SCHEME DOCUMENT

Customized Insurance coverage for Professional and Hobby Pilots Registered with Paragliding Association

About CARE Health Insurance Company Limited

CARE Health Insurance Company Limited (formally known as Religare Health Insurance Company Limited) is focused on the delivery of health insurance services. Our promoter's expertise in the spectrum of financial services, healthcare delivery and preventive health solutions, coupled with a robust distribution model, offers us a unique edge to deliver and excel in a business environment that hinges on serviceability and scale. Powered by the best-in-class product design and a customer centric approach, CARE Health Insurance Company Limited is committed to delivering on its innate values of being a responsible, trustworthy and innovative health insurer. CARE Health Insurance Company Limited is promoted by three strong entities- Religare Enterprise & Union Bank of India.

Policy Conditions & Policy Benefits

POLICY BENEFITS

Coverage Amount	PERMANENT ACCIDENT COVERAGE	ACCIDENTAL HOSPITALISATION	ADVENTURE SPORTS	MEDICAL EVACUATION	ROAD AMBULANCE
5 Lacs	Upto SI	11 LACS	Upto SI	25 Lacs	25000
10 Lacs	Upto SI	11 LACS	Upto SI	25 Lacs	25000
20 Lacs	Upto SI	11 LACS	Upto SI	25 Lacs	25000
40 Lacs	Upto SI	11 LACS	Upto SI	25 Lacs	25000
50 Lacs	Upto SI	11 LACS	Upto SI	25 Lacs	25000

Note :

- ✓ *Coverage is only available when the Insured member is involved in Paragliding Association approved activity*
- ✓ Maximum Amount of Rs. 5 Lacs payable per incident in case of Air Ambulance
- ✓ Maximum Amount allowed for Professional Pilots is 10 Lacs
- ✓ Claim can be made under only one benefits Personal Accident Coverage or Adventure Sports
- ✓ Policy will be terminated post Personal Accident Claim

BOUNDARY CONDITIONS

Particulars	***Description***
Entry Age	*18 Years to 70 Years*
Relationships with Policy holder	**Professional and Hobby Pilots Registered with Paragliding Association**
Relationships allowed	*Self*
Cover type	***Individual***
Claims service	*In-house - Re-imbursement*

POLICY TERMS AND CONDITIONS

DEFINITIONS

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

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

1.1. **Accident/ Accidental** is a sudden, unforeseen and involuntary event caused by external, visible and violent means;
1.2. **Acute condition** is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery;
1.3. **Age** means the completed age of the Insured Person on his last birthday;
1.4. **Alternative treatments** are forms of treatments other than treatment "Allopathy" or "modern medicine" and include Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
1.5. **Ambulance** means a road vehicle operated by a licensed / authorized service provider and equipped for the transport and paramedical treatment of the person requiring medical attention;
1.6. **Annual Multi Trip Policy** means a Policy under which there can be more than one Period of Insurance during the Policy Period, subject to the maximum trip duration (per trip) specified on the Policy Certificate/ Certificate of Insurance or as opted;
1.7. **Any One Illness** means a continuous Period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital / nursing home where the treatment may have been taken;
1.8. **Assistance Service Provider** means the service provider specified in the Policy Certificate and/or Certificate of Insurance, appointed by the Company from time to time;
1.9. **Cashless facility** means a facility extended by the Company to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the Policy terms and conditions, are directly made to the Network Provider by the Company to the extent pre-authorization approved;
1.10. **Certificate of Insurance** means the certificate the Company issues to an Insured Person evidencing cover under the Policy;
1.11. **Checked-In Baggage** means the baggage (luggage and personal possessions belonging to or in the lawful custody of the Insured Person) offered by the Insured Person and accepted for custody by a Common Carrier for transportation in the same Common Carrier in which the Insured Person is travelling and for which the Common Carrier has provided a baggage receipt, and the contents of the baggage checked-in by the Insured Person as long as such contents do not violate any policy or rule restricting the nature of items that may be carried on board. This shall exclude all the items that are carried/ transported under a contract of affreightment;
1.12. **City of Residence** means and includes any city, town or village in which the Insured Person is currently residing in India and as specified in the Insured Person's corresponding address in the Policy Certificate/Certificate of Insurance;
1.13. **Claim** means a demand made in accordance with the terms and conditions of the Policy for payment under a Benefit or Optional Benefit or Optional Extension in respect of an Insured Person;
1.14. **Company** (also referred as We/Us) means the Religare Health Insurance Company Limited;
1.15. **Common Carrier** means any civilian land or water conveyance or scheduled aircraft operated under a valid license for the transportation of fare paying passengers under a valid ticket;
1.16. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon;
1.17. **Congenital Anomaly** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.
    a) Internal Congenital Anomaly

