POLICY TERMS AND CONDITIONS

1. DEFINITIONS

For the purposes of interpretation and understanding of this Policy the Company has defined below some of the important words used in this Policy. Words not defined below are to be construed in the usual English language meaning as contained in Standard English language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, regulations notified by the Insurance Regulatory and Development Authority ("Authority") and circulars and guidelines issued by the Authority shall carry the meanings described therein. The terms and conditions, benefits, insurance coverage and exclusions, various procedures and conditions which have been built in to the Policy are to be construed in accordance with the applicable provisions contained in the Policy.

The terms defined below have the meanings ascribed to them wherever they appear in this Policy and, where appropriate, references to the singular include references to the plural; references to the male include the female and references to any statutory enactment include subsequent changes to the same and vice versa.

1.1. **Accident/ Accidental** is a sudden, unforeseen and involuntary event caused by external, visible and violent means;

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

1.3. **Age** means the completed age of the Insured Person on his last birthday;

1.4. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.

1.5. **Ambulance** means a road vehicle operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention;

1.6. **Annual Multi Trip Policy** means a Policy under which there can be more than one Period of Insurance during the Policy Period, subject to the maximum trip duration (per trip) specified on the Policy Certificate/ Certificate of Insurance or as opted;

1.7. **Any One Illness** means a continuous Period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital / nursing home where the treatment may have been taken;

1.8. **Assistance Service Provider** means the service provider specified in the Policy Certificate and/or Certificate of Insurance, appointed by the Company from time to time;

1.9. **Cashless facility** means a facility extended by the Company 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 Company to the extent pre-authorization approved;

1.10. **Certificate of Insurance** means the certificate the Company issues to an Insured Person evidencing cover under the Policy;

1.11. **Checked-In Baggage** means the baggage (luggage and personal possessions belonging to or in the lawful custody of the Insured Person) offered by the Insured Person and accepted for custody by a Common Carrier for transportation in the same Common Carrier in which the Insured Person is travelling and for which the Common Carrier has provided a baggage receipt, and the contents of the baggage checked-in by the Insured Person as long as such contents do not violate any policy or rule restricting the nature of items that may be carried on board. This shall exclude all the items that are carried/ transported under a contract of affreightment;

1.12. **City of Residence** means and includes any city, town or village in which the Insured Person is currently residing in India and as specified in the Insured Person's corresponding address in the Policy Certificate/Certificate of Insurance;

1.13. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment under a Benefit or Optional Benefit or Optional Extension in respect of an Insured Person;

1.14. **Company** (also referred as We/Us) means the Religare Health Insurance Company Limited;

1.15. **Common Carrier** means any civilian land or water conveyance or scheduled aircraft operated under a valid license for the transportation of fare paying passengers under a valid ticket;

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

1.17. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body

b) External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body;

1.18. **Contribution** means essentially the right of an Insurer to call upon other insurers, liable to the same Insured to share the cost of an indemnity claim on a ratable proportion of sum insured;

1.19. **Co-payment** is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum insured;

1.20. **Country of Residence** means the country in which the Insured Person is currently residing and as specified in the Insured Person's corresponding address as specified in the Policy Certificate or Certificate of Insurance;

1.21. **Cumulative Bonus** shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium;

1.22. **Damages** means sums payable following judgments or awards but shall not include fines, penalties, punitive damages, exemplary damages, any non-pecuniary relief, or any other amount for which an Insured Person is not financially liable, or which is without legal recourse to the Insured Person, or any matter that may be deemed to be uninsurable under Indian Law;

1.23. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under—

a) has qualified nursing staff under its employment;

b) has qualified Medical Practitioner/s in charge;

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

d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel;

1.24. **Day Care Treatment** refers to medical treatment, and/or surgical procedure as specified under Annexure I which is:

a) undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hours because of technological advancement, and

b) which would have otherwise required a hospitalization of more than 24 hours.

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

1.25. **Deductible** is a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any Benefits are payable by the insurer. A deductible does not reduce the Sum Insured;

1.26. **Dental Treatment** is carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants;

1.27. **Dependent Child** means a child (natural or legally adopted), who is :

a) Financially dependent on the Policyholder;

b) Does not have his independent sources of income; and

c) Has not attained Age 25 years;

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

1.29. **Domiciliary hospitalization** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

a) The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or;

b) The patient takes treatment at home on account of non-availability of room in a hospital.

1.30. **Emergency Care (Emergency)** means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health;

1.31. **Family** means and includes the Insured Person's legal spouse, dependent children, siblings, parents and parents–in-law;

1.32. **Geographical Scope** means the countries or geographical boundaries in which the coverage under the Policy is valid as specified in the Policy Certificate/ Certificate of Insurance;

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

1.34. **Hazardous Activities (Adventure Sports)** shall mean any sport or activity, which is potentially dangerous to the Insured Person whether he is trained or not. Such sport/activity includes racing and competitions, stunt activities of any kind, adventure racing, base jumping, blathlon, big game hunting, black water rafting, BMX stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/ pot holing, cave tubing, rock climbing/ trekking/ mountaineering, cycle racing, cyclo cross, drag racing, endurance testing, hand gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, lugging, risky manual labor, marathon running, martial arts, micro – lighting, modern pentathlon, motor cycle racing, motor rallying, parachuting, paragliding/ parapenting, piloting aircraft, polo, power lifting, power boat racing, quad biking, river boarding, scuba diving, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling and activities of similar nature;

1.35. **Hijack** means any act of unlawful seizure or control of a Common Carrier with a wrongful intent using force or violence or threat thereof;

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

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

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

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

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

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

or

Any institution established for in- patient care and day care and treatment of Injury or Illness and which has been registered as a Hospital or a clinic as per law rules and/or regulations applicable for the country where the contingency arises;

1.37. **Hospitalization** 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;

1.38. **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;

1.39. **Immediate Family Member** means an Insured Person's lawful spouse, dependent children and parents only;

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

1.41. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event;

1.42. **Intensive Care Unit** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards;

1.43. **Insured Person (Insured)** means a person whose name specifically appears under Insured in the Certificate of Insurance and is a covered group member;

1.44. **Life Threatening Medical Condition** means a medical condition suffered by the Insured Person which has the following characteristics:

a) Markedly unstable vital parameters (blood pressure, pulse, temperature and respiratory rate); or

b) Acute impairment of one or more vital organ systems (involving brain, heart, lungs, liver, kidneys and pancreas); or

c) Critical care being provided, which involves high complexity decision making to assess, manipulate and support vital system functions to treat single or multiple vital organ failures and requires interpretation of multiple physiological parameters and application of advanced technology; or

d) Critical care being provided in critical care area such as coronary care unit, Intensive Care Unit, respiratory care unit, or the emergency department;

and certified by the attending Medical Practitioner as a Life Threatening Medical Condition;

