A POLICY THAT GIVES **MAXIMUM PROTECTION FOR WOMEN.**

INTRODUCING

CHOLA SARVA SHAKTI POLICY

UIN: CHOHLIP21571V012021

REACH US THROUGH WHATSAPP

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POLICY WORDINGS

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POLICY WORDINGS

Whereas the insured described in the Schedule hereto (hereinafter called the 'Insured') has made a Proposal to Cholamandalam MS General Insurance Co Ltd (hereinafter called the Company) containing certain particulars and statements, which shall be the basis of this contract and be considered as incorporated herein for the Insurance hereinafter contained and has paid the premium as consideration for such insurance, now the Company agrees, subject to the following terms, conditions, exclusions, and limitations, to indemnify the Insured subject always to the Sum Insured against such loss as is herein provided.

The benefit applicable to you will depend on the Plan and Sum Insured opted by you as shown in your **Policy Schedule**.

1. DEFINITIONS

The terms defined below and at other junctures in the Policy Wording have the meanings ascribed to them wherever they appear in the 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:

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

2. **Accidental Damage** means an accident that causes physical damage to the Insured item, which is caused suddenly by an outside force and is not expected and not deliberate.

3. **Acquired Immune Deficiency Syndrome (AIDS)** means the meaning assigned to it by the World Health Organization and shall include Human Immune deficiency Virus (HIV), Encephalopathy (dementia) HIV Wasting Syndrome and ARC (AIDS Related Condition.

4. **Adventure Sports** (also called action sports, aggressive sports, and Extreme sports) are certain activities perceived as having a high level of inherent danger and include racing on wheels or horseback, big game hunting, mountaineering, winter sports, Skydiving, Parachuting, Scuba Diving, Riding or Driving in Races or Rallies, Mountain Climbing, hunting or equestrian activities, rock climbing, pot holing, bungee jumping, skiing, ice hockey, ballooning, hang gliding, diving or under-water activity river rafting, canoeing involving rapid waters, polo, yachting or boating outside coastal waters.

5. **AYUSH Treatment** refers to the medical and / or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems

6. **AYUSH Hospital:** An AYUSH Hospital is a healthcare facility wherein medical/ surgical/para-surgical treatment procedures and interventions are carried out by

AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

   i. Having at least 5 in-patient beds;

   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

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

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

7. *__AYUSH Day Care Centre:__ AYUSH Day Care Centre means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion:

   i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

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

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

8. **Bank** - means any Banking company as defined under Section 5 of the Banking Regulations Act, 1949; -a corresponding new Bank constituted by the Banking Companies (Acquisition and Transfer of Undertaking) Act, 1970. -the State Bank of India constituted by State Bank of India Act, 1955; -Associate Bank as defined in Section 2 of the State Bank of India (Subsidiary Banks) Act, 1959; -Co-operative Banks as defined in Section 56(a) of the Banking Regulation Act 1949; -Regional Rural Banks established under Section 3(1) of the Regional Rural Banks Act (21 of 1976) and Any Bank established under a Land Mortgage Bank Act or Land Development Bank Act of any State, Small Finance Banks governed by the provisions of RBI Act 1934, Banking Regulations Act 1949 and other Relevant Statutes and Any Other Bank/Financial Institution which has been established and is functioning under the Guidelines of RBI including Non-Banking Financial Institutions.

9. **Bodily Injury** means physical bodily harm or injury, sustained because of an Accident occurring during period of insurance for which immediate treatment by a Doctor is necessary, but does not include any mental disease or illness or sickness.

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

11. **Carcinoma-in-situ(CiS)** means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The diagnosis of the Carcinoma in situ must always be supported by a histopathological report. Furthermore, the diagnosis of Carcinoma in situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard. In the case of the cervix uteri, Pap smear alone is not acceptable and should be accompanied with cone biopsy or colposcopy with the cervical biopsy report clearly indicating presence of CIS. Clinical diagnosis of Cervical Intraepithelial Neoplasia (CIN) classification, which reports CIN I, CIN II and CIN III does not meet the required definition and are specifically excluded.

12. **Cashless facility** means a facility extended by the Insurer to the insured where the payments, of the costs of treatment undergone by the insured person in accordance with the policy terms and conditions, are directly made to the network provider by the Insurer to the extent pre-authorization is approved.

13. **Chemotherapy** means a kind of cancer treatment that uses drugs to destroy cancer cells, stop cancer cells from spreading or slow the growth of cancer cells.

    The following conditions are excluded:

    a. Drugs used only for palliation of symptoms
    b. Drugs still in trial stage or drugs not approved by DCGI (Drug Controller General of India) or CDSCO (Central Drug Standard Control Organization)
    c. Use of drugs which is inconsistent with commonly accepted clinical guidelines.

14. **Claim** means a claim under a covered Section in respect of an insured event. All Claims resulting from one and the same event or circumstance shall jointly constitute one Claim under this Policy and as having been made at the time when the first Claim was made in writing.

15. **Coma** means a profound state of unconsciousness where the patient cannot be awakened, fails to respond normally to pain or light, does not have sleep-awake cycles and cannot take voluntary actions and Comatose means a state of Coma.

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

17. **Congenital Anomaly** refer to a condition(s) which is present since birth, 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.

18. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion 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

19. **Day Care Procedure/Treatment** refers to medical treatment and/or surgical procedure which is

a. undertaken under general or local anesthesia in a hospital / day care centre in less than 24 hours because of technological advancement and

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

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

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

21. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.

22. **Dependent Child**- Dependent Child refers to a child (natural or legally adopted) and studying at an accredited educational institution, who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

23. **Domestic Help** means any person employed by the Insured solely to carry out domestic duties associated with the Insured's Home, but does not include any person employed in any capacity in connection with any Business, trade or profession.

24. **Early Stage Cancer** shall mean first ever diagnosis with the presence of one of the following malignant conditions:

    a. Tumour of the thyroid histologically classified as T1N0M0 according to the TNM classification;

    b. Prostate tumour should be histologically described as TNM Classification T1a or T1b or T1c are of another equivalent or lesser classification.

    c. Chronic lymphocytic leukaemia classified as RAI Stage I or II;

    d. Basal cell and squamous skin cancer that has spread to distant organs beyond the skin,

    e. Hodgkin's lymphoma Stage I by the Cotswold's classification staging system.

    f. All tumours of the urinary bladder histologically classified as T1N0M0 (TNM Classification)

    The Diagnosis must be based on histopathological features and confirmed by a Pathologist. Premalignant lesions and conditions, unless listed above, are excluded.

25. **Ectopic Pregnancy** means a Pregnancy in which the foetus develops outside the Uterus, typically in a Fallopian Tube.

26. **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's health.

27. **Equated Monthly Instalments (EMI)** shall mean a fixed payment made by a Borrower to a Lender at a specified date each calendar month. It is used to pay off both the Principal and Interest each month so that over a specified number of months the loan is paid off in full.

28. **Family/Family Members** means Insured 's spouse, children, Parents, Parents in law and Siblings residing with the insured.

29. **Financial Institution** means an establishment that completes and facilitates monetary transactions such as loans, mortgages and deposits, whose principle activities are regulated by the Indian financial regulatory bodies in the territories in which it operates.

30. **Fracture:** A fracture is a complete or incomplete break in a bone resulting from the application of excessive force.

31. **Genetic Test** means a type of medical test that identifies changes in Chromosomes, genes or proteins. This includes Molecular Genetic tests, Chromosomal genetic tests and Biochemical genetic tests.

32. **Geographical Limits** means Indian territory unless specified otherwise.

33. **Governmental Acts** means any expropriation, nationalization, confiscation, requisition, seizure or any other act by or under order of any governmental, de facto or public local authority.

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

    Provided the insurers shall offer coverage during the grace period, if the premium is paid in instalments during the policy period.

35. **Hazardous Activities** means Persons whilst working in underground mines, explosives, magazines, workers whilst involved in electrical installation with high tension supply, jockeys, circus personnel, Aircraft pilots and crew, Armed Forces personnel, Artistes engaged in hazardous performances, Aerial crop sprayer , Bookmaker (for gambling) , Demolition contractor, Explosives users, Fisherman (seagoing ,Jockey , Marine salvager ,Miner and other occupations underground , nuclear installations, Off-shore oil or gas rig worker , Policeman , Pop Musicians , Professional sports person , Roofing contractors and all construction, maintenance and repair workers at heights in excess of 50ft/15m , Saw miller , Scaffolder , Scrap metal merchant, Security guard (armed) , Ship crew , Steeplejack ,Stevedore ,Structural steelworker, Tower crane operator ,Tree feller.

36. **Hospital** means any institution established for in-patient care and day care treatment of disease 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 ten in-patient beds in towns having a population of less than ten lakhs and at least fifteen 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.

37. **Hospitalisation** means admission in a Hospital as an In-Patient for 'In-Patient Care/ treatment'.

38. **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.

39. **ICU Charges (Intensive Care Unit) charges** means the amount charged by a Hospital towards ICU expenses which shall include the expenses on a per day basis for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

40. **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.

a. **Acute condition** means 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.

b. **Chronic condition** means a disease, illness, or injury that has one or more of the following characteristics:
   i. It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests.
   ii. it needs ongoing or long-term control or relief of symptoms.
   iii. it requires rehabilitation for the patient or for the patient to be special trained to cope with it.
   iv. it continues indefinitely.
   v. it recurs or is likely to recur.

41. **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.

42. **Insured** means the person named as such in the policy schedule.

43. **Major Stage Cancer** A malignant tumour 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 leukaemia, lymphoma and sarcoma.

The following are excluded –

All tumours which are histologically described as carcinoma in situ, benign, pre-malignant borderline malignant, low malignant potential, neoplasm of unknown behaviours or non-invasive including but not limited to : Carcinoma insitu of breasts, Cervical dysplasia CIN-1, CIN-2 & CIN-3

a. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond.
b. Malignant melanoma that has not caused invasion beyond the epidermis.
c. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to atleast clinical TNM classification T2N0M0.
d. All Thyroid cancers histologically classified as T1N0M0 (TNM Classificaiton) or below.

e. Chronic lymphocyctic leukaemia less than RAI stage 3.

f. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification.

g. All Gastro-Intestinal Stromal Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs.

h. All tumours in the presence of HIV infection

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

45. **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.

46. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license. He/she should not be the insured or close member of the family.

47. **Membership Number** means an identification number of every insured person for our In-house Claims administration team. Membership number will be mentioned in the health card provided to each insured person.

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

a. is required for the medical management of the illness or injury suffered by Insured;

b. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;

c. must have been prescribed by a Medical Practitioner;

d. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

49. **Network Provider/ Hospital** means Hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility. The list is available with the insurer and subject to amendment from time to time.

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

51. **Nominee** is a person selected by the policyholder to receive the benefit in case of death of the insured thus giving a valid discharge to the insurer on settlement of claim under an insurance policy.

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

53. **OPD treatment** means the 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.

54. **Policy** means the Proposal, Policy Wording, the Schedule and Applicable Endorsements under the Policy. The Policy contains details of the extent of cover available to the Insured, the Exclusions under the Cover and the Terms, Conditions, Warranties and Limitations of the issue of the Policy.

