Policy Terms and Conditions

1. Definitions

For the purposes of interpretation and understanding of the product the Company has defined, herein below some of the important words used in the product and for the remaining language and the words the Company believes to mean the normal meaning of the English language as explained in the standard language dictionaries. The words and expressions defined in the Insurance Act, IRDA Act, Regulations notified by the Authority and Circulars and Guidelines issued by the Authority shall carry the meanings explained therein. The judicial pronouncements of the highest courts in India will have the effect on the definitions and the language used in this product. The Terms and Conditions, coverage's and exclusions, benefits, various procedures and concepts which have been built in to the product also carry the specified meaning assigned to them in the said language.

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** means a sudden, unforeseen and involuntary event caused by external and visible means.

1.2 **Age** means the completed age (in years) of the Insured Person as on his last birthday.

1.3 **Company** means Religare Health Insurance Company Limited

1.4 **Disclosure to Information Norm** means 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.

1.5 **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.

1.6 **Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he is trained or not. Such sport/activity includes stunt activities of any kind, adventure racing, base jumping, biathlon, big game hunting, black water rafting, BMX stunt/obstacle riding, bobsleighing/using skeletons, bouldering, boxing, canyoning, cavin/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 or wrestling of any type.

1.7 **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, 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 at least 10 in-patient beds, in those towns having a population of less than 10,00,000 and 15 in-patient beds in all other places;

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

(c) has qualified Medical Practitioner 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 will make these accessible to the Company's authorized personnel.

1.8 **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 24consecutive hours.

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

1.10 **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.

1.11 **Insured Person (Insured)** means a person whose name specifically appears under Insured in the Policy Certificate and with respect to whom the premium has been received by the Company.

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

1.13 **Network Hospitals (Network Provider)** means Hospitals or other health care providers enlisted by the Company, to provide medical services to the Insured Person on payment by a cashless facility. The list is available with the Company and subject to amendment from time to time.

1.14 **Nominee** means the person named in the Policy Certificate who is nominated to receive the benefits under this Policy in accordance with the terms of the Policy, if the Policyholder is deceased.

1.15 **Notification of Claim (Intimation)** is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address/telephone number to which it should be notified.

1.16 **Policy** means these Policy Terms & Conditions, Specific Policy Conditions, Add-on Benefits (if any),the Proposal Form, Policy Certificate and Annexures which form part of the policy contract and shall be read together.

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

1.18 **Policyholder** means the person named in the Policy Certificate as the Policyholder.

1.19 **Policy Period** means the period commencing from the Policy Period Start Date and ending on the Policy Period End Date as specified in the Policy Certificate.

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

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

1.22 **Portability** means the right accorded to an individual health insurance Policyholder (including family cover) to transfer the credit gained by the Insured Person for pre-existing conditions and time bound exclusions if the Policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the Company, provided the previous Policy has been maintained without any break.

1.23 **Pre-existing Disease** means any condition, ailment or Injury or related condition for which the Insured Person had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment within 48 months prior to the first Policy issued by the Company.

1.24 **Reasonable 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.

1.25 **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.

1.26 **Sum Insured** means the amount specified against each Insured Person in the Policy Certificate 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 Policy Period.

1.27 **Surgical Procedure** means manual and / or operative procedure 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.

2. Benefits

General Conditions applicable to all Benefits:

(a) Any Benefit shall be available only if the same is specifically mentioned in the Policy Certificate.

(b) Admissibility of a claim under Benefit 1 or Benefit 2 is a pre-condition to the admission of a claim for Benefit 3 and the event giving rise to the claim under the Benefit 1 or Benefit 2 shall be within the Policy Period for the claim for such Benefit to be accepted.

(c) The maximum, total and cumulative liability of the Company for an Insured Person for any and all claims incurred under this Policy during the Policy Period in relation to any Insured Person shall not exceed the Sum Insured for that Insured Person. All claims shall be payable subject to the terms, conditions and exclusions of the Policy and subject to availability of the Sum Insured.

(d) Benefit 1 and Benefit 2 are mutually exclusive.

2.1 Benefit 1 : Critical Illness, Medical Events & Surgical Procedures

(a) If, during the Policy Period, an Insured Person:

(i) is diagnosed to be suffering from a Critical Illness or a Critical Illness manifests in that Insured Person; or

(ii) undergoes any Covered Surgical Procedure; or

(iii) suffers from any of the Covered Medical Events,

the Company will pay the Sum Insured as specified in the Policy Certificate against this Benefit.

(b) In case any claim is admissible under this Benefit, coverage under the Policy for that Insured Person shall immediately and automatically terminate. However, other Insured Persons (if any) under this Policy shall continue to be covered under this Benefit.

(c) For the purpose of this Benefit, Critical Illness means the following illnesses and diseases to the extent described below only:

(i) Cancer

(I) A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy and confirmed by a pathologist.

(II) The term cancer includes leukemia, lymphoma and sarcoma.

(III) The following are excluded:

(A) Tumours showing the malignant changes of carcinoma in situ and tumours which are histologically described as pre-malignant or non-invasive, including but not limited to:

a. Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3;

(B) Any skin cancer other than invasive malignant melanoma;

(C) All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;

(D) Papillary micro - carcinoma of the thyroid less than 1 cm in diameter;

(E) Chronic lymphocytic leukaemia less than RAI stage 3;

(F) Microcarcinoma of the bladder;

(G) All tumours in the presence of HIV infection.

(ii) End Stage Renal Failure

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

(iii) Multiple Sclerosis

(I) The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

(A) Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;

(B) There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months; and

(C) Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart.

(II) Other causes of neurological damage such as SLE and HIV are excluded.

(iv) Benign Brain Tumor

(I) A benign tumour in the brain where all of the following conditions are met:

(A) It is life threatening;

(B) It has caused damage to the brain;

(C) It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit such as but not restricted to characteristic symptoms of increased intracranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment; and

(D) Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques.