1.45. **Maternity expenses** shall include–

a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).

b) expenses towards lawful medical termination of pregnancy during the policy period;

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

1.47. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment;

1.48. **Medical Practitioner** means a person who holds a valid registration from the medical council of any State and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of license. The term Medical Practitioner includes a physician and / or surgeon;

1.49. **Medically Necessary** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:

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

1.50. **Network Provider** means Hospitals or Health Care providers enlisted by an insurer or by a Assistance Service Provider and insured together to provide services to an insured on payment by a cashless facility;

1.51. **Newborn baby** means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

1.52. **Nominee** means the person named in the Certificate of insurance to receive the benefits payable under this Policy if the Insured Person is deceased. For the purpose of avoidance of doubt it is clarified that if the Nominee is a minor on the date when payment becomes due under the Policy, payment shall be made to the Appointee named in the Certificate of Insurance;

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

1.54. **Notification of claim** is the process of notifying a claim to the Company or Assistant Service Provider by specifying the timelines as well as the address/telephone number to which it should be notified;

1.55. **OPD Treatment (Out-patient Care)** is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient;

1.56. **Period of Insurance** means a period within the Policy Period which commences when the Insured Person crosses the international border of the Country of Residence if the Geographical scope is out of India to leave that country on a Common Carrier or City of Residence if the Geographical Scope is restricted to India to leave that city and expires automatically on the earliest of:

a) the Insured Person crossing the Indian international border to return to the Country of Residence on a Common Carrier if the Geographical scope is out of India or returning to the City of Residence if the Geographical Scope is restricted to India; or

b) the expiry of the period specified in the Policy Certificate or Certificate of Insurance from the commencement of the Period of Insurance; or

c) the Policy Period End Date.

The Policy Certificate or Certificate of Insurance shall specify whether the Policy is a Single Trip Policy or an Annual Multi Trip Policy;

1.57. **Place of Destination** means the destination place where the journey of the Insured Person, forming part of the Trip, is scheduled to be concluded through a scheduled Common Carrier;

1.58. **Place of Origin** means the starting point/ place from where the Insured Person's Trip is scheduled to be undertaken through a Common Carrier by which he finally leaves the Country of Residence or City of Residence;

1.59. **Place of Residence** means the dwelling place that the Insured Person is presently resident in as specified as the correspondence address of the Insured Person in the Policy Certificate or Certificate of Insurance;

1.60. **Policy** means these Policy Terms & Conditions, Benefit, Optional Benefits, Optional Extensions (if any), the Proposal Form, Policy Certificate, Certificate of Insurance, and Annexures which form part of the policy contract and shall be read together;

1.61. **Policy Certificate** means the certificate attached to and forming part of this Policy;

1.62. **Policyholder** (also referred as You) means the person who is the Group Administrator and named in the Policy Certificate as the Policyholder;

1.63. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specifically appearing in the Policy Certificate;

1.64. **Policy Period End Date** means the date on which the Policy expires, as specified in the Policy Certificate;

1.65. **Policy Period Start Date** means the date on which the Policy commences, as specified in the Policy Certificate;

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

1.67. **Post-hospitalization Medical Expenses** are Medical Expenses incurred immediately after the insured person is discharged from the hospital provided that:

a) Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
b) The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.

1.68. **Pre-existing Disease** means any condition, ailment or injury or related condition(s) for which the Insured Person had signs or symptoms, and/or were diagnosed, and/or received medical advice or treatment within 48 months to prior to the first policy issued by the Company;

1.69. **Pre-hospitalization Medical Expenses** are Medical Expenses incurred immediately before the Insured Person is Hospitalized, provided that:

a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

1.70. **Qualified Nurse** is a person who holds a valid registration from the Nursing Council;

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

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

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

1.74. **Single Trip Policy** means a Policy under which there cannot be more than one Period of Insurance during the Policy Period;

1.75. **Subrogation** shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source;

1.76. **Sum Insured** means the amount specified against the Benefit / Optional Benefit / Optional Extension in the Certificate of Insurance for each Insured Person which represents the Company's maximum, total and cumulative liability for that Insured Person for any and all Claims incurred in respect of that Insured Person during the Period of Insurance under that Benefit / Optional Benefit / Optional Extension;

1.77. **Surgery / 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 a Day Care Centre by a Medical Practitioner;

1.78. **Terrorism/Terrorist Incident** means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism;

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

2. SCOPE OF COVER

GENERAL CONDITIONS

(i) The maximum liability of the Company for an Insured Person for any and all Claims incurring under this Policy during the Policy Period for an insured event or occurrence that occurs during the Period of Insurance in relation to that Insured Person shall not exceed the Sum Insured specifically mentioned against each & every Benefit / Optional Benefit individually in the Certificate of Insurance. Sum Insured for all the Optional Extensions shall be a part of their respective Benefit / Optional Benefit Sum Insured except for Optional Extension 13 and Optional Extension 14 of Benefit – 'Medical Cover'. All Claims shall be payable subject to the terms, conditions and exclusions of the Policy and subject to availability of the Sum Insured.

(ii) Any Benefit or Optional Benefit or Optional Extension shall be available only if the same is specifically mentioned in the Certificate of Insurance and premium for the same has been received.

(iii) Benefit – 'Medical Cover', Optional Benefits and Optional Extensions are subject to the terms and conditions stated against them and the Policy Terms & Conditions.

(iv) Claim payable under any Benefit or Optional Benefit or Optional Extension shall be reduced by the Deductible and / or co-payment (if applicable) as specified against that Benefit or Optional Benefit or Optional Extension in the Certificate of Insurance or as opted.

(v) If the Geographical scope is out of India, Country of Residence is to be considered and whereas if the Geographical Scope is restricted to India, City of Residence is to be considered. Coverage will be restricted to the opted geographical scope.

(vi) The currency of the Sum Insured shall correspond to the currency mentioned against the Benefit, Optional Benefits and Optional Extensions in Certificate of insurance.

