Axis Max Life Group Smart Health Insurance Plan
(Non-Linked Non Participating Group Pure Risk Health Plan)
(UIN- 104N129V01)

Certificate of Insurance No.:

Congratulations on making the right choice by opting for an insurance cover under Axis Max Life Group Smart Health Insurance Plan (UIN 104N129V01) ("Policy"), a Non-Linked, Non-Participating Group Pure Risk Health Plan ("Insurance") offered by Axis Max Life Insurance Limited ("We", "Us", "Our", "Company") to <Master Policyholder>. It is hereby certified that Mr/ Ms. _____, has become an insured Member in accordance with the terms and conditions of the Policy. As a Member covered under the Policy, you will be entitled for an insurance cover for the Period of Coverage specified below.

Details of the Member		**Details of the Master Policyholder**	
Name of Member		Master Policy Holder	
Age		Policy Number	
Date of Birth		Address (For all Communication Purposes)	
Gender		Telephone No	
Address (For all Communication purposes)		Email	
Telephone No.		Date of Commencement of Master Policy	
Mobile No.			
Email			
Whether Age of the Member Admitted			
Enrollment Form No			
Date of Submission of Enrollment Form			

Effective Date of Coverage		

Details of Nominee						**Details of Appointee** (If nominee is minor)				
Name of Nominee	Date of Birth	Age	Gender	Relationship with Insured Member	Share in Percentage	Name of Appointee	Date of Birth	Age	Gender	Relationship with Nominee

Details of Insurance Agenct/Intermediary	
Name of Insurance Agent/ Intermediary	
Insurance Agent / Intermediary License No	
Insurance Agent/ Intermediary Code	
Telephone No/ Mobile No.	
Email	
Address	

Policy Details							
Risk Commencement Date	<<DD/MM/YYYY>						
Benefit Option	Fixed Daily Hospitalization Cash Benefit	Fixed Surgical Care Benefit	Accidental Total Permanent Disability	Critical Illness Benefit	Cardiac Cover	Cancer Cover	Optional Accidental Death Benefit
Applicable	<<Yes/No>>	<<Yes/No>>	<<Yes/No>>	<<Yes/No>>	<<Yes/No>>	<<Yes/No>>	<<Yes/No>>
Expiry Date	<<DD/MM/YYYY / NA>>	<<DD/MM/YYYY / NA>>	<<DD/MM/YYYY / NA>>	<<DD/MM/YYYY / NA>>	<<DD/MM/YYYY / NA>>	<<DD/MM/YYYY / NA>>	<<DD/MM/YYYY / NA>>
Sum Insured Cover Option	<<Level Cover/ NA>>	<<Level Cover/ NA>>	<<Level Cover / Decreasing Cover (<In Annual / Monthly>) / NA>>	<<Level Cover / Decreasing Cover (<In Annual / Monthly>) / NA>>	<<Level Cover / Decreasing Cover (<In Annual / Monthly>) / NA>>	<<Level Cover / Decreasing Cover (<In Annual / Monthly>) / NA >>	<<Level Cover / Decreasing Cover (<In Annual / Monthly>) / NA>>
Sum Insured	<<Rs.XXXX / NA>>	<<Rs.XXXX / NA>>	<<Rs.XXXX / Refer to Schedule in Annexures / NA>>	<<Rs.XXXX / Refer to Schedule in Annexures/ NA>>	<<Rs.XXXX / Refer to Schedule in Annexures / NA>>	<<Rs.XXXX / Refer to Schedule in Annexures / NA>>	<<Rs.XXXX / Refer to Schedule in Annexures / NA>>
Fixed Recuperation Cash Support Benefit (proportion)	<< % / NA>>	NA	NA	NA	NA	NA	NA
Policy Term (in Months)							

Premium Payment Mode	<<Annual/ Half Yearly/ Quarterly/ Monthly/ Single Pay / NA>>	<<Annual/ Half Yearly/ Quarterly/ Monthly/ Single Pay/ NA>>	<<Annual/ Half Yearly/ Quarterly/ Monthly/ Single Pay / NA>>		<<Annual/ Half Yearly/ Quarterly/ Monthly/ Single Pay / NA>>		<<Annual/ Half Yearly/ Quarterly/ Monthly/ Single Pay/ NA>>		<<Annual/ Half Yearly/ Quarterly/ Monthly/ Single Pay / NA>>		<<Annual/ Half Yearly/ Quarterly/ Monthly/ Single Pay / NA>>	
Settlement Option	<<Lump Sum / NA>>	<<Lump Sum / NA>>	<<Lump Sum/Lump Sum and Level Income>>		<<Lump Sum/Lump Sum and Level Income>>		<<Lump Sum/Lump Sum and Level Income>>		<<Lump Sum/Lump Sum and Level Income>>		<<Lump Sum/Lump Sum and Level Income>>	
In case Lump Sum and Level Income is selected	Not Applicable	Not Applicable	Lump Sum	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>	Lump Sum	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>	Lump Sum	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) /NA>>	Lump Sum	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>	Lump Sum	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>
			Level Income	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>	Level Income	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>	Level Income	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>	Level Income	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>	Level Income	<<XX% of applicable Sum Insured (Refer to Schedule in Annexures) / NA>>
			Income Duration		Income Duration		Income Duration		Income Duration		Income Duration	

			(In Years)		(In Years)		(In Years)		(In Years)		(In Years)	
			Frequency of Payout		Frequency of Payout		Frequency of Payout		Frequency of Payout		Frequency of Payout	
Total Annual Premium (A)												
Extra Premium (B)												
Applicable Taxes Cesses & Levies (C)												
Applicable Modal Factor (D)												
Total Premium along with Extra Premium and taxes for each benefit as per premium payment mode selected [(A+B+C) X D]												
Total Premium of all												

Benefit Options as per premium payment mode selected including extra premium and applicable taxes							
Due Date when the Premium is payable							

Schedule of Sum Insured

Accidental Total Permanent Disability

Year	Month	Sum Insured (at the start of the year/ month)	Settlement Section		
			Lump Sum	Income Amount (As per Frequency)	Income Duration (in years)

Critical Illness Benefit

Year	Month	Sum Insured (at the start of the year/ month)	Settlement Section		
			Lump Sum	Income Amount (As per Frequency)	Income Duration (in years)

Cardiac Cover

Year	Month	Sum Insured (at the start of the year/ month)	Settlement Section		
			Lump Sum	Income Amount (As per Frequency)	Income Duration (in years)

Cancer Cover

Year	Month	Sum Insured (at the start of the year/ month)	Settlement Section		
			Lump Sum	Income Amount (As per Frequency)	Income Duration (in years)

Optional: Accidental Death Benefit

Year	Month	Sum Insured (at the start of the year/ month)	Settlement Section		
			Lump Sum	Income Amount (As per Frequency)	Income Duration (in years)

In the event of any inconsistency or contradiction between the terms and conditions of the Policy (a Member can obtain or refer to the copy of the Policy which is available with the Master Policyholder) and this Certificate of Insurance, the terms and conditions contained in the Policy will prevail.

Please read this Certificate of Insurance carefully to ensure that you understand the terms and conditions of your coverage under this Insurance. You have a period of 30 (thirty) days, except for the Certificate of Insurance with tenure of less than a year, from the date of receipt of the Certificate of Insurance to review the terms and conditions of the Certificate of Insurance. If you disagree to any of the terms or conditions of the Certificate of Insurance and if no claim has been made under the Certificate of Insurance, you have an option to return the Certificate of Insurance to Us by stating the objections/reasons for such disagreement in writing. Upon return, the Certificate of Insurance

shall terminate forthwith and all rights, benefits and interests under the Certificate of Insurance shall cease immediately. We will only refund the Premiums received by Us, after deducting the proportionate risk Premium for the period of cover, charges of stamp duty paid and the expenses incurred on your medical examination, if any.

Yours Sincerely,

Axis Max Life Insurance Limited
Executive Vice President and Head (Customer Service and Operations)

Date:

Note: On examination of this Certificate of Insurance, if the Member notices any mistake or error, this Certificate of Insurance should be returned to Us for rectifying the same.

AXIS MAX LIFE INSURANCE

IMPORTANT TERMS & CONDITIONS OF THE CERTIFICATE OF INSURANCE

1. IMPORTANT DEFINITIONS

i. "**Accident**" means a sudden, unforeseen and involuntary event caused by external, visible and violent means;

ii. **"Accidental Death"** means death of the Member by or due to a Bodily Injury caused by an Accident, independent of any other causes. It must be caused within 180 (One Hundred Eighty) days of the date of any Bodily Injury. If the Bodily Injury occurred within the Member Cover Term and the Accidental Death happens after the end of Member Cover Term but within 180 days of Bodily Injury, a valid claim arising as a result of such Accidental Death shall not be denied;

iii. "**Accidental Death Benefit**" means the Sum Insured on death payable by Us on the happening of the Accidental Death of the Member;

iv. "**Accidental Total and Permanent Disability**" means when the Member is permanently, totally and continuously disabled due to Accident and such disability results in the total and irrecoverable loss of the use of two limbs; or the sight of both eyes; or the use of one limb and the sight of one eye; or Loss by severance of two or more limbs at or above wrists or ankles; or Sight of one eye and loss by severance of one limb at or above wrist or ankle.