(II) Exclusions :

(A) Cysts;

(B) Granulomas;

(C) Vascular malformations;

(D) Haematomas;

(E) Calcification;

(F) Meningiomas;

(G) Tumours of the pituitary gland or spinal cord; and

(H) Tumours of acoustic nerve (acoustic neuroma)

(v) Parkinson's Disease

(I) The unequivocal diagnosis of progressive degenerative idiopathic Parkinson's Disease by a consultant neurologist.

(II) This diagnosis must be supported by all of the following conditions:

(A) The disease cannot be controlled with medication

(B) Signs of progressive impairment

(C) Inability of the Insured Person to perform (whether aided or unaided) at least 3 of the following 5 "Activities of Daily Living" for a continuous period of at least 6 months .

(III) Activities of Daily Living:

(A) Transfer: Getting in and out of bed without requiring external physical assistance.

(B) Mobility: The ability to move from one room to another without requiring any external physical assistance.

(C) Dressing: Putting on and taking of all necessary items of clothing without requiring any external physical assistance.

(D) Bathing/Washing: The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by other means.

(E) Eating: All tasks of getting food into the body once it has been prepared.

(IV) Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

(vi) Alzheimer's Disease

(I) Alzheimer's (presenile dementia) disease is a progressive degenerative disease of the brain characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.

(II) Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. This diagnosis must be supported by the clinical confirmation of an appropriate consultant neurologist and supported by the Company's appointed doctor.

(III) Exclusions :

(A) Non organic diseases such as neurosis and psychiatric illnesses;

(B) Alcohol related brain damage;

(C) Any other type of irreversible organic disorder/dementia;

(vii) End Stage Liver Disease

(I) End stage liver disease resulting in cirrhosis and evidenced by all of the following criteria:

(A) Permanent jaundice;

(B) Uncontrollable ascites;

(C) Hepatic encephalopathy;

(D) Oesophageal or Gastric Varices and portal hypertension;

(II) Liver disease arising out of or secondary to alcohol or drug misuse is excluded.

(viii) Motor Neurone Disorder

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

(ix) End Stage Lung Disease

(I) End Stage Respiratory Failure including Chronic Interstitial Lung Disease. All of the following criteria must be met:

(A) Requiring permanent oxygen therapy as a result of a consistent FEV1 test value of less than one litre. (Forced Expiratory Volume during the first second of a forced exhalation);

(B) Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less;

(C) Dyspnoea at rest.

(II) This diagnosis must be confirmed by a chest physician.

(x) Bacterial Meningitis

(I) Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by:

(A) The presence of bacterial infection in cerebrospinal fluid by lumbar puncture;

(B) A consultant neurologist.

(II) Bacterial Meningitis in the presence of HIV infection is excluded.

(xi) Aplastic Anaemia

(I) Chronic persistent bone marrow failure which results in Anaemia, Neutropenia and Thrombocytopenia requiring treatment with at least one of the following:

(A) Blood product transfusion;

(B) Marrow stimulating agents;

(C) Immunosuppressive agents; or

(D) Bone marrow transplantation

(II) The diagnosis must be confirmed by a hematologist using relevant laboratory investigations including Bone Marrow Biopsy. Two out of the following three values should be present:

(A) Absolute Neutrophil count of 500 per cubic millimetre or less;

(B) Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and

(C) Platelet count of 20,000 per cubic millimetre or less.

(d) For the purpose of this Benefit, Covered Surgical Procedures means undergoing any of the following Surgical Procedures as more specifically described below only, for the first time during the lifetime of the Insured Person :

(i) Major Organ Transplant

(I) The actual undergoing of a transplant of:

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

(B) Human bone marrow using haematopoietic stem cells.

(II) The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

(III) The following are excluded:

(A) Other stem-cell transplants;

(B) Where only islets of langerhans are transplanted.

(ii) Heart Valve Replacement

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

(II) Exclusions:

(A) Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty.

(iii) Coronary Artery Bypass Graft

(I) The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is / are narrowed or blocked, by Coronary Artery Bypass Graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist Medical Practitioner.

(II) Excluded are:

(A) Angioplasty and/or any other intra-arterial procedures;

(B) Any key-hole or laser surgery.

(e) For the purpose of this Benefit, Covered Medical Events means occurrence of any of the following Medical Events as more specifically described below only, for the first time during the lifetime of the Insured Person :

(i) Stroke

(I) Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain.

(II) Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.

(III) The following are excluded:

(A) Transient ischemic attacks (TIA);

(B) Traumatic injury of the brain;

(C) Vascular disease affecting only the eye or optic nerve or vestibular functions.

(ii) Paralysis

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

(iii) Myocardial Infarction

(I) The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

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

(B) New characteristic electrocardiogram changes;

(C) Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

(II) The following conditions are excluded:

(A) Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;

(B) Other acute Coronary Syndromes;

(C) Any type of angina pectoris.

(iv) Major Burns

(I) Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured Person's body. The condition should be confirmed by a consultant physician.

(II) Burns arising due to self-infliction are excluded.

(v) Coma

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

(A) No response to external stimuli continuously for at least 96

hours;

(B) Life support measures are necessary to sustain life;

(C) Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

(II) The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

(vi) Blindness

(I) Total and irreversible loss of sight in both eyes as a result of Illness or Accident. The blindness must be confirmed by an ophthalmologist.

2.2 Benefit 2 : Personal Accident

(a) If the Insured Person suffers an Injury during the Policy Period solely and directly due to an Accident that occurs during the Policy Period, which directly results in:

(i) The Insured Person's death within 12 months of the occurrence of the Injury; or

(ii) The Insured Person's Permanent Total Disablement within 12 months of the occurrence of the Injury such that the Insured Person is unable to resume his normal occupation or engage in similar gainful employment due to the Permanent Total Disability suffered,

the Company will pay the Sum Insured as specified in the Policy Certificate against this Benefit.

(b) In case any claim is admissible under this Benefit, coverage under the Policy for that Insured Person shall immediately and automatically terminate. However, other Insured Person shall continue to be covered under this Policy.

(c) If the Company has admitted a claim for Permanent Total Disablement, then the Company shall not be liable to make any payment under the Policy on the death of the Insured Person, if the Insured Person subsequently dies.