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

b) External Congenital Anomaly

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

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

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

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

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

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

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

a) has qualified nursing staff under its employment;

b) has qualified Medical Practitioner/s in charge;

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

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

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

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

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

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

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

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

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

a) Financially dependent on the Policyholder;

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

c) Has not attained Age 25 years;

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

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

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

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

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

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

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

1.33. **Grace Period** means the specified period of time immediately following the premium due date during which payment can be made to renew or continue a policy in force without loss of continuity benefits such as

waiting periods and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received;

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

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

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

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

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

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

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

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

or

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

1.37. **Hospitalization** means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours;

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

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

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

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

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

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

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

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

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

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

d) Critical care being provided in critical care area such as coronary care unit, Intensive Care Unit, respiratory care unit, or the emergency department;
and certified by the attending Medical Practitioner as a Life Threatening Medical Condition;

1.45. **Maternity expenses** shall include—
a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).
b) expenses towards lawful medical termination of pregnancy during the policy period;

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

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

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

1.49. **Medically Necessary** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which:
i. Is required for the medical management of the Illness or Injury suffered by the Insured Person;
ii. Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii. Must have been prescribed by a Medical Practitioner;
iv. Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

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

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

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

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

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

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

1.56. **Period of Insurance** means a period within the Policy Period which commences when the Insured Person crosses the international border of the Country of Residence if the Geographical scope is out of India to leave that country on a Common Carrier or City of Residence if the Geographical Scope is restricted to India to leave that city and expires automatically on the earliest of:
a) the Insured Person crossing the Indian international border to return to the Country of Residence on a Common Carrier if the Geographical scope is out of India or returning to the City of Residence if the Geographical Scope is restricted to India; or
b) the expiry of the period specified in the Policy Certificate or Certificate of Insurance from the commencement of the Period of Insurance; or
c) the Policy Period End Date.
The Policy Certificate or Certificate of Insurance shall specify whether the Policy is a Single Trip Policy or an Annual Multi Trip Policy;

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

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

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

1.60. **Policy** means these Policy Terms & Conditions, Benefit, Optional Benefits, Optional Extensions (if any), the Proposal Form, Policy Certificate, Certificate of Insurance, and Annexures which form part of the policy contract and shall be read together;
1.61. **Policy Certificate** means the certificate attached to and forming part of this Policy;
1.62. **Policyholder** (also referred as You) means the person who is the Group Administrator and named in the Policy Certificate as the Policyholder;
1.63. **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specifically appearing in the Policy Certificate;
1.64. **Policy Period End Date** means the date on which the Policy expires, as specified in the Policy Certificate;
1.65. **Policy Period Start Date** means the date on which the Policy commences, as specified in the Policy Certificate;
1.66. **Portability** means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.
1.67. **Post-hospitalization Medical Expenses** are Medical Expenses incurred immediately after the insured person is discharged from the hospital provided that:
    a) Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
    b) The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
1.68. **Pre-existing Disease** means any condition, ailment or injury or related condition(s) for which the Insured Person had signs or symptoms, and/or were diagnosed, and/or received medical advice or treatment within 48 months to prior to the first policy issued by the Company;
1.69. **Pre-hospitalization Medical Expenses** are Medical Expenses incurred immediately before the Insured Person is Hospitalized, provided that:
    a) Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    b) The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
1.70. **Qualified Nurse** is a person who holds a valid registration from the Nursing Council;
1.71. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved;
1.72. **Renewal** defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods;
1.73. **Room Rent** means the amount charged by a Hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated Medical Expenses;
1.74. **Single Trip Policy** means a Policy under which there cannot be more than one Period of Insurance during the Policy Period;
1.75. **Subrogation** shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source;
1.76. **Sum Insured** means the amount specified against the Benefit / Optional Benefit / Optional Extension in the Certificate of Insurance for each Insured Person which represents the Company's maximum, total and cumulative liability for that Insured Person for any and all Claims incurred in respect of that Insured Person during the Period of Insurance under that Benefit / Optional Benefit / Optional Extension;
1.77. **Surgery / Surgical Procedure** means manual and / or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or a Day Care Centre by a Medical Practitioner;
1.78. **Terrorism/Terrorist Incident** means any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not. Terrorism shall also include any act, which is verified or recognized by the relevant Government as an act of terrorism;
1.79. **Unproven / Experimental Treatment** means treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

