice of the Doctor
  - The surgery/Procedure conducted should be supported by clinical protocols
  - The member must be 18 years of age or older and
  - Body Mass Index (BMI);
    - greater than or equal to 40 or
    - greater than or equal to 35 in conjunction with any of the following severe comorbidities following failure of less invasive methods of weight loss:
    - Obesity-related cardiomyopathy
    - Coronary heart disease
    - Severe Sleep Apnea
    - Uncontrolled Type2 Diabetes
- **Gender re-alignment for dependents:** Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- **Cosmetic or plastic surgery:** Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

- **Hazardous or adventure sports:** Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
  However, Treatment related to Injury or Illness associated with Hazardous activities related to particular line of employment or occupation (not for recreational purpose) is not excluded.
- **Breach of law:** Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- **Excluded providers:** Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
- **Treatment:** for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
  Treatments received in health hydros, nature-cured clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.
- Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.
- **Refractive error:** Expenses related to the treatment for correction of eyesight due to refractive errors of less than +/- 5 diopters for Base policy and less than +/- 7.5 diopters under AMC policy.
- **Unproven treatments:** Expenses are related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- **Sterility:** Expenses related to sterility
  This includes:
  - Any type of contraception, sterilization
  - Reversal of sterilization
- **War:** (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

  Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

  - Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
  - Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

    - Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically
    - produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.
- **Circumcision:** unless required to treat Injury or Illness.
- **Vaccination & inoculation:** excluded from the policy
- **Vision & hearing aid:** expenses related eyeglasses, Cost of spectacles and contact lenses, hearing aids, durable medical equipment
- **Dental:** All types of Dental treatments excluded except arising out of an accident. Cost of braces, equipment or external prosthetic devices, non-durable implants
- Convalescence, general debility.
- **Bodily injury(Dependents):** sickness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted injury, attempted suicide.

  However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It covers a sub-limit of 10% of Sum Insured per policy period.

  Treatment of any bodily injury sustained whilst or as a result of participating in any criminal act.
- **Naturopathy treatment**
- **Instrument used in treatment** of Sleep Apnea Syndrome (C.P.A.P.) and continuous Peritoneal Ambulatory dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition.
- **Domiciliary Hospitalization**
- **Treatment taken outside India**
- **Treatment:** Change of treatment from one system to another unless recommended by the consultant / hospital under whom the treatment is taken.
- **Service charges** or any other charges levied by hospital, except registration/admission charges. Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

General conditions & guidelines

- **Premium payment:** The Base policy premium for this policy is paid by Cognizant. Any Top-Up and Additional Member Coverage (AMC) premiums are payable by the Associate and shall be paid in advance.
- **Waiver:** Waiver of period of intimation may be considered in extreme cases of hardships where it is proved to the satisfaction of the Insurer/TPA that under the circumstances in which the insured was placed it was not possible for them or any other person to give such notice or file claim within the prescribed time limit. This waiver cannot be claimed as a matter of right.
- **Physical examination:** Any medical practitioner authorized by the Insurer shall be allowed to examine the Insured Person in case of any alleged injury or Illness requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Insurer.

- The Insurer shall not be liable to make any payment under this policy in respect of any claim if such claim, be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on their behalf.
- **Multiple policies**:
    - In case of multiple policies taken by Insured Person during a period from the Company or one or more Insurers to indemnify treatment costs, Insured Person shall have the right to require a settlement of Insured Person's claim in terms of any of their policies. In all such cases the Company, if chosen by an Insured person, shall be obliged to settle the claim if the claim is within the limits of and according to the terms of this Policy.
    - Insured having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the Sum Insured is not exhausted. Then We shall independently settle the claim subject to the terms and conditions of this Policy.
    - If the amount to be claimed exceeds the Sum Insured under a single policy after, Insured Person shall have the right to choose Insurers from whom they want to claim the balance amount.
    - Where an Insured has policies from more than one Insurer to cover the same risk on an indemnity basis, the Insured shall only be indemnified the Hospitalization costs in accordance with the terms and conditions of the chosen policy.

  Note: The Insured Person must disclose other insurance at the time of making a claim under this Policy.
- **Cashless service through Medi Assist:** Claims in respect of Cashless access services will be through the agreed list of networks of hospitals and is subject to pre-admission authorization. Medi Assist shall, upon getting the related medical information from the Insured Person / network provider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the hospital mentioning the sum guaranteed as payable also the ailment for which the person is seeking to be admitted as a patient. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details as required by the TPA. The TPA will make it clear to the insured person that the denial of cashless access is in no way construed to be denial of treatment. The insured person may obtain the treatment as per their treating Medical Practitioners medical advice and later on submit the full claim papers to the TPA for reimbursement.
- **Fraud, misrepresentation, concealment:** The claim shall be null, and void and no benefits shall be payable in the event of misrepresentation, misdescription or nondisclosure of any material fact/particulars if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured person or by any other person acting on their behalf.
- **Medical expenses falling under two policy periods:** If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured of the expiring Policy only. Sum Insured of the renewed Policy will not be available for the Hospitalization (including Pre & Post Hospitalization Expenses), which has commenced in the expiring policy. Claim shall be settled on per event basis.

- **Repudiation of claim:** A claim, which is not covered under the Policy conditions, can be rejected. All the documents submitted to TPA shall be electronically collected by insurer for settlement and denial of the claims by the appropriate authority.

  Post insurer's approval communication on repudiation shall be sent to Insured person, explicitly mentioning the grounds for repudiation, through TPA.