(d) For the purposes of this Benefit, Permanent Total Disablement means:

(i) the total and irrecoverable loss of sight of both eyes; or

(ii) the actual loss by physical separation of both hands or both feet or one entire hand and one entire foot; or

(iii) the total and irrecoverable loss of use of both hands or both feet or of one hand and one foot without physical separation

(e) For the purposes of this Benefit, physical separation means as regards the hand actual separation at or above the wrists, and as regards the foot actual separation at or above the ankle.

2.3 Benefit 3 : Child Education

(a) If a claim for any event under Benefit 1 or Benefit 2 of the Policy has been admitted, then in addition to any amount payable under that Benefit, the Company will pay the amount specified in the Policy Certificate against this Benefit, for the education of the Insured Person's child, provided that:

(i) The child is less than Age 24 at the time of occurrence of the event; and

(ii) Valid documentation establishing the relationship of the child with the Insured Person and the Age of the child is submitted.

2.4 Benefit 4 : Second Opinion

(a) If the Insured Person is diagnosed with any Critical Illness (as specified under Benefit 1 of the Policy Terms & Conditions) during the Policy Period, then at the Policyholder's / Insured Person's request, the Company shall arrange for a Second Opinion from a Medical Practitioner at its own cost.

(b) It is agreed and understood that the Second Opinion will be based only on the information and documentation provided to the Company which will be shared with the Medical Practitioner and is subject to the following:

(i) This Benefit can be availed a maximum of one time by an Insured Person during the Policy Year for each Critical Illness.

(ii) The Insured Person is free to choose whether or not to obtain the Second Opinion and, if obtained under this Benefit, then whether or not to act on it.

(iii) This Benefit is for additional information purposes only and does not and should not be deemed to substitute the Insured Person's visit or consultation to an independent Medical Practitioner.

(iv) The Company does not provide a Second Opinion or make any representation as to the adequacy or accuracy of the same, the Insured Person's or any other person's reliance on the same or the use to which the Second Opinion is put.

(v) The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or in any Second Opinion or for any consequences of actions taken or not taken in reliance thereon.

(vi) The Policyholder or Insured Person shall indemnify the Company and hold the Company harmless for any loss or damage caused by or arising out of or in relation to any opinion, advise, prescription, actual or alleged errors, omissions or representations made by the Medical Practitioner or for any consequences of any action taken or not taken in reliance thereon.

(vii) Any Second Opinion provided under this Benefit shall not be valid for any medico-legal purposes.

(viii) The Second Opinion does not entitle the Insured Person to any consultation from or further opinions from that Medical Practitioner.

(c) For the purposes of this Benefit only:

(i) Second Opinion means an additional medical opinion obtained by the Company from a Medical Practitioner solely on the Policyholder or Insured Person's express request in relation to a Critical Illness which the Insured Person has been diagnosed with during the Policy Period.

(d) Any claim under this Benefit can be made only at the Company's Network Hospitals.

2.5 Benefit 5 : Health check-up

(a) On the Insured Person's request, the Company shall arrange for the Insured Person's Health Check-up in accordance with the table below at its Network Hospitals, provided that:

(b) This Benefit shall only be available once during the Policy Year.

Age/Sum Insured	Upto 10 Lac	10 Lac - 50 Lac	Above 50 Lac
Upto 45 years	Set 1	Set 2	Set 3
46 years to 55 years	Set 2	Set 3	Set 4
56 years & above	Set 3	Set 4	Set 5

Set	List of Medical Tests
Set 1	Complete Blood Count, Urine Routine, Blood Group, ESR, Fasting Blood Glucose, S Cholesterol, SGPT, Creatinine
Set 2	Complete Blood Count, Urine Routine, Blood Group, ESR, Hb1Ac, ECG, S Cholesterol, SGPT, Creatinine
Set 3	Complete Blood Count, Urine Routine, Blood Group, ESR, Hb1Ac, ECG, Lipid Profile, Kidney Function Test, Complete Physical Examination by Physician
Set 4	Complete Blood Count, Urine Routine, Blood Group, ESR, Hb1Ac, Lipid Profile, Stress Test (TMT) or 2D echo, Kidney Function Test, Liver Function Test, Complete Physical Examination by Physician
Set 5	Complete Blood Count, Urine Routine, Blood Group, ESR, Hb1Ac, Lipid Profile, Stress Test (TMT) or 2D echo, Kidney Function Test, Liver Function Test, Pulmonary Function Test, Complete Physical Examination by Physician

(c) It is agreed and understood that details in the table above, including the list of medical tests is subject to review by the Company. The Company may revise or modify the above with prior approval from IRDA. In case these details are modified, the Policyholder shall be duly intimated at least three months prior to the date of Renewal when such modification comes into effect.

(d) Any claim under this Benefit can be made only at the Company's Network Hospitals.

3. Exclusions

3.1 Waiting Period

(a) 90-Day waiting period

(i) The Company shall not be liable to make any payment under Benefit 1 in respect of any Critical Illness, Medical Event or Surgical Procedure whose signs or symptoms first occur within 90 days of the Policy Period Start Date.

(ii) This exclusion shall not apply for subsequent Policy Periods provided that there is no break in insurance cover for that Insured Person and that the Policy has been renewed with the Company for that Insured Person on time and for the same or lower Sum Insured.

3.2 Permanent Exclusions applicable to Benefit 1

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

(a) Any claim with respect to any Critical Illness diagnosed or which manifested prior to Policy Period Start Date.

(b) Any congenital illness or condition or inherited disorder.

(c) Any medical procedure or treatment, which is not medically necessary or not performed by a Medical Practitioner.

(d) Any physical, medical or mental condition or treatment or service that is specifically excluded under the Special Conditions in the Policy Certificate.

(e) Any treatment relating to birth defects.

(f) Birth control procedures and hormone replacement therapy.

(g) Any treatment through self-medication or any treatment that is not scientifically recognized.

3.3 Permanent Exclusions applicable to Benefit 2

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

(a) Payment of compensation in respect of death, Injury or disablement of Insured Person directly or indirectly caused by venereal disease or insanity except where such condition arises directly as a consequence of an Accident during the Policy Period.