SCOPE OF COVER

GENERAL CONDITIONS

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

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

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

(iv) *Coverage will be restricted to India.*

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

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

PERSONAL ACCIDENT

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

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

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

Documents to be submitted for any Claim under this Benefit:

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

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

- *Any other document that may be required by the company to process the claim*

EMERGENCY HOSPITALIZATION

If the Insured Member's medically necessary Hospitalization occurs solely and directly due to Accidental Injury suffered by that Insured Member, then the Company will indemnify the Medical Expenses incurred for such Hospitalization, provided that:

- The Hospitalization is on the written advice of a Medical Practitioner; and
- The Hospitalization commences within 7 (seven) days from the date of occurrence of the Injury.

IN-PATIENT CARE FOR INJURY OR ACCIDENTAL HOSPITALIZATION

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

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

ADVENTURE SPORTS INJURY

This benefit will cover medical expenses incurred for the Insured Person due to any injury arising out of Adventure Sports, provided that Claims under this benefit shall be admissible only if Medical Expenses are incurred;

Documents to be submitted for any Claim under this Benefit

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

- Original pathological and diagnostic reports, consultation detail, case papers and prescriptions issued by the treating Medical Practitioner or Hospital.
- Original bills and receipts for:
    - Charges paid towards medical services rendered.
    - Fees paid to the Medical Practitioner and for special nursing charges.
    - Charges incurred towards any and all test and / or examinations rendered in connection with the treatment.
    - Charges incurred towards medicines or drugs purchased from a registered pharmacy duly supported by the prescriptions of the Medical Practitioner attending to the Insured Person.

Exclusions applicable under this Benefit :

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

- Medical treatment taken outside the Country of Residence
- Any treatment or Medical Expense incurred for any injury which was pre-existing at the time of commencement of Policy
- Any treatment, which could reasonably be delayed until the Insured Person's return to the City of Residence.
- Radiotherapy and Chemotherapy charges
- Rest or recuperation at a spa or health resort, sanatorium, convalescence home or similar institution.
- Routine physical tests and / or examination of any kind not consistent with or incidental to the diagnosis and treatment of any Illness or Injury either in a Hospital or as an outpatient and any type of vaccination or inoculation if it does not apply to post-bite treatment.
- Physiotherapy expenses or any services provided by chiropractitioner.

MEDICAL EVACUATION

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

- The treating Medical Practitioner certifies in writing that the severity or the nature of the Insured Person's Illness or Injury warrants the Insured Person's Emergency medical evacuation;
- These transportation expenses are limited to transporting the Insured Person from the place of contracting or sustaining such Illness or Injury to the nearest appropriate Hospital;
- This benefit will be provided on a cashless basis if the costs are certified and authorized by the Company or the Assistance Service Provider in advance, unless the Insured Person has a Life Threatening Medical Condition and the Insured Person (or his representatives) arrange for the Medical evacuation at their own cost and expense in which case the Company will indemnify the costs incurred on the Medical evacuation in accordance with the terms of this Optional Benefit;
- Payment under this Optional Benefit is subject to a Claim for the Illness or Injury which requires Hospitalization and is Medically Necessary.