(vii) The Deductible and/or Co-payment amount specified in the Policy Certificate/ Certificate of Insurance or as opted shall be borne by the Insured Person on each Claim or the timeframe specified in the Policy Certificate/ Certificate of Insurance for which the Medical Expenses/ or other costs and expenses incurred in respect of the Insured Person for that timeframe shall be borne by the Insured Person on each Claim. The Company shall be liable to make payment under the Policy for any Claim in respect of the Insured Person only when the Deductible and/or Co-payment (if applicable) on that Claim is exhausted;

(viii) Claim under Optional Benefit 2 to Optional Benefit 37 can be made on reimbursement basis only.

(ix) Claim documents as specified in Clause 6.3 is applicable to each and every claim. Additional Claim documents related to specific Benefit / Optional Benefit / Optional Extension are mentioned against respective Benefit / Optional Benefit / Optional Extension.

(x) Scope of cover under the Policy will be defined as per the opted Benefit / Optional Benefit / Optional Extension.

(xi) Loadings and discounts are applied on the cumulative premium arrived based on the total man days.

(xii) This product offers a mandatory benefit – 'Medical Cover', which includes 'In-patient Care with Day care Treatment' (this includes 'Pre-Existing Disease Cover In Life Threatening Medical Condition' for up to 10% of Sum Insured of Medical Cover) or 'In-patient Care for Injury with Day care Treatment'. Policyholder has the option to choose any of the 14 optional extensions with this mandatory benefit.

Along with the mandatory Benefit – 'Medical Cover' and its optional extensions, Policyholder has further choice to opt for any of the 38 Optional Benefits, together with any of their Optional Extensions, if applicable. Please note that apart from mandatory benefit – 'Medical Cover', Optional Extensions are available only for Optional Benefit 25 – Out-patient Cover.

2.1. BENEFIT - MEDICAL COVER

The Company shall indemnify the Insured for the Medical Expenses reasonably incurred during Hospitalization by the Insured for medical treatment undertaken on account of any Illness contracted or Injury sustained whilst on a Trip during the Period of Insurance, subject to the overall liability of the Company not exceeding the Sum Insured for the coverage as specified in the Certificate of Insurance.

a) The Company has provided an option to cover either Clause 2.1 (a.1): In-patient care with Day Care Treatment or Clause 2.1(a.2): In-patient care for injury with Day Care Treatment.
Note – 'In-patient Care with Day care Treatment' includes 'Pre-Existing Disease Cover in Life Threatening Medical Condition' for up to 10% of Sum Insured of Medical Cover, subject to the conditions specified in Clause 2.1 (c) (i).

1. IN-PATIENT CARE FOR INJURY

If an Insured Person suffers an Injury during the Period of Insurance that requires the Insured Person's Hospitalization, then the Company will indemnify the Medical Expenses incurred on Hospitalization provided that:

(i) the Hospitalization is on the written advice of a Medical Practitioner;
(ii) the treatment for the Injury commences within 7 days of the occurrence of the Injury during the Period of Insurance;
(iii) Day Care Treatment and all Optional Extension(s) are restricted to Injury in case of cover restricted to in-patient care for Injury only.

b) DAY CARE TREATMENT

If an Insured Person has to undergo Day Care Treatment (as specified in Annexure – I) at a Day Care Centre or Hospital, the Company will indemnify the Medical Expenses incurred on that Day Care Treatment, provided that the treatment was taken on the written advice of a Medical Practitioner.

c) Documents to be submitted for any Claim under this Benefit

It is a condition precedent to the Company's liability under this Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Benefit:

(i) Original pathological or diagnostic reports, discharge summary, indoor case papers and prescriptions issued by the treating Medical Practitioner or Hospital.
(ii) Original bills and receipts for:
  i. Charges paid towards Hospital accommodation, nursing facilities and other medical services rendered.
  ii. Fees paid to the Medical Practitioner and for special nursing charges.
  iii. Charges incurred towards any and all test and / or examinations rendered in connection with the treatment.
  iv. Charges incurred towards medicines or drugs purchased from a registered pharmacy other than the Hospital duly supported by the prescriptions of the Medical Practitioner attending to the Insured Person.

2.2. OPTIONAL BENEFIT 1 – MEDICAL EVACUATION

a) The Company will indemnify up to the Sum Insured specified in the Certificate of Insurance for the reasonable cost incurred for the Medical Evacuation of the Insured Person in an Emergency through an Ambulance or any other transportation and evacuation services (including necessary medical care en-route forming part of the treatment) for any Illness contracted or Injury sustained by the Insured Person during the Period of Insurance, provided that:

(i) The treating Medical Practitioner certifies in writing that the severity or the nature of the Insured Person's Illness or Injury warrants the Insured Person's Emergency medical evacuation;

(ii) These transportation expenses are limited to transporting the Insured Person from the place of contracting or sustaining such Illness or Injury to the nearest appropriate Hospital;

(iii) This Optional benefit will be provided on a cashless basis if the costs are certified and authorized by the Company or the Assistance Service Provider in advance, unless the Insured Person has a Life Threatening Medical Condition and the Insured Person (or his representatives) arrange for the Medical evacuation at their own cost and expense in which case the Company will indemnify the costs incurred on the Medical evacuation in accordance with the terms of this Optional Benefit;

(iv) Payment under this Optional Benefit is subject to a Claim for the Illness or Injury which requires Hospitalization and is Medically Necessary.

b) **Documents to be submitted for any Claim under this Optional Benefit :**

It is a condition precedent to the Company's liability under this Optional Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Optional Benefit:

(i) Medical reports and transportation details issued by the evacuation agency, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirming the necessity of evacuation;

(ii) Documentary proof for all expenses incurred towards the Medical Evacuation.

2.3. OPTIONAL BENEFIT 2 – REPATRIATION OF MORTAL REMAINS

a) If the Insured Person dies solely and directly due to an Accident, the Company will indemnify for the costs of repatriation of the mortal remains of the Insured Person back to the Country of Residence / City of Residence or, up to an equivalent amount, for a local burial or cremation at the place where death has occurred.

b) **Documents to be submitted for any Claim under this Optional Benefit :**

It is a condition precedent to the Company's liability under this Optional Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Optional Benefit:

(i) Copy of the death certificate providing details of the place, date, time, and the circumstances and cause of death;

(ii) Copy of the postmortem certificate;

(iii) Documentary proof for expenses incurred towards disposal of the mortal remains;

(iv) In case of transportation of the body of the deceased to the Country of Residence / City of Residence, the receipt for expenses incurred towards preparation and packing of the mortal remains of the deceased and also for the transportation of the mortal remains of the deceased.

