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DIVYANG BIMA, CHOLA MS
UIN: CHOHLIP23216V012223
PROSPECTUS

Divyang Bima, Chola MS is a Specialized Health Indemnity Insurance that provides financial protection against the unforeseen medical contingencies for Persons with Disability, Mental Illness and Persons with HIV/AIDS.

Health care expenses for People with special needs is often not affordable. They often do not receive any needed health Insurance covers. This product stands alone and lends a helping hand for persons with Disabilities and HIV/AIDS to cover the medical expenses.

1. PERSONS WHO CAN BE INSURED:

- Persons with Disability shall be covered, if 40% or more disability is certified by the Medical Board appointed by the government for certifying Disability as per the Disability act 2016, Individuals with HIV/AIDS as defined under the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017.
- **Only Indian Nationals can be covered under this policy.**
- **Only one policy can be purchased for this product across all insurers.**

Persons who can be covered	**Entry Age**	**Important Conditions**
Age mentioned below refers to completed age at the commencement date of this policy		
Adults	Minimum – 18 years Maximum – 65 Years	The Proposer should be minimum 18 years on the Commencement date of the policy.
Dependent Children upto 4	Minimum – New Born Maximum – 17 Years	Children between New born to 17 years can be insured. Maximum Renewal age for children is 17 years. On renewal after completion of 17 years, such Insured Person will have the option to migrate to new health insurance policy under the same product, with continuity benefits. Married Children of the proposer are not eligible for coverage under the policy

2. TYPE OF SUM INSURED (SI) OPTIONS:

- **Individual Sum Insured –** Each covered person will have an independent Sum Insured limit within the same policy.
- No multi Individual Policies shall be allowed

3. POLICY TENURE:

- One Year

4. SUM INSURED OPTIONS

- Rs. 4 lakhs and Rs. 5 lakhs

5. PREMIUM PAYMENT OPTIONS:

- Annual or
- Half-Yearly or

- Quarterly or
- Monthly mode.

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.

6. SCOPE OF COVER:

The covers listed below are in-built policy benefits and shall be available to all Insured Persons in accordance with the procedures set out in the policy.

Benefits	
In-Patient Hospitalisation Expenses	Covered
Pre-Hospitalisation	Upto 30 days
Post Hospitalisation	Upro 60 days
Emergency Ground Ambulance	Expenses covered up to Rs. 2000 per hospitalisation
AYUSH	Covered upto 100% of SI
Sublimit & Co-Payment	
Room/ Medical Practitioner's fee	Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital/Nursing Home up to maximum of 1% of the sum insured per day. Intensive Care Unit {ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital/ Nursing Home up to maximum of 2% of the sum insured per day.
Cataract Treatment	Up to Rs.40,000/-, per each eye in one policy year
Modern Treatment	Covered for listed procedures up to 50% of SI available for Inpatient Hospitalisation Care
Co-pay	20% on all claims made under the policy unless waiver for Co-pay is opted and premium is paid for the same
Waiting periods	
30 days Waiting period	Applicable
PED waiting period	48 months (For pre-existing diseases other than the pre-existing Disability and HIV/AIDS covered)
Specific Disease/ illness waiting period	24 months
Waiting Period for HIV AIDS Cover	For HIV/AIDS cover: Initial waiting period of 30 days will be applicable for Indemnity basis cover Sum Insured would be available for Hospitalisation Expenses as per terms and conditions of the policy.
Waiting Period for Disability Cover	For Disability Cover: 24 months initial waiting period is applicable for the pre-existing Disability covered under the policy.

7. WAITING PERIODS

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1. Pre –Existing Diseases (Code –Excl01)

1. Expenses related to the treatment of a Pre-Existing Disease (PED) and its direct complications shall be excluded until the expiry of 24 months for Pre-existing Disability/ 36 months for all pre-existing conditions other than HIV/AIDS and Disability (as mentioned in Policy Schedule) of continuous coverage after the date of inception of the first policy with insurer.
2. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
3. 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.
4. Coverage under the policy after the expiry of number of months (as mentioned in Policy Schedule) for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. First 30 Days 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.