Documents to be submitted for any Claim under this Benefit :

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

- Medical reports and transportation details issued by the evacuation agency, prescriptions and medical report by the attending Medical Practitioner furnishing the name of the Insured Person and details of treatment rendered along with the statement confirming the necessity of evacuation;
- Documentary proof for all expenses incurred towards the Medical Evacuation.

Permanent Exclusions:

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

1. Any claim related to illness

2. Any item or condition or treatment specified in List of Non-Medical Items (Annexure – II).

3. Any pre-existing injury / illness or disability and any complications thereof and its associated medical conditions unless we had agreed otherwise in writing;

4. 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 following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

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

6. Maternity: Code Excl18: Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
7. Expenses towards miscarriage and lawful medical termination of pregnancy during the policy period.
8. Any treatment directly related to surrogacy whether the member is acting as surrogate, or is the intended parent; Any treatment begun or for which the need has arisen during the first ninety (90) days after birth, for any child conceived by artificial means or any form of assisted conception or if the child is born via surrogacy;

9. Birth control, Sterility and Infertility: Code- Excl17:Expenses related to Birth Control, sterility and infertility. This includes:
    a. Any type of contraception, sterilization
    b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    c. Gestational Surrogacy;
    d. Reversal of sterilization;
10. Treatment taken from anyone who is not a Medical Practitioner or from a Medical Practitioner who is practicing outside the discipline for which he is licensed or any kind of self-medication.
11. Charges incurred in connection with routine eye examinations and ear examinations, dentures, crowns, artificial teeth and all other similar external appliances and / or devices whether for diagnosis or treatment;
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. Expenses incurred on advanced treatment methods
15. Any expenses incurred on providing or fitting any external prosthesis or orthosis or appliance or medical aids or durable medical equipment of any kind, like wheelchairs, walkers, crutches, ambulatory devices, unless allowed under the Policy, cost of Cochlear implants;
16. Any treatment related to sleep disorder or sleep apnea syndrome, general debility convalescence and any treatment in an establishment that is not a Hospital;
17. Treatment of any external Congenital Anomaly or Illness or defects or anomalies including their associated medical conditions or chronic medical conditions or vegetative state cover (on the basis of declaration by the treating doctor) or treatment relating to external birth defects;
    a. We define vegetative state as a condition of profound non-responsiveness with no sign of awareness or consciousness or a functioning mind, even if the Insured can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery;
18. Treatment whilst staying in a hospital for more than ninety (90) continuous days for permanent neurological damage on the basis of declaration by the treating doctor. It is stated that treatment up to 90 days for permanent neurological damage will be covered under this Policy.
19. Treatment of mental retardation, arrested or incomplete development of mind of a person, subnormal intelligence or mental intellectual disability
20. Obesity/ Weight Control(Code- Excl06): Expenses related to the surgical treatment of obesity
21. Expenses for cosmetic or plastic surgery or any treatment
22. Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex;
23. Out-patient treatment
24. Treatment received outside India;
25. Domiciliary hospitalization or treatment\
26. Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded
27. 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;

28. An Insured Member operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft or Scheduled Airline or any airline personal
29. An Insured Member flying in an aircraft other than as a fare paying passenger in a Scheduled Airline
30. Participation in actual or attempted felony, riot, civil commotion or criminal misdemeanor or activity;
31. Professional fees charged by a member of the Insured Member's immediate family or by a person normally resident in the household of the Insured or under his employment
32. Training for or participating in professional sport of any kind or any sport for which the insured receives a salary or monetary reimbursement, including grants or sponsorship
33. The Insured Member serving in any branch of the military, navy, air force or any branch of armed forces or any paramilitary forces;
34. 33) Radioactive contamination whether arising directly or indirectly ionizing radiation, toxic, explosive or other hazardous properties of nuclear material
35. Circumcision unless necessary for treatment of an Illness or as may be necessitated due to an Accident;
36. All preventive care, Vaccination including Inoculation and Immunizations (except in case of post-bite treatment) and tonics
37. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure (Code- Excl14);
38.) All expenses related to donor treatment, including screening, surgery to remove organs from the donor, in case of transplant surgery;
39. Non-Allopathic Treatment or treatment related to any unrecognized systems of medicine
40. War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds
41. Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent
42. Act of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, Areca nut intoxicating drugs and alcohol or hallucinogens;
43. Any charges incurred to procure documents related to treatment or Illness pertaining to any period of Hospitalization or Illness or any administration costs or any other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services;
44. Personal comfort and convenience items or services including but not limited to T.V. (wherever specifically charged separately), charges for access to cosmetics, hygiene articles, body care products and bath additives, as well as similar incidental services and supplies;
45. Expenses related to any kind of RMO charges, Service charge, Surcharge, night charges levied by the hospital under whatever head or any room upgrades, menu items not included as standard or visitors meals
46. Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:
47. (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;
    a. 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;
    b. 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;