2.4. OPTIONAL BENEFIT 7 - PERSONAL ACCIDENT

a) If the Insured Person dies or suffers Permanent Total Disablement within twelve months from the date of occurrence of an Injury solely and directly due to an Accident occurring during the Period of Insurance, the Company will pay up to the Sum Insured specified in the Certificate of Insurance in accordance with the table below provided that death or Permanent Total Disablement is solely and directly due to the Injury and the Insured Person or his representative arranges for the immediate treatment of the Insured Person in a Hospital.

Sr. No.	Event	% of the Sum Insured payable
1	Death	100%
2	Permanent Total Disablement (PTD)	
A	Loss of sight of both eyes, or actual loss by physical separation of two entire hands or two entire feet, or one entire hand and one entire foot, or loss of sight of one eye and loss of one entire hand or one entire foot	100%
B	Loss of sight of one eye, or actual loss by physical separation of one entire hand or one entire foot	50%

For the purpose of this Optional Benefit only, physical separation of a hand or foot means actual severance of hand at or above the wrist, and of foot at or above the ankle.

b) Documents to be submitted for any Claim under this Optional Benefit:

It is a condition precedent to the Company's liability under this Optional Benefit that the following information and documentation shall be submitted to the Company or the Assistance Service Provider immediately and in any event within 30 days of the event giving rise to the Claim under this Optional Benefit:

(i) Medical reports giving the details of the Accident, nature of the Injury, the extent of disability (if applicable) and the details of treatment provided.
(ii) Death certificate (if applicable).
(iii) Postmortem certificate
(iv) Police report.
(v) Medical Practitioner's certificate in case of Injury stating the reasons for and the extent of the Injury

2.5. OPTIONAL BENEFIT 25 – OUT-PATIENT COVER

The Company shall indemnify the Insured for the Out-Patient Cover reasonably incurred by the Insured whilst on a Trip during the Period of Insurance.

a) The Company has provided an option to cover Clause 2.26(a.2) : Out-patient care for injury.

1. OUT-PATIENT CARE FOR INJURY

If an Insured Person suffers an Injury that requires the Insured Person to take Out-patient Care, then the Company will indemnify for the Medical Expenses incurred on that Out-patient Care.

3. GENERAL EXCLUSIONS (applicable to Benefit – 'Medical Cover', all Optional Benefits & Optional Extensions)

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(a) Any condition or treatment as specified in Annexure – II.

(b) The Company shall not admit any Claim in respect of an Insured Person which involves treatment/consultation in any of the hospitals as listed in Annexure – III.

(c) Any events occurring outside the Period of Insurance except for a Claim for Trip Cancellation under Optional Benefit 12.

(d) The Insured Person:
  (i) traveling against the advice of a Medical Practitioner; or
  (ii) receiving, or is supposed to receive, medical treatment; or
  (iii) having received terminal prognosis for a medical condition; or
  (iv) travelling for the purpose of obtaining medical treatment; or
  (v) taking part or is supposed to participate in a naval, military or air force operation or war like or peace keeping operation.
  (vi) traveling to Country from which his/her visa is allotted.

(e) An act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness.

(f) Any Illness or Injury directly or indirectly resulting or arising from or occurring during the commission of any breach of any law by the Insured Person with any criminal intent.

(g) Any condition directly or indirectly caused by or associated with any sexually transmitted disease, including Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis, Acquired Immuno Deficiency Syndrome (AIDS) whether or not arising out of HIV, Human T-Cell Lymphotropic Virus Type III (HTLV–III or IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the mutants derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind.

(h) Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy, which is proved by diagnostic means and certification by a gynecologist that it is life threatening.

(i) Any treatment arising from or traceable to any fertility, infertility, sub fertility or assisted conception procedure or sterilization or procedure, birth control procedures, hormone replacement therapy, contraceptive supplies or services including complications arising due to supplying services or Assisted Reproductive Technology.

(j) Any treatment or surgery for any dental illness or injury.

(k) Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.

(l) Charges incurred in connection with cost of spectacles (unless to the extent covered under Optional Benefit 15) and contact lenses, hearing aids, routine eye and ear examinations, laser surgery for correction of refractory errors, dentures, artificial teeth and all other similar external appliances and or devices whether for diagnosis or treatment.

(m) Experimental, investigational or unproven treatments which are not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness for which confinement is required at a Hospital. Any Illness or treatment which is a result or a consequence of undergoing such experimental or unproven treatment. Any diagnosis or treatment of an Illness / Injury which does not require Hospitalization.

(n) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, walker, belts, collar, caps, splints, braces, stockings of any kind, diabetic footwear, glucometer or thermometer, crutches, ambulatory devices, instruments used in treatment of sleep apnea syndrome (C.P.A.P) or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for asthmatic condition, cost of cochlear implants.

(o) Weight management services and treatment, vitamins and tonics related to weight control programmers, services and supplies including treatment of obesity (including morbid obesity).

(p) Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence, cure, rest cure, health hydros, nature cure clinics, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care, custodial care or any treatment in an establishment that is not a Hospital.

(q) Treatment of all external Congenital Anomalies or Illness or defects or anomalies or treatment relating to external birth defects.

(r) Treatment of mental Illness, stress, psychiatric or psychological disorders.

(s) Aesthetic treatment, cosmetic surgery and plastic surgery or related treatment of any description, including any complication arising from these treatments, other than as may be necessitated due to an Injury.

(t) Any treatment or surgery for change of sex or gender reassignments including any complication arising from these treatments.

(u) Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident.

(v) All preventive care, vaccination, including inoculation and immunizations (except in case of post-bite treatment), vitamins and tonics.

(w) Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.

(x) All expenses related to donor screening, treatment, including surgery to remove organs from the donor, in case of transplant surgery.

(y) Non-allopathic treatment.

(z) Illness or Injury attributable to the consumption, use, misuse or abuse of tobacco, intoxicating drugs or alcohol.

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

(bb) 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.

(cc) Stem cell implantation, harvesting, storage or any kind of treatment using stem cells.

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

  (i) Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile or fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

  (ii) Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

  (iii) Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

  In addition to the foregoing, any loss, Claim or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing, minimizing or in any way relating to the above is also excluded.

(ee) Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants.

(ff) Any sporting activities in so far as they involve the training or participation in competitions of professional or semi-professional sports persons, unless declared beforehand and agreed by the Company subject to additional premium being paid and incorporated accordingly in the Policy.

(gg) Any Claim relating to Hazardous Activities.