55. **Policy Period** means the Period commencing from Policy Start Date and hour as specified in the Schedule and terminating at midnight on the Policy End Date as specified in the Schedule to this Policy.

56. **Policy Year** means 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 the purpose of 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, till the policy period, as mentioned in the Policy Schedule.

57. **Post-Hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital, provided that

    a. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and

    b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

58. **Pre-existing Disease** means any condition, ailment, injury or disease:

    a. That is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

    b. For which medical advice or treatment was recommended by, or received from, a physician, not more than 36 months prior to the date of commencement of the policy.

59. **Pre-Hospitalization Medical Expenses** means medical expenses incurred during pre-defined number of days preceding the hospitalization of the Insured Person, provided that

    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and

    b. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

60. **Professional Sports** means a sport which is the primary livelihood earning of the player,

61. **Proposal:** - It means any signed proposal by filling up the questionnaires and declarations, written statements and any information regarding the Insured to be covered under the Policy.

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

63. **Radiotherapy** is a cancer treatment given by a specialist for therapeutic radiology or radiation oncology that uses high doses of radiation to kill cancer cells and stop them from spreading. Radiotherapy can be prescribed through external beam radiation therapy, internal radiation therapy or radioisotope therapy.

64. **Sum Insured** means the amount stated in the Schedule, which is the maximum amount for any one Claim and in the aggregate for all Claims for which the Company will make payment in relation to the Various Sections during the Cover Period.

65. **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.

66. **Survival Period** means the period after an insured event that the insured person has to survive before a claim becomes valid.

67. **Terrorism:** An act of terrorism means an act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), or unlawful associations, recognized under Unlawful Activities (Prevention) Amendment Act, 2008 or any other related and applicable national or state legislation formulated to combat unlawful and terrorist activities in the nation for the time being in force, committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public or any section of the public in fear for such purposes.

68. **Third Party Administrator (TPA)** means a company registered with the Authority and engaged by an insurer for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

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

70. **Specific Waiting Period** means a period up to 36 months from the commencement of a health insurance policy during which period specified diseases/treatments (except due to an accident) are not covered. On completion of the period, diseases/ treatments shall be covered provided the policy has been continuously renewed without any break

71. **You, Your, yourself** means the Insured that We insure as set out in the Policy Schedule.

72. **We/Us/Our** means The Cholamandalam MS General Insurance co ltd.

2. ELIGIBILITY FOR COVER

- Chola Sarva Shakti is a retail insurance product exclusively meant for woman
- Any Employed /Self Employed/ Unemployed Woman in the age group of 18 -65 years who is a Resident of India can buy the policy. The age shall be computed as on the date of commencement of risk. The policy can be continually renewed without any age limit.

3. APPLICABILITY OF COVERS

The proposer can opt for sections required by her.

It is compulsory for opting cover under any one of the following sections	1A-AD or 1B-PTD or 2A- Cancer Care Benefit or 2B- Critical Illness-Standard benefit or 2C- Critical Illness-Extra benefit
Following Sections can be offered, only if the Insured is covered under Section 1A-AD or 1B-PTD	1D- Education Benefit for Dependent children 1E- Medical Expenses for accident 1F-Temporary Total Disablement 1G- EMI Protection Benefit 1H- Vehicle loan Protection Benefit 1I- Family Transportation Cover
Section 1F- Temporary Total Disablement and Section 6 - EMI Benefit due to loss of Job can be offered only in respect of salaried woman only	
Only one sub-section out of 2B- Critical Illness-Standard benefit and 2C- Critical Illness-Extra benefit can be offered	
Under Section 3-Health Cover, 3B-Maternity Coverage can be opted only along with 3A-Health Indemnity Cover	
Multiple policies are not permitted for the same Insured. This information to be checked while evaluating the proposal form	
Addition of section 1G- EMI Protection Benefit, 1H- Vehicle loan Protection Benefit and Section 6- EMI Benefit due to loss of Job during the policy period is allowed, subject to payment of premium on short period basis for the period of cover. However the addition of these sections during the policy period would be allowed only where the relevant loans are availed during the policy period.	

4. COVERAGES

SECTION 1-PERSONAL ACCIDENT COVERS (PA):

SECTION 1 A-ACCIDENTAL DEATH (AD)

a. Coverage:

If during the Policy period the Insured sustains Accidental Bodily Injury which directly and independently of all other causes results in Death of the Insured within twelve (12) months from the Date of accident, the Company agrees to pay the Sum Insured stated in the Section 1 A of the Policy Schedule to the Nominee or legal representative as the case may be.

In addition to Accidental Death Sum Insured, the Company will also pay, subject to submission of bills:

a) an amount of Rs. 1,000/- will be paid for Ambulance hiring charges following an accident.

b) upto 3% of Sum Insured or Rs. 6,000/- (whichever is lower), towards the cost of transporting the mortal remains from the place of death to the hospital and/or residence and/or cremation and/or burial ground.

c) the actual costs or Rs. 5,000.00 (whichever is lower), incurred in connection with performance of religious ceremonies incurred upto the time of cremation and costs incurred for any one post cremation ceremony, within 30 days of the cremation.

SECTION 1 B-PERMANENT TOTAL DISABILITY (PTD)

a. Coverage:

If during the policy period, the Insured sustains Accidental Bodily Injury which directly and independently of all other causes results in permanent total disability shown below within twelve (12) months from the Date of accident, the Company agrees to pay the Insured the percentage shown in the Table below applied to the Sum Insured shown under Section 1 B of the schedule. The Company's maximum liability however shall not exceed 100% of the Sum Insured.

Permanent Total disability	**Benefit Percentage of Sum Insured**
Loss of sight of both eyes	100%
Loss of two entire hands or two entire feet	100%
Loss of one entire hand and one entire foot	100%
Loss of sight of one eye and such loss of one entire foot, or hand	100%
Complete loss of hearing of both ears & complete loss of Speech	100%

Complete loss of hearing of both ears or complete loss of speech and loss of one limb or loss of sight of one eye	100%
Comatose State	100%

SECTION 1 C-PERMANENT PARTIAL DISABILITY (PPD)

a. Coverage:

If during the policy period the Insured sustains Accidental Bodily Injury which directly and independently of all other causes results in permanent partial disability shown below within twelve (12) months from the Date of accident, the Company agrees to pay the percentage shown in the table below applied to the Sum Insured shown under section 1 C of the schedule. The Company's maximum liability however shall not exceed 100% of the Sum Insured.

S. No.	Permanent Partial disability	Benefit Percentage of Sum Insured
i.	Loss of toes – all	20%
	Loss of Great toe– both phalanges	5%
	Loss of Great toe – one phalanx	2%
	Loss of Other than great toe, if more than one toe lost, each	2%
ii.	Loss of hearing – both ears	60%
iii.	Loss of hearing – one ear	30%
iv.	Loss of speech	60%
v.	Loss of four fingers and thumb of one hand	40%
vi.	Loss of four fingers	35%
vii.	Loss of thumb – both phalanges	25%
	Loss of thumb- one phalanx	10%
viii.	Loss of index finger –three phalanges or two phalanges or one phalanx	10%
ix.	Loss of middle finger –three phalanges or two phalanges or one phalanx	6%
x.	Loss or ring finger – three phalanges or two phalanges or one phalanx	5%
xi.	Loss of little finger – three phalanges or two phalanges or one phalanx	4%
xii.	Loss of metacarpals – first or second, third, fourth or fifth	3%

xiii.	Loss of Sense of smell	10%
xiv.	Loss of Sense of taste	5%
xv.	Loss of Sight of one eye	50%
xvi.	Loss of One hand	50%
xvii.	Loss of One foot	50%
xviii.	Any other permanent partial disablement	Percentage as assessed by the panel doctor of the Company

If the Accidental Injury sustained by the Insured causes a subsequent claim by her under Death or Permanent Total Disablement, then this part of the coverage shall not be applicable and the amounts payable under the coverage of Death or Permanent Total Disablement shall be reduced by the amount of any payment made under this coverage.

SECTION 1 D-EDUCATIONAL BENEFIT FOR DEPENDENT CHILDREN:

a. Coverage:

If the Company has accepted a claim for the Insured under Section 1 A or Section 1 B (Accidental death/ permanent total Disablement), then the Company will make an additional onetime payment of 25% of the respective sum insured under section 1 A or 1 B, subject to a maximum of Rs 500,000/-, towards educational expenses of dependent children. This is subject to Insured's unmarried dependent child studying in an educational institution on the date the Insured met with an accidental bodily injury. The benefit amount shall remain unchanged irrespective of number of dependent children.

SECTION 1 *E-MEDICAL EXPENSES COVER FOR ACCIDENT:

a. Coverage:

In the event of Accidental Injury, The Company will reimburse the Insured:

i. The cost of treatment by a Medical Practitioner including AYUSH treatment as defined in the policy and use of Hospital facilities in India, provided the Insured is admitted as an inpatient for medical treatment of Injury arising out of an Accident during the policy period, subject to the hospitalization commencing during the policy period and the sum insured limit as shown in the Policy Schedule for inpatient treatment.

ii. The cost of plastic surgery for removal of Scars, provided the Scars have resulted from accidental injury or burns within 12 calendar months of the accident/burn. This cover is subject to the accident/burn happening during the policy period and Insured being admitted as an inpatient for this treatment. Maximum liability of the Company is upto the sum insured as shown in the Policy Schedule, applicable for this section.

iii. The Company will reimburse the Insured the cost of treatment by a Medical Practitioner and use of Hospital facilities in India for medical treatment of Injury arising out of an Accident during the policy period on OPD basis, subject to the treatment commencing during the policy period. This cover is subject to a deductible of Rs.2500/-, applicable on aggregate basis on the total OPD medical expenses incurred for the treatment of injury due to any single accident. In case there are multiple accidents during the policy period, the deductible shall apply for each accident separately. This cover is subject to sub limit of 25% of the sum Insured shown under the benefit 1 E in the policy schedule. For the purpose of this cover, OPD treatment is one in which the Insured visits a clinic/hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner and the Insured is not admitted as a day care or in-patient.

The total benefit payable under this Section shall not exceed the sum insured limit shown in the Policy Schedule for this section.

The benefit under this section shall be payable for expenses, which are not covered under any other sections of the policy.

If the claim for inpatient treatment as above is accepted, then the Company will also pay below expenses:

a. Pre-Hospitalization expenses: Medical Expenses incurred during the 60 days immediately before the Insured was hospitalized for Accidental Bodily Injury, provided that such Medical Expenses were incurred for the same injury for which subsequent Hospitalization was required.

b. Post-Hospitalization Expenses: Medical Expenses incurred during the 90 days immediately after the Insured was discharged post Hospitalization provided that such costs are incurred in respect of the same injury for which the inpatient treatment claim is accepted.