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

48. Impairment of an Insured Person's intellectual faculties by abuse of stimulants or depressants unless prescribed by a medical practitioner
49. Continuous ambulatory peritoneal dialysis. Coverage for 'Continuous ambulatory peritoneal dialysis' is available on OPD basis and as part of Pre-Post hospitalization expenses
50. Charges for items not listed in the policy schedule applicable to the member or considered as not medically necessary or which may be considered as elective;
51. Alopecia wigs and/or toupee and all hair or hair fall treatment and products including any investigations; all forms of acne;
52. Any treatment taken in a clinic, rest home, convalescent home for the addicted, detoxification center, sanatorium, home for the aged, remodeling clinic or similar institutions;
53. Any medical or physical condition or treatment or service, which is specifically excluded under the Policy Schedule including the associated medical conditions shown on the endorsement
54. Cryopreservation or harvesting or storage of stem cells as a preventive measure against possible disease/illness/injury, or implantation or re-implantation of living cells or living tissue whether autologous or provided by a donor
55. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- Excl12
56. Any other weight management services, treatment and supplies unless requires hospitalization and surgery

Claims Intimation, Assessment and Management

Upon occurrence of any Injury that may give rise to a Claim under this Policy, then as a condition precedent to the Company's liability under the Policy, the Insured Member shall undertake all of the following:

Claims Intimation

If any Injury is suffered or any other contingency occurs which has resulted in a Claim or may result in a Claim under the Policy, the Insured Member (or Nominee or legal heir if the Insured Member is deceased), shall notify the Company either at Company call Centre or in writing immediately and in any event within the timeframe (if any) specified in the Benefit under which the Claim is made.

Claim must be filed within 15 days from actual date of loss in case of non-hospitalization benefits.

The following details are to be provided to the Company at the time of intimation of Claim:

1. Policy Number ;
2. Name of Primary Insured Member;
3. Name and unique identification number of the Insured Member in respect of whom the Claim is being made;
4. Nature of Injury and the Benefit under which the Claim is being made;
5. Date and place of Injury or Death and/or date and place of admission to Hospital (as applicable);
6. Name and address of the attending Medical Practitioner and Hospital;
7. Date of admission to Hospital
8. Any other information / document as required by the Company or Assistance Service Provider to assess the Claim, in case fraud is suspected.

A Claim has to be notified to the Company within 24 hours or before discharge (whichever is earlier) for Emergency Hospitalization.

Claims Procedure

Re-imbursement:

It is agreed and understood that in all cases where intimation of a Claim has been provided under Reimbursement Facility and/or the Company specifically states that a particular Benefit is payable only under Reimbursement Facility, all the information and documentation shall be submitted to the Company at Insured Member's own expense, immediately and in any event within 30 days of Insured Member's discharge from Hospital.