3. Specific disease/ procedure 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 months (as mentioned in Policy Schedule) 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.

24 Months Waiting period

1. Benign ENT disorders
2. Tonsillectomy
3. Andenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy
7. All internal and external benign tumours, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele

14. Non-infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy
19. Varicose Veins and Varicose ulcers
20. Internal Congenital Anomalies (except for New Born)

SPECIFIC CONDITIONS APPLICABLE FOR PERSONS WITH DISABILITY

The Company will indemnify reasonable and customary charges for medical expenses incurred towards Inpatient Hospitalisation arising due to the pre-existing disability covered, or condition as listed under The Rights of Persons With Disabilities Act, 2016 subject to the terms and limits mentioned below.

i. Any treatment for the pre-existing disability covered, will have a waiting period of 24 months from the first policy inception date.
ii. Any reconstructive / Cosmetic / prosthesis / external or internal device implanted/ used at home for the purpose of treatment of existing disability or used for activities of daily living are/is excluded from the policy

SPECIFIC CONDITIONS APPLICABLE FOR PERSONS WITH HIV/AIDS

The Company will indemnify the Reasonable and Customary Charges for any Medical Condition which requires Inpatient Hospitalization of the Insured Person, up to the sum insured opted as mentioned in the Policy Schedule, provided,

Condition

i. This cover will exclude cost for any Anti-Retroviral Treatment.

8. EXCLUSIONS

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

a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

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 – Excl10):**
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 up to 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: (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.

8.2 Specific Exclusions

1. Any medical treatment taken outside India.
2. Hospitalization for donation of any body organs by an Insured including complications arising from the donation of organs.
3. Nuclear damage caused by, contributed to, by or arising from ionising radiation or contamination by radioactivity from:
   a. any nuclear fuel or from any nuclear waste; or
   b. from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission);
   c. nuclear weapons material.
   d. nuclear equipment or any part of that equipment.
4. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority.
5. Injury or Disease caused by or contributed to by nuclear weapons/materials.
6. Circumcision unless necessary for treatment of a disease, illness or injury not excluded hereunder, or as may be necessitated due to an accident.
7. Treatment with alternative medicines or Treatment, experimental or any other treatment such as acupuncture, acupressure, magnetic, osteopath, naturopathy, chiropractic, reflexology and aromatherapy.
8. Suicide, lntentional self-injury (including but not limited to the use or misuse of any intoxicating drugs or alcohol) and any violation of law or participation in an event/activity that is against law with a criminal intent.
9. Vaccination or inoculation except as post bite treatment for animal bite.
10. Convalescence, general debility, "Run-down" condition, rest cure, Congenital external illness/disease/defect.
11. Outpatient diagnostic, medical and surgical procedures or treatments, non-prescribed drugs and medical supplies, hormone replacement therapy and expenses related to Domiciliary hospitalization shall not be covered.
12. Venereal/ Sexually Transmitted disease
13. Stem cell storage.
14. Any kind of service charge, surcharge levied by the hospital.

15. Personal comfort and convenience items or services such as television, telephone, barber or guest service and similar incidental services and supplies.
16. Non-Payable items: The expenses that are not covered in this Policy are placed under List-I of Annexure-II
17. Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

9. CLAIM PROCEDURE

9.1 Procedure for Cashless claims

i. Treatment may be taken in a network provider as well as identified list of hospitals by GIC for common empanelment through anywhere cashless facility and is subject to pre authorisation by the Company or its authorised TPA.
ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorisation
iii. The Company /TPA upon getting cashless request form and related medical information from the insured person/network provider will issue pre-authorisation letter to the hospital after verification
iv. At the time of discharge , the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses
v. The Company/TPA reserves the right to deny pre-authorisation in case the insured person is unable to provide the relevant medial details
vi. In case of denial of cashless access the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/TPA for reimbursement.
vii. 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-authorization 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