B. Special exclusions applicable for section 1 e- medical expenses cover for accident:

In addition to the Exclusions listed for section 1 of the policy, this sub-section shall not cover and no payment shall be made with respect to:

i. Any Hospitalization for an existing disability from a previous Accident which has occurred prior to the first inception of this Policy.

ii. Any stay in Hospital for an Injury due to Accident without undertaking any treatment.

iii. Any Hospitalization for Accidental Injury aggravated by an existing disability or pre-existing illness / condition / injury.

iv. Any Hospitalization due to an Accidental Injury where the treatment is undertaken by a family member and self-medication or any treatment that is not scientifically recognized.

v. Vaccination and inoculation of any kind unless forming part of treatment for Injury due to an Accident as prescribed by the Medical Practitioner.

vi. Vitamins and tonics unless forming part of treatment for Injury due to an Accident as prescribed by the Medical Practitioner.

vii. Aesthetic treatment, cosmetic surgery and plastic surgery unless necessitated

due to Accident or as a part of any Injury.

viii. Treatment taken from persons not registered as Medical Practitioners under respective Medical Councils.

ix. Any other medical or surgical treatment except as may be necessary solely as a result of Injury.

x. Any treatment taken outside India.

xi. Whilst engaged in adventure sports

xii. Dental treatment or surgery of any kind unless as a result of Accidental Bodily Injury to natural teeth and also requiring hospitalization.

xiii. Unproven Treatments Code – Excl16: 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.

SECTION 1 F - TEMPORARY TOTAL DISABLEMENT

a. Coverage:

i. In the event of Accidental Injury resulting in temporary disability which completely prevents the insured from each and every duty pertaining to her employment or occupation, the company will pay a benefit amount to the Insured Person for the period of continuous Temporary Total Disability, as certified by a Medical Practitioner, provided that:

ii. Such Injury shall be the sole and direct cause of Temporary Total Disablement, and so long as the Insured Person shall be totally disabled from engaging in any employment or occupation of any description whatsoever

iii. Amount payable per week shall be at the rate of 1 % of the Sum Insured stated in the schedule, subject to a maximum of Rs.50,000/- per week or 25% of the monthly salary, whichever is lower, in all under all PA policies covering such Insured person, for a period not exceeding 100 weeks. In case the disability period is part of a week, the amount payable shall be proportionately considered. Monthly salary shall mean monthly income of the person excluding overtime payments, bonuses and any other special Compensation

iv. If the Insured person becomes comatose due to an accident during the policy period and is certified to be comatose by a medical practitioner, such comatose period shall be treated as period of temporary total disablement for the purpose of this benefit.

v. Claim under this Benefit will be paid at the end of the disability period. In case the disability period is longer than 12 weeks, part claim payment will be done once after every 12 weeks on receipt of claim documents, till the end of disability period.

vi. The bodily injury sustained should be detectable by means of clinical examination and radiological scanning or imaging. Injuries to the spine, the ligamentous system, cartilage and nervous system should be detectable by means of radiological scanning or imaging or neurological fallout testing. If the bodily injury sustained is not detectable by means of clinical examination and radiological scanning and

imaging or neurological fallout testing, then the company shall not be liable in respect of the insured for any claim under this cover

vii. In the event of a dispute arising with regards to the duration of Temporary total disability, the duration shall be finally determined by a physician mutually appointed by both the parties, who certifies the final date upon which the insured recovered and fit to perform each and every duty pertaining to his / her employment or occupation.

SECTION 1 G-EMI PROTECTION BENEFIT

a. Coverage:

In the event of Accidental Injury during the policy period resulting in hospitalization of Insured for a minimum period of 7 days, resulting in complete prevention of Insured from engaging in her occupation for a duration of atleast 30 days, the Company shall make a payment of 1/3rd of the Sum Insured specified for this cover or the EMI whichever is lower, per month of temporary total disability. In case the temporary total disability period is beyond 30 days, is part of a month, the amount payable shall be proportionately considered. The payment payable is for a maximum period of 3 months from the date of accident or till your being declared fit by the Medical Practitioner to engage in your occupation again whichever is earlier. This cover is applicable for any one loan at any point of time. In case, Insured person has multiple loans at the time of hospitalization, the benefit is available only in respect of the loan with highest EMI.

SECTION 1 H-VEHICLE LOAN PROTECTION BENEFIT

a. Coverage:

In the event of Accidental Injury during the policy period resulting in admissible claim due to accidental death or accidental permanent total disability claim under section 1 A or 1 B, the Company will pay the Insured's balance outstanding vehicle loan amount as on the date on which she met with accidental bodily injury. This benefit applies in respect of all vehicle loans in the name of Insured as on the date of accident. The claim amount payable shall be the outstanding loan amount as on the date of accident and EMI amounts overdue, if any, not exceeding 3 EMIs, in respect of all outstanding vehicle loans as on the date of accident, subject to a maximum of the sum Insured specified for the section.

In case the details of the Vehicle loan to be covered under the policy are specified while opting for this cover and details are included in the policy schedule, the payment of the claim amount shall be in the name of named financier. In the absence of such declaration in the proposal/policy schedule, the claim amount shall be payable to the nominee (in case of death) or insured (in case of Permanent Total disability) only.

SECTION 1 I-FAMILY TRANSPORTATION COVER:

a. Coverage:

If the Insured sustains Accidental Bodily Injury with in policy period which directly and independently of all other causes results in the Insured being in a Hospital which is outside the City/town of her usual place of residence as mentioned on the policy schedule, then

the Company will reimburse the travel expenses of one Family Member. The travel expenses payable shall be the actual cost of economy class transportation by the most direct route via a common carrier to the location of the Insured person and back, upto the maximum limit as mentioned in policy schedule. For this purpose, family member shall mean spouse, Children above age of 18 years, sibling, either parent or either parent-in-law of the insured.

SPECIAL CONDITION APPLICABLE FOR SECTION 1-PERSONAL ACCIDENT COVERS:

The company shall not be liable under this policy for:

(a) Compensation under more than one of the foregoing sub sections (1A-AD), 1(B-PTD), 1(C-PPD) and 1(F-Temporary Total Disablement) in respect of the same period of disablement.

b) Any payment in case of more than one claim in respect of such insured person under this Policy during any one period of insurance by which the maximum liability of the company in that period would exceed the sum payable under (1A-AD) of the Policy to such insured person.

EXCLUSIONS APPLICABLE FOR SECTION 1-PERSONAL ACCIDENT COVERS

We will not be liable to make any payment under this Policy, for any claim directly attributable to, or based on, or arising out of, or connected with any of the following:

1. Any Events/incidences that happened before the policy inception would not be covered. All events should fall under the policy duration
2. Any Pre-existing Condition(s) and complications arising out of or resulting therefrom
3. Through suicide, attempted suicide (whether sane or insane) or intentionally self-inflicted injury or illness,
4. Whilst engaging in Adventure Sports and/or hazardous activities
5. While under the influence of liquor or drugs, alcohol or other intoxicants, unless administered on the advice of a physician. For the purposes of this exclusion, the expression “drug” means any intoxicant other than alcohol, natural or synthetic, or any natural material or any salt, or preparation of such substance or material as may be notified by the Central Government under M V Act and includes a narcotic drug and psychotropic substance as defined in clause (xiv) and clause (xxiii) of section 2 of the Narcotic Drugs and Psychotropic Substances Act, 1985.’
6. Through deliberate or intentional, unlawful or criminal act, error, or omission, participation in an actual or attempted felony, riot, crime, misdemeanour, civil commotion
7. Whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or traveling in any balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world,
8. Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trial runs,
9. Arising out of your participation in any police, naval, military or air force

operations whether peace or in war in the form of military exercises or war games or actual engagement with the enemy, Whether foreign or domestic,

10. Consequential losses of any kind or actual or alleged legal liability.
11. Operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft; or Scheduled Airlines
12. Any claim caused by osteoporosis (porosity and brittleness of the bones due to loss of protein from the bones matrix) or pathological fracture (any fracture in an area where pre-existing Disease has caused the weakening of the bone) if osteoporosis or bone Disease diagnosed prior to the Policy Effective Date. However, this exclusion shall not apply if the Insured sustains Accidental Bodily Injury which directly and independently of all other causes results in accidental injury, insured under the policy.
15. No benefit would be paid under this policy, unless the nature and extent of injury is established medically with appropriate investigation reports and certified by the treating doctor
16. Loss caused directly, wholly or partly by:
    a. Bacterial infections (except pyogenic infections which shall occur through an accidental cut or wound) or any other kind of disease;
    b. Medical or surgical treatment except as may be necessary solely as a result of Injury;
17. Dental care or Dental surgery except as occasioned by Accidental Injury.

CLAIM DOCUMENTATION FOR SECTION 1-PERSONAL ACCIDENT COVERS

If the Insured meets with any Accidental Bodily Injury that may result in a claim, than as a condition precedent to our liability, the Insured or someone claiming on her behalf must

i. Insured must immediately consult a Doctor and follow the advice and treatment that he recommends. Insured must take reasonable steps to lessen the consequence of Bodily injury.
ii. Inform us in writing immediately and in any event within 30 days from the date of the accident and Submit all documents to us within 30 days from the date of intimation.
iii. Insured should allow examination by our medical advisors if we ask for this.
iv. The Claim Form duly signed by the insured (Nominee/legal heirs in case of Death Claim) should be submitted to the Company along with the below mentioned documents (depending on the nature of claim):

Section 1 A

1. Copy of FIR / Police Report
2. Copy of Post Mortem Report/Coroner's report
3. Copy or Panchanama / Inquest report
4. Copy of viscera report, if available
5. Death Certificate

Section 1 B or 1 C

1. Report of the attending Doctor confirming disability
2. Admit / Discharge card
3. Investigation reports such as X-rays, Lab test, Films etc
4. FIR/ Police report, wherever necessary

Section 1 D

1. Documents as per Death / PTD benefit
2. Bonafide Certificate issued by the educational institution confirming that he/she is a full time student of the institution
3. Copy of any document showing the names and address of Insured and her children, for ex: Ration Card

Section 1 E

1. Report of the attending Doctor confirming the line of treatment
2. Admit/Discharge Card
3. Investigation reports such as X-rays, Lab test etc
4. Police report wherever necessary
5. Medical bills and receipts for reimbursement of medical expenses

Section 1 F

1. Report of the attending Doctor confirming disability
2. Admit / Discharge card
3. Investigation reports such as X-rays, Lab test etc
4. Police report wherever necessary
5. Leave certificate from the employer in case of salaried persons
6. Fitness certificate issued by the treating doctor

Section 1 G

1. Hospital admit/discharge card
2. Certificate from treating doctor mentioning the extent of injury, period of disability, treatment details
3. All X-Ray / Investigation reports and films supporting to disability.
4. Certificate from HR with details of medical leave availed during the period of Injury
5. Loan disbursement letter along with EMI and the payment record till the date of Accident

Section 1 H

1. Documents as required under Section 1 A or 1 B
2. Loan disbursement letter along with EMI and the payment record till the date of Accident
3. Current outstanding loan certificate from financier

Section 1 I Family Transportation cover

1. Hospital Discharge Card as proof of the Insured's hospitalization
2. Proof of Travel of Family member and bill/invoice towards cost of Ticket

SECTION 2 – CRITICAL ILLNESS COVER (CI):

SECTION 2 A-CANCER CARE BENEFIT

A. SCOPE OF COVER

The Company shall pay a lumpsum benefit on diagnosis/treatment of cancer as specified below:

A. Cancer Therapy Benefit: The policy will pay a lumpsum of 20% of sum Insured towards Chemotherapy or Radiotherapy undergone by the Insured as per advice from the Medical Practitioner in the specified Medical speciality as part of treatment for the cancer diagnosed during the policy period. The benefit can be claimed after the first session of undergoing the defined Chemotherapy or Radiotherapy by the Insured.