Note: This benefit shall be payable subject to the following:

a. The Member must be unable to perform (whether aided or unaided) at least 3 of the Activities of Daily Living.

b. The above disabilities must last, without interruption, for at least 6 consecutive months and must, in the opinion of a Medical Practitioner, be deemed permanent.

c. This benefit shall commence upon the completion of this uninterrupted period of 6 months. However, for the disabilities mentioned in (iv) and (v) above, such 6 months period would not be applicable, and the benefit shall commence immediately.

v. "**Accidental Total and Permanent Disability Sum Insured"** means the maximum amount (as specified in the Certificate of Insurance Schedule), payable in accordance with Clause 3.1 below;

vi. "**Activities of Daily Living**" shall include the following: -

a. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.
b. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
c. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa.
d. Mobility: the ability to move indoors from room to room on level surfaces.
e. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
f. Feeding: the ability to feed oneself once food has been prepared and made available.

vii. **"Annualized Premium"** is the amount specified in the Schedule, and means Premium amount payable in a Policy Year, excluding taxes, rider Premiums, loadings for modal premiums and underwriting Extra Premium, if any;

viii. "**Age**" means age of the Member as at last birthday on the Effective Date of Coverage for existing Members and Age as on entry date for new Members;

ix. "**Appointee**" means the person named by Member (as applicable and registered with Us in the Schedule) who is authorised to receive and hold in trust the benefits under this Certificate of Insurance on behalf of the Nominee/(s), if the Nominee/(s) is/are less than Age 18 on the date of payment of such benefit;

x. "**Assignment**" is the process of transferring the rights and benefits to an Assignee, in accordance with the provisions of Section 38 of Insurance Act, 1938, as amended from time to time;

xi. **"Benefit Option(s)"** means one or more of the following benefit option chosen by master policyholder or Member (as applicable) and as specified in the Schedule:

S. No.	Benefit options
1	Fixed Daily Hospitalization Cash Benefit

2	Fixed Surgical Care Benefit
3	Accidental Total Permanent Disability
4	Critical Illness Benefit
5	Cardiac Cover
6	Cancer Cover

Note-

i. Where multiple Benefit Options are chosen, the benefits payable under each Benefit Option shall be independent of benefits payable under other Benefit Options. The Premium would vary basis the Benefit Option(s) chosen. Once any Benefit Option is selected, it cannot be changed later;

ii. If Member has opted for multiple Benefit Options, and coverage under one Benefit Option has been exhausted, the coverage under other Benefit Options (if any) shall continue to be in force till the end of Member Cover Term;

iii. The renewal of the Benefit Option(s) will be as per Our Underwriting Policy only.

xii. **"Bodily Injury"** means injury must be evidenced by external signs such as contusion, bruise and wound except in cases of drowning and internal injury;

xiii. **"Cancer Cover Sum Insured"** means the maximum amount (as specified in the COI Schedule), payable in accordance with Clause 3.1 below;

xiv. **"Cardiac Cover Sum Insured"** means the maximum amount (as specified in the COI Schedule), payable in accordance with Clause 3.1 below;

xv. "**Certificate of Insurance (COI)"** means, a certificate issued by Us, on the basis of the details mentioned in the Member's enrollment form, to each Member evidencing the acceptance of risk on the life of the Member under the Policy;

xvi. "**Claimant**" means Nominee(s) (if valid Nomination is effected), Assignee(s) or their heirs, legal representatives or holders of a succession certificatesin case Nominee(s) or Assignee(s) is/are not alive at the time of claim;

xvii. "**Critical Illness**" means the first time Diagnosis of the Member with any of the Illness or the first performance of any of the certain medical procedures/Surgeries by a Medical Practitioner in respect of the Member during his/her lifetime. List of Critical Illness covered are as specified under Clause 3.1 below;

xviii. "**Critical Illness Sum Insured**" means the maximum amount (as specified in the COI Schedule), payable in accordance with Clause 3.1 below;

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

i. has qualified nursing staff under its employment;

ii. has qualified Medical Practitioner/s in charge;

iii. has fully equipped operation theatre of its own where surgical procedures are carried out;

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

xx. "**Date of Revival**" means the approval date of Revival of the chosen Benefit Option under Certificate of Insurance, as per Underwriting Policy;

xxi. "**Diagnosis**" or "**Diagnosed**" means the definitive diagnosis made by a specialist Medical Practitioner, based upon radiological, clinical, and histological or laboratory evidence acceptable to Us provided the same is acceptable and concurred by Our appointed specialist Medical Practitioner. In the event of any doubt regarding the appropriateness or correctness of the Diagnosis, We will have the right to call for Member's examination and/or the evidence used in arriving at such Diagnosis, by a specialist Medical Practitioner selected by Us. The opinion of such an expert as to such Diagnosis shall be binding on both Member and Us;

xxii. "**Effective Date of Coverage**" means the date on which the insurance coverage under the Certificate of Insurance in respect of the Member commences which will be later of, the date of realization of the Premium by Us or the date of underwriting decision by Us;

xxiii. **"Employer-Employee Group"** means a group where an employer-employee relationship exists between master policyholder and the Members in accordance with the applicable laws;

xxiv. "**Extra Premium**" means an additional amount mentioned in the Schedule and charged by Us, as per Our Underwriting Policy, which is determined on the basis of disclosures made by master policyholder or the Member including medical examination, if any, of the Member;

xxv. **"Fixed Daily Hospitalization Cash Benefit**" means the benefit payable in accordance with Clause 3.1 below;

xxvi. **"Fixed Daily Hospitalization Cash Benefit Sum Insured"** means the maximum amount (as specified in the COI Schedule), payable in accordance with Clause 3.1 below;

xxvii. "**Fixed Surgical Care Benefit Sum Insured"** means the maximum amount (as specified in the COI Schedule), payable in accordance with Clause 3.1 below;

xxviii. "**Fixed Surgical Care Benefit**" means the benefit payable in accordance with Clause 3.1 below;

xxix. "**Free look**" means a period of 30 (Thirty) days beginning from the date of receipt of the Certificate of Insurance, except for the Certificate of Insurance with tenure of less than a year, to review the terms and conditions of the Certificate of Insurance. The Member have an option to cancel the Certificate of Insurance, if they disagree with any of the Certificate of Insurance terms and conditions or otherwise by sending a written request to Us stating the reason for objections;
Where Free look cancellation is exercised by Member of Non Employer-Employee Group, Upon receipt of request, if no claim has been made under the Certificate of Insurance, the Certificate of Insurance shall terminate forthwith and all rights, benefits and interests shall cease immediately. The Member will be entitled to refund of the Premiums paid less proportionate risk Premium for the period of cover, the expenses, if any incurred on medical examination of the Member(s) and stamp duty paid, if any;

xxx. "**Grace Period**" (other than single premium group health insurance) means the time granted by Us from the due date of payment of Premium, without any penalty or late fee, during which time the Policy/ Certificate of Insurance is considered to be in-force with the risk cover without any interruption, as per the terms & condition of the Policy/ Certificate of Insurance. The Grace Period for payment of the Premium for all types of life insurance policies shall be 15 days where the premium is paid on monthly mode and 30 days in all other cases;

xxxi. "**Hospital**" means any institution established for in-patient care and day care treatment of illness and/or injury(es) 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 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 inpatient beds in towns having a population of less than 10,00,000 and at least 15 inpatient 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 shall make these accessible to the Company's authorized personnel;

xxxii. **"Hospitalization"** means admission in a Hospital for a minimum period of twenty-four (24) consecutive Inpatient Care hours except for specified procedures/treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours;

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

xxxiv. **"Income Modal Factor"** means the applicable factor specified in the Schedule, which is used to determine level modal income , and will be as follows: i) for annual Premium payment mode - (1.000); ii) for semi-annual Premium payment mode - (0.5061); iii) for quarterly Premium payment mode - (0.2546); or iv) for monthly Premium payment mode - (0.0852);