I. Additional Exclusions applicable to Benefit – 'Medical Cover', Optional Benefit 19 to 24, Optional Benefit 27, Optional Benefit 32 & Optional Benefit 36:

Any Claim in respect of any Insured Person for, arising out of or directly or indirectly due to any of the following shall not be admissible under this Optional Benefit unless expressly stated to the contrary elsewhere in the Policy terms and conditions:

(i) Medical treatment taken outside the Country of Residence/City of Residence if that is the sole reason or one of the reasons for the journey.

(ii) Any treatment or Medical Expense incurred for any illness/injury which was pre-existing at the time of commencement of Policy except for those covered under Optional Extension 1 to Benefit – 'Medical Cover' which is subject to those Pre-existing Diseases being declared and accepted by the Company prior to Policy Period Start Date and specified in the Certificate of Insurance.

(iii) Any treatment, which could reasonably be delayed until the Insured Person's return to the Country of Residence/City of Residence.

(iv) Rest or recuperation at a spa or health resort, sanatorium, convalescence home or similar institution.

(v) Routine physical tests and / or examination of any kind not consistent with or incidental to the diagnosis and treatment of any Illness or Injury either in a Hospital or as an outpatient and any type of vaccination or inoculation if it does not apply to post-bite treatment.

(vi) Physiotherapy expenses or any services provided by chiropractitioner.

(vii) Expenses related to any kind of Non-medical charges, service charge, surcharge, night charges levied by the hospital under whatever head.

4. SPECIAL CONDITIONS

Special Conditions shall be applicable only if the same is specified in the Policy Certificate / Certificate of Insurance.

4.1. **Special Condition 2 : Co-payment**

(a) Notwithstanding anything to the contrary in the Policy, it is hereby agreed and declared that the Insured Member will bear a Co-payment as specified in the Policy Certificate / Certificate of Insurance accordance with Clause 6.5 and Company's liability shall be restricted to the balance amount payable.

(b) The Co-payment shall be applicable to each and every claim for each Insured Person as defined in the Policy.

4.2. **Special Condition 3 : Deductible**

The claim amount assessed by the Company for a particular claim shall be reduced by the Deductible as specified in the Policy Certificate / Certificate of Insurance. The Company shall be liable to make payment under the Policy for any Claim only when the Deductible on that Claim is exhausted.

4.3. **Special Condition 4 : Trip Type**

The Company provides an option to the Insured Person to opt for Single Trip Policy or / and Annual Multi Trip Policy and same have been specified in Policy Certificate / Certificate of Insurance.

5. GENERAL CONDITIONS

The General Conditions shall be applicable to Benefit – 'Medical Cover', all Optional Benefits, Optional Extension and Specific Policy Terms & Conditions under the Policy.

5.1. The cover under the Policy shall not attach to any journey that has already commenced prior to the Policy Period Start Date.

5.2. Extension of the Period of Insurance for a Single Trip Policy:

On the Policyholder's written request, the Company will extend the Period of Insurance provided that the total Period of Insurance shall not exceed the maximum trip duration (as opted by the Policyholder) specified in the Policy Certificate / Certificate of Insurance. If a Claim has been made under the Certificate of Insurance:

(i) No insurance cover will be available under the Benefit or Optional Benefit or Optional Extension in respect of which the Claim is made if such Benefit or Optional Benefit or Optional Extension is available on a fixed benefit amount basis;

(ii) Insurance cover up to the available Sum Insured will be available under the Benefit or Optional Benefit or Optional Extension in respect of which the Claim is made if such Benefit or Optional Benefit or Optional Extension is available on an indemnity basis.

5.3. Extension of the Geographical Scope :

On the Policyholder's written request, the Company will extend Geographical Scope specified in the Certificate of Insurance provided that the additional premium specified by the Company is received in advance of commencement of coverage and provided that the Insured Person has not already entered any part of the proposed extended Geographical Scope made any medical related Claim under the Policy.

5.4. All requests for extensions must be made at least 1 day before the expiry of the original Period of Insurance and accompanied by all the following information and documentation:

(a) Duly completed application for extension;

(b) Details of complete particulars of all Claims;

(c) A good health declaration.

5.5. This product may be withdrawn / modified by the Company after due approval from the IRDA. In case this product is withdrawn / modified by the Company, this Policy can be extended under the then prevailing product or its nearest substitute approved by IRDA. The Company shall duly intimate the Policyholder at least three months prior to the date of such withdrawal / modification of this product and the options available to the Policyholder at the time of extension of this policy.

5.6. Extension will automatically be granted except on ground of fraud, moral hazard or misrepresentation or non-co-operation by the Insured Person.

5.7. Cancellation / Termination - At the request of the Policyholder, the Certificate of Insurance will be cancelled any time prior to the Period of Insurance End Date specified in the Certificate of Insurance subject to the following conditions:

(a) Full refund shall be made if the request for cancellation is received by the Company not later than 7 days from the Period of Insurance Start Date and before commencement of the first Period of Insurance if the sole reason for such cancellation is denial of visa for the countries where the Insured Person was scheduled to visit. The visa denial or cancellation letter issued by appropriate authorities shall be submitted to the Company along with the request for cancellation.

(b) Cancellation of Certificate of Insurance, issued for a Single Trip, at a date earlier than the Period of Insurance End Date specified in Certificate of Insurance can be done only if the Insured Person returns to the Country of Residence / City of Residence before the Period of Insurance End Date. Refund of premium shall only be applicable if the difference between the arrival date to the Country of Residence and the Certificate of Insurance End Date is at least 1 day. Premium refunded will be the difference of the amount of premium paid for the original Period of Insurance and the premium applicable by taking the arrival date as the new Period of Insurance End Date.

(c) Cancellation of Certificate of Insurance, issued for an Annual Multi Trip , at a date earlier than the Period of Insurance End Date will be effected by the Company and the Company shall retain premium on short period scales as specified hereunder:

Period from Period of Insurance Start Date	**Number of Trip days utilized**	**Premium Retained by the Company**
Up to 1 month	Less than or equal to 7 days	25% annual rate
	Greater than 7 days & upto 21 days	50% annual rate
	Greater than 21 days	75% annual rate
From 2nd month Up to 3 months	Less than or upto 21 days	50% annual rate
	Greater than 21 days and upto 35 days	75% annual rate
	Greater than 35 days	Full annual rate
From 4th month Up to 6 months	Less than or upto 35 days	75% annual rate
	Greater than 35 days	Full annual rate
Exceeding 6 months	Any Trip duration	Full annual rate

(d) No refund of premium shall be eligible in case of cancellation of this Certificate of Insurance where a Claim has been incurred/ registered. The Company shall have no liability to make payment of any claims which are incurred post cancellation of the Certificate of Insurance.