I. The Company shall give an acknowledgement of collected documents. However, in case of any delayed submission, the Company may examine and relax the time limits mentioned upon the merits of the case.
II. For Claim settlement under reimbursement, the Company will pay the Insured Member. In the event of death of the Insured Member, the Company will pay the nominee (as named in the Certificate of Insurance) and in case of no nominee, to the legal heirs or legal representatives of the Insured Member whose discharge shall be treated as full and final discharge of its liability under the Policy.
III. 'Date of Loss' under Reimbursement Facility is the 'Date of Admission' to Hospital in case of Hospitalization & actual Date of Loss for non-Hospitalization related Benefits.
IV. Insured Member (or Nominee or legal heir if the Insured Member is deceased) shall (at his expense) give the documentation specified at Clause 6.4 and any additional documentation specified in the Benefit provision and/or Optional Extension under which the Claim is being made to the Company immediately and in any event within 30 days of the occurrence of the Injury.

Policyholder's and Insured Member's duty at the time of Claim

As a condition precedent for a Claim to be considered under this Policy:

I. All reasonable steps and measures must be taken to avoid or minimize the quantum of any Claim that may be made under this Policy.
II. Intimation of the Claim, notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance with the procedures and within the timeframes specified in Clause 6 of the Policy.
III. The Insured Member will, at the Company request submit himself/herself for a medical examination by the Company's/Assistance Service Provider nominated Medical Practitioner as often as the Company consider reasonable and necessary. The cost of such medical examination shall be borne by the Company.
IV. The Company's /Assistance Service Provider Medical Practitioner and representatives shall be given access and co-operation to inspect the Insured Member's medical and Hospitalization records and to investigate the facts and examine the Insured Member.
V. The Company shall be provided with complete documentation and information which the Company has requested to establish the Company liability for the Claim, its circumstances and its quantum.

Claim Documents

The following information and documentation shall be submitted to the Company /Assistance Service Provider in accordance with the procedures and within the timeframes specified in Clause 6 of the Policy in respect of all Claims:

I. Duly completed and signed Claim form, in original;
II. Identity proof with photo, Age proof and Address Proof;
III. Medical Practitioner's referral letter advising Hospitalization;
IV. Medical Practitioner's prescription advising drugs / diagnostic tests / consultation;
V. Original bills, receipts and discharge card from the Hospital / Medical Practitioner;
VI. Original bills from pharmacy / chemists;

VII. Original pathological / diagnostic test reports and payment receipts;
VIII. Indoor case papers (if applicable);
IX. Accident proof - First Information Report/ final police report, if applicable;
X. Disability Certificate from Government Medical Board, Fitness Certificate, Medical Prescription
XI. Post mortem report, if conducted;
XII. Any other information/document as required by the Company or Assistance Service Provider to assess the Claim, in case fraud is suspected
XIII. Only in the event that original bills, receipts, prescriptions, reports or other documents have already been given to any other insurance company or to a reimbursement provider. The Company will accept properly verified photocopies of such documents attested by such other insurance company/reimbursement provider along with an original certificate of the extent of payment received from such insurance company/reimbursement provider.
XIV. The Company will only accept bills/invoices which are made in the Insured Member's name.
XV. The Company may give a waiver to one or few of the above mentioned documents depending upon the case.
XVI. However, claims filed even beyond the timelines mentioned above should be considered if there are valid reasons for any delay

Additional Claim documents for Personal Accident:

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

I. Medical reports giving the details of the Accident, nature of Injury and the details of treatment provided, Admission and Death Summary, Accident Report
II. Original Death Certificate; if applicable
III. Disability Certificate issued by CMO (Chief Medical Officer) as appointed by the Hospital Authorities; if applicable
IV. A newspaper cutting about accident (if available)
V. Certificate from Bank for outstanding amount of loan

Claim Assessment

I. The Company shall scrutinize the Claim and supportive documents, once received. In case of any deficiency, the Company may call for any additional documents or information as required, based on the circumstances of the Claim.
II. All admissible Claims under this Policy shall be assessed by the Company in the following progressive order:
III. The Claim amount assessed would be deducted from the Coverage Amount of respective Benefit
IV. All claims incurred in India are dealt by the Company directly.