9.2 Procedure for Reimbursement of claims

For reimbursement of claims the insured person may submit the necessary document to Company within the prescribed time limit as specified hereunder:

SI. No	Type of Claim	Prescribed Time Limit
1.	Reimbursement of hospitalisation ,day care and pre hospitalisation expenses	Within thirty days of discharge from hospital
2.	Reimbursement of post hospitalisation expenses	Within fifteen days from completion of post hospitalisation treatment

9.3 Notification of Claim:

Notice with full particulars shall be sent to the Company/TPA (if applicable) as under:

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

	72 hours prior to the date of planned 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

9.4 Documents to be submitted:

The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit:

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical Practitioner's prescription advising admission
iv. Original Bills with itemized break –up
v. Payment receipts
vi. Discharge Summary including complete medical history of the patient along with other details
vii. Investigation /Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
ix. Sticker/Invoice of the Implants, wherever applicable
x. MLR (Medico Legal Report) copy if carried out and FIR (First Information report) if registered, where ever applicable
xi. NEFT details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML guidelines
xiii. Legal heir/succession certificate, wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment of the claim

1. The company shall only accept bills/invoices/medical treatment related documents in the Insured person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

On receipt of claim documents from Insured, Insurer shall assess the admissibility of claim as per Policy terms and conditions. Upon satisfactory completion of assessment and admission of claim, the Insurer will make the payment as per the contract. In case if the claim is repudiated Insurer will inform the Insured about the same in writing with reason for repudiation.

10. DOCUMENTS TO BE SUBMITTED FOR PURCHASING THE POLICY:

Following list of documents have to be submitted by the proposer for purchasing the policy:

- Completed proposal form and
- Proof of Date of Birth

- Last CD4 count certificate, wherever applicable
- Disability certificate mentioning percentage of Disability, wherever applicable

11. UNDERWRITING CONSIDERATIONS:

- Any and all Proposals under this product shall be referred for Tele MER/Video MER
- Pre-Policy Medical Check Up (PPMC) shall be applicable for persons above the age of 50 Years

Age Criteria	Process
*All members	Video/Tele MER
Age above 50 years	PPMC - Package 1

- *Proposals may also be referred to PPMC based on the findings from Video/Tele MER
- Based on the declarations in the Proposal form, Disability and CD4 certificate and findings of PPMC reports and/or Tele MER / Video MER, Underwriter may refer for additional tests and following type of exclusions or loading shall be applied in the policy.
- Wherever the findings are within acceptable range, the proposal can be accepted as per normal rates and terms. In case of abnormal values, the same will be sent for medical opinion of the company doctor and based on the opinion, a suitable specific exclusion or permanent exclusion may be included in the policy or loading may be collected as per the Risk Loading listed herein.
- Only PEDs declared in the Proposal Form and accepted for coverage by the company shall be covered.

a) SPECIFIC EXCLUSION:

The specific exclusions would be subject to the waiting period applicable to Pre-existing diseases or conditions of the policy.

b) Risk Loading:

Following are the parameters based on which loadings will be applied.

1. Loading based on Body Mass Index
2. i. Risk loading may be applied on premium payable (excluding taxes and cess) based on the details of the Insured Persons, including the health status, habits and lifestyle, past medical records, declarations on the Proposal Form and results of the Pre-Policy medical check-up. The maximum risk loading for an individual shall not exceed 200%. These loadings are applicable from commencement date of policy including subsequent renewal(s).
   ii. These loadings may only be applied if the proposal is accepted with the declared illness/ with the deviated value of medical test report, at the time of underwriting and only if the proposed policyholder accepts these loadings being applied for the underlying illness/condition at the time of underwriting.
   iii. The proposal shall be declined wherever more than 2 Co-morbid conditions are disclosed in the proposal form and / or detected during the PPMC or Tele /Video MER.
3. Loading for Co-morbidities based on disclosure in proposal form or findings from PPMC, Tele/Video MER for persons existing HIV/AIDS
4. Loading for HIV / AIDS condition basis Current CD4 Count less than 501