B. Early Stage Cancer diagnosis Benefit: The policy will pay a lumpsum of 30% of Sum Insured, if the Insured is diagnosed to be suffering from early stage malignant cancer or Cancer-in-situ, as defined in the policy. This benefit is not available for Skin and prostate cancers. This benefit will be available only once during the life time of the Insured. The coverage is applicable for the first occurrence of early stage cancer or cancer-in-situ only.

C. Major Stage Cancer Diagnosis Benefit: The policy will pay a lumpsum of 100% of Sum Insured, if the Insured is diagnosed to be suffering from Major stage cancer, as defined in the policy. This benefit will be available only once during the life time of the Insured.

Total benefit amount payable under this SECTION 2A shall be limited to 150% of the policy sum insured shown in the schedule.

It is hereby agreed and declared that the benefits under this section extends to any type of cancer including, but not limited to the following:

a. Breast Cancer
b. Fallopian Tube Cancer
c. Uterine/Cervical Cancer
d. Ovarian Cancer
e. Vaginal Cancer
f. Colorectal Cancer
g. Lung Cancer
h. Kidney Cancer

SECTION 2B-CRITICAL ILLNESS -STANDARD BENEFIT

A. SCOPE OF COVER

If at any time during the currency of this policy, the Insured is diagnosed as suffering from any of the Critical Illness defined below, the first occurrence of which manifests itself during the Policy Period mentioned in the Policy schedule, the Company shall pay a Lumpsum Benefit equal to the Sum Insured mentioned in the Policy schedule.

1) Stroke Resulting In Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.

The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

2) Myocardial Infarction (First Heart Attack - of Specified Severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3) Open Chest CABG

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

The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

4) Kidney Failure Requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to

function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner

5) Multiple Sclerosis With Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

Neurological damage due to SLE is excluded.

6) Major Organ /Bone Marrow Transplant

The actual undergoing of a transplant of:

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

ii. Human bone marrow using haematopoietic stem cells The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

7) Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

8) Surgery to Aorta

The actual undergoing of surgery for a disease of the aorta (meaning the thoracic and abdominal aorta but not its branches, and excluding traumatic injury of the aorta and congenital narrowing of the aorta) needing excision and surgical replacement of the diseased aorta with a graft

9) Primary (Idiopathic) Pulmonary Hypertension

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

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

i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present event at rest.

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

10) Parkinson's Disease

The unequivocal diagnosis of progressive degenerative idiopathic Parkinson's disease by a consultant Neurologist. This diagnosis must be supported by all of the following conditions:

a. The disease cannot be controlled with medication;

b. Signs of progressive impairment; and

c. Inability of the insured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months

Activities of Daily Living:

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

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

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

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

V. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

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

Exclusions: Drug induced or toxic causes of Parkinsonism are excluded

11) Motor Neuron Disease with Permanent Symptoms

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

12) Open Heart Replacement OR Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to

be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

13) Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

14) Aplastic Anaemia

A chronic persistent bone marrow failure which results in total aplasia of the bone marrow and requires treatment with at least one of the following:

a) Regular blood product transfusion

b) Marrow stimulating agents

c) Immunosuppressive agents

d) Bone marrow transplantation

The diagnosis and suggested line of treatment must be confirmed by a Haematologist using relevant laboratory Investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

1. Absolute Neutrophil count of 500 per cubic millimeter or less;
2. Absolute Reticulocyte count of 20,000 per cubic millimeter or less; and
3. Platelet count of 20,000 per cubic millimeter or less

15) Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit lasting for a minimum period of 30 days. It should result in a permanent inability to perform at least three of the Activities of Daily Living either with or without the use of mechanical equipment, special devise or other aids and adaptations in use for disabled persons.

16) COMA of specified severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

17) Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period

of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

18) End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy

Liver failure secondary to drug or alcohol abuse is excluded.

19) Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means 'the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing' in both ears.

20) End stage lung Failure

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less tha 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis wit partial oxygen pressure of 55 mmHg or less (PaO2<55mmHg); and

iv. Dyspnea at rest

SECTION 2C-CRITICAL ILLNESS -EXTRA BENEFIT

A. SCOPE OF COVER

If at any time during the currency of this policy, the Insured is diagnosed as suffering from any of the Critical Illness defined below, the first occurrence of which manifests itself during the Policy Period mentioned in the Policy schedule, the Company shall pay a Lumpsum Benefit equal to the Sum Insured mentioned in the Policy schedule.

1) Stroke Resulting In Permanent Symptoms

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.

The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

2) Myocardial Infarction (First Heart Attack - of Specified Severity)

The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3) Open Chest CABG

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

The following are excluded:

Angioplasty and/or any other intra-arterial procedures.

4) Kidney Failure Requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

5) Multiple Sclerosis With Persisting Symptoms

The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:

iii. investigations including typical MRI findings which unequivocally confirm

the diagnosis to be multiple sclerosis and

iv. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

Neurological damage due to SLE is excluded.

6) Major Organ /Bone Marrow Transplant

The actual undergoing of a transplant of:

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

II. Human bone marrow using haematopoietic stem cells The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

I. Other stem-cell transplants

II. Where only islets of langerhans are transplanted

7) Permanent Paralysis of Limbs

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months

8) Surgery to Aorta

The actual undergoing of surgery for a disease of the aorta (meaning the thoracic and abdominal aorta but not its branches, and excluding traumatic injury of the aorta and congenital narrowing of the aorta) needing excision and surgical replacement of the diseased aorta with a graft

9) Primary (Idiopathic) Pulmonary Hypertension

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

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

a. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

b. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present event at rest.

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

10) Parkinson's Disease

The unequivocal diagnosis of progressive degenerative idiopathic Parkinson's disease by a consultant Neurologist. This diagnosis must be supported by all of the following conditions:

d. The disease cannot be controlled with medication;

e. Signs of progressive impairment; and

f. Inability of the insured to perform (whether aided or unaided) at least 3 of the following 6 "Activities of Daily Living" for a continuous period of at least 6 months

Activities of Daily Living:

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

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

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

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

V. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

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

Exclusions: Drug induced or toxic causes of Parkinsonism are excluded

11) Motor Neuron Disease with Permanent Symptoms

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

12) Open Heart Replacement OR Repair of Heart Valves

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

13) Third Degree Burns

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

14) Aplastic Anaemia

A chronic persistent bone marrow failure which results in total aplasia of the bone marrow and requires treatment with at least one of the following:

a) Regular blood product transfusion

b) Marrow stimulating agents

c) Immunosuppressive agents

d) Bone marrow transplantation

The diagnosis and suggested line of treatment must be confirmed by a Haematologist using relevant laboratory Investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

1. Absolute Neutrophil count of 500 per cubic millimeter or less;
2. Absolute Reticulocyte count of 20,000 per cubic millimeter or less; and
3. Platelet count of 20,000 per cubic millimeter or less

15) Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit lasting for a minimum period of 30 days. It should result in a permanent inability to perform at least three of the Activities of Daily Living either with or without the use of mechanical equipment, special devise or other aids and adaptations in use for disabled persons.

16) COMA of specified severity

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

i. no response to external stimuli continuously for at least 96 hours;

ii. life support measures are necessary to sustain life; and

iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

17) Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

18) End Stage Liver Failure

Permanent and irreversible failure of liver function that has resulted in all three of the following:

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy

Liver failure secondary to drug or alcohol abuse is excluded.

19) Deafness

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means 'the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing' in both ears.

20) End stage lung Failure

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

i. FEV1 test results consistently less tha 1 litre measured on 3 occasions 3 months apart; and

ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and

iii. Arterial blood gas analysis wit partial oxygen pressure of 55 mmHg or less (PaO2<55mmHg); and

iv. Dyspnea at rest

21) Goodpasture's syndrome

Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for a continuous period of atleast 30 days. The diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist)

22) Apallic syndrome

A persistent vegetative state in which patients with severe brain damage (universal necrosis of the brain cortex with the brainstem remaining intact), are in a state of partial arousal rather than true awareness. The diagnosis must be confirmed by a Specialist Medical Practitioner (Neurologist) and condition must be documented for at least 30 days.

23) Systemic lupus erythematosis

A diagnosis of systemic lupus erythematosis by a Rheumatologist resulting in either of the following: Permanent neurological deficit with persisting clinical symptoms for a continuous period of 30 days; or The permanent impairment of kidney function tests as follows: Glomerular Filtration Rate (GFR) below 30 ml/min

24) Multiple system atrophy

A diagnosis of multiple system atrophy by a Specialist Medical Practitioner (Neurologist). There must be evidence of permanent clinical impairment for a minimum period of 30 days of either:

i. Motor function with associated rigidity of movement; or

ii. The ability to coordinate muscle movement; or

iii. Bladder control and postural hypotension

25) Progressive scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following conditions are excluded:

i. Localized scleroderma (linear scleroderma or morphea);

ii. Eosinophilicfascitis; and

iii. CREST syndrome

26) Pneumonectomy

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

The following conditions are excluded:

a. Removal of a lobe of the lungs (lobectomy)

b. Lung resection or incision

27) Pulmonary artery graft surgery

The undergoing of surgery requiring median sternotomy on the advice of a cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

28) Alzheimer's disease

The unequivocal diagnosis of Alzheimer's disease (presenile dementia) before age 60 that has to be confirmed by a specialist Medical Practitioner (Neurologist) and evidenced by typical findings in cognitive and neuroradiological tests (e.g. CT Scan, MRI, PET of the brain).

The disease must also result in a permanent inability to perform independently three or more Activities of Daily Living or must result in need of supervision and the permanent presence of care staff due to the disease.

These conditions must be medically documented for at least 90 days.

29) Benign brain tumor

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT Scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or

ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:

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

30) Cardiomyopathy

A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist). There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least class 3 of the New York Heart Association classification's of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain) and LVEF of 40% or less.

The following conditions are excluded:

a. Cardiomyopathy secondary to alcohol or drug abuse

b. All other forms of heart disease, heart enlargement and myocarditis

31) Progressive supranuclear palsy

A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days.

32) Creutzfeldt-jakob disease (CJD)

A diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

Social functioning is defined as the ability of the individual to interact in the normal or usual way in society

Mental functioning would mean functions / processes such as perception, introspection, belief, imagination reasoning which can do with our minds.

33) Major head trauma

I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This

diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

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

III. Activities of Daily Living:

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

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

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

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

V. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

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

IV. The following are excluded:

i. Spinal cord injury;

34) Encephalitis

It is a severe inflammation of brain tissue, resulting in permanent neurological deficit lasting for a minimum period of 30 days. This must be certified by a Specialist Medical Practitioner (Neurologist). The permanent deficit must result in an inability to perform at least three of the Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons.

The following condition is excluded:

a. Encephalitis as a result of HIV infection

35) Blindness

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:

i. corrected visual acuity being 3/60 or less in both eyes or;

ii. The field of vision being less than 10 degrees in both eyes

III. The diagnosis of blindness must be confirmed and must not be correctable by aids or surgical procedure.

36) Brain surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed.

For the above definition, the following condition is excluded:

Burr Hole and brain surgery as a result of an accident.

37) Fulminant Viral Hepatitis

A sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure.