  The expenses that are not covered in this policy are placed under List-I of Annexure-I. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-I, respectively.

- Grievance Redressal: In the event of Insured has any grievance relating to the insurance, Insured Person may contact any of the grievance cells at regional offices of the Insurer or Office of the Insurance Ombudsman under the jurisdiction of which the policy Issuing office falls. The contact details of the office of the Insurance Ombudsman are provided in Annexure VII.

- **Payment of claim:**
  The Insurer shall settle or reject a claim, as may be the case, within thirty days of receipt of the last 'necessary' document.
  While efforts will be made by the Insurer to not call for any document not listed in policy clause where any additional document or clarification is necessary to take a decision on the claim, such additional documents will be called for.

  All necessary claim documents pertaining to Hospitalization should be furnished by the insured person in original to the TPA, within thirty days from the date of discharge from the Hospital. However, claims filed even beyond such period will be considered if there are valid reasons for delay in submission.
  - In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.
  - In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.
  - The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder. If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.
- **Payment:** All medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.
- **Arbitration:** If Insurer admit's liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration. The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996.
- If a claim is declined and within 12 calendar months from such disclaimer any suit or proceeding is not filed, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

- **Portability:** Associate will have the option to port the policy by applying to Insurer along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the last working day, as per IRDAI guidelines related to portability.

  If such a person is presently covered and has been continuously covered without any lapses under Cognizant Group Medical Insurance policy with the Insurer, the proposed Insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

Claims process

This section explains the step-by-step process for making a claim under the Group Medical Insurance Policy, whether through cashless transactions, reimbursement, or using digital tools.

- **Cashless claims (Network Hospitals):**
  Cashless claims are available when treatment is availed at a network hospital. The insurer settles the bill directly with the hospital, subject to policy terms.
  - The period of hospitalisation should be greater than 24 hours with an active line of treatment and listed day care procedures.
  - Claim for hospitalisation in a network hospital will be taken care of through the cashless mode.
  - Associates must submit the pre-authorisation form by clicking “e-Cashless” in the Medi Assist app, seven (7) days prior to the date of admission for a planned hospitalisation, to avail the cashless benefit.
  - Medi Assist shall validate and provide necessary approvals for the pre-authorisation submitted.
  - The Associate will receive a pay confirmation receipt once Medi Assist approves the pre-authorisation via e-mail. The Associate can also access the information by logging into the Medi Assist app under “Your Claims”.
  - The cost of non-medical expenses (refer Annexure I), Co-pay, proportionate charges or any other deductions as per the policy will have to be borne by the Associate.
  - In case of any denial of cashless claims, Associates can claim through the reimbursement mode (subject to terms and conditions of the policy).
  - Associates will have to claim pre and post hospitalisation only through the reimbursement mode.

- **Contact and support:**
  - For any assistance during hospitalisation, Associates may contact the 24/7 dedicated India toll-free number 1800-258-5895, or the toll number +91 7337700014 (exclusive for Cognizant Associates in India).
  - Associates from outside of India can get in touch with Medi Assist on their International landline number: (International call prefix) 91 80 67617555 (chargeable as per Telecom tariff).

- **Reimbursement Claims**
  If treatment is availed at a non-network hospital, or if cashless is denied, Associates can claim reimbursement by submitting the required documents, subject to policy terms and conditions. Treatment can be taken from any registered hospital. The period of hospitalization must be

more than 24 hours with an active line of treatment or for a listed day care procedure (refer to Annexure).

Claim Type	Timelines for Submission
Main Hospitalisation Claim	Within 30 days from the date of discharge
Pre-Hospitalisation Expenses	Within 30 days from the date of discharge
Post-Hospitalisation Expenses	Within 30 days from the completion of post hospitalisation period (post hospitalisation period: 60 days from the date of discharge)

- **How to Submit a Reimbursement Claim?**
  1. **Login & Initiate Claim**
     - Login to the 1C portal → Open the Medi Assist App → Go to "All Services" → Select "Submit Claim."
     - Follow the on-screen instructions to submit a claim online.
  2. **Claim Form Generation**
     After successful claim creation, an online claim form with pre-filled details will be generated automatically.
  3. **Document Upload**
     - Upload all required documents (original bills, breakup of bills, prescriptions, discharge summary, receipts, investigation reports, etc.) via the Medi Assist portal or MAven app.
     - Refer to the document checklist in the app for the required set of documents based on the cause of admission.
  4. **Additional Document Requests**
     If any additional documents are required, Medi Assist will raise a query. Associates can upload the requested documents again via the portal or app.
  5. **Claim Processing**
     - The turnaround time for claim processing starts from the date the last required document is submitted.
     - Medi Assist will take at least 5 business days to process an Associate's claim after receiving all required documents.
  6. **Notifications**
     Once Associate's claim is processed, they will be notified of the final decision. For payment release, hard copies must be sent (see below).
  7. **Submission of Hard Copies**
     - Print the claim form, attach it with the original documents, and courier them to the Medi Assist office or the Cognizant office address.
       Medi Assist office address for submission:
       RWD Atlantis Building, 2nd Floor,
       Door No: 24, Nelson Manickam Road,
       Aminjikkarai, Chennai 600029

Cognizant Technology Solutions India Pvt Limited
Payroll & Benefits shared services (Medical insurance team)
MEPZ-Special Economic Zone,
Plot No A-17, D-2, C-10 & C-1, A-15 to 17, B-20 & A-33
National Highway 45, Tambaram, GST road, Chennai 600045.