3.4 Permanent Exclusions applicable to all Benefits

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

(a) Any condition 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.

(b) Any Pre-existing Disease or any complication arising therefrom.

(c) Any mental Illness, stress, psychiatric or psychological disorders.

(d) Acts of self-destruction or self-inflicted Injury, attempted suicide or suicide while sane or insane or any Illness or Injury attributable to consumption, use, misuse or abuse of tobacco, intoxicating drugs and alcohol or hallucinogens.

(e) Participation in any flying activity except as a bonafide fare-paying passenger in an aircraft that is authorized by the relevant regulations to carry such passengers between established aerodromes.

(f) 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.

(g) Participation in actual or attempted felony, riots, civil commotion, criminal misdemeanor;

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

(i) Engaging in sporting activities in so far as they involve the training for or participation in competitions of professional sports.

(j) Working in underground mines, tunneling or explosives, or involving electrical installation with high tension supply, or as jockeys or circus personnel, or engaged in Hazardous Activities.

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

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

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

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

(l) Any treatment arising from or traceable to pregnancy (including voluntary termination), miscarriage (unless due to an Accident), childbirth, maternity (including caesarian section), abortion or complications of any of these. This exclusion will not apply to ectopic pregnancy.

4. Portability

(a) If the Policyholder and/or Insured Person applies to the Company for a health insurance policy, and provided that

(i) The proposed Insured Person has been covered without any break under any health insurance policy from any non-life insurance company registered with the IRDA; and

(ii) The Sum Insured opted for by the proposed Insured Person with the Company is equal to or higher than the Sum Insured of the expiring health insurance policy, then

the Waiting Periods as defined in Clauses 4.1 (a) of this Policy shall be waived to the extent of the Sum Insured under the expiring health insurance policy.

The Waiting Periods under Clauses 4.1 (a) shall be applicable afresh to the amount by which the Sum Insured under this Policy exceeds the total of Sum Insured under the terms of the expiring health insurance policy.

(b) The Waiting Periods as defined in Clauses 4.1 (a) shall be applicable individually for each Insured Person and claims shall be assessed accordingly.

(c) In case the Policyholder has opted to switch to any other insurer under Portability and the outcome of acceptance of the Portability is awaited from the new insurer on the date of Renewal:

(i) The Company may at the request of the Policyholder, extend the Policy for a period not less than 1 month at an additional premium to be paid on a pro-rated basis.

(ii) In case any claim is reported during the extended Policy Period, the Policyholder shall first pay the premium so as to make the Policy Period of 12 full calendar months. The Company's liability for the payment of the claim shall commence only once such premium is received.

Note: Portability provisions will apply even if the Insured Person migrates to any other health insurance policy.

5. Claims Intimation, Assessment and Management

Upon the occurrence of any event, Illness or Injury that may give rise to a claim under this Policy, then as a condition precedent to the Company's liability under the Policy, the Policyholder or Insured Person shall undertake all of the following:

5.1 Intimation

(a) If any event as covered under this Policy occurs, the Policyholder or Insured Person or Nominee as the case may be shall notify the claim to the Company within thirty (30) days from the date of its occurrence either at the Company's call center or in writing.

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

(i) Policy Number;

(ii) Name of the Policyholder;

(iii) Name of the Insured Person in respect of whom the claim is made;

(iv) Nature of the event;

(v) Name and address of the attending Medical Practitioner and Hospital, if applicable;

(vi) Date of admission to Hospital, if applicable;

(vii) Any other information, documentation or details requested by the Company.

5.2 Claims Documents

The following information and documentation shall be submitted to the Company at the earliest and in any event within 30 days of occurrence of the event in respect of all claims:

(a) General claim documents

(i) Duly completed and signed claim form, in original.

(ii) Original discharge/death summary from the Hospital;

(iii) Certificate from the attending Medical Practitioner of the Insured Person confirming, at least the following:

(I) Name of the Insured Person;

(II) Name, date of occurrence and medical details.

(iv) Any other information, documentation or details requested by the Company.

(b) Additional claim documents for Benefit 1

(i) Certificate from the attending Medical Practitioner of the Insured Person confirming that the claim does not relate to any Pre-Existing Illness or any Illness or Injury which was diagnosed or existed within the first ninety (90) days of the Policy Period Start Date.

(ii) Original investigation test reports, indoor case papers and medical documents as specified under the respective Critical Illness, Covered Surgical Procedure or Covered Medical Event.

(c) Additional claim documents for Benefit 2

Purpose of Document - Category	Indicative List of Documents
Identity Proof	Voter ID, Passport, PAN Card, Driving License, ration card, Aadhar, or any other proof accepted by the KYC norms as approved by the Company and which is admissible in court of law
Address Proof	Voter ID, Passport, Driving License
Age Proof	Voter ID, Passport, PAN Card, Matriculation Pass Certificate, Driving License, Birth Certificate
Incident Proof	FIR, Panchnama, Final Police Report, State Electricity Board Report, Factory Inspection Report, Forensic Report, Valid Passenger Ticket/Boarding Pass of the Common Carrier, or any other proof to the satisfaction of the Company
Cause of Loss	Viscera Report, Post Mortem Report (if conducted), MLC report, Medical Report/Certificate stating the cause of death
Disability	Disability Certificate from Government Medical Board, Fitness Certificate, Medical Prescription
Death	Death Certificate
Claimant Identity	Succession Certificate, Identity Proof of Nominee, legal heirs or any other proof to the satisfaction of the Company for the purpose of a valid discharge
Medical Expenses	Hospital Discharge Summary, Bills, Receipts, Medical Practitioner Certificate, Medical/Clinical /Pathological/Diagnostics Records

Note:

(i) The Company reserves the right to seek additional documents depending upon the cause of claim or the Benefit under which the claim is made.

(ii) Any one of the above documents under each category needs to be provided.

(d) The Company shall condone delay on merit for delayed claims where delay is proved to be for reasons beyond the control of the Policyholder or the Insured Person.