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

xxxvi. "**Inpatient Care**" means treatment for which the Member has to stay in a Hospital for more than 24 hours for a covered event;

xxxvii. "**Intensive Care Unit (ICU)**" 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;

xxxviii. "**Lapsed Certificate of Insurance**" means a Certificate of Insurance for which the Premium has not been received during the Grace Period;

xxxix. **"Major Surgery"** is defined as any Surgery directly involving the brain, heart (including arteries), liver or lung. For list of Major Surgeries under the Fixed Surgical Care Benefit, refer Annexure F to this Certificate of Insurance;

xl. "**Member**" means an Eligible Member on whose life the insurance cover has been effected in accordance with the provisions of this Policy and whose name has been entered in the Register of Members or to whom a Certificate of Insurance has been issued (as applicable);

xli. "**Member Cover Term**" means the maximum term during which the coverage under the Policy or the Certificate of Insurance (if applicable) shall continue under the Policy;

xlii. "**Medical Practitioner**" means a person who holds a valid registration from the Medical Council of any State of India or National Medical Commission or Council for Indian Medicine or for homeopathy set up by the Government of India or by a state Government and is thereby entitled to practice medicine within its jurisdiction and is acting within the scope and jurisdiction of license, provided such Medical Practitioner shall not include master policyholder, the Member covered under this Policy or Member's spouse, lineal relative of the Member or the Policyholder or a Medical Practitioner employed by master policyholder or the Member covered under this Policy;

xliii. "**Minor Surgery**" means any other valid Surgery of the Member which is not categorized as Major Surgery;

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

- is required for the medical management of the Illness or Injury suffered by the Member;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a Medical Practitioner;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India;

xlv. "**Modal Factor**" means the applicable factor specified in the Schedule, which is used to determine the Premium, and will be as follows: i) for annual Premium payment mode - (1.000); ii) for semi-annual Premium payment mode - (0.520); iii) for quarterly Premium payment mode - (0.265); or iv) for monthly Premium payment mode - (0.090);

xlvi. "**Non-Employer-Employee Group**" means a group other than an Employer-Employee Group, where a clearly evident relationship between master policyholder and the Member exists for services/activities other than insurance;

xlvii. **"Nomination"** is the process of nominating a person(s) in accordance with provisions of Section 39 of the Insurance Act, 1938 as amended from time to time;

xlviii. "**Nominee**" means nominee nominated by the Member to receive the benefit upon death of the Member under the Certificate of Insurance and whose name, age and relationship with Member will be registered and recorded by master policyholder in the Register of Members, along with name of guardian in case of minor person or recorded in the Certificate of Insurance issued by Us, as the case may be;

xlix. "**Period of Coverage**" means the period from the respective Entry Date, during which the coverage of the chosen Benefit Option by the Member continues under this Certificate of Insurance, as specified in the Schedule and/ or the Certificate of Insurance, as the case may be;

l. **"Policy**" means the contract of insurance entered into between master Policyholder and Us as evidenced by this document, the Proposal Form, the Member enrolment forms (if applicable), the Schedule, the Register of Members/Certificates of Insurance, illustration issued by Us and accepted by master policyholder and any additional information/document(s) provided to Us in respect of the Proposal Form, along with any written instructions from Member subject to Our acceptance of the same and

any duly signed endorsement issued by Us;"**Policy Year**" means 12 (Twelve) months period commencing from the Date of Commencement of Risk and every Policy Anniversary thereafter;

li. "**Premium**" means sum total of Annualized Premium and Extra Premium (if any) excluding applicable taxes, cesses and levies, if any specified in the Schedule, payable by master policyholder or the Member, as the case may be, by the due dates to secure the benefits under the Policy/ Certificate of Insurance (as applicable);

lii. "**Pre-Existing Diseases**" means any condition, ailment or injury or disease:

a. that is/are Diagnosed by a Medical Practitioner not more than 36 months prior to Effective Date of Coverage under the Certificate of Insurance issued by Us; or

b. for which medical advice or treatment was recommended by, or received from a physician/ Medical Practitioner, not more than 36 months prior to Effective Date of Coverage under the Certificate of Insurance issued by Us;

liii. **"Revival"** means restoration by Us of the Member cover, which was discontinued due to non-payment of Premium, with all the benefits mentioned in the Policy or Certificate of Insurance (as applicable), with or without Rider Benefits, if any, upon the receipt of all the due Premiums and other charges/ late fee during the Policy Term, as per the terms and conditions of the Certificate of Insurance, upon being satisfied as to the continued insurability of the Member on the basis of the information, documents and reports furnished by the master policyholder/Member, in accordance with the Underwriting Policy;

liv. **"Schedule"** means the Certificate of Insurance Schedule and any endorsements attached to and forming part of the Policy and if an updated Schedule is issued, then the updated Schedule which is latest in time;

lv. **"Sum Insured" or "Sum Insured under Health Cover"** means an absolute amount of benefit which is guaranteed to become payable on happening of insured health related contingency in accordance with the terms and conditions of the Certificate of Insurance for each of the chosen Benefit Option;

lvi. "**Surgery" or Surgical Procedure"** means manual and/or operative procedure(s) required for treatment of an Illness or Injury, correction of deformities and defects, Diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner;

lvii. "**Surrender**" means complete withdrawal or termination of the entire Certificate of Insurance of a Member;

lviii. "**Surrender Value**" means the amount, if any, that becomes payable on the Surrender of the Certificate of Insurance during its term in accordance with Clause 6 below;

lix. **"Survival Period"** means a period of 30 days for 'Critical Illness' & 'Cardiac Cover' and 7 days for 'Cancer Cover' applicable from the first Diagnosis and fulfilment of the definition of the conditions covered during which the Member must survive before the benefit will be paid;

lx. "**TPA**" means a Third Party Administrator appointed by Us;

lxi. "**Total Premiums Paid**" means total of all the premiums paid under the Certificate of Insurance, excluding any Extra Premium and taxes, if collected explicitly;

lxii. **"Unclaimed Benefit Sum Insured"** means the Benefit Option Sum Insured as reduced by any claims already made for the Benefit Option since the Effective Date of Coverage or date of Revival, whichever is later;

lxiii. **"Underwriting Policy"** means the underwriting Policy approved by Our board of directors;

lxiv. **"Waiting Period"** means the period starting from Effective Date of Coverage or Revival during which no benefits are payable under the following Benefit Options. In case the insured event happens during this period, no benefit shall be payable, except the case wherein claim has been made due to an Accident:

- For 'Fixed Daily Hospitalization Cash Benefit' and 'Fixed Surgical Care Benefit': an initial period of 60 days from Effective Date of Coverage or Revival, whichever is later, if the cause of claim is not due to an Accident;
- Additionally, for list of Surgeries specified below in Table A and Table B, the Waiting Period of 1 Year and 2 Year will apply respectively, from the Effective Date of Coverage or Revival, whichever is later.

  Waiting Period for specified diseases/ailments/conditions:

- In case of Hospitalization or treatment of any of the following Injury, sickness, diseases or Surgical Procedure and any complications arising out of them during a period of 1 or 2 years from Effective Date of Coverage, the Daily Fixed Daily Hospitalization Cash Benefit and Fixed Surgical Care Benefit' will not be payable. This

exclusion will be deleted after one year and two years (as per the below list of impairments), provided the cover under the Policy has been continuously in force without any break.

❖ Table A

Sr. No	Injury / Sickness / Disease / Surgical Procedure (1 year Waiting Period)
1	Tonsillitis/Adenoiditis
2	Hernia (Inguinal / Ventral / Umbilical / Incisional)
3	Hydrocoele / Varicocoele / Spermatocoele
4	Piles / Fissure / Fistula / Rectal prolapsed
5	Benign Enlargement of Prostrate
6	Lumps, nodules, cysts and polyps
7	Chronic Suppurative Otitis Media / Tympanoplasty

❖ Table B

Sr. No	Injury / Sickness / Disease / Surgical Procedure (2 year Waiting Period)
1	Cataract
2	Uterus Related Disorders
3	Hysterectomy or Myomectomy for benign conditions
4	Deviated Nasal Septum /Sinusitis
5	Thyroid Nodule / Multi Nodular Goitre
6	Cholecystitis or stones of the gall bladder / pancreatic system
7	Stones of the urinary tract
8	Treatment of Prolapsed Inter Vertebral Disc
9	Varicose Veins
10	Degenerative joint conditions

Note: There is no Waiting Period between two successive Hospitalization.

- For 'Critical Illness Benefit': an initial period of 90 days from Effective Date of Coverage or Revival, whichever is later;
- For 'Cancer Cover', and 'Cardiac Cover': an initial period of 180 days from the Effective Date of Coverage or Revival, whichever is later;

Note - No Waiting Period applies for Critical Illness or optional Accidental Death Benefit or Accidental Total Permanent Disability or 'Cardiac Cover' claims arising solely due to an Accident.

In case of one-year renewable group health insurance, the Waiting Period shall not apply to those existing Member(s) of a group, who have already completed their

Waiting Period fully. However, if the Member has not completed the stipulated Waiting Period in the previous year, then the remaining Waiting Period shall be carried forward at renewal, and only on completion of entire Waiting Period, We will pay the claim.

If the Certificate of Insurance is revived before Waiting Period from the due date of Premium, then the remaining Waiting Period has to be completed and If the Certificate of Insurance is revived after Waiting Period from the due date of Premium, then the Waiting Period shall start afresh.

lxv. "**We**", "**Us**", or "**Our**" means Axis Max Life Insurance Limited; and

Please note that the terms not defined herein shall have the meaning assigned to them in the Policy Document issued to Master Policyholder.