6. CLAIM INTIMATION, ASSESSMENT AND MANAGEMENT

Upon the occurrence of any event, Illness or Injury that may give rise to a Claim under this Policy, then as a Condition Precedent to the Company's liability under the Policy, the Policyholder or Insured Person (or the Nominee or legal heir if the Policyholder / the Insured Person is deceased) shall undertake all the following in addition to any specific requirements specified within the Benefit / Optional Benefit / Optional Extension under which the Claim is made:

6.1. Claims Intimation

(a) If any Illness is diagnosed or discovered or any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Policyholder or Insured Person (or the Nominee or legal heir if the Insured Person is deceased), shall notify the Company either at the Company's call center or in writing immediately and in any event within the timeframe (if any) specified in the Benefit / Optional Benefit under which the Claim is made.

(b) It is agreed and understood that the following details are to be provided to the Company at the time of intimation of the Claim:

(i) Policy Number/ Certificate of Insurance;
(ii) Claimant's Name;
(iii) Name of the Insured Person in respect of whom the Claim is being made;
(iv) Nature of Illness or Injury or contingency for which Claim is being made and the Benefit and/or Optional Benefit and/or Optional Extension under which the Claim is being made;
(v) Date of admission to Hospital or loss;
(vi) Name and address of the attending Medical Practitioner and Hospital (if applicable);
(vii) Any other information, documentation or details requested by the Company or the Assistance Service Provider;

(c) Any event that may give rise to a Claim has to be notified to the Company or the Assistance Service Provider, within 48 hours of Hospitalization or before discharge (whichever is earlier). However, the Company will examine and relax the timeframe specified for Claim intimation depending upon the merits of the case.

6.2. Claims Procedure

(a) **Cashless:** Cashless treatment facilities are available only at Network Providers of the Company or the Assistance Service Provider. The Insured Person can avail of this cashless facility at the time of admission into a Network Provider, by completing the following procedure:

(viii) Pre-authorization : The Policyholder or Insured Person must call the Company's / Assistance Service Provider's call center specified in the Certificate of Insurance and request authorization for the proposed treatment by way of submission of a completed pre-authorization form at least within 24 hours of admission to Hospital.

(ix) The Company will process the request for authorization after having obtained accurate and complete information in respect of the Illness or Injury for which cashless facility is sought to be availed. The Company or the Assistance Service Provider will confirm in writing authorization or rejection of authorization to avail cashless facility for the Insured Person's Hospitalization.

(x) If the request for availing cashless facility is authorized by the Company or the Assistance Service Provider, then payment for the Medical Expenses incurred in respect of the Insured Person shall not have to be made to the extent that such Medical Expenses are covered under this Policy and fall within the amount authorized in writing by the Company for availing cashless facility. Payment in respect of all Deductibles/co-payments (if applicable) shall be made directly by the Policyholder or Insured Person to the Network Provider.

(xi) If the Company does not authorize the cashless facility due to insufficient Sum Insured or insufficient information provided to the Company to determine the admissibility of the Claim

or if the treatment is not taken at a network provider, payment for the treatment will have to be made by the Policyholder or Insured Person to the Network Provider, following which a Claim for reimbursement may be made to the Company which will be considered by the Company subject to the terms, conditions and exclusions under the Policy.

(xii) It is agreed and understood that in all cases where availing of cashless facility has been authorized in writing by the Company, all the information and documentation specified below shall be submitted to the Company or the Assistance Service Provider immediately and in any event before the Insured Person's discharge from Hospital:

i. Duly filled and signed Claim form
ii. Duly filled and signed 'Release of Medical information Form'

(b) It is agreed and understood that:

(i) When authorizing the availing of cashless facility under this Policy, the Company may authorize the Policyholder's or Insured Person's request for direct settlement of admissible Claims resulting from the Hospitalization in accordance with the agreed charges and the terms and conditions between the Network Provider and the Company. If this authorization is provided then, the Company will directly pay all amounts payable in accordance with the terms and conditions of the Policy to the Network Provider to the extent the Claim is admissible under the Policy.

(ii) The Company may modify or add to the list of Network Providers or modify or restrict the extent of cashless facilities that may be availed at any particular Network Provider. The updated list would be available at the Company's or Assistance Service Provider's website or call centre.

(iii) Before availing the cashless facility, Policyholder or the Insured Person is required to check the applicable list of Network Providers for the area where he intends to avail the cashless facility through the call center number as provided in the Certificate of Insurance.

(c) **Reimbursement :**

(i) It is agreed and understood that in all cases where intimation of a Claim has been provided under this provision, all the information and documentation specified against the Benefit / Optional Benefit and Clause 6.3 below shall be submitted (at the Insured Person's expense) to the Company immediately and in any event within 30 days of Insured Person's discharge from Hospital or completion of treatment or date of loss, whichever is later.

6.3. Claim Documentation

The Policyholder or Insured Person (or Nominee or legal heir if the Insured Person is deceased) shall (at his expense) give the documentation specified below and any additional information or documentation specified in the Benefit and/or Optional Benefit and/or Optional Extension under which the Claim is being made to the Company or the Assistance Service Provider immediately and in any event within 30 days of the occurrence of the Injury / Illness or treatment or loss.

(i) Duly completed and signed Claim form, in original;
(ii) Passport copy with entry/exit stamp;
(iii) Any other document as required by the Company or Assistance Service Provider
(iv) Additional documents as specified for each benefit

Note : All invoices and bills should be in Insured Person's name or as per the documents mentioned in the respective Benefit / Optional Benefits. Depending on the nature of the Claim, treatment undertaken or illness, there would be a possibility of seeking more information / document from the Claimant concerned without prejudice to his interest and the same shall be requested by any means of recognized communication channels.

However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay.

6.4. Policyholder's or Insured Person's or Claimant's duty at the time of Claim

It is agreed and understood that as a condition precedent for a Claim to be considered under this Policy:

(a) All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.

(b) The Insured Person shall follow the directions, advice or guidance provided by a Medical Practitioner and the Company shall not be obliged to make payment that is brought about or contributed to by the Insured Person failing to follow such directions, advice or guidance.

(c) Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 6 of the Policy and the specific procedures and timeframes specified under the respective Benefit or Optional Benefit or Optional Extension under which the Claim is being made.

(d) The Insured Person will, at the request of the Company and at his / her own cost and expense, submit himself / herself for a medical examination by the Company's/Assistance Service Provider's nominated Medical Practitioner as often as the Company considers reasonable and necessary.