12. PPMC PROCESS FLOW:

Our designated Service Provider will contact the persons falling within the criteria above for Pre-Policy Medical Checkup and arrange for the Medical Checkup at the Diagnostic Centres on Cashless basis. The various medical reports required are as under:

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Package 1	Abbreviation	Medical test Name
MER	MER	Medical Examination Report
CBC with ESR	CBC	Complete Blood Count
	ESR	Erythrocyte Sedimentation rate
ECG	ECG	Electro Cardio Gram
HbA1C	HbA1c	Haemoglobin A 1c
T Cholesterol	T Cholesterol	Total Cholesterol
SGPT	SGPT	Serum Glutamic Pyruvic Transaminase
Serum Creatinine	S Creatinine	Serum Creatinine
RUA	RUA	Routine Urine Analysis

Note:

1. Each medical examination report of the proposer shall necessarily contain the qualified practicing medical professional's name, signature, contact number (in case of an emergency) and registration number.
2. A qualified practicing medical professional (minimum qualification of MBBS required) shall perform the medical examination. For this purpose, practicing means practicing as a general medical practitioner or physician
3. Reports from unregistered diagnostic labs and other entities will not be admissible.
4. Any medical examination report and test report would only be valid for 30 days from date of report.

13. COST OF PRE POLICY MEDICAL CHECK UP:

- Pre Policy Medical Check up for the proposed customers will be arranged by our Designated Service Provider on Cashless basis.
- No cost will be collected from the Customers towards the same.
- In case after undergoing the PPMC, the Proposal gets rejected by us or Insured decides not to take the policy, the expenses incurred by the Insurer for the purpose of PPMC shall be deducted from the Insured's premium to the extent of 50% of PPMC charges incurred and the balance premium would be refunded.

14. CANCELLATION OF COVER:

i. The policyholder may cancel this policy at any time during the term, by giving 7 days written notice in writing and in such an event, the Company shall

a. refund proportionate premium for the unexpired policy period, if the term of policy upto one year and there is no claim(s) made during the policy period

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

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.

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 on grounds of misrepresentation, non-disclosure of material facts or fraud.

15. MIGRATION

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the company as per extant Guidelines related to Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, as per Guidelines on migration, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as per below:

i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Migration benefit will be offered to the extent of sum of previous insured and accrued bonus (as part of the sum insured), migration benefit shall not apply to any other additional increased Sum Insured.
iii. Migration under this product shall be allowed only due to withdrawal of the product subject to IRDAI Regulations

16. PORTABILITY

The Insured Person will have the option to port the Policy to same product of other insurers as per extant Guidelines related to portability, If such person is presently covered and has been continuously covered without any lapses under this health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Section 5 shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Policy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

17. RENEWAL OF POLICY:

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years.
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

18. 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.

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

The Company, with prior approval of the Product Management Committee of the Company, may revise or modify the terms of the policy including the premium rates. The Insured Person shall be notified three (3) months before the changes are affected.

20. PREMIUM PAYMENT IN INSTALMENTS

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

i. Grace period of 15 days for Monthly and 30 days for Quarterly and Half-yearly mode would be given to pay the instalment premium due for the policy
ii. 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.
iii. The Benefits provided under - "Waiting Periods", "Specific Waiting Periods" Sections shall continue in the event of payment of premium within the stipulated grace Period.
iv. No interest will be charged If the instalment premium is not paid on due date.
v. In case of instalment premium due not received within the grace Period, the Policy will get cancelled.
vi. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
vii. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

21. 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.

lf 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

22. NOMINATION:

The policy holder 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 policy holder. 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 Insured Person, the Company will pay the nominee (as named in the Policy Schedule/endorsement (if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Insured Person whose discharge shall be treated as full and final discharge of its liability under the Policy.

23. CHANGE OF SUM INSURED:

Sum Insured can be changed (increase / decrease) only at the time of Renewal or at any time, subject to underwriting by the Company. For any increase in Sum Insured, the waiting period shall start afresh only for the enhance portion of the Sum Insured.