2. **Sum Insured Cover Option** – The following cover options (as opted by master policyholder or the Member) are available under the Policy to be selected at the time of inception:

a. **Decreasing Cover**: *(applicable only for single premium group health insurance)* The Sum Insured chosen at inception reduces at a fixed rate over a Policy Term based on a chosen frequency (monthly or annually). The fixed reduction rate will be calculated as 1/Policy Term (in years) for annual decreasing sum insured cover and the fixed reduction rate will be calculated as 1/ Policy Term (in months) for monthly decreasing sum insured cover. The resulting percentage will be rounded down to five decimal places and applied accordingly on each Policy Anniversary (yearly or monthly) on the Sum Insured chosen at inception. In case of occurrence of any covered contingency, the applicable Benefit Option Sum Insured at that time will be paid. This cover option is available only for Critical Illness Benefit, Cardiac Cover, Accidental Total Permanent Disability, Accidental Death Benefit (optional) and 'Cancer Cover'. Decreasing sum insured cover option is not available under one-year renewable group health insurance. Furthermore, it is not applicable to the Fixed Daily Hospitalization Cash Benefit or the Fixed Surgical Care Benefit options as well. The Sum Insured applicable at time period 't' shall be equal to:

Sum Insured at time 't' = Sum Insured chosen at inception * (1 – fixed reduction rate * (t - 1))

where 't' denotes the current Policy Year for the annual decreasing sum insured cover option, and the current Policy month for the monthly decreasing sum insured cover option.

b. **Level Cover:** The Sum Insured chosen at inception under the chosen Benefit Option will be payable on happening of covered contingency. The chosen Benefit Option Sum Insured remains constant throughout the Policy Term. This cover option is available for all the Benefit Options.

2.2 Where coverage is provided in connection with any loan obligations, the sum insured for each Benefit Option, including optional Accidental Death Benefit, shall correspond to the original loan amount sanctioned for level cover or the loan schedule at inception. The sum insured chosen at inception for each of the chosen Benefit Option and optional Accidental Death Benefit option shall not exceed the principal loan amount when coverage is linked to such loan. Furthermore, if the product is offered in conjunction with a loan, the coverage term shall not exceed the loan tenure and shall be subject to a maximum duration of five (5) years.

3. BENEFITS: The benefits offered by this plan under the available Benefit Option provided the Policy/Certificate of Insurance is in force are explained herewith:

3.1 The Benefit Options are:

a. **Fixed Daily Hospitalization Cash Benefit:** Subject to the conditions as specified below, if the Member is hospitalized for undergoing any Medically Necessary Treatment due to any Lapse, injury, sickness or disease, during the Member Cover Term, for a minimum, continuous and complete period of 24 hours, and if the claim is considered admissible by Us, We will pay the following as Fixed Daily Hospitalization Cash Benefit amount for each day of Hospitalisation, starting from the first day of Hospitalisation, provided all due Premiums have been received by Us.

Hospitalization Type	Benefit Payable
Non – ICU (Intensive Care Unit)	Benefit amount shall be equal to 1% of the Fixed Daily Hospitalization Cash Benefit Sum Insured for each day of Hospitalization beginning from the 1st day of Hospitalization.
ICU (Intensive Care Unit)	Benefit amount shall be equal to 2% of the Fixed Daily Hospitalization Cash Benefit Sum Insured for each day of Hospitalization in the Intensive Care Unit (ICU) beginning from the 1st day of Hospitalization.

Conditions for the Fixed Daily Hospitalization Cash Benefit:

i) An initial Waiting Period for Fixed Daily Hospitalization Cash Benefit must have been completed prior to the Hospitalization due to any injury, sickness, or disease. No benefit shall be payable for any Hospitalization during the Waiting Period for Fixed Daily Hospitalization Cash Benefit. Such a Waiting Period for Fixed Daily Hospitalization Cash Benefit is not applicable to claims arising due to Accident occurring after the Effective Date of Coverage or Revival date, as the case may be. No Waiting Period shall be applicable between two successive Hospitalizations.

ii) We will pay a lumpsum and consolidated Fixed Daily Hospitalization Cash Benefit amount, irrespective of the actual Hospitalization expenses incurred during Hospitalization.

iii) This Fixed Daily Hospitalization Cash Benefit is a fixed per-day benefit and will be calculated on the basis of the number of continuous and completed days of Hospitalization.

iv) More than one claim can be considered in respect of the Member under this benefit during the Member Cover Term, subject to the maximum payment of 100% of Fixed Daily Hospitalization Cash Benefit Sum Insured. On exhaustion of the 100% Fixed Daily Hospitalization Cash Benefit Sum Insured, the cover under this benefit will terminate in relation to such Member. The Fixed Daily Hospitalization Cash Benefit Sum Insured payable towards any claim shall not exceed Unclaimed Benefit Sum Insured i.e. benefit payable towards any subsequent claim shall not exceed the unclaimed benefit of Fixed Daily Hospitalization Cash Benefit Sum Insured.

v) Upon making a valid claim under this Benefit Option, the Sum Insured available under this Benefit Option upon renewal of the Certificate of Insurance shall be limited to the Unclaimed Benefit Sum Insured as last available prior to renewal for the same benefit.

vi) Any procedure / treatment which leads to Hospitalization of less than 24 hours is not covered. Out-patient treatment or Day-Care Procedures / treatments are categorically excluded.

vii) Member has an option to allocate a portion of their per day Fixed Daily Hospitalization Cash Benefit Sum Insured as the 'Fixed Recuperation Cash Support Benefit'. It will be a part of the per day Fixed Daily Hospitalization Cash Benefit Sum Insured and not payable in addition to it.

viii) This Fixed Daily Hospitalization Cash Benefit will cease at the end of Member Cover Term. However, the coverage under other benefit options (if any) shall continue to be in force till the end of Member Cover Term.

ix) Geographical coverage is applicable only for Hospitalization within India.

x) For applicable exclusions to the Fixed Daily Hospitalization Cash Benefit, please refer to Clause 13 below.

b. **Fixed Surgical Care Benefit Option:** Subject to the conditions as specified below, if the Member is hospitalized during the Member Cover Term for a minimum continuous and complete period of 24 hours for undergoing any Medically Necessary Treatment through Surgery in India for an Illness/Injury due to Accident and actually undergoes that Surgery while Hospitalized, and if the claim is considered admissible by Us, We will pay the following Fixed Surgical Care Benefit Sum Insured for the following types of Surgery, provided all due Premiums have been received by Us:

Surgery Type	Benefit payable as % of Fixed Surgical Care Benefit Sum Insured
Major Surgery	100% of the Fixed Surgical Care Benefit Sum Insured
Minor Surgery	50% of the Fixed Surgical Care Benefit Sum Insured

This Fixed Surgical Care Benefit Sum Insured shall be payable subject to the following:

i) An initial Waiting Period for Fixed Surgical Care Benefit must have been completed prior to Hospitalization due to sickness. No benefit shall be payable for any Hospitalization due to Illness during the Waiting Period for Fixed Surgical Care Benefit. Such a Waiting Period for Fixed Surgical Care Benefit is not applicable to claims arising due to Accident occurring after the Effective Date of Coverage or Revival date as the case may be. No Waiting Period shall be applicable between two successive Hospitalizations.
ii) The Surgery must be for Medically Necessary Treatment for an Illness/Injury due to Accident and is commenced and continued on the written advice of the treating Medical Practitioner.
iii) The Surgery should have been performed by a qualified surgeon for a surgical operation at a Hospital due to injury or sickness for covered Surgical procedures advised by Medical Practitioner.
iv) If more than one Surgery is performed on the Member, through the same incision or by making different incisions, during the same Surgical session, the claim shall be payable for one Surgery only.
v) More than one claim can be considered in respect of the Member under this benefit during the Member Cover Term, subject to the maximum of 100% of Fixed Surgical Care Benefit Sum Insured. On exhaustion of the 100% of the Fixed Surgical Care Benefit Sum Insured, the cover under this benefit will terminate in relation to such Member. The Fixed Surgical Care Benefit Sum Insured payable towards any claim shall not exceed Unclaimed Benefit Sum Insured i.e. benefit payable towards any subsequent claim shall not exceed the unclaimed benefit of Fixed Surgical Care Benefit Sum Insured.
vi) Upon making a valid claim under this Benefit Option, the Sum Insured available under this Benefit Option upon renewal of the Certificate of Insurance shall be limited to the Unclaimed Benefit Sum Insured as last available prior to renewal for the same benefit.
vii) The benefit amount shall be paid based on the Surgery resulting in the highest claim amount in case of more than one Surgery is performed on the Member during the same Hospitalization.
viii) Coverage under other Benefit Options (if any) shall continue to be in force till the end of the Member Cover Term.
ix) The Member will receive 100% of Fixed Surgical Care Benefit Sum Insured in case the Policyholder undergo Major Surgery as per Annexure F and 50% of Fixed Surgical Care Benefit Sum Insured in case of Minor Surgery.