(e) The Company's/Assistance Service Provider's Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Person's medical and Hospitalization records and to investigate the facts and examine the Insured Person.

(f) The Company shall be provided with complete documentation and information which the Company has requested to establish its liability for the Claim, its circumstances and its quantum.

(g) Report any information / document which helps the insurance system to eliminate bad practices in the market.

6.5. Claim Assessment

(a) All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:

i. If the provisions of the Contribution Clause in Clause 7.9 are applicable, the Company's liability to make payment under that Claims shall first be apportioned accordingly.

ii. If any sub-limits on Medical Expenses are applicable in accordance with Clause 2.1 (c) (xi), the Company's liability to make payment shall be limited to such extent as applicable.

iii. The Deductible shall be applied to each Claim that is either paid or payable (and not excluded), under this Policy. The Company's liability to make payment shall commence only once the amount of the Claim payable or paid exceeds the Deductible.

iv. Co-payment shall be applicable on the amount payable by the Company after applying Clause 6.5(a) (i), (ii) and (iii).

6.6. Payment terms

(a) The Company may change the Assistance Service Provider or utilize the service of any other assistance service provider by giving written notification to the Policyholder.

(b) All payments under this Policy shall be made in Indian Rupees and within India. For all admissible reimbursement Claims, the exchange rate on the date of payment shall be applied and for all admissible benefit (fixed pay-out) Claims, the exchange rate on the date of loss shall be applied.

(c) If the Assistance Service Provider or the Company requests that bills or vouchers in a local language or vernacular be accompanied by an appropriate translation into English then the costs of such translation must be borne by the Policyholder or the Insured Person.

(d) The Sum Insured of the Insured Person shall be reduced by the amount payable or paid under the Policy Terms and Conditions or any Benefit / Optional Benefit / Optional Extension applicable under this Policy and only the balance amount shall be available as the Sum Insured for the unexpired Policy Period.

(e) The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Person, once the Sum Insured for that Insured Person is exhausted.

(f) If the Insured Person suffers a relapse within 45 days of the date of discharge from the Hospital for which a Claim has been made, then such relapse shall be deemed to be part of the same Claim and all the limits for Any One Illness under this Policy shall be applied as if they were under a single Claim.

(g) For Cashless Claims, the payment shall be made to the Network Provider whose discharge would be complete and final.

(h) For the Reimbursement Claims, the Company will pay to the Insured Person unless specified otherwise in the Certificate of Insurance. In the event of death of the Insured Person, unless specified otherwise in the Certificate of Insurance, the Company will pay to the Nominee (as named in the Certificate of Insurance) and in case of no Nominee to the legal heir of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

(i) The Company shall settle any Claim within 30 days of receipt of all the necessary documents/ information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder an offer of settlement of Claim and upon acceptance of such offer by the Policyholder the Company shall make payment within 7 days from the date of receipt of such acceptance. In case there is delay in the payment beyond the stipulated timelines, the Company shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India, unless the extent regulation requires payment based on some other prescribed interest rate.

(j) No loading based on individual claim experience shall be applicable on renewal premium payable in case of Annual Trip Policy.

7. STANDARD TERMS AND CONDITIONS:

7.1. Disclosure to Information Norm

If any untrue or incorrect statements are made or there has been a misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld, or if a Claim is fraudulently made or any fraudulent means or devices are used by the Policyholder, the Insured Person or any one acting on his or their behalf, the Company shall have no liability to make payment of any Claims and the premium paid shall be forfeited to the Company on cancellation of the Policy.

7.2. Observance of Terms and Conditions

The due observance and fulfillment of the terms and conditions of this Policy (including the realization of premium by their respective due dates and compliance with the specified procedure on all Claims) in so far as they relate to anything to be done or complied with by the Policyholder or any Insured Person, shall be condition precedent to the Company's liability under the Policy.

7.3. Reasonable Care

Insured Persons shall take all reasonable steps to safeguard the interests against any Illness or Injury that may give rise to a Claim.

7.4. Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in occupation or business at his own expense, as per Annexure -IV. The Company may adjust the scope of cover and / or the premium paid or payable, accordingly.

7.5. Records to be maintained

The Policyholder and Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require under this Policy at any time during the Policy Period or until final adjustment (if any) and resolution of all Claims under this Policy.

7.6. No constructive Notice

Any knowledge or information of any circumstance or condition in relation to the Policyholder or Insured Person which is in possession of the Company other than that information expressly disclosed in the Proposal Form or otherwise in writing to the Company, shall not be held to be binding or prejudicially affect the Company.

7.7. Complete Discharge

Payment made by the Company to the Policyholder or Insured Person or the Nominee or the legal heir or representative of the Insured Person, as the case may be, under the Policy shall in all cases be complete and construe as an effectual discharge in favor of the Company.

7.8. Subrogation

The Policyholder and Insured Person shall at his own expense do or concur in doing or permit to be done all such acts and things that may be necessary or reasonably required by the Company for the purpose of enforcing and / or securing any civil or criminal rights and remedies or obtaining relief or indemnity from any other party to which the Company is or would become entitled upon the Company paying for a Claim under this Policy, whether such acts or things shall be or become necessary or required before or after its payment. Neither the Policyholder nor any Insured Person shall prejudice these subrogation rights in any manner and shall at his own expense provide the Company with whatever assistance or cooperation is required to enforce such rights. Any recovery the Company makes pursuant to this clause shall first be applied to the amounts paid or payable by the Company under this Policy and any costs and expenses incurred by the Company of effecting a recovery, where after the Company shall pay any balance

remaining to the Policyholder. This clause shall not apply to any Benefit or Optional Benefit or Optional Extension offered on a fixed benefit basis.

7.9. Contribution

(a) In case any Insured Person is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder/Insured Person shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to the sum insured of such Policy.

(b) In case the Claim amount under a single policy exceeds the Sum Insured after considering the deductible or co-payment, then Policyholder shall have the right to choose the companies with whom the Claim is to be settled. In such cases, the settlement shall be done as under:

(i) If at the time when any Claim arises under this Policy, there is any other insurance which covers (or would have covered but for the existence of this Policy), the same Claim (in whole or in part), then the Company may not be liable to pay or contribute more than its ratable proportion of any Claim.

(ii) This clause shall not apply to any Benefit offered on a fixed benefit basis.

7.10. Policy Disputes

Any and all disputes or differences under or in relation to the validity, construction, interpretation and effect to this Policy shall be determined by the Indian Courts and in accordance with Indian law.