(e) 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.

5.3 Policyholder's or Insured Person's duty at the time of claim

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

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

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

(c) Intimation of the claim, Notification of the Claim and submission or provision of all information and documentation shall be made promptly and in any event in accordance within time frame specified in Clause 5 of the Policy Terms and Conditions.

(d) The Insured Person will, at the request of the Company, submit himself for a medical examination by the Company's nominated Medical Practitioner as often as the Company considers reasonable and necessary. The cost of such examination will be borne by the Company.

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

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

5.4 Payment Terms

(a) All payments under this Policy shall be made in Indian Rupees and within India.

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

(c) The Company shall not be liable for any claims which are incurred from the due date of installment till the date and time of revival of the Policy.

(d) The Company shall settle any claim within 30 days of receipt of all the necessary documents/ information as required for settlement of such claim and sought by the Company. The Company shall provide the Policyholder an offer of settlement of claim and upon acceptance of such offer by the Policyholder the Company shall make payment within 7 days from the date of receipt of such acceptance. In case there is delay in the payment beyond the stipulated timelines, the Company shall pay additional amount as interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

(e) Additionally in the event of any claim being lodged under the Policy for any cause whatsoever, all the subsequent premium installments shall immediately become due and payable notwithstanding anything to the contrary herein above contained. The Company shall have the right to recover and deduct any or all the pending installments from the claim amount due under the Policy.

(f) Claim under Benefit 1 or Benefit 2 can be made only once during the Policy Period. The claim shall be paid only for the Policy Period in which the event giving rise to claim under Benefit 1 or Benefit 2 occurs.

6. General Terms and Conditions

6.1 Disclosure to Information Norm & Fraud

If any untrue or incorrect statements are made or there has been a misrepresentation, mis-description or non-disclosure of any material particulars or any material information having been withheld, or if a claim is fraudulently made or any fraudulent means or devices are used by the Policyholder or the Insured Person 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.

6.2 Observance of Terms and Conditions

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

6.3 Reasonable Care

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

6.4 Material Change

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

6.5 Records to be maintained

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

6.6 No constructive notice

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

6.7 Complete discharge

Payment made by the Company to the Policyholder or the Nominee or the legal heir of the Policyholder, as the case may be, of any amount under the Policy shall in all cases be treated as full and final and construe as an effectual discharge in favor of the Company.

6.8 Policy Disputes

(a) Wherever there is a decision to be taken by the Insurer, which happens to be at variance with the Customers proposal, declarations and other such conduct an opportunity of natural justice shall be provided to him before a decision is taken on the merit and circumstances of the question.

(b) 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.

6.9 Free Look Period

(a) The Policyholder may, within 15 days from the receipt of the Policy document, return the Policy stating reasons, if the Terms and Conditions are not acceptable to the Policyholder.

(b) 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 (as per the below mentioned grid) 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.

Pre-policy	Assure 2		Assure 3 & Assure 4	
Age/Sum Insured	Upto 3 crores	Above 3 crores	Upto 10 Lacs	Above 10 Lacs
Upto 45 years	Nil	₹ 1,000	Nil	₹ 1,000
46 years to 55 years	Nil	₹ 2,000	₹ 1,000	₹ 2,000
56 years & above	₹ 1,000	₹ 4,500	₹ 2,000	₹ 4,500

(c) It is agreed and understood that this clause cannot be exercised on any Renewal of this Policy, if the Policy Terms and Conditions remain unchanged.

6.10 Renewal Notice

(a) This Policy will automatically terminate on the Policy Period End Date. All Renewal applications should reach the Company on or before the Policy Period End Date.

(b) The Company may, in its sole discretion, revise the Renewal premium payable under the Policy provided that revisions to the Renewal premium are in accordance with the IRDA rules and regulations as applicable from time to time. The premium payable on Renewal shall be paid to the Company on or before the Policy Period End Date and in any event before the expiry of the Grace Period.

(c) The Company will ordinarily not refuse to renew the Policy except on ground of fraud, moral hazard or misrepresentation or non-co-operation by the Insured.

(d) The Company reserves the right to carry out underwriting in relation to any request for increase of the Sum Insured / change of plan at the time of Renewal of the Policy.

(e) This product may be withdrawn by the Company after due approval from the IRDA. In case this product is withdrawn by the Company, this Policy can be renewed under the then prevailing Health Insurance Product or its nearest substitute approved by IRDA. The Company shall duly intimate the Policyholder regarding withdrawal of this product and the options available to the Policyholder at the time of Renewal of this Policy.

6.11 Cancellation/Termination

(a) The Company may at any time, cancel this Policy on grounds as specified in Clause 6.1, by giving 15 days' notice in writing to the Policyholder at his last known address.

(b) The Policyholder 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 no claim has been made and full premium has been received under the Policy.

Cancellation date up to (x months) from Policy Period Start Date	1 Year	2 Year	3 Year
Upto 1 month	75.0%	87.0%	91.0%
Upto 3 months	50.0%	74.0%	82.0%
Upto 6 months	25.0%	61.5%	73.5%
Upto 12 months	0.0%	48.5%	64.5%
Upto 15 months	N.A.	24.5%	47.0%
Upto 18 months	N.A.	12.0%	38.5%
Upto 24 months	N.A.	0.0%	30.0%
Upto 30 months	N.A.	N.A.	8.0%
Beyond 30 months	N.A.	N.A.	0.0%

(c) In case of demise of the Policyholder,

(i) Where the Policy covers only the Policyholder, this Policy shall stand null and void from the date and time of demise of the Policy holder.

(ii) Where the Policy covers other Insured Persons, this Policy shall continue till the end of Policy Period or next premium due whichever is earlier. If the other Insured Persons wish to continue with the same Policy, the Company will renew the Policy subject to the appointment of a Policyholder provided that:

(I) Written notice in this regard is given to the Company before the Policy Period End Date; and

(II) A person over Age 18 who satisfies the Company's criteria to become a Policyholder.

Note: The Company's liability in respect of an Insured Person shall cease upon making any refund of premium under this Policy in accordance with the Terms and Conditions hereof in respect of such an Insured Person and the benefit in respect of that Insured Person shall forthwith terminate.