x) The Member shall not be allowed to claim for the same Surgery more than once. However, multiple Minor Surgery claims under this benefit can be claimed during the Member Cover Term irrespective of any previous claims paid subject to the maximum of 100% of Fixed Surgical Care Benefit Sum Insured.
xi) The benefit will be paid as fixed lump sum amount, irrespective of actual surgery expenses.
xii) The Fixed Surgical Care Benefit ceases on earlier of:
    a. Claiming 100% of the chosen Fixed Surgical Care Benefit Sum Insured; and
    b. End of Member Cover Term.
xiii) Out-patient treatment or day-care procedures / treatments are categorically excluded.
xiv) Renewal of this benefit shall be as per Underwriting Policy.
xv) For applicable exclusions to the Fixed Surgical Care Benefit, please refer to Clause 13 below.

c. Accidental Total and Permanent Disability

In the event of Accidental Total and Permanent Disability of a Member during the Member Cover Term, and if the claim is considered admissible by Us, We will pay 100% of the applicable Accidental Total and Permanent Disability Sum Insured as benefit to the Member as per settlement options specified in Clause 4 below. In case decreasing sum insured cover option is chosen, the applicable Accidental Total and Permanent Disability Sum Insured shall be equivalent to the 'Sum Insured applicable at time 't' as per Clause 2 above i.e. sum Insured at the time of insurable event.

No Waiting Period is applicable for this Benefit Option.

For applicable exclusions applicable to the Accidental Total and Permanent Disability, please refer to Clause 13 below.

d. Critical Illness Benefit

Subject to the Waiting Period for Critical Illness, in case a Member is first time Diagnosed with Critical Illness conditions covered below, during the Member Cover Term, We will pay 100% of the Critical Illness Benefit Sum Insured as benefit applicable at the time of insured event, provided the Illness/ condition has occurred for the first time. In case decreasing sum insured cover option is chosen, the applicable Critical Illness Sum Insured shall be equivalent to the 'Sum Insured applicable at time 't' as per Clause 2 above i.e. Sum Insured at the time of insurable event.

The cover under this benefit terminates on the first occurrence of any of the following applicable Major Critical Illnesses.

Sr No.	Name of Critical Illness
1	Myocardial Infarction (First Heart Attack of specified severity)
2	Open Heart Replacement or Repair of Heart Valves
3	Cancer of Specified Severity
4	Kidney Failure requiring Regular Dialysis

5	Stroke resulting into permanent symptoms
6	Alzheimer's Disease
7	Apallic Syndrome
8	Coma of Specified Severity
9	End Stage Liver Failure
10	End Stage Lung Failure
11	Loss of Independent Existence
12	Blindness
13	Third Degree Burns
14	Major Head Trauma
15	Parkinson's Disease
16	Permanent Paralysis of Limbs
17	Multiple Sclerosis with Persisting Symptoms
18	Motor Neuron Disease with Permanent Symptoms
19	Benign Brain Tumor
20	Major Organ / Bone Marrow Transplant
21	Progressive Scleroderma
22	Muscular Dystrophy
23	Poliomyelitis
24	Loss of limbs
25	Deafness
26	Loss of Speech
27	Medullary Cystic Disease
28	Systemic Lupus Erythematosus with Renal Involvement
29	Aplastic Anemia

i) For all the above mentioned 29 Major Critical Illnesses conditions, an initial Waiting Period, shall apply. In case the insured event happens during the applicable Waiting Period, no benefit shall be payable and 100% of the Premiums paid will be refunded and the insurance cover under this Benefit Option will terminate. However, no such Waiting Period applies, if the claim has arisen solely and directly due to an Accident.

ii) Critical Illness Sum Insured will only be made post confirmatory Diagnosis of above covered Critical Illnesses while the Member is alive (i.e., a claim would not be admitted if the Diagnosis is made post-mortem), as per settlement options specified in Clause 4 below.

iii) Once 100% of the Critical Illness Sum Insured has been paid as lumpsum, the Member coverage will cease post that and the Certificate of Insurance will terminate. Critical Illness Sum Insured payable under each claim shall not exceed the Unclaimed Benefit Sum Insured.

iv) A Survival Period of 30 days from the date of first Diagnosis is applicable for this benefit.

v) If the Diagnosis is made within the Member Cover Term and the Survival Period crosses the end point of Member Cover Term, a valid claim arising as a result of such a Diagnosis shall not be denied.

vi) The lives with any of the above 29 Critical Illness existing or occurred previously shall not be offered this benefit.

vii) No further renewal of this Benefit Option will be applicable, if a valid claim under this Benefit Option has been paid once.

viii) For necessary permanent exclusions applicable under this Benefit Option, please refer to Annexure D.

ix) For applicable exclusions to the Critical Illness Benefit Option, please refer to Clause 13 below.

x) For the detailed definitions of the diseases covered under Critical Illness Benefit Option, please refer to Annexure G.

e. Cancer Cover

Subject to the Waiting Period and Survival Period applicable for 'Cancer Cover', if a Member is Diagnosed with any of the below listed Cancer condition, during the Member Cover Term, provided the Member survives for a period of 7 days from the date of Diagnosis of the Cancer condition, We will pay a lump sum Cancer Cover Sum Insured benefit to a Member as follows:

In the event of Diagnosis of	Percentage (%) of Cancer Cover Sum Insured payable
Minor Cancer	25% Cancer Cover Sum Insured
Major cancer	100% of Cancer Cover Sum Insured less minor Cancer claims paid, if any

This list of Cancer conditions covered, and their category will be as below:

Type of Cancer	Major / Minor
Cancer of Specified Severity	Major
Carcinoma in situ (CIS)	Minor
Early-Stage cancer	Minor

i) If the insured event happens during the Waiting Period, no benefit shall be payable and 100% of the Premiums paid will be refunded and the insurance cover under this Benefit Option will terminate.

ii) Only one minor 'Cancer Cover' claim will be covered under this benefit during the Member Cover Term i.e. only one claim can be made for Diagnosis of Early-Stage Cancer or Carcinoma-in-situ (CIS). Two or more minor Cancer cover conditions will not be considered during the Member Cover Term.

iii) In case decreasing sum insured cover option is chosen, the applicable 'Cancer Cover' Sum Insured shall be equivalent to the 'Sum Insured applicable at time 't'' as per Clause 2 above i.e. sum Insured at the time of insurable event.

iv) Any payout for a minor Cancer claim will accelerate the payout for major Cancer benefit.

v) Member coverage under this benefit shall terminate once 100% of the Cancer Cover Sum Insured has been paid against all valid claims during the Member Cover Term.

vi) A Waiting Period and Survival Period will be applicable for this benefit. If the Diagnosis is made within the Member Cover Term and the Survival Period crosses the end point of Member Cover Term, a valid claim arising as a result of such a Diagnosis shall not be denied.

vii) Claim payment will only be made post confirmed Diagnosis of above covered Cancer condition while the Member is alive (i.e., a claim would not be admitted if the Diagnosis is made post-mortem), as per settlement options as specified in Clause 4 below.

viii) Coverage under other Benefit Options (if any) shall continue to be in force till the end of the Member Cover Term.

ix) Cancer Cover Sum Insured payable towards any claim shall not exceed the Unclaimed Benefit Sum Insured.

x) Upon making a valid claim under this Benefit Option, the Sum Insured available under this Benefit Option upon renewal of the Certificate of Insurance shall be limited to the Unclaimed Benefit Sum Insured as last available prior to renewal for the same benefit.

xi) If master policyholder/ Member has chosen a decreasing sum insured cover option and a minor claim is made initially, 25% of the Cancer Cover Sum Insured applicable at the time 't' i.e. insurable event, will be paid to the Member. For any subsequent claims, the minor claim amount previously paid will be deducted from the remaining Benefit Option Sum Insured at the time 't' i.e. insurable event.

xii) In case, the Cancer Cover Sum Insured applicable for any Member at any time 't' becomes less than the minor claim amount already paid off, then this Benefit Option will cease and no benefit shall be payable.

xiii) For necessary details of the above covered Cancer condition, please refer to Annexure H.

xiv) For applicable exclusions to the covered 'Cancer' condition, please refer to Clause 13 below.

f. <u>Cardiac Cover:</u>

Subject to the Waiting Period and Survival Period applicable for Cardiac Cover, in the event of first occurrence/Diagnosis/undergoing of below covered cardiac conditions /Surgeries (as listed below) during the Member Cover Term while the coverage is in force, We will pay a lump sum payout (as a percentage of Cardiac Cover Sum Insured) to the Member. The percentage of Cardiac Cover Sum Insured payable shall be as per table below:

In the event of Diagnosis of	% Cardiac Cover Sum Insured payable
Minor cardiac	25% Cardiac Cover Sum Insured

Major cardiac	100% of Cardiac Cover Sum Insured less minor cardiac claims paid, if any