7.11. Cancellation / Termination

The Company may at any time, cancel this Policy on grounds as specified in Clause 7.1 and the Company shall have no liability to make payment of any claims and the premium paid shall be forfeited by the Company, by giving 15 days' notice in writing by Registered Post Acknowledgment Due / recorded delivery to the Policyholder at his last known address.

Policies where the Policyholder and Insured Person are different, in the event of the demise of the Policyholder, this Policy shall continue till the Policy Period End Date.

7.12. Limitation of liability

Any Claim under this Policy for which the notification or intimation of Claim is received 12 calendar months after the event or occurrence giving rise to the Claim shall not be admissible, unless the Policyholder/Insured Person proves to the Company's satisfaction that the delay in reporting of the Claim was for reasons beyond its/his control.

7.13. Communication

(a) Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Certificate/ Certificate of Insurance. Any communication meant for the Policyholder or Insured Person will be sent by the Company to his last known address or the address as shown in the Policy Certificate/ Certificate of Insurance.

(b) All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Certificate/ Certificate of Insurance. Agents are not authorized to receive notices and declarations on the Company's behalf.

(c) Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

7.14. Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company.

7.15. Cause of Action

No Claims shall be payable under this Policy unless the event or occurrence giving rise to the Claim occurs in the Geographical Scope specified in the Certificate of Insurance.

7.16. Overriding effect of Policy Certificate/ Certificate of Insurance

In case of any inconsistency in the terms and conditions in this Policy vis-a-vis the information contained in the Policy Certificate and/or Certificate of Insurance, the information contained in the Policy Certificate or Certificate of Insurance shall prevail.

7.17. Electronic Transactions

The Policyholder and Insured Person agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of the Company, for and in respect of the Policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

7.18. Grievances

(a) The Company has developed proper procedures and effective mechanism to address complaints, if any of the customers. The Company is committed to comply with the Regulations, standards which have been set forth in the Regulations, Circulars issued from time to time in this regard.

(b) If the Policyholder/Insured Person has a grievance that the Policyholder/Insured Person wishes the Company to redress, the Policyholder/Insured Person may contact the Company with the details of his grievance through:

Website : www.religarehealthinsurance.com
Contact No.:1800-200-4488
Fax :1800-200-6677

Or write to :

Manager – Customer Services
Religare Health Insurance Company Limited
GYS Global,
Plot No. A3, A4, A5, Sector - 125,
Noida, Uttar Pradesh - 201301
E-mail : resolve1@religarehealthinsurance.com
Post/Courier : Any branch office or the correspondence address, during normal business hours. The detailed list of our branch in operations in the country is available on our website.

(c) If the Policyholder/Insured Person is not satisfied with the Company's redressal of the Policyholder's/Insured Person's grievance through one of the above methods, the Policyholder/Insured Person may contact the Company at:

Head – Customer Services
Religare Health Insurance Company Limited
GYS Global,
Plot No. A3, A4, A5, Sector - 125,
Noida, U.P. - 201301
E-mail : resolve2@ religarehealthinsurance.com

(d) If the Policyholder/Insured Person is not satisfied with the Company's redressal of the Policyholder's/Insured Person's grievance through one of the above methods, the Policyholder/Insured Person may approach the nearest Insurance Ombudsman for resolution of the grievance. The contact details of Ombudsman offices are mentioned below:

Office of the Ombudsman	Name of the Ombudsman	Contact Details	Areas of Jurisdiction
AHMEDABAD		Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, 5, Navyug Colony Nr. C.U. Shah College, Ashram Road, **AHMEDABAD-380 014.** Tel.: 079-27546150/139 Fax: 079-27546142 Email: ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL	Shri Raj Kumar Srivastava	Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL(M.P.)-462 011. Tel.: 0755-2569200/201/202 Fax: 0755-2569203 Email: bimalokpalbhopal@gmail.com	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri B.N. Mishra	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR-751 009. Tel.: 0674-2596455/2596461 Fax: 0674-2596429 Email: ioobbsr@dataone.in	Orissa
CHANDIGARH	Shri Manik Sonawane	Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building. Sector 17-D, CHANDIGARH-160 017. Tel.: 0172-2706468/6196/5861 Fax: 0172-2708274 Email: ombchd@yahoo.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh
CHENNAI	Shri Virander Kumar	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI-600 018. Tel.: 044-24333668/664/678 Fax: 044-24333664 Email: chennaiinsuranceombudsman@gmail.com	Tamil Nadu, UT–Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Ms. Sandhya Baliga	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI-110 002. Tel.: 011-23239633/7539/7532 Fax: 011-23230858	Delhi & Rajasthan

		Email: iobdelraj@rediffmail.com	
GUWAHATI		Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI-781 001 (ASSAM). Tel.: 0361-2132204/2205/1307 Fax: 0361-2732937 Email: ombudsmanghy@rediffmail.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri G.Rajeswara Rao	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD-500 004. Tel: 040-23325325/23312122 Fax: 040-23376599 Email: insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam – a part of the UT of Pondicherry
KOCHI	Shri P.K. Vijayakmar	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM-682 015. Tel: 0484-2358759/734/9338 Fax: 0484-2359336 Email: iokochi@asianetindia.com	Kerala , UT of (a) Lakshadweep , (b) Mahe – a part of UT of Pondicherry
KOLKATA	Shri K.B. Saha	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, Kolkatta – 700 072. Tel: 033 22124346/22124339 Fax: 033 22124341 Email:insombudsmankolkata@gmail.com	West Bengal , Bihar , Jharkhand and UT of Andeman & Nicobar Islands , Sikkim
LUCKNOW	Shri N.P. Bhagat	Insurance Ombudsman, Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazaratganj, LUCKNOW-226 001. Tel: 0522 -2201188/31330/1 Fax: 0522-2231310 Email: insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI	Shri A.K. Dasgupta	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI-400 054. Tel: 022-26106928/360/6552/6960 Fax: 022-26106052 Email: ombudsmanmumbai@gmail.com	Maharashtra , Goa

The updated details of Insurance Ombudsman are available on IRDA website : www.irda.gov.in, on the website of General Insurance Council: www.generalinsurancecouncil.org.in, the Company's website xxxx. xxxxxxxxxxxx or from any of the Company's offices. Address and contact number of Governing Body of Insurance Council –

Office of the Governing Body of Insurance Council
3rd Floor, Jeevan Seva Annexe,
S. V. Road, Santacruz (W),
Mumbai - 400 054.
Tel.: 022-26106245/889/671
Fax: 022-26106949
Email: inscoun@gmail.com