6.12 Limitation of Liability

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

6.13 Communication

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

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

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

6.14 Alterations in the Policy

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

6.15 Overriding effect of Policy Certificate

In case of any inconsistency in the Terms and Conditions in this Policy vis-a-vis the information contained in the Policy Certificate, the information contained in the Policy Certificate shall prevail.

6.16 Electronic Transactions

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

6.17 Grievances

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

Regulations, Circulars issued from time to time in this regard.

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

Website : www.religarehealthinsurance.com

E-mail : customerfirst@religarehealthinsurance.com

Contact No.: 1800-200-4488

Fax : 1800-200-6677

Post/Courier : Any branch office or the correspondence address, during normal business hours

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

The Grievance Cell,
Religare Health Insurance Company Limited
GYS Global,
Plot No. A3, A4, A5,
Sector - 125,
Noida, U.P. - 201301

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

Office of the Ombudsmen	Name of the Ombudsmen	Contact Details	Area of Jurisdiction
AHMEDABAD	Shri P. Ramamoorthy	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, Ambica House, Nr. C.U. Shah College, Ashram Road, AHMEDABAD - 380 014. Tel : 079-27546840, Fax : 079-27546142 E-mail : ins.omb@rediffmail.com	Gujarat , UT of Dadra & Nagar Haveli, Daman and Diu
BHOPAL		Insurance Ombudsman, Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL(M.P.) - 462 023. Tel : 0755-2569201, Fax : 0755-2769203 E-mail : bimalokpalbhopal@airtelmail.in	Madhya Pradesh & Chhattisgarh
BHUBANESHWAR	Shri B. P. Parija	Insurance Ombudsman, Office of the Insurance Ombudsman, 62, Forest Park, BHUBANESHWAR - 751 009. Tel : 0674-2596455, Fax : 0674-2596429 E-mail : ioobbsr@dataone.in	Orissa
CHANDIGARH		Insurance Ombudsman, Office of the Insurance Ombudsman, S.C.O. No.101-103, 2nd Floor, Batra Building, Sector 17-D, CHANDIGARH - 160 017. Tel : 0172-2706468, Fax : 0172-2708274 E-mail : ombchd@yahoo.co.in	Punjab , Haryana, Himachal Pradesh, Jammu & Kashmir , UT of Chandigarh
CHENNAI	Shri V. Ramasaamy	Insurance Ombudsman, Office of the Insurance Ombudsman, Fathima Akhtar Court, 4th Floor, 453 (old 312), Anna Salai, Teynampet, CHENNAI - 600 018. Tel : 044-24333668/5284, Fax : 044-24333664 E-mail : chennaiinsuranceombudsman@gmail.com	Tamil Nadu, UT - Pondicherry Town and Karaikal (which are part of UT of Pondicherry)
NEW DELHI	Shri Surendra Pal Singh	Insurance Ombudsman, Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Bldg., Asaf Ali Road, NEW DELHI - 110 002. Tel : 011-23239633, Fax : 011-23230858 E-mail : iobdelraj@rediffmail.com	Delhi & Rajasthan
GUWAHATI	Shri D. C. Choudhury	Insurance Ombudsman, Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near Panbazar Overbridge, S.S. Road, GUWAHATI - 781 001 (ASSAM). Tel : 0361-2132204/5, Fax : 0361-2732937 E-mail : ombudsmanghy@rediffmail.com	Assam , Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura
HYDERABAD	Shri K. Chandrahas	Insurance Ombudsman, Office of the Insurance Ombudsman, 6-2-46, 1st Floor, Moin Court, A.C. Guards, Lakdi-Ka-Pool, HYDERABAD - 500 004. Tel : 040-65504123, Fax : 040-23376599 E-mail : insombudhyd@gmail.com	Andhra Pradesh, Karnataka and UT of Yanam - a part of the UT of Pondicherry
KOCHI	Shri R. Jyothindranathan	Insurance Ombudsman, Office of the Insurance Ombudsman, 2nd Floor, CC 27/2603, Pulinat Bldg., Opp. Cochin Shipyard, M.G. Road, ERNAKULAM - 682 015. Tel : 0484-2358759, Fax : 0484-2359336 E-mail : iokochi@asianetindia.com	Kerala, UT of (a) Lakshadweep, (b) Mahe - a part of UT of Pondicherry
KOLKATA	Ms. Manika Datta	Insurance Ombudsman, Office of the Insurance Ombudsman, 4th Floor, Hindusthan Bldg. Annexe, 4, C.R.Avenue, Kolkatta - 700 072. Tel : 033-22124346/(40), Fax : 033-22124341 E-mail : iombsbpa@bsnl.in	West Bengal, Bihar, Jharkhand and UT of Andeman & Nicobar Islands, Sikkim
LUCKNOW	Shri G. B. Pande	Insurance Ombudsman, Office of the Insurance Ombudsman, Jeevan Bhawan, Phase-2, 6th Floor, Nawal Kishore Road, Hazaratganj, LUCKNOW - 226 001. Tel : 0522-2231331, Fax : 0522-2231310 E-mail : insombudsman@rediffmail.com	Uttar Pradesh and Uttaranchal
MUMBAI	Shri S. Viswanathan	Insurance Ombudsman, Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), MUMBAI - 400 054. Tel : 022-26106928, Fax : 022-26106052 E-mail : ombudsmanmumbai@gmail.com	Maharashtra, Goa

The details of Insurance Ombudsman are available on IRDA website : www.irda.gov.in, on the website of General Insurance Council : www.generalinsurancecouncil.org.in, the Company's website www.religarehealthinsurance.com or from any of the Company's offices.