Payment Terms

I. Payments under this Policy shall be made in Indian Rupees and within India.
II. If the Assistance Service Provider or the Company requests that bills or vouchers in a local language or vernacular be accompanied by an appropriate translation into English then the costs of such translation must be borne by the Policyholder or the Insured Member.
III. The Claim amount assessed for any Benefit would be deducted from the Coverage Amount and for the unexpired Cover Year, balance Coverage Amount shall be available.
IV. The Company shall have no liability to make payment of a Claim under the Policy in respect of an Insured Member, once the Coverage Amount for that Insured Member is exhausted.

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

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

VII. **The Company shall settle or reject any Claim within 30 days** of receipt of all the necessary documents / information as required for settlement of such Claim and sought by the Company. The Company shall provide the Policyholder / Insured Member an offer of settlement of Claim and upon acceptance of such offer by the Policyholder / Insured Member, the Company shall make payment within 7 days from the date of receipt of such acceptance. However, if a claim warrants an investigation in the opinion of the Company, then the Company shall settle the claim within 45 days from the date of receipt of last necessary document. In case there is delay in the payment beyond the stipulated timelines from the date of receipt of last necessary document to the date of payment of claim, the Company shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it. For the purpose of this clause, 'bank rate' shall mean the existing bank rate as notified by Reserve Bank of India at the beginning of financial year, unless the extent regulation requires payment based on some other prescribed interest rate.

   a. The Claim shall be paid only for the Cover Year in which the Insured event which gives rise to a Claim under this Policy occurs.
   b. The Company may change the Assistance Service Provider or utilize the service of any other assistance service provider by giving written notification to the Policyholder.

General Terms and Conditions

Disclosure to Information Norm

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

Observance of Terms and Conditions

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

Material Change

It is a condition precedent to the Company's liability under the Policy that the Policyholder shall immediately notify the Company in writing of any material change in the risk on account of change in nature of occupation or business at his own expense or any material information that the Insured Member and/or Policyholder is aware of, or could reasonably be expected to know, that relates to questions in the Proposal Form and which is relevant to the Company in order to accept the risk of insurance and if so on what terms. The Insured Member/Policyholder must exercise the duty of disclosure to Company before Renewal, extension, variation, endorsement. The Company may, in its discretion, adjust the scope of cover and / or the premium paid or payable, accordingly.

Records to be maintained

Policyholder and the Insured Members shall keep an accurate record containing all relevant medical records and shall allow the Company or the Company representatives to inspect such records. Policyholder or the Insured Member shall furnish such information as the Company may require under this Policy at any time during the Cover Period and up to three years after the Policy Period End Date, or until final adjustment (if any) and resolution of all Claims under this Policy.

No constructive Notice

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

Complete Discharge

Payment made by the Company to Policyholder / to the Insured Member or their legal representatives / to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete and construed as an effectual discharge in favor of the Company.

Multiple Policies

1. In case any Insured Member is covered under more than one indemnity insurance policies, with the Company or with other insurers, the Policyholder/Insured Member shall have the right to settle the Claim with any of the Company, provided that the Claim amount payable is up to the Coverage Amount of such Policy.
2. In case the Claim amount under a single policy exceeds the Coverage Amount, then Policyholder/Insured Member shall have the right to choose the companies with whom the Claim is to be settled. Further, policyholder/Insured Member shall have the right to choose the companies from whom he/she wants to claim the balance amount. Insured shall only be indemnified the hospitalization costs in accordance with terms & conditions of chosen Policy.
3. Policyholder/Insured Members shall also have the right to prefer claims from other policy / policies for the amounts disallowed under the earlier chosen policy / policies, even if the sum insured is not exhausted.

Free Look Period

i. The Policyholder/Insured Member may, within 15 days from the receipt of the Policy document, return the Policy stating reasons for his objection, if the Policyholder disagrees with any Policy terms and conditions.

ii. If no Claim has been made under the Policy, the Company will refund the premium received after deducting proportionate risk premium for the period on cover, expenses for medical examination and stamp duty charges. If only part of the risk has commenced, such proportionate risk premium shall be calculated as commensurate with the risk covered during such period. All rights under the Policy will immediately stand extinguished on the free look cancellation of the Policy.

iii. Provision for Free look period is not applicable and available at the time of renewal of the Policy.