This diagnosis must be supported by all of the following:

a. rapid decreasing of liver size;

b. necrosis involving entire lobules, leaving only a collapsed reticular framework;

c. rapid deterioration of liver functions tests;

d. deepening jaundice; and

e. hepatic encephalopathy

Acute Hepatitis infection or carrier status alone, does not meet the diagnostic criteria

38) Muscular Dystrophy

Muscular Dystrophy is a disease of the muscle causing progressive and permanent weakening of certain muscle groups. The diagnosis of Muscular Dystrophy must be made by a Consultant neurologist, and confirmed with the appropriate laboratory, biochemical, histological and electromyographic evidence. The disease must result in the permanent inability of the insured to perform (whether aided or unaided) at least three (3) of the six (6) 'Activities of Daily Living'.

39) Medullary Cystic Disease

Medullary Cystic Disease where the following criteria are met:

a) the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and intestinal fibrosis;

b) Clinical manifestation of anaemia, polyuria and progressive deterioration in kidney function; and

c) the diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

Isolated or benign kidney cysts are specifically excluded from this benefit.

WAITING PERIOD APPLICABLE FOR THIS SECTION

This section is subject to a waiting period of 90 days from the date of commencement of policy period. This waiting period shall not apply in case of policies which are continuously renewed after a cover of 365 days. In case of enhancement of Sum Insured during renewal of the policy, the waiting period shall apply afresh only to the extent of the amount by which the sum insured has been increased (i.e. enhanced sum insured) if the Policy is a renewal of the policy without break in cover. In case of renewal of the policy after a break in cover for 30 days or more, the policy shall be

deemed to be fresh and the waiting period shall apply.

SURVIVAL PERIOD:

Survival Period is not applicable under this policy. Wherever there is a mention of survival period it denotes nil survival days.

SPECIFIC EXCLUSIONS-APPLICABLE FOR CRITICAL ILLNESS COVER

We shall not be liable to make any payment for any claim directly caused by, based on, arising out of or attributable to any of the following:

1) Any Pre-Existing Disease.
2) If the Insured does not submit a medical certificate from the Doctor evidencing diagnosis of Illness or Injury or occurrence of the medical event or the undergoing of the medical/surgical procedure.
3) Any Event, as stated in this Section, diagnosed before the commencement of the Policy Period.

SPECIFIC CONDITIONS APPLICABLE FOR CRITICAL ILLNESS COVER:

1. Claim under this cover shall be payable only once during the lifetime of the Insured with Us.
2. This Section shall terminate on payment of full benefit under any of the above sub-sections and cannot be renewed further.

CLAIM PROCEDURE -APPLICABLE FOR CRITICAL ILLNESS COVER:

In the event of a claim under this Section, an intimation of claim needs to be sent to the Insurer within 15 days of first diagnosis of the said disease along with the details of Insured (name/address/age/contact no/email id), Policy Number, Date of Diagnosis/ treatment with details. This claim intimation can be done over telephone / fax through toll free 1800-208-9100 or in writing.

The insured would need to submit the duly filled in and signed claim form along with the following original documents within 30 days of completion of survival period:

a. Detailed discharge summary confirming the given treatment/surgery
b. Detailed attending physician's report mentioning the past medical and surgical history of the patient with duration of the ailment and confirming the diagnosis/Diagnosis Certificate from Specialist
c. All supporting lab reports to prove the diagnosis along with relevant histological classification/stage (pathological, imaging or any other reports)
d. First consultation letter for Illness
e. Proof of identity and residence of the insured.
f. Bank details along with Original cancelled cheque and NEFT details

Note: In case the Insured is claiming for the same event under an indemnity based policy of another insurer and is required to submit the original documents related to his treatment with that particular insurer, then the Insured may provide the company with the attested Xerox copies of such documents along with a

declaration from the particular insurer specifying the availability of the original copies of the specified treatment documents with it.

CANCER SCREENING BENEFIT ON RENEWAL:

If the Insured has opted for cover under any of the sub-sections under section 2 and no claim has been made by the insured in respect of these benefits for three continuous policy years, the Insured is eligible for cancer screening benefit on renewal. The benefit payable is as below:

1. The expenses incurred by the Insured for health check-up which shall include any of the below mentioned tests shall be reimbursed
   a. PAP Smear Test
   b. Mammogram
   c. Colon Cancer Screening
   d. Skin Examination
2. The amount payable shall not exceed 1% of the total sum insured subject to a maximum of Rs 10,000/-
3. Any unutilised amount shall lapse once the policy expires.

SECTION 3-HEALTH COVER

3.A. – HEALTH INDEMNITY COVER:

If anytime during the policy period, the Insured Person(s) is required to be hospitalized for treatment of an Illness or Injury at a Hospital/Day Care Centre, following Medical Advice of a duly qualified Medical Practitioner, the Company shall indemnify Medically necessary expenses towards the Coverage mentioned herein below, subject to terms of coverage, exclusions and conditions. Maximum liability of the Company under this section per policy year, shall be Sum Insured opted and as specified in the Policy Schedule.

A. COVERAGE

i. In-Patient Hospitalisation

The Company shall indemnify medical expenses incurred for Hospitalisation of the Insured Person during the Policy Year, upto the Sum Insured specified in the policy schedule for,

i. Room, Boarding, ICU, Nursing expenses as provided by the Hospital/Nursing Home
ii. Surgeon, Anaesthetist, Medical Practitioner, Consultants ,Specialist Fees whether paid directly to the treating doctor /surgeon or to the hospital
iii. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines and Drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

i) Other Expenses

i. Dental treatment, necessitated due to disease or injury
ii. Plastic surgery necessitated due to disease or injury

iii. All the day care treatments

iv. Expenses incurred on road Ambulance subject to a maximum of Rs 2,000 per hospitalisation

Note:

Expenses of Hospitalisation for a minimum period of 24 consecutive hours shall only be admissible .However, the time limit shall not apply in respect of Day Care Treatment.

ii. *AYUSH Treatment

The Company shall indemnify medical expenses incurred for inpatient care and day care procedures treatment under Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each Policy Year up to the limit of sum Insured as specified in the policy schedule in any AYUSH hospital / AYUSH day care centre as defined in the policy.

iii. Pre Hospitalisation

The Company shall indemnify pre hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, for a fixed period of 30 days prior to the date of admissible hospitalisation covered under the policy.

iv. Post Hospitalisation

The Company shall indemnify post hospitalisation medical expenses incurred, related to an admissible hospitalisation requiring inpatient care, for a fixed period of 60 days from the date of discharge from the hospital, following an admissible hospitalisation covered under the policy.

v. The expenses that are not covered in this policy are placed under List-I of Annexure –1. 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 –A respectively

B. WAITING PERIOD APPLICABLE TO HEALTH INDEMNITY COVER:

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

1.1 Pre –Existing Diseases (Code –Excl01)

a) Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with us.

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

c) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

1.2 First Thirty Day Waiting Period (Code –Excl03)

a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

1.3 Specific Waiting Period (Code –Excl02)

a) Expenses related to the treatment of the following listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage after the date of inception of the first Policy with the Insurer. This exclusion shall not be applicable for claims arising due to an accident.

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

c) If any of the specified disease/procedure falls under the waiting period specified for Pre-Existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

i. 24 Months Waiting Period

i. Benign ENT disorders
ii. Tonsillectomy
iii. Adenoidectomy
iv. Mastoidectomy
v. Tympanoplasty
vi. Hysterectomy
vii. All internal and external benign tumours,cysts,polyps of any kind, including benign breast lumps
viii. Benign prostate hypertrophy
ix. Cataract and age related eye ailments
x. Gastric/Duodenal Ulcer
xi. Gout and Rheumatism

xii. Hernia of all types

xiii. Hydrocele

xiv. Non-infective Arthritis

xv. Piles, Fissures and Fistula in anus

xvi. Pilonidal sinus, Sinusitis and related disorders

xvii. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident

xviii. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy

xix. Varicose Veins and Varicose ulcers

xx. Internal Congenital Anomalies

ii.36 Months Waiting Period

1. Treatment for joint replacement unless arising from accident
2. Age-related Osteoarthritis and Osteoporosis

C. EXCLUSIONS APPLICABLE TO HEALTH INDEMNITY SECTION:

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

1. Investigation & Evaluation – (Code – Excl04):

a. Expenses related to any admission primarily for diagnostics and evaluation purposes

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

2. Rest Cure, rehabilitation and respite care – (Code – Excl05):

a. Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons

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

3. Obesity/Weight Control: Code – (Excl06):

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

1. Surgery to be conducted is upon the advice of the Doctor
2. The surgery/Procedure conducted should be supported by clinical protocols
3. The member has to be 18 years of age or older and
4. Body Mass Index (BMI);
   a. Greater than or equal to 40 or
   b. Greater than or equal to 35 in conjunction with any of the following

severe co-morbidities following failure of less invasive methods of weight loss:

i. Obesity-related cardiomyopathy
ii. Coronary heart disease
iii. Severe Sleep Apnea
iv. Uncontrolled Type2 Diabetes

4. Change-of-Gender treatments: (Code – Excl07):

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex

5. Cosmetic or plastic Surgery: (Code – Excl08):

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.

6. Hazardous or Adventure sports: (Code – Excl09):

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.

7. Breach of law: (Code – Excl 10):

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

8. Excluded Providers: (Code – Excl11):

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 upto the stage of stabilization are payable but not the complete claim

9. Treatment for ,Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. (**Code – Excl12)**

10. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code – Excl13)**

11. 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 hospitalisation claim or day care procedure. **(Code – Excl14)**

12. Refractive Error: (Code – Excl15):

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres

13. Unproven Treatments (Code – Excl16):

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.

14. Sterility and Infertility: (Code – Excl17):

Expenses related to Sterility and infertility. This includes:

i. Any type of contraception, sterilization

ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

iii. Gestational Surrogacy

iv. Reversal of sterilization

15. Maternity Expenses: (Code – Excl18):

i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy;

ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

16. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolution, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

17. 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 purpose of this exclusion:

a) 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.

b) 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

c) 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.

18. Any expenses incurred on Domiciliary Hospitalisation and OPD treatment

19. Treatment taken outside the geographical limits of India.

20. Treatment other than Allopathy and AYUSH*

3.B. MATERNITY COVERAGE:

The policy will pay for medical expenses incurred by the Insured towards Normal or Caesarean section delivery of child during the policy period, limited to 2 deliveries during the lifetime of the Insured.

This will include pre-natal and post-natal expenses per delivery and medically necessary treatment of the new born baby within the policy period provided that

a. Maximum liability per delivery shall be limited to the amount as stated in the Policy Schedule

b. Pre- and post-hospitalisation expenses are not covered under this benefit.

c. A waiting period of 24 months from the date of commencement of this policy shall be applicable for any claim to be payable under this coverage

This cover is also extended to cover the Stem Cell Storage charges incurred by the Insured towards preservation of Stem Cells of the new born baby in Government authorised centers or Stem Cell Banks, provided the maternity claim is admissible under the cover.

The maximum liability towards delivery and stem cell storage shall be limited to the Sum Insured opted mentioned against this cover in the policy schedule.