Address and contact number of Governing Body of Insurance Council -

Shri M.V.V. Chalam, Secretary General
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz(W),
MUMBAI - 400 021
Tel : 022-26106245
Fax : 022-26106949
E-mail : inscoun@gmail.com

The Secretary
3rd Floor, Jeevan Seva Annexe,
S.V. Road, Santacruz (W),
MUMBAI - 400 021.
Tel : 022 26106980
Fax : 022-26106949

Annexure I - List of Critical Illness

S.No.	Particulars	Plan Name		
		Assure 2	Assure 3	Assure 4
1	Cancer	Yes	Yes	Yes
2	End Stage Renal Failure	Yes	Yes	Yes
3	Multiple Sclerosis	Yes	Yes	Yes
4	Benign Brain Tumour	Yes	Yes	Yes
5	Total Blindness	Yes	Yes	Yes
6	Motor Neurone Disorder	Yes	Yes	Yes
7	End Stage Lung Disease	Yes	Yes	Yes
8	Major Organ Transplant	Yes	Yes	Yes
9	Heart Valve Replacement	Yes	Yes	Yes
10	Coronary Artery Bypass Graft	Yes	Yes	Yes
11	Stroke	Yes	Yes	Yes
12	Paralysis	Yes	Yes	Yes
13	Myocardial Infarction	Yes	Yes	Yes
14	Major Burns	Yes	Yes	Yes
15	Coma	Yes	Yes	Yes
16	Parkinson's Disease	No	No	Yes
17	Alzheimer's Disease	No	No	Yes
18	End Stage Liver Disease	No	No	Yes
19	Bacterial Meningitis	No	No	Yes
20	Aplastic Anaemia	No	No	Yes

Add-on Benefits

1. The Add-on Benefits shall be available only if the same is specifically mentioned in the Policy Certificate.

2. The Add-on Benefits are subject to the terms and conditions stated below and the Policy Terms & Conditions.

3. Add-on Benefit 1: Everyday Care

3.1 Definition :
For the purpose of this Add-on Benefit :

(a) Deductible:
A Deductible is a cost-sharing requirement under this Add-on Benefit that provides that the Company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Company. A deductible does not reduce the Sum Insured.

(b) Everyday Care Services :
The Company will provide the following Everyday Care Services (the "Services") under this Add-on Benefit to the Insured Person during the Policy Period:

(i) Health Care Services which include only the following :

I. Doctor Anytime /Free Health Helpline: The Insured Person may seek medical advice from a Medical Practitioner through the telephonic or on online mode by contacting the Company on the helpline details specified on the Company's website;

II. Health Portal: The Insured Person may access health related information and services available through the Company's website;

III. Health & Wellness Offers: The Insured Person may avail discounts on the health and wellness products and services listed on the Company's website through the Network Service Provider.

(ii) Doctor consultations:

I. The Insured Person may consult a Medical Practitioner within the Company's Network, on payment of ₹100 per consultation.

II. Maximum 4 consultations in a Policy Year are permissible for the same Illness or Injury.

(c) **Service Provider** means any person, organization, institution that has been empanelled with the Company to provide Services specified under this Add-on Benefit to the Insured Person.

(d) Clause 4.3(a)(xx) of the Policy Terms & Conditions is superseded only to the extent expressly specified in this Add-on Benefit.

3.2 Claim Process applicable to this Add-on Benefit.

(a) If the Service is being availed in person, the Insured Person shall present his unique identification number along with a valid identification document (Voter ID card/driving license/passport/PAN card/any other identity proof as approved by the Company) to the Service Provider and pay ₹100 per consultation (in case of Doctor Consultation as specified under Clause 3.1(b)(ii)) prior to availing such Services.

The Service Provider will provide the Services only after validation and authorization of the unique identification number by the Company.

(b) If the Services are availed over the telephone or through online mode, the Insured Person will be required to provide the details as sought by the Company/ Service Provider in order to establish authenticity and validity prior to availing such Services.

(c) If the Services are availed through the discount/redeemable voucher provided by the Company, the Insured Person shall present the discount/redeemable voucher along with a valid identification document (Voter ID card/ driving license/ passport/PAN card/ any other identity proof as approved by the Company) to the Service Provider prior to availing such Services.

3.3 General Terms & Conditions

(a) If the Policyholder opts for this Add-on Benefit during the Policy Period, the expiry of this Add-on Benefit would coincide with the Policy Period End Date.

(b) It is agreed and understood that the Company may, at its sole discretion, modify the list of Service Providers, Medical Practitioners or Health & Wellness Offers..

(c) The rate of discount and the name of Service Provider offering the Services can be obtained either through Company's website or from the Company's call centre. Before availing the Services, the Policyholder or Insured Person may check the updated details of the available Service Providers and the applicable discounts/services from the Company's website or call centre.

(d) The list of Services and discounts offered may vary with location and may be time barred and/or may change depending upon availability of Service Providers and discounts/Services available at such locations.

(e) The Insured Person is free to choose whether to obtain the Services and, if obtained under this Add-on Benefit, then whether or not to act on the advice/information received and/or use the Services obtained.

(f) These Services are for additional information purposes only and do not and should not be deemed to substitute the Insured Person's visit/ consultation to an independent Medical Practitioner.

(g) The Company does not make any representation as to the adequacy or accuracy of the Services, the Insured Person's or any other person's reliance on the same or the use to which the Services are put. The Company does not assume any liability for and shall not be responsible for any actual or alleged errors, omissions or representations made by any Medical Practitioner or Service Provider or for any consequences of actions taken or not taken in reliance thereon.

(h) The Insured Person understands and agrees that although the confidentiality of the information provided by him shall be maintained however the calls made by him shall be recorded for the purposes of quality and for maintaining the record of their health information.

3.4 Cancellation

(a) The Policyholder may give 15 days' notice in writing, to the Company, for the cancellation of this Add-on Benefit, in which case the Company shall from the date of receipt of the notice, cancel this Add-on Benefit and refund the premium for the unexpired period at the short period scales, as mentioned below, provided that the Insured Person has not utilized any of the Everyday Care Services specified in Clause 3.1(b) of this Add-on Benefit.