- Medi Assist requires the hard copy documents to release payment. They take at least 7 business days from the date they receive the hard copies to release payment.

8. **Claim settlement**
   All reimbursement claims will be settled directly by the insurer. Once approved, the insurer will initiate NEFT payment directly to the Associate's bank account as updated in the Medi Assist app.
9. **Track Associate Claims**
   Associates can track their claim status anytime by logging in to the Medi Assist portal (Claims section) or directly on the home page.
10. **Document Retention**
    All copies of all documents submitted for Associate records, must be kept. Documents once submitted will not be returned by Medi Assist.

Documents required

- Hospital bill, receipt, and discharge certificate/card
- Cash memos from hospital/chemist with prescriptions
- Receipts and test reports with the doctor's prescription or recommendation note
- Surgeon's certificate stating the nature of the operation, along with the bill and receipt
- Attending doctor/consultant/specialist/anesthetist's bill, receipt, and diagnosis certificate
- Certificate from the attending doctor confirming that the patient is fully cured (if applicable)
- Original reports for all medical investigations and diagnostic tests (including X-rays)
- Important Guidelines:
  - All original reports must be furnished with the corresponding bills and receipts.
  - Medicine bills must be accompanied by the relevant original prescriptions.
  - Retain photocopies of all documents, reports, and bills submitted for Associate records, as originals will not be returned by the TPA once submitted.

Additional documentation requests

- If any additional documents are required to process Associates claim, Medi Assist will send up to three reminders over a period of 21 days to the Associate's Cognizant e-mail ID, specifying the documents needed.
- If Associates do not respond to these reminders, their claim will be marked as "document recovery failure" and will not be processed until the pending documents are submitted.
- Once Associates receive the third reminder, they must send the required documents to Medi Assist within 10 days, along with a delayed submission clarification letter.

- The hospital discharge summary must be on the hospital's letterhead, duly signed by the attending doctor and affixed with the hospital's seal.
- After all required documents are submitted, Medi Assist will validate Associates claims as per policy norms and forward it to the insurer for reimbursement.

Contact information:

- **For Claims Submission (Courier):**
  Medi Assist (TPA)
  RWD Atlantis Building, 2nd Floor
  Door No: 24, Nelson Manickam Road
  Aminjikkarai, Chennai 600029

- **For Assistance During Hospitalisation (India):**
  24/7 Toll-Free number: 1800-258-5895
  Toll number: +91 73377 00014 (exclusive for Cognizant Associates in India)

- **For Associates Outside India:**
  - International landline number: (International call prefix) 91 80 67617555 (chargeable as per telecom tariff)
  - Email for enrollment queries (Midterm inclusion of spouse/newborn): ctsenrollment@Mediassist.in

Version history

Revision date	Description of change
Nov-01-2012	Initial Release, based on practice and precedence in Cognizant India. Introduction of new levels, titles, template and version control
Nov-01-2013	Annual review and process changes, if any, incorporated
Nov-01-2013	Addition in AMC room rent charges and expenses covered
Nov-01-2014	Annual review and process changes, if any, incorporated
Nov-01-2015	Annual review and process changes, incorporated clarification on Coverage of medical insurance for Associates hired in India and taking onsite assignments
Apr-01-2015	Change in Address incorporated for medical insurance document delivery during BCP
Apr-01-2015	Change in Address incorporated for medical insurance document delivery
Nov-01-2015	Change in service tax. AMC and Top-up table updated with revised values
Nov-01-2016	Annual review and process changes, if any, incorporated
Nov-01-2017	Change in third party administrator. Annual review and process changes, if any
Nov-01-2017	Clarity on AMC Coverage
Nov-01-2018	Annual review and process changes incorporated
Nov-01-2018	Inclusion of medical insurance benefit for LGBTQ
Nov-01-2019	Annual review and process changes
May-01-2020	Top-Up Coverage for COVID 19 for India Hires and Dependents
NOV-01-2020	Annual review and process changes, Introduction of Covid19 rider for Covid 19 treatment, Increase in Top-up Limits, enhanced Maternity Limits
NOV-01-2021	Coverage for Covid 19 for India Hires and deputed assignees dependents based out of India
NOV-01-2021	Annual review and process changes

NOV-01-2022	Standardization of the Template Annual review and process changes, Changes in Covid 19 rider plan benefit
NOV-01-2023	Annual review and process changes
NOV-01-2024	Annual review change in copay for Associate spouse and children, No ICU room rent capping; Change of address
FEB-14-2025	The definition for dependents updated; Change of Cognizant address in the Annexure
NOV-1-2025	Annual review and process changes; Base and AMC cover room rent capping increased, proportionate deductions reduced, New AMC sum insured options introduced.