This benefit shall be over and above the Health Indemnity cover Sum Insured

CLAIM PROCEDURE APPLICABLE TO SECTION 3 - HEALTH COVER:

1. Claim Procedure

If You happen to suffer Accidental Bodily Injury or is diagnosed with an Illness which gives rise to or may give rise to a claim, then it is a condition precedent to our liability that You shall immediately:

a. Give us notice of the claim irrespective of notice provided to any other insurer for the same illness in case you are holding multiple insurance policies.

b. Expeditiously give or arrange for us to be provided with any and all information and documentation in respect of the claim and/or our liability for it that may be requested by the us.

Type of hospitalization	**Claim Intimation - Turn Around Time**	
Cashless - Admission in Network Hospital	**Planned Hospitalization:** pre-authorization has to be obtained 72 hours prior to the date of planned admission	**Emergency Hospitalization:** within 48 hours of an emergency admission

Reimbursement - Admission in Non - Network Hospital (E mail: customercare@ cholams. murugappa,com) or phone (@ Toll free no. 1800-208-9100)	**Planned Hospitalization:** Claim intimation has to be given to us on email or at the Toll free Number within 48 hours for planned hospitalization	**Emergency Hospitalization:** Claim intimation has to be given to us on email or at the Toll free Number within 24 hours of an emergency hospitalization

A. Procedure for Cashless Claims:

Obtain our pre-authorisation for any medical treatment in any of our network hospitals as well as identified list of hospitals by GIC for common empanelment through anywhere cashless facility. Insured can view or download the updated Hospital Network from the Company's website www.cholainsurance.com as well as Chola MS mobile application. In case of planned admission, pre-authorisation has to be obtained 72 hours prior to the date of admission and within 48 hours of an emergency admission. Pre-authorisation request shall, if we are satisfied as to the validity of the claim, specify:

1. The treatment authorised;
2. The place at which it has been authorised, and
3. Any other conditions applicable to either.

B. Procedure for submission of Reimbursement Claims:

a. Upon Hospitalisation, the insured Person or his/her dependents shall provide us with fully particularised details of the quantum of any claim to be reimbursed and any and all other information and documentation in respect of the claim and/or our liability for it sought by our In-House Claims team at the earliest possible opportunity not exceeding 30 days from date of discharge.

b. We shall be under no obligation to pay or arrange to make payment for any claim until and unless it is satisfied as to the validity and quantum of Your claim.

c. You shall expeditiously provide us with or arrange for us to be provided with any and all information or documentation, in respect of the Illness, the claim or our liability that may be requested. The expenses towards doctors' fees for any additional medical examination required by us, at the time of claim shall be borne by us.

d. We shall only make payment (unless already paid direct to the service provider/hospital) to You or your Nominee.

e. You acknowledge and agree that the payment of any claim by or on behalf

of us shall not constitute on the part of us any guarantee or assurance as to the quality or effectiveness of any medical treatment obtained by You, it being agreed and recognised by You that we are not in any way responsible or liable for the availability or quality of any service (medical or otherwise) rendered by any institution (including a Network Hospital) whether pre-authorised or not.

f. Following documents are to be submitted for processing of the claim:

- Claim Form duly filled and signed by patient/You.
- Original Discharge summary in the hospital letter head with the seal and sign of the doctor with complete details of diagnosis, treatment given, treatment advised etc.
- Original Main bill from the hospital with cost wise break up.
- Original payment receipt (Receipt should have Serial No).
- Original investigation reports (such as X Ray, Lab Reports, Scan reports etc) – These are required for supporting the ailment, hence all reports taken prior / at the time or after the hospitalization are required.
- All pharmacy bills should be accompanied with relevant prescriptions. Bills should contain date and patient name. If pharmacy is charged in the Main Hospital bill, then proper itemized break up of those medicines should be obtained from the hospital.
- Implant stickers or invoice where ever applicable.
- In case of Road traffic accident (RTA), copy of FIR and/or Medico legal Certificate (MLC) would be required.
- Proof of identity and residence of the Insured/Nominee for claims exceeding Rs 1 Lakh.

SECTION 4 - MEDICAL TERMINATION OF PREGNANCY COVER

A. SCOPE OF COVER:

If during the policy period the Insured has been admitted to a Hospital for Medical Termination of Pregnancy under Medical Advice due to any of the following conditions, the Company shall pay a lumpsum benefit equal to the sum Insured mentioned in the policy schedule

a) Ectopic Pregnancy provided that Diagnosis of Ectopic Pregnancy is confirmed by Ultrasound / CT

b) Due to Accidental Injuries

c) Any other Pregnancy Complications which in the opinion of the Medical Practitioner is life threatening of the insured

B. SPECIFIC EXCLUSIONS-APPLICABLE FOR MEDICAL TERMINATION OF PREGNANCY COVER

We shall not be liable to make any payment for any claim directly caused by, based

on, arising out of or attributable to any of the following:

1. Medical Termination due to any pre-existing condition of the foetus diagnosed prior to the policy inception
2. Intentional self-injury (including but not limited to the use or misuse of any intoxicating drugs unless administered on the advice of a physician or alcohol)
3. Ailments requiring treatment due to use or abuse of any substance, drug or alcohol and treatment for de-addiction.
4. Medical Expenses related to Hospitalization for Treatment of any illness/ disease /accident except what is specifically included under the Scope of cover above
5. Medical Expenses relating to any hospitalization primarily and specifically for diagnostic, X-ray or laboratory examinations and investigations
6. Any fertility, sub fertility, Infertility, sterility, assisted conception operation or sterilization procedure.
7. Weight management services and treatment related to weight reduction programs including treatment of obesity and treatment of complications directly arising due to Obesity.
8. Any treatment arising from or traceable to pregnancy, child birth including cesarean section and/or any treatment related to pre and postnatal care and complications arising out of Pregnancy and Childbirth. However, this exclusion will not apply to medical Termination of Pregnancy due accidental injuries, Ectopic Pregnancy proved by diagnostic means and any other Pregnancy complications certified to be life threatening by the attending medical practitioner.
9. Any treatment received outside India is not covered under this policy.

C. CLAIM PROCEDURE -APPLICABLE FOR MEDICAL TERMINATION OF PREGNANCY COVER

On the occurrence or the discovery of any Illness or Injury that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy the following procedure shall be complied with:

1) Intimation of the claim immediately, in any event within 48 hours of admission to the hospital
2) The below documents have to be submitted within 30 days from the date of discharge from the Hospital
   a. Duly completed Claim Form
   b. Original Discharge Card
   c. Copy of Indoor case papers with nursing sheet detailing medical history of the patient, treatment details, & patient's progress
   d. All previous consultation papers indicating history and treatment details

for current ailment

e. All original diagnostic reports (including imaging and laboratory) along with Medical Practitioner's prescription

f. Photo ID & Age Proof

g. Bank details along with Original cancelled cheque and NEFT details

SECTION 5-GENETIC TESTING COVER FOR MOTHER AND CHILD

A. SCOPE OF COVER:

If during the policy period the Insured undergoes any genetic tests based on medical advice, for the purpose of diagnosis or confirmation or treatment of a disease, the Company shall reimburse the cost of the test, subject to a maximum of the sum Insured for the section. This cover is also applicable for the tests conducted on biological children of the Insured, if the same is required for diagnosis or confirmation or treatment of disease of the child, provided the child was born after commencement of the policy and during continuous renewal.

B. SPECIFIC EXCLUSIONS-APPLICABLE FOR GENETIC TESTINGCOVER FOR MOTHER AND CHILD

We shall not be liable to make any payment for any claim directly caused by, based on, arising out of or attributable to any of the following:

1. Test conducted in relation to any Pre-existing disease or condition.
2. Any fertility, sub fertility, Infertility, sterility, erectile dysfunction, impotence, assisted conception operation or sterilization procedure.
3. Any treatment received outside India is not covered under this policy.

C. CLAIM PROCEDURE -APPLICABLE FOR GENETIC TESTING COVER FOR MOTHER AND CHILD

On the occurrence or the discovery of any Illness or Injury that may give rise to a claim under this Policy, then as a Condition Precedent to Our liability under the Policy the following procedure shall be complied with:

1. Intimation of the claim immediately, in any event within 48 hours of admission to the hospital
2. The below documents have to be submitted within 30 days from the date of undergoing the medical test
   a. Duly completed Claim Form
   b. Photo ID & Age Proof
   c. Original Discharge Card, if admitted in hospital
   d. All previous consultation papers indicating history and treatment details for current ailment
   e. Medical Practitioner's detailed prescription advising Genetic test and the reason

f. All original or certified test reports and the original invoice and payment receipt

g. Bank details along with Original cancelled cheque and NEFT details

SECTION 6-EMI BENEFIT ON LOSS OF JOB:

A. SCOPE OF COVER:

The Company will pay the EMI of the Insured's loan, subject to a maximum of 3 EMIs, not exceeding the sum insured specified in the policy schedule, if Insured becomes unemployed during the policy period due to the following:

Termination or temporary suspension of the Insured from employment during the policy period imposed on her by the employer, in consequence of an accident sustained or illness diagnosed by the Insured while the policy is in force, subject to the insurance being in force continuously from the date of accident or date of diagnosis of the illness till the date of insured event.

B. SPECIAL CONDITION APPLICABLE FOR EMI BENEFIT ON LOSS OF JOB:

1. The company will make the payment when the Insured satisfies the Company that due to the above reasons, Insured has become unemployed and the period of unemployment has commenced during the policy period. The company will stop making payments when the Insured is employed again or when the payments for a maximum of 3 EMIs is due and paid, whichever is earlier.

2. The Company shall make a payment of 1/3rd of the Sum Insured specified for this cover or the EMI whichever is lower, per month of unemployment period. In case the unemployed period is part of a month, the amount payable shall be proportionately considered. The EMI amount payable under this Section would not include any arrears due to any reasons whatsoever.

3. This cover is applicable for any one loan at any point of time. In case, Insured person has multiple loans at the time of hospitalization, the benefit is available only in respect of the loan with highest EMI.

4. This section is subject to a waiting period of 90 days from the date of commencement of policy period, except if the unemployment was caused due to an accident occurring after the policy commencement. This waiting period shall not apply in case of policies which are continuously renewed after a cover of 365 days.

C. SPECIFIC EXCLUSIONS-APPLICABLE FOR EMI BENEFIT ON LOSS OF JOB

We will not pay for any unemployment event that arises because of, is caused by, or is attributable to:

1. Termination, dismissal, temporary suspension or retrenchment from employment of the Insured Person being attributed to any dishonesty or fraud or poor performance on the part of the Insured Person or his/her wilful violation of any rules of the employer or laws for the time being in force or any disciplinary action against the Insured Person by employer.