(b) Refund % to be applied on annual premium rates

Cancellation date up to (x months) from Policy Period Start Date	1 Year	2 Year	3 Year
Upto 1 month	75.0%	87.0%	91.0%
Upto 3 months	50.0%	74.0%	82.0%
Upto 6 months	25.0%	61.5%	73.5%
Upto 12 months	0.0%	48.5%	64.5%
Upto 15 months	N.A.	24.5%	47.0%
Upto 18 months	N.A.	12.0%	38.5%
Upto 24 months	N.A.	0.0%	30.0%
Upto 30 months	N.A.	N.A.	8.0%
Beyond 30 months	N.A.	N.A.	0.0%

(c) If any of the Everyday Care Services specified in Clause 3.1(b) of this Add-on Benefit has been utilized and the Policyholder chooses to cancel this Add-on Benefit then Company shall not be liable to refund any premium paid in respect to this Add-on Benefit.

4. Add-on Benefit 2 : HIV Cover

4.1 Benefit:

If, during the Policy Period, an Insured Person is first diagnosed to be suffering from an HIV Infection, then the Company will pay the Sum Insured mentioned against this Add-on Benefit and the benefits under this Add-on Benefit shall be terminated for that Insured Person provided that, the HIV Infection is caused by any of the reasons other than as specified below :

(i) Parent to child transmission.

(ii) Transmission through unprotected sex (Heterosexual, Homosexual or Bisexual)

(a) For the purposes of this Add-on Benefit, "HIV Infection" means a positive HIV antibody testing (rapid or laboratory-based enzyme immunoassay). This is usually confirmed by a second HIV antibody test (rapid or laboratory-based enzyme immunoassay) relying on different antigens or of different operating c characteristics.

and /or;

a positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virological test obtained from a separate determination.

(b) The coverage under the Policy for other Benefits for that Insured Person shall continue under this Policy.

4.2 Exclusions

(a) Waiting Period

90-Day waiting period

The Company shall not be liable to make any payment under this Add-on Benefit in respect of any HIV infection whose signs or symptoms, first occur within 90 days of the Policy Period Start Date.

(b) Permanent Exclusions

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

(I) Any Claim with respect to an HIV infection detected, diagnosed or which manifested prior to Policy Period Start Date or after the Policy Period End Date.

(II) Any congenital illness or condition or inherited disorder.

(III) Detection of HIV infection other than by an Accident.

4.3 Claim Process

(a) Intimation

(i) If an event as covered under this Add-on Benefit occurs, the Policyholder or Insured Person or Nominee as the case may be shall notify the Claim to the Company within thirty (30) days from the date of its occurrence either at the Company's call center or in writing.

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

(I) Policy Number;

(II) Name of the Policyholder;

(III) Name of the Insured Person in respect of whom the Claim is made;

(IV) Nature of the event;

(V) Name and address of the attending Medical Practitioner and Hospital, f applicable;

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(VI) Date of diagnosis of HIV infection;

(VII) Any other information, documentation or details requested by the Company.

(iii) The Policyholder / Insured person is required to intimate to the Company for Claim if any event as covered under this Policy occurs.

(b) Claim Documents

The following information and documentation shall be submitted to the Company at the earliest and in any event within 30 days of occurrence of the event in respect of all Claims:

(i) Duly completed and signed claim form, in original.

(ii) Certificate from the attending Medical Practitioner of the Insured Person confirming, at least the following:

(I) Name of the Insured Person;

(II) Name, date of occurrence and medical details.

(iii) Certificate from the attending Medical Practitioner of the Insured Person confirming that the Claim does not relate to any Pre-Existing Illness or any Illness or Injury which was diagnosed or existed within the first ninety (90) days of the Policy Period Start Date.

(iv) Original investigation test reports, indoor case papers and medical documents as specified under the respective Critical Illness, Covered Surgical Procedure or Covered Medical Event.

(v) Any other information, documentation or details requested by the Company.

(vi) Only in the event that the 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/reimbursements provider.

(c) Payment Terms

(i) All payments under this Add-on Benefit shall be made in Indian Rupees and within India.

(ii) The Company shall have no liability to make payment of a Claim under this Add-on Benefit in respect of an Insured Person, once the Sum Insured under this Add-on Benefit for that Insured Person is exhausted or the Policy gets terminated before the first diagnosis of HIV Infection.

4.4 General Terms and Conditions

(a) If the Policyholder opts for this Add-on Benefit during the Policy Period, the expiry of this Add-on Benefit would coincide with the Policy Period End Date.

(b) Admissibility of a Claim under this Add-on Benefit is independent and mutually exclusive to admissibility of any Claim under Benefit 1 or Benefit 2 and the event giving rise to the Claim shall be within the Policy Period for the Claim to be accepted.

(c) The maximum, total and cumulative liability of the Company for an Insured Person for any and all Claims incurred under this Add-on Benefit during the Policy Year in relation to any Insured Person shall not exceed the Sum Insured under this Add-on Benefit for that Insured Person.

(d) Cancellation

(i) The Policyholder may give 15 days' notice in writing, to the Company, for the cancellation of this Add-on Benefit, in which case the Company shall from the date of receipt of the notice, cancel this Add-on Benefit and refund the premium for the unexpired period at the short period scales, as mentioned below, provided that the Insured Person has not made any Claim under this Add-on Benefit.

(ii) Refund % to be applied on annual premium rates

Cancellation date up to (x months) from Policy Period Start Date	1 Year	2 Year	3 Year
Upto 1 month	75.0%	87.0%	91.0%
Upto 3 months	50.0%	74.0%	82.0%
Upto 6 months	25.0%	61.5%	73.5%
Upto 12 months	0.0%	48.5%	64.5%
Upto 15 months	N.A.	24.5%	47.0%
Upto 18 months	N.A.	12.0%	38.5%
Upto 24 months	N.A.	0.0%	30.0%
Upto 30 months	N.A.	N.A.	8.0%
Beyond 30 months	N.A.	N.A.	0.0%

(iii) If any Claim has been made under this Add-on Benefit and the Policyholder chooses to cancel this Add-on Benefit, then Company shall not be liable to refund any premium paid in respect to this Add-on Benefit.

(iv) If this Add-on Benefit is cancelled at the Policyholder's request, then no Claim shall be admissible under this Add-on Benefit subsequently.