This list of Cardiac Cover conditions covered, and their category will be as below:

Sr No.	Type of 'Cardiac Cover'	Major/Minor
1	Myocardial Infarction (First Heart Attack of specified severity)	Major
2	Open Chest CABG (Coronary Artery Bypass Graft)*	Major
3	Open Heart Replacement or Repair of Heart Valves*	Major
4	Major Surgery of Aorta*	Major
5	Cardiomyopathy	Major
6	Heart Transplant*	Major
7	Primary (Idiopathic) Pulmonary Hypertension	Major
8	Insertion of Pacemaker*	Minor
9	Balloon Valvotomy or Valvuloplasty*	Minor
10	Angioplasty*	Minor
11	Minimally invasive Surgery of Aorta*	Minor
12	Pericardiectomy*	Minor
13	Infective Endocarditis*	Minor
14	Surgery for Cardiac Arrhythmia*	Minor
15	Pulmonary Thrombo Embolism*	Minor

** If a claim is made for this condition, in addition to satisfying the definitions and exclusion criteria, the procedure or Surgery must be determined to be medically necessary by a consultant 'Cardiologist' / Surgeon and must be supported by relevant imaging findings & evidenced by established Diagnostic reports.*

i.) Any payout for a minor Cardiac claim will accelerate the payout for major Cardiac Cover benefit.

ii.) Only one minor Cardiac Cover claim will be payable under this benefit.

iii.) Member coverage under this benefit shall terminate once 100% of the Cardiac Cover Sum Insured has been paid against all valid claims during the Member Cover Term. Cardiac Cover Sum Insured payable under each claim shall not exceed the Unclaimed Benefit Sum Insured.

iv.) Upon making a valid claim under this Benefit Option, the Sum Insured available under this Benefit Option upon renewal of the Certificate of Insurance shall be limited to the Unclaimed Benefit Sum Insured as last available prior to renewal for the same benefit.

v.) If master policyholder/ Member has chosen a decreasing sum insured cover option and a minor claim is made initially, 25% of the Cardiac Cover Sum Insured

applicable at the time 't' i.e. insurable event, will be paid to the Member. For any subsequent claims, the minor claim amount previously paid will be deducted from the remaining Benefit Option Sum Insured at the time 't' i.e. insurable event. .

vi.) In case, the Cardiac Cover Sum Insured applicable to any Member at any time 't' becomes less than the minor claim amount already paid off, then this Benefit Option will cease, and no benefit shall be payable.

vii.) A Waiting Period and Survival Period will be applicable for this benefit. However, no Waiting Period applies for 'Cardiac Cover' claims arising solely and directly due to an Accident. If the insured event happens during the Waiting Period, no benefit shall be payable and 100% of the Premium paid will be refunded and the insurance cover under this Benefit Option will terminate.

viii.) In case a decreasing sum insured cover option is chosen, the applicable 'Cardiac Cover' Sum Insured shall be equivalent to the 'Sum Insured applicable at time *'t'*" as per Clause 2 above i.e. sum Insured at the time of insurable event.

ix.) If the Diagnosis is made within the Member Cover Term and the Survival Period crosses the end point of Member Cover Term, a valid claim arising as a result of such a Diagnosis shall not be denied.

x.) Coverage under other benefit options (if any) shall continue to be in force till the end of Member Cover Term.

xi.) Claim payment will only be made post confirmed Diagnosis of above covered Cardiac Cover condition while the Member is alive (i.e., a claim would not be admitted if the diagnosis is made post-mortem), as per settlement options as specified in Clause 4 below.

xii.) For necessary details of the above covered Cardiac Cover condition, please refer to Annexure I.

xiii.) For applicable exclusions to the Cardiac Cover, please refer to Clause 13 below.

g. <u>Optional Accidental Death Benefit Cover</u>

i) Member or the master policyholder have the flexibility to add an optional Accidental Death Benefit cover with any of the above available Benefit Options for additional Premium at the time of inception of the Policy. This optional Accidental Death Benefit cover shall not be offered on a stand-alone basis and can only be attached in conjunction with available benefit options. In the event of Accidental Death of a Member, during the Member Cover Term, 100% of the Accidental Death Benefit Sum Insured shall be payable to the Nominee and this cover will terminate thereafter.

ii) The optional Accidental Death Benefit Sum Insured chosen at inception shall not exceed the sum insured of any chosen Benefit Option in any case. If multiple Benefit Options are opted by the Master Policyholder/Member, the optional Accidental Death Benefit Sum Insured at inception shall not exceed the highest sum insured among the selected Benefit Options.

iii) The payment of the claim will be as per the chosen settlement option as provided in Clause 4 below.

iv) No Waiting Period is applicable for this Benefit Option.

v) In case decreasing sum insured cover option is chosen, the applicable Accidental Death Benefit Sum Insured shall be equivalent to the 'Sum Insured applicable at time 't' as per Clause 2 above i.e. sum Insured at the time of insurable event.

vi) No benefit is payable on death of a Member, other than the Accidental Death of the Member under this cover. In case the Member passes away where the monthly income benefit is still being paid under the selected settlement option, the outstanding benefit payments shall continue to be paid to the Nominee..

vii) Coverage under other benefit options (if any) shall continue to be in force till the end of Member Cover Term.

viii) For necessary details of the Accidental Death Benefit, please refer to Annexure C.

ix) For applicable exclusions to the Accidental Death Benefit, please refer to Clause 13 below.

3.2. MATURITY BENEFIT, SURVIVAL BENEFIT AND LOAN

No maturity benefit or Survival Benefit is payable under the Certificate of Insurance. Members will not be entitled to any loan under the Certificate of Insurance.

4. SETTLEMENT OPTION

The settlement option provides flexibility to take the applicable Benefit Option Sum Insured in lumpsum or in installments over a chosen period. Under this option, income payment frequency which may be chosen is annual, semi-annual, quarterly and monthly. The following two settlement options are available for applicable Benefit Option Sum Insured and can be selected by master policyholder or Member under the Policy/ Certificate of Insurance (as applicable):

i. Lumpsum benefit: to take the entire benefit amount as lumpsum immediately on happening of insured event.

ii. Lumpsum and level income: Under this option, a percentage (X%) of benefit amount (in multiples of 10), chosen by master policyholder or the Member (as the case may be) will be paid as lump sum immediately on happening of an insured event to the Member. The balance amount (1-X%) shall be paid as level income, spread over the chosen income period (in years), subject to a maximum income period of 10 years. The income will be payable immediately following the happening of insured event basis the chosen income pay-out frequency.

Level income shall be calculated basis the below formula:

*Level modal income = [(1-X%) * applicable benefit amount/income period (in years)] * income factor*Income Modal Factor*

Note: where 'X' is the percentage of the Benefit Option Sum Insured as may be chosen by master policyholder or the Member (as the case may be) to be paid as lumpsum.

'income factor' herein shall mean the factor which varies based on the chosen income period, used for converting the lump sum benefit amount into a level modal income. The income factors may be reviewed periodically by Us.

During the level income period, Member/ Nominee shall have the right to commute the remaining level incomes or can change income benefit payment frequency by submitting a written request to Us at least 30 days before the next claim anniversary. On receipt of such a request, We shall pay the present value of all future level incomes discounted at the rate of 5% p.a. to the Member/Nominee (as the case may be). Please note that the rate of 5% p.a. used here is based on Our long-term expectation of interest rates and may be reviewed from time to time by Us.

Thus, lumpsum amount = commutation factor x level modal income

Commutation factor = $\frac{\boldsymbol{level\ modal\ income} \times (1 - \frac{1}{(1+i)^t}) \times (1+i)}{i}$

Where 't' is the outstanding number of income payments and where 'i' equals (1+5%)^(1/ Income Frequency) – 1

Note:

i. In case the Member passes away where the monthly income benefit is still being paid under the selected settlement option, the outstanding benefit payments shall continue to be paid to the Nominee.
ii. The settlement option is available under all the benefit variants and add-on benefits except Fixed Daily Hospitalization Cash Benefit and Fixed Surgical Care Benefit.
iii. The income factors may be reviewed periodically by Us.

5. GRACE PERIOD AND LAPSATION OF POLICY (Except in case of single premium group health insurance)

5.1 The Premium is due and payable by the due date specified in the Schedule of this Certificate of Insurance. If the Premium is not paid by the due date, the Member may pay the same during the Grace Period without any late fees or interest.

5.2 The insurance coverage continues during the Grace Period. However, if the due Premium is not paid within the Grace Period and the insured event takes place, then, We will pay the applicable benefit after deducting the due Premium (if any) from the benefits payable under the Certificate of Insurance.

5.3 If the Premium is received by master policyholder from a Member within the Grace Period, We shall provide risk cover to that Member.

5.4 If the Premium is not paid within the Grace Period, the Policy shall lapse with effect from the Premium due date and any claims that occur after Premium due date shall not be admissible.