ANNEXURE I

List I – Items for which coverage is not available in the policy

#	Item
1	Baby Food
2	Baby utilities charges
3	Beauty services
4	Belts / braces
5	Buds
6	Cold pack / hot pack
7	Carry bags
8	Email / internet charges
9	Food charges (other than patient's diet provided by hospital)
10	Leggings
11	Laundry charges
12	Mineral water
13	Sanitary pad
14	Telephone charges
15	Guest services
16	Crepe Bandage
17	Diaper of any type
18	Eyelet collar
19	Slings
20	Blood grouping and cross matching of donors samples
21	Service charges where nursing charges also charged
22	Television charges
23	Surcharges
24	Attendant charges
25	Extra diet of patient (other than that which forms part of bed charge)
26	Birth certificate
27	Certificate charges
28	Courier charges
29	Conveyance charges
30	Medical certificate
31	Medical records
32	Photocopies charges
33	Mortuary charges
34	Walking aids charges
35	Oxygen cylinder (for usage outside the hospital)
36	Spacer
37	Spirometre
38	Nebulizer kit
39	steam inhaler
40	Armsling
41	Thermometer
42	Cervical collar
43	Splint
44	Diabetic footwear
45	Knee braces (long / short / hinged)

46	Knee immobilizer / shoulder immobilizer
47	Lumbo sacral belt
48	Nimbus bed or water or air bed charges
49	Ambulance collar
50	Ambulance equipment
51	Abdominal binder
52	Private nurses charges - special nursing charges
53	Sugar free tablets
54	Creams powders lotions (toiletries are not payable, only prescribed medical pharmaceuticals payable
55	ECG electrodes
56	Gloves
57	Nebulization kit
58	Any kit with no details mentioned (delivery kit, orthokit, recovery kit, etc)
59	Kidney tray
60	Mask
61	Ounce glass
62	Oxygen mask
63	Pelvic traction belt
64	Pan can
65	Trolly cover
66	Urometer, urine jug
67	Ambulance
68	Vasofix safety

LIST II - Items that are to be subsumed into room charges

#	Item
1	Baby charges (unless specified/indicated)
2	Hand wash
3	Shoe cover
4	Caps
5	Cradle charges
6	Comb
7	Eau-de-cologne/room fresheners
8	Foot cover
9	Gown
10	Slippers
11	Tissue paper
12	Toothpaste
13	Toothbrush
14	Bed pan
15	Face mask
16	Flexi mask
17	Hand holder
18	Sputum cup
19	Disinfectant lotions
20	Luxury tax

21	HVAC
22	Housekeeping charges
23	Air conditioner charges
24	IM IV injection charges
25	Clean sheet
26	Blanket/warmer blanket
27	Admission kit
28	Diabetic chart charges
29	Documentation charges/administrative expenses
30	Discharge procedure charges
31	Daily chart charges
32	Entrance pass/visitors pass charges
33	Expense related to prescription on discharge
34	File opening charges
35	Incidental expenses/misc. charges (not explained)
36	Patient identification band/name tag
37	Pulse oxy-meter charges

List III - Items that are to be subsumed into procedure charges

Sl. No	Item
1	Hair removal cream
2	Disposables razors charges (for site preparations)
3	Eye pad
4	Eye shield
5	Camera cover
6	DVD, cd charges
7	Gause soft
8	Gauze
9	Ward and theatre booking charges
10	Arthroscopy and endoscopy instruments
11	Microscope cover
12	Surgical blades, harmonic scalpel, shaver
13	Surgical drill
14	Eye kit
15	Eye drape
16	x-Ray film
17	Boyles apparatus charges
18	Cotton
19	Cotton bandage
20	Surgical tape
21	Apron
22	Torniquet
23	Ortho bundle, gynaec bundle

List IV - Items that are to be submitted into costs of treatment

Sl. No	Item
1	Admission/registration charges
2	Hospitalisation for evaluation/diagnostic purpose
3	Urine container
4	Blood reservation charges and ante natal booking charges
5	Bipap machine
6	CPAP / CAPD Equipment’s
7	Infusion pump - cost
8	Hydrogen peroxide/spirit/disinfectants etc
9	Nutrition planning charges - dietician charges - diet charges
10	HIV kit
11	Antiseptic mouthwash/ Mouth paint
12	Lozenges
13	Urine bag
14	Vaccination charges
15	Alcohol Swabs
16	Scrub solution / sterillium
17	Glucometer & strips

ANNEXURE II - List of day care procedures

1	Stapedotomy	2	Reconstruction of the middle ear
3	Mastoidectomy	4	Labyrinthectomy for severe vertigo
5	Stapedectomy	6	Oculoplasty
7	Myringotomy with grommet insertion	8	Tympanoplasty
9	Incision (opening) and destruction (Elimination of the inner ear	10	Incision of the mastoid process and middle ear
11	Other Microsurgical Operations On The Middl Ear	12	Endolymphatic sac surgery for meniere's disease
13	Turbinectomy	14	Removal of Tympanic Drain under LA
15	Fenestration of the inner ear	16	Incision and drainage of perichondritis
17	Septoplasty	18	Vestibular Nerve section
19	Thyroplasty	20	Reduction of fracture of Nasal Bone
21	Excision and destruction of lingual tonsils	22	Conchoplasty
23	Excision and destruction of diseased tissue of the nose	24	Tracheostomy
25	Excision of Angioma Septum	26	Turbinoplasty
27	Incision & Drainage of Pharyngeal Abscess	28	Uvulo palato pharyngo plasty
29	Palatoplasty	30	Nasal Sinus Aspiration
31	Adenoidectomy with Grommet insertion	32	Adenoidectomy without Grommet insertion
33	Vocal Cord lateralization Procedure	34	Tonsillectomy without adenoidectomy
35	Tonsillectomy with adenoidectomy	36	Tracheoplasty
37	Other operations on the auditory ossicles	38	Plastic surgery to the floor of the mouth
39	Incision of the hard and soft palate	40	External incision and drainage in the regior of the mouth, jaw and face
41	Other operations on the salivary glands and salivary ducts	42	Incision of tear glands
43	Other operation on the tear ducts	44	Incision of diseased eyelids
45	Excision and destruction of the diseased tissu of the eyelid	46	Removal of foreign body from eye
47	Corrective surgery of the entropion and ectropion	48	Operations for pterygium
49	Corrective surgery of blepharoptosis	50	Glaucoma
51	Retinal detachment	52	Operations on the cornea
53	Operation on the canthus and epicanthus	54	YAG Laser in Ophthalmology
55	Surgery for cataract	56	Treatment of retinal lesion
57	Parenteral Chemotherapy	58	CCRT-concurrent Chemo + RT
59	SRS- Stereotactic radiosurgery	60	Radiotherapy
61	Radical chemotherapy	62	Chemotherapy
63	AV fistula	64	URSL with stenting
65	URSL	66	DJ Stent removal
67	ESWL	68	Hemodialysis
69	CAPD (Excluding the cost of machine)	70	Cystoscopy (Therapeutic)
71	Follow-up cystoscopy in case of bladder canc	72	Excision of urethral diverticulum
73	Ureter endoscopy and treatment	74	Surgery for pelvi ureteric junction obstruction
75	Frenular tear repair	76	Meatotomy for meatal stenosis
77	Surgery for fournier's gangrene scrotum	78	Surgery filarial scrotum
79	Surgery for watering can perineum	80	Repair of penile torsion
81	Drainage of prostate abscess	82	TURBT