2. Unemployment which has occurred prior to the commencement of the policy period
3. Unemployment if it is attributed to any impending job losses due to restructuring, reorganisation, slowdown in Business, weak financial position of the Organization and or any other similar reasons which Insured was aware of at the Commencement of policy period
4. Unemployment which follows a period of casual, temporary or occasional or contract work or due to normal or seasonal occurrence which is a regular feature of the employment
5. Unemployment if it arises as a result of Termination of Service due to non -renewal of the contract of employment between Insured and her Employer on its expiry or such contract being terminated under a stipulation in that behalf contained therein
6. If Insured was/is self-employed either at the commencement date of the policy or during the policy period
7. Any unemployment from a job under which no salary or any remuneration is provided to the Insured Person
8. Any unemployment due to non-confirmation of employment after or during such period under which the Insured was under probation.
9. Any unemployment due to resignation, voluntary superannuation, voluntary retirement if opted by the Insured on personal grounds or retirement at the age specified for retirement by the employer.
10. Unemployment if it arises as a result of termination of service on the grounds of pre-existing ailment or disease
11. Unemployment arising from or attributable to Your pregnancy or childbirth and/ or any complications directly arising therefrom.
12. Unemployment which results from deliberate self-inflicted Injury and/or consumption of alcohol and/or drug abuse.
13. Any unemployment due to death of the Insured Person
14. Retrenchment and lay off

D. CLAIM PROCEDURE -APPLICABLE FOR EMI BENEFIT ON LOSS OF JOB

1. Insured to intimate the Insurer upon happening of an event that may lead / leads to a claim for EMI Benefit due to Unemployment within 7 days of it coming to her notice
2. On happening of an event that results in / leads to a claim for EMI Benefit due to Unemployment, to make a claim, Insured shall within 14 days from the start of such unemployment deliver to the Company its completed claim form detailing the circumstances of the claim that has occurred along with all documentation required to support and substantiate the amount of indemnification sought from the Company.
3. Insured shall expeditiously provide the Company and its representatives and

appointees with all the information, assistance, records and documentation that they might reasonably require, and/or instruct the parties who may hold such information, records & documentation (for e.g. employer, attending Doctor) to cooperate and share such information, records & documentation with the Company and its representatives and appointees.

4. Insured shall allow the Company and its representatives and appointees to carry out any examination or investigation of the circumstances of the claim and/or her physical medical examination (including but not limited to giving access to employment, Salary and medical records)

Insured shall submit the following documents to the Company:

1. Copy of Insured's employment contract
2. Written communication received from her employer if her employment is terminated due to illness or Accident
3. In case Insured's employment is terminated because of a debilitating Illness and/or Injury, which prevents Insured from carrying out her employment duties,

a. Copies of all diagnostic test reports recommended by Insured's attending Doctor/s and if treatment taken as inpatient, copy of the discharge summary.

b. Medical certificate/s from attending Doctor/s giving detailed explanation of Your Disability

4. Relieving letter/release order from Your employer
5. Loan disbursement letter along with the payment record till the date of Unemployment
6. Current outstanding Loan certificate from financer,

SECTION- 7 HELPING HANDS COVER

A. SCOPE OF COVER:

In the event of accidental injury or illness to Insured during the policy period resulting in inpatient admission in hospital for treatment for a continuous period of 7 days, the Company shall reimburse the following expenses:

A. **TEMPORARY DOMESTIC HELP:** Company will reimburse the expenses incurred for engaging the services of a temporary domestic help for the duration of hospital stay. The amount payable shall not exceed Rs 1000/- per day and the maximum period of cover shall be 10 days.

B. **LITTLE BABY CAREGIVER HELP:** Company will reimburse the expenses incurred for engaging the services of a Care Giver to take care of the Insured's Infant child below 3 completed years of age during the period of the Insured's Hospitalization. The amount payable shall not exceed Rs 1000/- per day and the maximum period of cover shall be 10 days. For this purpose, the caregiver is a person or agency, not related to Insured, appointed by the Insured to look after the infant child and receives payment

from the Insured for the services rendered.

The maximum amount payable under A and B above shall not exceed the sum insured shown for the Section 7 in the policy schedule.

Sum Insured

The Sum Insured under this section shall be on First Loss Basis. The liability of the company for any one claim or for all the claims in the aggregate during the policy period shall be limited to the sum insured specified in the policy schedule.

B. EXCLUSIONS APPLICABLE FOR HELPING HANDS COVER

We will not be liable to make any payment under this Policy, for any claim directly attributable to, or based on, or arising out of, or connected with any of the following:

1. Any Events/incidences that happened before the policy inception would not be covered.
2. Any Pre-existing Condition(s) and complications arising out of or resulting therefrom
3. Through suicide, attempted suicide (whether sane or insane) or intentionally self-inflicted injury or illness
4. Whilst engaging in Adventure Sports and/or hazardous activities
5. While under the influence of liquor or drugs, alcohol or other intoxicants, unless administered on the advice of a physician. For the purposes of this exclusion, the expression “drug” means any intoxicant other than alcohol, natural or synthetic, or any natural material or any salt, or preparation of such substance or material as may be notified by the Central Government under M V Act and includes a narcotic drug and psychotropic substance as defined in clause (xiv) and clause (xxiii) of section 2 of the Narcotic Drugs and Psychotropic Substances Act, 1985.’
6. Through deliberate or intentional, unlawful or criminal act, error, or omission, participation in an actual or attempted felony, riot, crime, misdemeanour, civil commotion
7. Whilst engaging in aviation or ballooning, whilst mounting into, dismounting from or traveling in any balloon or aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world,
8. Whilst participating as the driver, co-driver or passenger of a motor vehicle during motor racing or trial runs,
9. Arising out of your participation in any police, naval, military or air force operations whether peace or in war in the form of military exercises or war games or actual engagement with the enemy, Whether foreign or domestic,
10. Pregnancy, resulting childbirth, miscarriage, abortion, or complications arising out of any of these,

11. Operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft; or Scheduled Airlines

12. Any claim caused by osteoporosis (porosity and brittleness of the bones due to loss of protein from the bones matrix) or pathological fracture (any fracture in an area where pre-existing Disease has caused the weakening of the bone) if osteoporosis or bone Disease diagnosed prior to the Policy Effective Date. However, this exclusion shall not apply if the Insured sustains Accidental Bodily Injury which directly and independently of all other causes results in accidental injury, insured under the policy.,

13. Loss caused directly, wholly or partly by:

    a. Bacterial infections (except pyogenic infections which shall occur through an accidental cut or wound) or any other kind of disease;

    b. Medical or surgical treatment except as may be necessary solely as a result of Injury;

14. Dental care or Dental surgery except as occasioned by Accidental Injury.

15. Expenses incurred by the Insured after the expiration date of the policy unless the date of commencement of hospitalisation falls within the policy period.

C. CLAIM DOCUMENTATION FOR HELPING HANDS COVER

On the occurrence or the discovery of any Illness or Injury that may give rise to a claim under this section, then as a Condition Precedent to Our liability under the Policy the following procedure shall be complied with:

1. Intimation of the claim immediately, in any event within 48 hours of admission to the hospital

2. The below documents have to be submitted within 30 days from the date of discharge from the Hospital

    a. Duly completed Claim Form

    b. Original Discharge Card

    c. All previous consultation papers indicating history and treatment details for current ailment

    d. Bills/Invoices for Engagement of the Domestic help and/or Little Baby caregiver Photo ID & Age Proof

    e. Bank details along with Original cancelled cheque and NEFT details

5. GENERAL EXCLUSIONS APPLICABLE TO ALL SECTIONS UNDER THE POLICY

The Insurer shall not be liable for any claim under any Cover in the policy that is caused by, attributable to, arises out of or is howsoever connected to any of the following:

1) Loss, destruction or damage caused by war, invasion, act of foreign enemy hostilities or war like operations (whether war be declared or not), civil war, mutiny, civil

commotion assuming the proportions of or amounting to a popular rising, military rising, rebellion, revolution, insurrection or military or usurped power.

2) Loss, destruction or damage directly caused by

a. ionising radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel

b. the radioactive toxic, explosives or other hazardous properties of any explosive nuclear assembly or nuclear component thereof

3) Terrorism Damage Exclusion Warranty: This Policy excludes loss, damage, cost or expense of whatsoever nature directly caused by, resulting from or in connection with any act of terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss. For the purpose of this exclusion, an act of terrorism means an act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization (s) or government(s), or unlawful associations, recognized under Unlawful Activities (Prevention) Amendment Act, 2008 or any other related and applicable national or state legislation formulated to combat unlawful and terrorist activities in the nation for the time being in force, committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public or any section of the public in fear for such purposes. This exclusion also includes loss, damage, cost or expense of whatsoever nature directly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to the above.

However, this exclusion shall not be applicable for all covers under Section 1 of this policy.

6. GENERAL TERMS AND CONDITIONS APPLICABLE TO ALL SECTIONS OF THE POLICY:

1. Condition Precedent to Admission of Liability:

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

2. Disclosure of Information:

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: “Material facts” for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

3. Free Look Period:

Every policyholder of new individual health insurance policies, except for those policies with

tenure of less than a year, shall be provided a free look period of 30 days beginning from the date of receipt of policy document, whether received electronically or otherwise, to review the terms and conditions of such policy and to return the same if not acceptable.

Free Look Period shall not be applicable on renewals or at the time of porting/migrating the policy.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. A refund of premium paid less any expenses incurred by the company on medical examination of the insured person and the stamp duty charges, where the risk has not commenced or

ii. Where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover, expenses if any incurred by the Company on medical examination of the policyholder and stamp duty charges or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period, expenses if any incurred by the Company on medical examination of the policyholder and stamp duty charges.

4. Moratorium Period:

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

5. Nomination:

The policyholder is required at the inception of the policy and at the time of renewal to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

6. Fraudulent Claims

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this

policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

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

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

7. Multiple Policies (Applicable for Section 1E-Medical Expenses for Accident and Section3-Health cover):

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be treated as the Primary Insurer and shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person 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 the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the Primary Insurer shall seek the details of other available policies of the policyholder and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

Benefit Based Covers:

i. On occurrence of the insured event, the Insured Person or his Nominee can claim from all Insurers under all policies.

8. CLAIM SETTLEMENT (Provision for Penal Interest)

a. The Company shall settle or reject a claim ,as the case may be, within 30 days from the date of receipt of last necessary document

b. In case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

c. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

d, In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: “Bank rate” shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the Financial Year in which claim has fallen due)

9. COMPLETE DISCHARGE:

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

10. TERMS OF RENEWAL

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.

v. No loading shall apply on renewals based on individual claims experience.

vi. The cover for the Insured shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under Coverage Death or Permanent Total Disability and no Renewal of contract will be permissible

11. POSSIBILITY OF REVISION OF TERMS OF THE POLICY INCLUDING THE PREMIUM RATES

The company may revise or modify the terms of the policy including the premium rates with prior approval of the Product Management Committee, of the Company. The insured person shall be notified three months before the changes are effected.

12. WITHDRAWAL OF THE PRODUCT:

i. In the likelihood of this product being withdrawn in future, the company will intimate the insured person about the same 90 days prior to expiry of the policy.

ii. Insured person will have the option to migrate to similar health insurance product available with the company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

13. CANCELLATION:

i. The policyholder may cancel this policy by giving 15 days written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below:

Month	1 Year Policy Term	2 Year Policy Term	3 Year Policy Term
	Rate of Premium to be retained	Rate of Premium to be retained	Rate of Premium to be retained
1	0%	0%	0%
2	17%	8%	6%
3	25%	13%	8%
4	33%	17%	11%
5	42%	21%	14%
6	50%	25%	17%
7	58%	29%	19%
8	67%	33%	22%
9	75%	38%	28%
10	83%	42%	31%
11	92%	46%	33%
12	100%	50%	36%
13		54%	39%
14		58%	42%
15		63%	44%
16		67%	47%
17		71%	50%

18		75%	53%
19		79%	56%
20		83%	58%
21		88%	61%
22		92%	64%
23		96%	67%
24		100%	69%
25			72%
26			75%
27			78%
28			81%
29			83%
30			86%
31			89%
32			92%
33			94%
34			97%
35			100%
36			100%

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

ii. The Company may cancel the Policy at any time on grounds of misrepresentation, non-disclosure of material facts, fraud by the Insured Person, by giving 15 days written notice. There would be no refund of premium on cancellation of grounds of misrepresentation, non-disclosure of material facts or fraud.