Policy Disputes

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

Renewal Notice

The Coverage will automatically terminate on the Cover End Date.

Cancellation / Termination

The Company may at any time, cancel this Policy on grounds of misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld or if a Claim is fraudulently made or any fraudulent means or devices are used by Policyholder/Insured member or any one acting on Policyholder/Insured member behalf. The Company shall have no liability to make payment of any claims and the premium paid shall be forfeited ab initio to the Company and no refund of premium shall be effected by the Company, by giving 15 days' notice in writing by Registered Post Acknowledgment Due/recorded delivery to Policyholder/Insured member last known address.

Policyholder/Insured member may also give 15 days' notice in writing, to the Company, for the cancellation of this Policy, in which case the Company shall from the date of receipt of the notice cancel the Policy and refund the premium for the unexpired period of this Policy at the short period scales as mentioned below, provided that no refund shall be made for those Insured Member who has incurred Claim under the Policy.

Refund % to be applied on total premium received as on the date of receipt of the cancellation request

Cancellation date up to (x months) from Policy Period Start Date	1 Year
Up to 1 month	75.00%
1 month to 3 months	50.00%
3 months to 6 months	25.00%
6 months to 12 months	0.00%

In case of demise of the Primary Insured Member,
Where the Policy covers only the Primary Insured Member, this Policy shall stand null and void from the date and time of demise of the Primary Insured Member.

Limitation of Liability

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

Communication

- ✓ Any communication meant for the Company must be in writing and be delivered to its address shown in the Policy Schedule/ Certificate of Insurance. Any communication meant for the Policyholder or Insured Member will be sent by the Company to his last known address or the address as shown in the Policy Schedule/ Certificate of Insurance.
- ✓ All notifications and declarations for the Company must be in writing and sent to the address specified in the Policy Schedule/ Certificate of Insurance. Agents are not authorized to receive notices and declarations on the Company's behalf.
- ✓ Notice and instructions will be deemed served 10 days after posting or immediately upon receipt in the case of hand delivery, facsimile or e-mail.

Alterations in the Policy

This Policy constitutes the complete contract of insurance. No change or alteration shall be valid or effective unless approved in writing by the Company, which approval shall be evidenced by a written endorsement signed and stamped by the Company.
Out of all the details of the various benefits provided in the Policy Terms and Conditions, only the details pertaining to benefits chosen by policyholder as per Policy Schedule shall be considered relevant

Electronic Transactions

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

Nominee

The Primary Insured Member can at the inception or at any time before the expiry of the Policy, make the nomination for the purpose of payment of Claims.

Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement to the Policy is made by the Company.

In case of any Insured Member other than the Primary Insured Member under the Policy, for the purpose of payment of Claims in the event of death, the default nominee would be the Primary Insured Member.

Proximate Clause

The Company covers the Policyholder/Insured Member only to the extent of Proximity cause which means active and efficient cause that sets in motion a chain of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.

Sanctions and Compliance with Laws

This insurance does not apply to the extent that trade or economic sanctions or other similar laws or regulations prohibit the coverage provided by this insurance.

Grievances

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

If the Policyholder / Insured Member has a grievance that the Policyholder / Insured Member wishes the Company to redress, the Policyholder / Insured Member may contact the Company with the details of the grievance through:
Website: www.careinsurance.com
Email: customerfirst@carehealthinsurance.com
Contact No.: 1860-500-4488, 1800-102-4488
Courier: Any of Our Branch Office or corporate office

The Policyholder/Insured Member may also approach the grievance cell at any of the Company's branches with the details of his/her grievance during the Company's working hours from Monday to Friday.

If the Policyholder / Insured Member is not satisfied with the Company's redressal of the Policyholder's / Insured Member's grievance through one of the above methods, the Policyholder / Insured Member may contact the Company's Head of Customer Service at:
Head – Customer Services,
Care Health Insurance Company Limited,
Unit No. 604-607. 6th Floor, Tower C, Unitech Cyber Park, Sector-39,Gurgaon– 122001 (Haryana)