83	Radical prostat ovesiculectomy	84	Operations on the prostate
85	D&C	86	Hysteroscopic adhesiolysis
87	Removal of Abnormal Tissue from Cervix	88	Vulval wart excision
89	Cyst Excision / Cystectomy	90	Uterine artery embolization
91	Endometrial ablation	92	Myomectomy
93	Surgery for SUI	94	Pelvic floor repair (excluding fistula repair)
95	Laparoscopic oophorectomy	96	Incision of the ovary
97	Insufflation of the fallopian tubes	98	Dilatation of the cervical canal
99	Hysterotomy	100	Therapeutic curettage
101	Culdotomy	102	Incision of the vagina
103	Local excision and destruction of diseased tissue of the vagina and the pouch of douglas	104	Incision of the vulva
105	Infected keloid excision	106	Incision of a pilonidal sinus / abscess
107	Infected sebaceous cyst	108	Infected lipoma excision
109	Maximal anal dilatation	110	Surgical treatment of haemorrhoids
111	Liver Abscess- catheter drainage	112	Fissure in Ano- fissurectomy
113	Surgical Treatment of anal fistulas	114	Fibroadenoma breast excision
115	Oesophageal varices sclerotherapy	116	ERCP – pancreatic duct stone removal
117	Perianal abscess I&D	118	Excisional Biopsy
119	Perianal hematoma evacuation	120	Fissure in ano sphincterotomy
121	Therapeutic Endoscopy	122	Breast abscess I& D
123	Feeding Gastrostomy	124	Feeding Jejunostomy
125	ERCP – Bile duct stone removal	126	Ileostomy closure
127	Polypectomy	128	Splenic abscesses Laparoscopic Drainage
129	Sclerotherapy	130	Colostomy
131	Ileostomy	132	Colostomy closure
133	Pancreatic Pseudocysts Endoscopic Drainage	134	Subcutaneous mastectomy
135	Excision of Ranula under GA	136	Hydrocele Repair
137	Scrotoplasty	138	Surgical treatment of varicocele
139	Epididymectomy	140	Circumcision for Trauma
141	Meatoplasty	142	Abscess incision and drainage
143	TIPS procedure for portal hypertension	144	Pair procedure of hydatid cyst liver
145	Excision of Cervical RIB	146	Surgery for fracture Penis
147	Laparoscopic cardio myotomy (Hellers)	148	Laparoscopic pyloromyotomy (Ramstedt)
149	Orchidectomy	150	Operations on the nipple
151	Incision and excision of tissue in the perianal region	152	Division of the Anal Sphincter (Sphincterotomy)
153	Glossectomy	154	Reconstruction of the Tongue
155	Incision, excision and destruction of diseased tissue of the tongue	156	Operations on the Seminal Vesicles
157	Other operations on the spermatic cord, epididymis and ductus deferens	158	Operations on the Penis
159	Other excisions of the skin and subcutaneous tissues	160	Other incisions of the skin and subcutaneou tissues
161	Free skin transplantation, donor site	162	Free Skin Transplantation, Recipient Site