14. CONSIDERATION:

The Policy is issued subject to payment of premium in advance. No payment shall be valid unless made under us official receipt. The cover shall not be valid prior to the date and time of receipt of premium.

15. PREMIUM PAYMENT IN INSTALMENTS:

a. Premium Payment Modes available under the policy: The proposer shall have the following options to pay the premium:
   1. Single Premium payment prior to commencement of cover or
   2. Payment of premium on Monthly, Quarterly, Half-Yearly and Annual modes. This

mode is applicable for One, Two and Three year policy Terms.

This option shall be made at the time of proposing for insurance and the opted mode will be shown on the policy schedule. Mode of Premium payment can be changed only at the time of renewal.

b. Specific Conditions applicable to other than single premium payment mode:

If the Insured person has opted for Payment of Premium on an instalment basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in the policy schedule, the following conditions shall apply (not withstanding any terms contrary elsewhere in the policy)

1. Premium payable for the first 3 Months from the date of commencement of cover has to be paid upfront by way of Cheque/Direct Debit mode and Debit Mandate has to be submitted for the balance premium applicable for the policy period.
2. The premium should be paid on or before the respective due date.
3. Grace period of 15 days for Monthly and 30 days for Quarterly, Half-yearly and Annual mode would be given to pay the installment premium due for the policy.
4. The policy will be in force during such grace period and any claim arising during the grace period will be payable subject to policy terms and conditions.
5. The Insured Person will get the accrued continuity benefit in respect of the 'Waiting Periods', 'Specific Waiting Periods' in the event of payment of premium within the stipulated grace period.
6. No interest will be charged if the instalment premium is not paid on due date
7. In case of instalment premium due not received within the grace period, the policy will get cancelled
8. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
9. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

16. ENTIRE CONTRACT CHANGES:

This Policy together with the Proposal Form, as well as any forms and endorsements constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our authorized official and such approval is endorsed hereon. No agent has authority to change this Policy or to waive any of the provisions of this Policy.

17. NOTIFICATION OF CHANGES:

It is a condition precedent to Our liability to make any payment under this Policy that the Insured shall give Us written notice immediately of any change in the address, and any other changes affecting the Insured/ any Insured. Any communication meant for Us must be in writing and be delivered to Our address shown in the Schedule. Any communication meant for the Insured will be sent by Us to Your address shown in the Schedule.

18. NO CONSTRUCTIVE NOTICE:

Any of the circumstances in relation to these conditions coming to the knowledge of any official of the Company shall not be the notice to or be held to bind or prejudicially affect the Company notwithstanding subsequent acceptance of any premium.

19. REASONABLE CARE:

The Insured shall take all reasonable steps to safeguard against any action, any accident or injury that may give rise to any claim under this policy.

20. TERRITORIAL LIMITS:

The Coverage under Section 1 Personal Accident is Worldwide. The coverage under all other sections is restricted to India only. Our liability shall be to make payment within India and in Indian Rupees only

21. CLAIM PROCEDURE:

a. Claim Procedure:

The claim procedure to be followed in respect of the various section under the policy is provided in their respective sections.

b. TPA

There is no TPA tie –up envisaged for this product. Any arrangement in future will be disclosed in the Policy to the Policyholders.

Chola MS customer support operates 24/7 basis and the contact details are as followed for any queries / grievances:

- Toll Free Phone No: 1800-208-9100
- E-Mail: customercare@cholams.murugappa.com

Address of Chola MS Health Claims Office:

Chola MS HELP – Health Claims Department

New No.2, Old No. 234, Parry House, 3rd Floor,

N. S. C. Bose Road, Chennai - 600001.

Customer Care Toll Free No: 1800-208-9100

E-Mail: customercare@cholams.murugappa.com

c PAYING A CLAIM:

a. The Insured agrees that We need only to make payment when the Insured or someone claiming on his/her behalf has provided Us with necessary documentation and information.

b. We will make payment to You or Your Nominee. If there is no Nominee and You are incapacitated or deceased, we will pay Your heir, executor or validly appointed legal representative and any payment We make in this way will be a complete and final discharge of Our liability to make payment.

22. SUM INSURED ENHANCEMENT:

Sum Insured can be enhanced only at the time of renewal subject to reported claim status and health condition of the insured. The insured may also avail an optional cover or opt out of the optional cover at the time of renewal.

If you decide to increase the sum insured or opt for an optional cover or opt out of the optional cover at the time of renewal, the same shall be subject to written application and our acceptance.

Addition of section 1G- EMI Protection Benefit, 1H- Vehicle loan Protection Benefit and Section 6- EMI Benefit due to loss of Job, during the policy period is allowed, subject to payment of premium on short period basis for the period of cover

23. AUTOMATIC TERMINATION OF COVER FOR INSURED:

The cover for the Insured shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under Coverage Section 1 A Death or Section 1 B Permanent Total Disability.

24. APPLICABLE LAW:

Indian law governs the construction, interpretation and meaning of the provisions of this Policy and the relationship between us. The section headings in this Policy are included for descriptive purposes only and do not form part of this Policy for the purpose of its construction or interpretation.

25. LIMITATION PERIOD

It being expressly agreed and declared that if the Company shall disclaim liability for any claim hereunder and such claim shall not within 12 calendar months from the date of disclaimer have been made the subject matter of a suit in court of law then the claim for all such purposes be deemed to have been abandoned and the liability of the company shall stand discharged.

26. POLICY DISPUTES:

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed to by both the Insured and the Company to be subject to Indian Law. Each party agrees to submit such dispute to a Court of competent jurisdiction and to comply with all requirements necessary to give such Court the jurisdiction. All matters arising hereunder shall be determined in accordance with the law and practice of such Court.

27. ASSIGNMENT:

The policy can be assigned subject to applicable laws.

7. RESOLVING ISSUES

Mechanism for Grievance Redressal:-

In case of any grievance the insured person may contact the company through

Website : www.cholainsurance.com

Toll free : 1800 208 9100

E-Mail : customercare@cholams.murugappa.com

Courier : Manager, Customer Care, Chola MS General Insurance Company Limited
Hari Nivas Towers First Floor, #163, Thambu Chetty Street,
Parry's Corner, Chennai -600001

Procedure of Grievance Redressal

- Please write to customercare@cholams.murugappa.com to register your complaint.
- In Case of Senior Citizen please write to seniorcitizensupport@cholams.murugappa.com or call our Toll free @ 1800 208 9100 (for Health products)
- On lodging the complaint, a complaint reference number will be provided. An acknowledgement will also be sent with the details of turn around time for resolution and complaint registration details.
- In case you are not happy with the resolution provided or delay of greater than 7 working days, you may follow the below escalation matrix.

Escalation Matrix

- In case you are dissatisfied with the response or have not received a response, you may escalate the same to our Nodal Officer – Nodalescalation@cholams.murugappa.com (Quoting the previous Service request number)
- In case you are still unhappy with the response or have not received a response within 7 working days, you may escalate the same to our Chief Grievance Officer - GRO@cholams.murugappa.com (Quoting the previous Service request number)
- If after having followed the above steps and your issue still remain unresolved, you may approach the Insurance Ombudsman for Redressal. Login to https://www.cioins.co.in/Ombudsman to get details on Insurance Ombudsman Offices.

Office Details	Jurisdiction of Office
AHMEDABAD - Shri Kuldip Singh, Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad - 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@ecoi.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu
BENGALURU – Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru - 560 078. Tel.: 080 - 26652048 I 26652049 Email: bimalokpal.bengaluru@ecoi.co.in	Karnataka

Office Details	Jurisdiction of Office
BHOPAL- Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal - 462 003. Tel.: 0755 - 2769201 / 2769202 Fax: 0755 - 2769203 Email: bimalokpal.bhopal@ecoi.co.in	Madhya Pradesh, Chhattisgarh
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar - 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@ecoi.co.in	Orissa
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 - D, Chandigarh - 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@ecoi.co.in	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 Floor, 453, Anna Salai, Teynampet, CHENNAI -600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: ,bimalokpal.chennai@ecoi.co.in	Tamil Nadu, Tamil Nadu PuducherryTown and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi - 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@ecoi.co.in	Delhi & Following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.

Office Details	Jurisdiction of Office
GUWAHATI- Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati - 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@ecoi.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD- Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A.C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Union Territory of Puducherry
JAIPUR - Office of the Insurance Ombudsman, Jeevan Nidhi - II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@ecoi.co.in	Rajasthan
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA- Shri P.K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R.Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax: 033 - 22124341 Email: bimalokpal.kolkata@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands

Office Details	Jurisdiction of Office
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29 /30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514252 I 2514253 Email: bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.

Office Details	Jurisdiction of Office
PATNA- Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune- 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region

ANNEXURE - 1 (attached to and forming part of policy wordings)

LIST I – NON MEDICAL EXPENSES EXCLUDED UNDER THE POLICY	
Sl. No.	**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	SERVICES CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISON 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	MEDICAL RECORDS
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	SPLINLT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/SHORT/HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELTT
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 POWDER LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERYKIT, 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	
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU0DE-COLOGNE/ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING 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 EXPENSE

30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES
LIST III – ITEM THAT ARE TO BE SUBSUMED INTO PROCEDURE CHARGES	
1	HAIR REMOVAL CREAM
2	DISPOSABLE RAZORS CHARGES (FOR SITE PREPARATIONS)
3	EYE PAD
4	EYE SHEILD
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, HARMONICSCALPEL, 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	ORTHOBUNDLE, GYNAEC BUNDLE

LIST IV – ITEMS THAT ARE TO BE SUBSUMED INTO COSTS OF TREATMENT	
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 EQUIPMENTS
7	INFUSION PUMP – COST
8	HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES – DIETICIAN CHARGES – DIET CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOLT SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

*Revision/Inclusion in compliance with IRDAI Circular Ref. IRDAI/HLT/CIR/GDL/31/01/2024 dt. 31st January, 2024
Sub: Guidelines on providing AYUSH coverage in Health Insurance policies.

Cholamandalam MS General Insurance Company Limited
(A Joint Venture between Murugappa Group & Mitsui Sumitomo Insurance Company Ltd., Japan)
Regd. Office: New No. 2, Old No. 234, Dare House, 2nd Floor, N. S. C. Bose Road, Parrys Corner, Chennai - 600 001. India.
T: +91-44-4044 5400 | F: +91-44-4044 5550 | E: customercare@cholams.murugappa.com

Reach us at:

customercare@cholams.murugappa.com | CholaMSInsurance | @cholams | 7305234433 (CholaMS)
chola_ms | cholainsurance.com | 1800-208-9100 (Toll Free) | virtual assistant JOSHU

CHOLA SARVA SHAKTI POLICY

*SMS charges as applicable

For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale.Terms and Conditions apply.

Prohibition of rebates 41. (1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the insurer:

(2) Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

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