24. APPLICABILITY OF TAX EXEMPTION:

- The premium paid for covering Self, Spouse, Dependent Children and Dependent Parents is eligible for deduction under Section 80D of Income Tax Act.
- AML norms as per IRDA guidelines currently in force shall be insisted upon.

25. MULTIPLE POLICIES:

i. In case of multiple policies taken by an Insured person during a period from the same or 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 be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

v. Under this product, no insured can take more than one policy from any or all insurers.

vi. In case of this product, the maximum liability of all policies put together from all insurers cannot exceed the maximum sum insured under this product.

26. REVISION AND MODIFICATION OF THE POLICY PERIOD-

Any revision or modification will be done with the approval of the Product Management Committee of the Company. We shall notify You about revision /modification in the Policy including premium payable thereunder. Such information shall be given to You at least ninety (90) days prior to the effective date of modification or revision coming into effect. Existing Policy will continue to remain in force till its expiry, and revision will be applicable only from the date of next renewal. Credit of continuity/waiting periods for all the previous policy years would be extended in the new policy on Renewal with Us.

27. PREMIUM:

Premium for a Tenure of One Year (Excl. GST)

Premium (excl. GST)				
Age bands/ Sum Insured(in Rs.)	With Co-pay		Without Co-pay	
	₹ 4 L	₹ 5 L	₹ 4 L	₹ 5 L
Less than 18	13,700	14,379	16,281	17,096
18-25	16,286	17,102	19,384	20,363
26-30	19,031	19,991	22,678	23,829

31-35	21,941	23,054	26,170	27,505
36-40	25,025	26,300	29,870	31,400
41-45	28,290	29,737	33,789	35,525
46-50	31,746	33,375	37,936	39,891
51-55	41,684	43,807	49,753	52,300
56-60	60,878	64,011	72,785	76,545
61-65	88,765	93,367	1,06,250	1,11,772
66-70	1,29,160	1,35,887	1,54,724	1,62,796
Greater than 70	1,87,505	1,97,304	2,24,738	2,36,496

Discounts:

Discount in Lieu of Intermediation	
Intermediation Channel	**Discount (%) on Premium**
Direct	7.5%

Loading:

Premium Payment	
Mode	**Loading %**
Annual	0%
Half-Yearly	2%
Quarterly	3%
Monthly	4%

22. Illustrations

Illustration 1

Policy Details	
Term	1 year
Mode of Premium Payment	Annual
Business Channel	Direct
Sum Insured	₹ 5 L
Age of insured	40
Co-pay opted	Yes
Premium Calculation	
Premium	26,300
Loading for Mode of Premium Payment	0%
Discount in-lieu-of Intermediation	7.5%
Final Premium	26,300 * (1+0%) * (1-7.5%) = 24,327

Illustration 2

DIVYANG BIMA, CHOLA MS
UIN: CHOHLIP23216V012223
PROSPECTUS

Policy Details	
Term	1 year
Mode of Premium Payment	Quarterly
Business Channel	Agent
Sum Insured	₹ 4 L
Age of insured	19
Co-pay opted	No
Premium Calculation	
Premium	19,384
Loading for Mode of Premium Payment	3%
Discount in-lieu-of Intermediation	0.0%
Final Premium	19,384 * (1+3%) * (1-0.0%) = 19,966

Illustration 3

Policy Details	
Term	1 year
Mode of Premium Payment	Half-Yearly
Business Channel	Intermediary
Sum Insured	₹ 5 L
Age of insured	65
Co-pay opted	No
Premium Calculation	
Premium	1,11,772
Loading for Mode of Premium Payment	2%
Discount in-lieu-of Intermediation	0.0%
Final Premium	1,11,772 * (1+2%) * (1-0.0%) = 1,14,007

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.

Section 41 of Insurance Act, 1938

Section 41 of Insurance Act, 1938 – Prohibition of Rebates:(1) No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person totake or renew or continue an insurance in respect of any kind of risk relating to livesor 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..

Insurance is the subject matter of the solicitation.