5.5 In case, master policyholder/Member has chosen multiple Benefit Options under one-year renewable group health insurance, no individual Benefit Option shall lapse independently. The entire Policy/ Certificate of Insurance (as the case may be) will lapse, if the Premium for any selected Benefit Option remains unpaid by the end of the Grace Period.

6. **SURRENDER**

6.1 If the Certificate of Insurance is in force and all the due Premiums have been paid, provided no valid claim has been made by the Member during the Member Coverage Term, the Certificate of Insurance shall acquire a Surrender Value.

6.2 On Surrender of the Policy by master policyholder, the Members will be provided an option, to continue the insurance coverage until the expiry of the Period of Coverage or to exit from the Policy.

6.3 In case the Members continue, where:

6.3.1 the Premium is borne and paid by master policyholder, We will pay Surrender Value to master policyholder and We will continue the coverage for the unexpired Period of Coverage with respect to those Members provided We have received Premium from them for the unexpired Period of Coverage subject to Our Underwriting Policy;

6.3.2 the Premium is and continued to be borne by the Members, We will continue the coverage for those Members till the expiry of the Period of Coverage.

6.4 In case the Members opt to Surrender, where:

6.4.1 the Premium is borne and paid by master policyholder an amount equal to the Surrender Value will be paid to master policyholder;

6.4.2 the Premium is borne by the Members, the cover will continue till the end of the coverage period for which the Premium has been received unless a specific request has been received from a Member for Surrender Value and the same shall be paid to those Members.

6.5 The Surrender Value applicable will be calculated as following:

6.5.1. The Surrender Value applicable on single premium group health insurance shall be determined basis the formula provided below:

70% x (Sum of Total Premium Paid, underwriting Extra Premium and loadings for Modal Premiums, if any) x (unexpired risk period in months[1])/(total period of cover in months) x Sum Insured applicable at the time of Surrender[2])/ (Sum Insured at inception).

Note: 1. Ignoring fraction of a month.

2. As per the Schedule mentioned in Certificate of Insurance at the outset.

6.5.2. The Surrender Value applicable on one-year renewable group health insurance will be an amount equal to the Premium without interest for the unexpired Period of Coverage.

6.6 The risk cover under the Policy will cease after the Surrender request has been processed.

6.7 In case multiple Benefit Options are opted by master policyholder or Members, Surrender of only one particular Benefit Option will not be allowed. All Benefit Options will need to be surrendered together.

7. REVIVAL MEMBER COVER

7.1 A Lapsed Certificate of Insurance may be revived during the Policy Term in accordance with our Underwriting Policy, provided that:

7.1.1 We receive a written request to revive the Certificate of Insurance;

7.1.2 The Member or the master Policyholder provides Us, at their cost, satisfactory evidence of insurability in respect of the Members, which is acceptable to Us; and

7.1.3 Payment of all due Premiums (along with the applicable taxes, cesses and levies, if any) is made to Us with late fee as on the date of Revival as may be determined by Us from time to time.

Currently the applicable late fees are as below:

No. of days between Date of Revival and date of lapse of Policy	**Revival Interest Rate Basis**	**Currently Applicable Revival interest rate***
0-60	Nil	0.00%
61-180	RBI Bank Rate + 1% p.a. compounded annually on due Premiums	7.50%
>180	RBI Bank Rate + 3% p.a. compounded annually on due Premiums	9.50%

***Note**: The current applicable revival interest rate is based on RBI Bank rate of 6.50% p.a. prevailing as at 31st March, 2025 plus relevant margins stated in the table above. The 'RBI Bank Rate' for the financial year ending 31st March (every year) will be considered for determining the revival interest rate and the same shall be made effective w.e.f. 01st July every year. The revival interest rate is revised only if the 'RBI Bank Rate' changes by 1% or more from the 'RBI Bank Rate' used to determine the prevailing revival interest rate (reviewed on every 31st March). For further details and the Revival interest rate applicable as on date, please refer to our website https://www.axismaxlife.com. Any change in methodology to derive the Revival rate of interest shall be with prior approval from IRDAI.

7.2 The Revival of the Lapsed Certificate of Insurance will take effect only after We have approved the same in accordance with Underwriting Policy and communicated Our decision to the Member in writing. We will not be liable to pay any benefit occurring during the period for which the Certificate of Insurance was lapsed.

7.3 Revival of the Policy/ Certificate of Insurance (as the case may be) during the Revival period is permitted only upon payment of all outstanding Premiums corresponding to all originally selected Benefit Options.

7.4 Under one-year renewable group health insurance, Revival may be allowed within the Member Coverage Term of one year. A Policy/Certificate of Insurance (as applicable) lapsed within the Member Coverage Term of one year due to non-payment of Modal Premium can be Revived. However, If a lapsed Policy/ Member cover (where the Premium is borne by the Members) is not revived within the Member Coverage Term, the Policy/Certificate of Insurance (as applicable) will terminate without value, on the expiry of the Member Coverage Term.

7.5 In case master policyholder has opted for one-year renewable group health insurance, on Revival under the following Benefit Option, the Waiting Period will apply as below:

i. For Critical Illness-
   - If the Policy/Certificate of Insurance (as applicable) is revived within 90 days, only the remaining part of the applicable Waiting Period will apply.
   - If the Policy/Certificate of Insurance (as applicable) is revived after 90 days, full waiting period will apply afresh.

ii. Cancer Cover and Cardiac Cover -
   - If the Policy/Certificate of Insurance (as applicable) is revived within 180 days, only the remaining part of the applicable Waiting Period will apply.
   - If the Policy/Certificate of Insurance (as applicable) is revived after 180 days, the full Waiting Period will apply afresh.

iii. For Fixed Daily Hospitalization Cash Benefit and Fixed Surgical Care Benefit:
   - If the Policy/Certificate of Insurance (as applicable) is revived within 60 days, only the remaining part of the applicable Waiting Period will apply.
   - If the Policy/Certificate of Insurance (as applicable) is revived after 60 days, full Waiting Period will apply afresh.

7.6 We may, from time to time, at Our sole discretion, introduce Revival schemes or modify or terminate existing Revival schemes. Please contact Us for details on 1860 120 5577 or visit Our website https://www.axismaxlife.com.

8. PAYMENT OF BENEFITS

a. The benefits under the Certificate of Insurance will be payable to the Claimant only on submission of satisfactory proof of the insured event to Us.

b. Once 100% of the applicable Benefit Option Sum Insured under chosen Benefit Option are paid to the Claimant, the same will constitute a valid discharge of Our liability under that Benefit Option.

9. TERMINATION OF MEMBER'S COVER UNDER THE CERTIFICATE OF INSURANCE

9.1 A Member's insurance coverage under the Certificate of Insurance shall terminate upon the occurrence of the earliest of the following:

9.1.1 Free look cancellation on account of request from the Member (for Non Employer-Employee Group) or the date on which We receive a Free look cancellation request from the master Policyholder (in case of Employer-Employee group);

9.1.2 at the end of 3 months from the date of receipt of notice of termination by any party

9.1.3 the Member ceases to be an Eligible Member;
9.1.4 the Member ceases to be a Member of master Policyholder's group;
9.1.5 on the death of the Member;
9.1.6 on the Surrender of the Certificate of Insurance;
9.1.7 on payment of entire Benefit Option chosen Sum Insured as per Certificate of Insurance Schedule.
9.1.8 on occurrence of misstatement, fraud or non-disclosure subject to Section 45 of the Insurance Act, 1938 as amended from time to time;
9.1.9 on termination of the Policy for the entire group by master policyholder;
9.1.10 on attaining Age of maturity;
9.1.11 in case of Claim during Waiting Period;
9.1.12 on the expiry of the coverage term for all the chosen Benefit Options.

9.2 In an Employer-Employee Group, if a Member's insurance coverage under the Policy is terminated due to reasons other than death or claim under the Certificate of Insurance, We will refund the Premium without interest for the unexpired Period of Coverage to master policyholder in respect of that Member in case the Premium is borne and paid by master policyholder.

9.3 In a Non-Employer-Employee Group, if a Member's insurance coverage under the Certificate of Insurance is terminated due to reasons other than death, We will continue the insurance coverage of the Member till the end of the Period of Coverage unless We receive a written request from the Member to terminate the insurance coverage under the Policy. On receipt of a written request, We will refund the proportionate Premium received without interest in respect of that Member for the unexpired Period of Coverage.

10. TAXES

10.1 All Premiums received, benefits payable, and/or funds accumulated under the Policy/ Certificate of Insurance or as may be maintained by Us for Members are subject to applicable taxes, cesses, and levies, including but not limited to Goods and Services Tax (GST) and Income Tax, as applicable, which shall be entirely borne by master policyholder/Member and will always be paid by master policyholder/Member at the time of Premium payment, receipt of benefits and/or fund payout, as applicable.