163	Reconstruction of the testis	164	Incision of The Scrotum and Tunica Vaginalis Testis
165	Revision of skin plasty	166	Other Restoration and Reconstruction of Th Skin and Subcutaneous Tissues
167	Destruction of diseased tissue in the skin and subcutaneous tissues	168	Arthroscopic Repair of ACL tear knee
169	Arthroscopic repair of PCL tear knee	170	Tendon shortening
171	Tendon lengthening	172	Arthroscopic Meniscectomy – Knee
173	Treatment of clavicle dislocation	174	Arthroscopic meniscus repair
175	Hemarthrosis knee- lavage	176	Abscess knee joint drainage
177	Repair of kneecap tendon	178	ORIF with K wire fixation- small bones
179	ORIF with plating- Small long bones	180	Arthrotomy Hip joint
181	Syme's amputation	182	Arthroplasty
183	Partial removal of rib	184	Treatment of sesamoid bone fracture
185	Amputation of metacarpal bone	186	Repair / graft of foot tendon
187	Revision/Removal of Knee cap	188	Remove/graft leg bone lesion
189	Repair/graft achilles tendon	190	Biopsy elbow joint lining
191	Biopsy finger joint lining	192	Surgery of bunion
193	Tendon transfer procedure	194	Removal of kneecap bursa
195	Treatment of fracture of ulna	196	Treatment of scapula fracture
197	Removal of tumor of arm/ elbow under RA/GA	198	Repair of ruptured tendon
199	Revision of neck muscle (Torticollis release)	200	Treatment fracture of radius & ulna
201	Incision On Bone, Septic and Aseptic	202	Closed reduction in fracture, luxation or epiphysiolysis with osteosynthesis
203	Reduction Of Dislocation Under Ga	204	Vaginoplasty
205	Dilatation of accidental caustic stricture esophageal	206	Presacral Teratomas Excision
207	Removal of vesical stone	208	Excision Sigmoid Polyp
209	Sternomastoid Tenotomy	210	High Orchidectomy for testis tumors
211	Excision of cervical teratoma	212	Rectal-Myomectomy
213	Rectal prolapse (Delorme's procedure)	214	Orchidopexy for undescended testis
215	Detorsion of torsion Testis	216	Lap. Abdominal exploration in cryptorchidis
217	Coronary Angiography	218	Ultrasound Guided Aspirations
219	Digital subtraction Angiography (DSA)	220	Anti Rabies Vaccination
221	Pacemaker- Battery replacement	222	Plasmapheresis
223	Radio Iodine therapy post thyroidectomy	224	Barrage laser/ Pan retinal photocoagulation
225	Keratoconus	226	BCG Intravascular injection for carcinoma bladder

ANNEXURE III - General Exclusions

- Injury or disease 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) or by nuclear weapons / materials.
- Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident).
- Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
- Surgery for correction of eyesight, cost of spectacles, contact lenses, hearing aids.
- Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear unless arising from disease. Except for injury due to accident and which requires hospitalization for treatment. Convalescence, general debility, “run down” condition or rest cure or defects or anomalies, sterility, or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric and psychosomatic disorders and diseases / accident due to and or use, misuse or abuse of drugs / alcohol or use of intoxicating substances or such abuse or addiction etc.
- Any cosmetic or plastic surgery except for correction of injury.
- Expenses incurred at hospital or nursing home primarily for evaluation / diagnostic purposes which is not followed by active treatment for the ailment during the hospitalized period.
- Expenses on vitamins and tonics unless forming part of treatment for injury or disease as certified by the attending physician.
- Any treatment arising from or traceable to pregnancy, miscarriage, abortion, or complications of any of these including changes in chronic condition as a result of pregnancy except were covered under the maternity section of benefits.
- Doctor's home visit charges, attendant / nursing charges during pre and post hospitalization period.
- Treatment which is continued before hospitalization and continued even after discharge for an ailment/ disease/ injury different from the one for which hospitalization was necessary.
- Naturopathy treatment, unproven procedure, or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies.
- External and or durable medical / non-medical equipment of any kind used for diagnosis and or treatment including CPAP, CAPD, Infusion pump etc., Ambulatory devices i.e., walker, crutches, belts, collars, caps, splints, slings, braces, stockings of any kind, diabetic footwear, glucometer / thermometer, and similar related items and any medical equipment which is subsequently used at home etc.
- Note: Cost of braces will not be covered if cosmetic in nature.
- All non-medical expenses including personal comfort and convenience items or services such as telephone, television, aaya / barber or beauty services, diet charges, baby food, cosmetics, napkins, toiletry items etc., guest services and similar incidental expenses or services etc. Change of treatment from one pathy to other pathy unless being agreed / allowed and recommended by the consultant under whom the treatment is taken.

- Treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control program, services or supplies etc.
- Any treatment required arising from Insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc. unless specifically agreed by the Insurance Company.
- Any treatment received in convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
- Any stay in the hospital for any domestic reason or where no active regular treatment is given by the specialist.
- Massages, steam bathing, shirodhara and alike treatment under ayurvedic treatment.
- Any kind of service charges, surcharges, admission fees / registration charges levied by the hospital.
- Outpatient diagnostic, medical or surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy.
- Expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalization or primary reasons for admission. Private nursing charges, Referral fee to family doctors, outstation consultant’s / Surgeons’ fees.
- Intentional self-Injury, outpatient treatment.
- Family planning surgeries (Vasectomy or tubectomy).
- All expenses arising out of any condition directly or indirectly caused by or associated with Human T-cell Lymphotropic Virus Type III (HTLD - III) or Lymphadenopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of similar kind commonly referred to as AIDS, HIV and its complications including sexually transmitted diseases.
- External and or durable Medical / Non-medical equipment of any kind used for diagnosis and or treatment like prosthetics etc.
- Lasik treatment or any other procedure for correction/enhancement of vision is < +/- 5.
- Any device/instrument/machine that does not become part of the human anatomy/body but would contribute/replace the function of an organ is not covered.
- Warranted those treatments on trial/experimental basis are not covered under scope of the policy.
- Coverage for palliative care and palliative chemotherapy is limited to 50% of the current base sum insured for dependents.
- This policy does not cover expenses incurred on account of domiciliary hospitalization (a situation where medical treatment is administered within the precincts of the patient's residence).
- This policy does not cover any other Outpatient treatment except OPD treatment for children with disability and for Associates with suspected head/skull injury due to accidents.
- This policy also doesn’t cover hospitalization for observation/ evaluation/ diagnostic/ investigation procedure and oral medications (except those covered under pre and post hospitalization expenses).
- Medical treatment such as ongoing hormone therapy, voice correction, vocal cord alignment and cosmetic surgery will not be eligible for Coverage.
- Outpatient treatment for gender realignment will not be eligible for Coverage.
- Dependents are not eligible for coverage of gender realignment benefit.

- Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.
- Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- Expenses related to sterility and secondary infertility. This includes.
- Any type of contraception, sterilization
- Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
- Gestational Surrogacy
- Reversal of sterilization
- Treatment taken outside India.
- Change of treatment from one system to another unless recommended by the consultant / hospital under whom the treatment is taken.
- Service charges or any other charges levied by hospital, except registration/admission charges.
- Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.
- If cap limits are met there is no coverage for pre and post hospitalization expenses.

ANNEXURE IV - Gender Transition Affidavit Template

Date:

To,
The New India Assurance Co. Ltd
Tarapore towers,
3rd floor, 826, Anna Salai
Chennai,
Tamil Nadu – 600002

AFFIDAVIT

I,<name>, aged about <age> years, and employed as <designation> with Cognizant Technology Solutions India Private Limited ('Cognizant') having its office at Siruseri–Software Technology Park of India, Plot no H-4, SIPCOT Siruseri IT Park, Padur Post, Siruseri, Kancheepuram District Chennai 603 103, Tamil Nadu, do hereby solemnly affirm and declare as under:

I am employed as <designation> and I am part of the Cognizant since <DOJ>.

I hereby declare and affirm that I am undergoing Gender Transition treatment under the supervision of registered medical practitioner at <name and place of hospital>. It is certified that I have complied with other legal requirements in the connection.

That the above-mentioned contents of this affidavit are true and correct to the best of my knowledge, belief, and information.

Deponent

VERIFICATION

Verified at <place> on this <date> day of <month> <year> that the contents of the above affidavit are true and correct.

Deponent

ANNEXURE V - Gender Transition Self Declaration Template

Date:

To

Cognizant Technology Solutions India Pvt. Ltd.

Siruseri–Software Technology Park of India
Plot no H-4, SIPCOT Siruseri IT Park
Padur Post, Siruseri
Kancheepuram District
Chennai 603 103 Tamil Nadu.

I, <name>, aged about <age> years, and employed as <designation> with Cognizant Technology Solutions India Private Limited ('Cognizant') having its office at Siruseri–Software Technology Park of India, Plot no H-4, SIPCOT Siruseri IT Park, Padur Post, Siruseri, Kancheepuram District Chennai 603 103, Tamil Nadu, do hereby solemnly affirm and declare as under:

I am employed as <designation> and I am part of the Cognizant since <DOJ>.

I hereby declare and affirm that I am undergoing Gender Transition treatment under the supervision of registered medical practitioner <name of medical practitioner> at <name and place of hospital>. Medical practitioner certificate certifying the Gender Transition treatment is being shared along with this declaration form.

My transition is from <current gender> to <transitioned gender>. Henceforth I would like to be referred to as <New Name>.

I authorize Cognizant to verify relevant records pertaining to my gender transition and make necessary amendments in the respective systems.

It is certified that I have complied with other legal requirements in the connection.

That the above-mentioned contents of this declaration are true and correct to the best of my knowledge, belief, and information.

Yours Sincerely,

<<Signature>>

<<Name>>

<<Associate id>>

<<Current work location>>

ANNEXURE VI - Same Sex Partner Affidavit Template

Date:

To,

The New India Assurance Co. Ltd
Tarapore towers,
3rd floor, 826, Anna Salai
Chennai,
Tamil Nadu – 600002
AFFIDAVIT

I,<name>, aged about <age> years, and employed as <designation> with Cognizant Technology Solutions India Private Limited ('Cognizant') having its office at Siruseri–Software Technology Park of India, Plot no H-4, SIPCOT [IT Park, Padur Post, Siruseri, Kancheepuram District Chennai 603 103, Tamil Nadu, do hereby solemnly affirm and declare as under:

I am employed as <designation> and I have been part of the Cognizant since <DOJ>.

I hereby declare and affirm that Mr./Ms. /Mx. <name>, is my same sex domestic partner with whom I share residence having address at <detailed address>.

That the above-mentioned contents of this affidavit are true and correct.

Deponent

VERIFICATION

Verified at <place> on this <date> day of <month> <year> that the contents of the above affidavit are true and correct.

Deponent

ANNEXURE VII - Same Sex Partner Self-Declaration Template

Date:

To

Cognizant Technology Solutions India Pvt. Ltd.

Siruseri–Software Technology Park of India
Plot no H-4, SIPCOT Siruseri IT Park
Padur Post, Siruseri
Kancheepuram District
Chennai 603 103 Tamil Nadu.

I,<name>, aged about <age> years, and employed as <designation> with Cognizant Technology Solutions India Private Limited ('Cognizant') having its office at Siruseri–Software Technology Park of India, Plot no H-4, SIPCOT Siruseri IT Park, Padur Post, Siruseri, Kancheepuram District Chennai 603 103, Tamil Nadu, do hereby solemnly affirm and declare as under:

I am employed as <designation> and I have been part of the Cognizant since <DOJ>.

I hereby declare and affirm that Mr./Ms. /Mx. <name>, is my same sex domestic partner with whom I share residence having address at <detailed address>.

That the above-mentioned contents of this declaration are true and correct.

Yours Sincerely

<<Signature>>

<<Name>>

<<Associate id>>

<<Current work location>>

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ANNEXURE VIII - Contact details of Insurance Ombudsman

AHMEDABAD Office of the Insurance Ombudsman, Jeevan Prakash, 6th floor, Near S.V. College Relief Road, Tilak Marg, Ahmedabad-380 001, Gujarat Tel.: 079-25501201, 079-25501202 Email: oio.ahmedabad@cioins.co.in Jurisdiction : Gujarat, Dadra & Nagar Haveli, Daman and Diu.	**BHOPAL** Office of the Insurance Ombudsman, LIC of India Zonal Office Bldg., 1st Floor, South Wing, Jeevan Shikha, Opp. Gayatri Mandir, 60-B, Hoshangabad Road, Bhopal-462 011 Tel.: 0755-2769201, 0755-2769202, 0755-2769203, 0755-2769200 Email: oio.bhopal@cioins.co.in Jurisdiction : Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar, PIN -751 009. Tel.: 0674-2596455, 0674-2596429, 0674-2596003, 0674-2596461 Email: oio.bhubaneswar@cioins.co.in Jurisdiction : Odisha	**CHANDIGARH** Office of the Insurance Ombudsman, Jeevan Deep, Ground Floor, LIC of India Bldg, SCO 20-27, Sector 17-A, Chandigarh-160 017 Tel.: 0172-2704648, 0172-2773101, 0172-2706398, 0172-2706196, 0172-2706468, 0172-2772101, 0172-2999942 Email: oio.chandigarh@cioins.co.in Jurisdiction : Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh & Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th flr, 453 (old 312), Anna Salai, Teynampet, Chennai 600 018 Tel.: 044-24333668, 044-24333678 Email: oio.chennai@cioins.co.in Jurisdiction : Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry)	**DELHI** Office of the Insurance Ombudsman, 2/2 A, 1st Floor, Universal Ins. Building, Asaf Ali Road, New Delhi-110 002. Tel.: 011-46013992 Email: oio.delhi@cioins.co.in Jurisdiction : Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh Bldg., 5th Floor, Near Pan Bazar, S. S. Road, Guwahati-781 001 Tel.: 0361-2631307, 0361-2632204, 0361-2732937, 0361-2632205 Email: oio.guwahati@cioins.co.in Jurisdiction : Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.	**HYDERABAD** Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court Lane Opp. Hyundai Showroom, A. C. Guards, Lakdi-ka-pool, Hyderabad 500 004 Tel.: 040-23376911, 040-23312122, 040-23375699, 040-23388709, 040-23325325 Email: oio.hyderabad@cioins.co.in Jurisdiction : Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry.
KOCHI Office of the Insurance Ombudsman, 10th Floor, LIC Bldg, Jeevan Prakash, Opp Maharaja College Ground, M.G. Road, Ernakulam, Kochi-682 011 Tel.: 0484-2358759, 0484-2358734, 0484-2359336 Email: oio.ernakulam@cioins.co.in Jurisdiction : Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.	**KOLKATA** Office of the Insurance Ombudsman, 7th Floor of Hindusthan Building (Annex), 4, C R Avenue, Kolkata-700 072 Tel.: 033-22124339, 033-22124341 Email: oio.kolkata@cioins.co.in Jurisdiction : West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW Office of the Insurance Ombudsman, Jeevan Bhavan, Phase II, 6th Floor, Nawal Kishore Road, Hazratganj, Lucknow-226 001. Tel.: 0522-400082 Email: oio.lucknow@cioins.co.in Jurisdiction : Districts of Uttar Pradesh : Lalitpur, 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,	**MUMBAI** Office of the Insurance Ombudsman, IIITrd Floor, Jeevan Seva Annexe S.V.Road, Santacruz West, Mumbai-400 054. Tel.: 022-69038800, 022-69038827/8829, 022-69038831/8832, 022-69038833 Email: oio.mumbai@cioins.co.in Jurisdiction : Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and excluding areas of Navi Mumbai.

Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.	
JAIPUR Jeevan Nidhi II, Ground Floor, Bhawani Singh Road, Ambedkar Circle, Jaipur-302 005. Tel.: 0141-2740363 Email: oio.jaipur@cioins.co.in Jurisdiction : Rajasthan	**PUNE** Office of the Insurance Ombudsman, 3rd Floor, Jeevan Darshan -LIC of India Bldg, N.C. Kelkar Road, Narayan Peth, Pune-411 030 Tel.: 020-24471175 Email: oio.pune@cioins.co.in Jurisdiction : State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district,Palghar District, Raigad district & Mumbai Metropolitan Region
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No.57-27-N-19, Ground Floor, No.19/19, 24th Main Rd, 1st Phase, J.P. Nagar, Bengaluru-560 078. Tel.: 080-26652048, 080-26652049 Email: oio.bengaluru@cioins.co.in Jurisdiction : Karnataka	**NOIDA** Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th flr Main Road, Naya Bans, Sector 15, Noida-201301 Dist: G.B. Nagar Uttar Pradesh Tel.: 0120-2514252, 0120-2514253, 0120-4072589 Email: oio.noida@cioins.co.in Jurisdiction : State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA Office of the Insurance Ombudsman, 2nd Floor, Lalit Bhawan, Bailey Road, Patna-800 001 Tel.: 061-22540767, 061-22540768 Email: oio.patna@cioins.co.in Jurisdiction : Bihar, Jharkhand.	**THANE** Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West), Thane-400 604 Tel.: 022-20812868, 022-20812869 Email: oio.thane@cioins.co.in Jurisdiction : Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T.