10.2 Notwithstanding anything contained in this Policy/ Certificate of Insurance or otherwise, We hereby reserve the right to claim, deduct, reduce and/or set-off a sum equivalent to any tax, interest, penalty, and/or other payments, as maybe imposed by any legislation, regulation, order, judgment, or otherwise, from any benefits payable to Member, their nominee, or Assignee or from the funds accumulated under the Policy/ Certificate of Insurance or funds maintained by Us.

10.3 Tax benefits may be available as per prevailing tax laws. Tax laws, their interpretation and/or application, including benefits arising thereunder are subject to change. Members/master policyholder are advised to consult your tax advisor regarding the tax benefits and liabilities applicable to master policyholder Members.

11. CLAIM PROCEDURE:

11.1 For processing a claim request under this Certificate of Insurance, We will require all of the following documents based on Benefit Option chosen:

11.1.1 The documents required under Fixed Daily Hospitalization Cash Benefit, Fixed Surgical Care Benefit, Accidental Total and Permanent Disability, Critical Illness, 'Cardiac Cover', 'Cancer Cover' and Accidental Death Benefit Option:

11.1.1.1 <u>Documents required for Fixed Daily Hospitalization Cash Benefit & Fixed Surgical Care Benefit:</u>

a. Duly filled and signed Claimant's statement in the prescribed form;
b. Copy of Certificate of Insurance;
c. Copy of photo ID/ KYC documents of insured /, if applicable;
d. PAN card of claimant /Insured;

e. Photocopy of Hospital discharge summary and Hospital final bill or Hospital bill summary
f. Original cancelled cheque with pre- printed name of Claimant on it;
g. Proof of undergoing with surgical notes Surgery and its necessary documents;
h. In addition to the above mandatory documents, if the admission in Hospital is more than 48 hrs, please provide the below:
   - copy of all Indoor case papers/ In Hospital records;
   - copy of all medical tests done during Hospitalization;
   - all pre and post Hospitalization records.
i. first consultation report confirming the disease or condition by registered Medical Practitioner;
j. any other documents or information required by Us for assessing and approving the claim request.

11.1.1.2 Documents required for Critical Illness Benefit:

a. Duly filled Claimant's statement in the prescribed form;
b. Copy of Certificate of Insurance;
c. Copy of photo ID /KYC Documents of insured, if applicable;
d. PAN card of claimant/insured;
e. Photocopy of Hospital discharge summary and Hospital final bill or Hospital bill summary;
f. Original cancelled cheque with pre- printed name and account number of Claimant on it;
g. All confirmatory diagnostic reports confirming the Diagnosis of Critical Illness;
h. Copy of all Indoor case papers/ In Hospital records;
i. Copy of all medical tests done during Hospitalization;
j. All pre and post Hospitalization records;
k. First consultation report confirming the disease or condition by registered Medical Practitioner;
l. Any other documents or information required by Us for assessing and approving the claim request.

11.1.1.3 Documents required for Accidental Total and Permanent Disability and optional Accidental Death Benefit:

a. Duly filled Claimant's statement in the prescribed form;
b. Copy Certificate of Insurance;
c. Copy of photo ID /KYC documents of Insured, if applicable;
d. PAN card of claimant/ Nominee;
e. Disability certificate issued by the medical CMO (for ATPD Benefit);
f. Copy of driving license (In case of road traffic accident);
g. Original cancelled cheque with pre- printed name and account number of claimant on it;
h. Copy of first investigation report / final police investigation report;
i. A copy of duly certified post mortem report, autopsy/viscera report and a copy of the final police investigation report /charge sheet;(In case of optional Accidental death Benefit);
j. Original/ attested copy of death certificate (applicable only for Accidental Death Benefit) issued by the local/municipal authority;
k. Original/ attested copy copy of death certificate issued by the local/municipal authority.

11.1.1.4 Documents required for 'Cancer Cover' Benefit:

a. Duly filled Claimant's statement in the prescribed form;
b. Copy of Certificate of Insurance;
c. Copy of photo ID /KYC of insured, if applicable;
d. PAN card of claimant /insured ;
e. Photocopy of Hospital discharge summary and Hospital final bill or Hospital bill summary;
f. Original cancelled cheque with pre- printed name and account number of Claimant on it;
g. All confirmatory diagnostic reports confirming the diagnosis of cancer;
h. Duly filled APS form by treating oncologist confirming the stage of cancer;
i. Copy of all Indoor case papers/ In Hospital records;
j. Copy of all medical tests done during Hospitalization;
k. All pre and post Hospitalization records;
l. Biopsy report /FNAC report/Histopathological report (With TNM Grading);
m. Any other documents or information required by Us for assessing and approving the claim request.

11.1.1.5 Documents required for 'Cardiac Cover' Benefit:

a. Duly filled Claimant's statement in the prescribed form;
b. Copy of Certificate of Insurance;
c. Copy of photo ID / KYC documents of insured if applicable;
d. PAN card of Claimant /Insured;
e. Photocopy of Hospital discharge summary and Hospital final bill or Hospital bill summary;
f. Original cancelled cheque with pre- printed name and account number of Claimant on it;
g. Copies of all Diagnostic test reports conducted, including but not limited to ECG, angiography, echocardiography (Echo), cardiac markers, PET scan, etc;
h. Copy of all Indoor case papers/ In Hospital records;
i. Copy of all medical tests done during Hospitalization;
j. All pre and post Hospitalization records;
k. Any other documents or information required by Us for assessing and approving the claim request.

11.2 Notwithstanding anything contained in this Certificate of Insurance, in case master Policyholder is a financial institution, the following shall apply:

a) Subject to the applicable IRDAI guidelines as amended from time to time, We will make the payment of outstanding loan balance amount to master policyholder by deducting from the claim proceeds payable under the Certificate of Insurance and the balance of the claim (i.e., the difference between the Sum Insured payable on insurable event and the outstanding loan amount on the date of occurrence of the insured event) will be paid directly to the Claimant or the Member (as applicable);

b) Member/master policyholder (as applicable) shall provide Us details of the credit account statement with respect to the Members as per the guidelines issued by IRDAI from time to time;

11.3 In case of absence of authorization or in cases of master policyholder being other than financial institution, the entire claim amount shall be payable to the Nominee/ beneficiary.

11.4 A Claimant can download the claim request documents from Our website https://www.axismaxlife.com or can obtain the same from any of Our branches and offices.

11.5 Subject to the provisions of Section 45 of the Insurance Act, 1938, as amended from time to time, We will pay the benefits under the Policy subject to Our satisfaction:

11.5.1 that the benefits have become payable as per the terms and conditions of the Policy; and

11.5.2 of the bonafides and credentials of the Claimant.

11.6 A Claimant may contact the TPA at the details mentioned on Our website https://www.axismaxlife.com for any claims relating to Fixed Daily Hospitalization Cash Benefit and Fixed Surgical Care Benefit.

11.7 Subject to Our discretion and satisfaction, in exceptional circumstances such as on happening of a force majeure event, We may decide to waive all or any of the requirements mentioned in the Policy.

11.8 We reserve the right to:

i) audit or cause an audit into the accuracy of the credit account statements of the Members in respect of which claims will be settled, on completion of every financial year and shall audit or cause an audit into the accuracy of the credit account statement of the deceased Members furnished by master policyholder; or

ii) master policyholder shall provide a certification from their internal statutory auditors that the outstanding loan balance being shown in the credit account statement/claim discharge form is correct as per the conditions governing the credit account/loan account.

11.9 The benefits under the Certificate of Insurance will be payable to the Claimant only on submission of satisfactory proof of the Member's death to Us and Once the benefits under this Policy are paid to the Claimant, the same will constitute a valid discharge of Our liability under this Certificate of Insurance.

11.10 All claim cases must be notified immediately to us in writing. However, We may condone delay on merit for delayed claims where the reason for delay is proved to be for reasons beyond the control of the Claimant. Claim forms as required by us must be completed and furnished to us, at the Claimant's expense, within 90 days after the date the insured event happens, unless specified otherwise. A list of primary claim documents listing the normally required documents is attached to the Policy. Submission of the listed documents, forms or other proof, however, shall not be construed as an admission of liabilities by the Company. We reserve the right to require any additional proof and documents in support of the claim"

11.11 The Claimant is required to intimate Us along with necessary documents as mentioned above, regarding a claim, at the earliest possible time either in person or through online mode or Our distribution channel or authorized call center. For any support or guidance in relation to claims, please contact us at Helpline No. – 1860 120 5577, Email: service.helpdesk@axismaxlife.com.

12. PREMIUMS (Except in case of single premium group health insurance)

The Premium can be paid prior to the Date of Commencement/ Effective Date of Coverage of Risk, annually, semiannually, quarterly or monthly, as per the Premium payment mode chosen by master policyholder or the Member by the due dates specified in the COI Schedule, at any of Our offices or through Our website https://www.axismaxlife.com or by any other means, as informed by Us. The Premium payment receipt will be issued subject to realization of cheque or any other instrument/medium.

13. EXCLUSIONS

a. **Exclusions Applicable to Fixed Daily Hospitalization Cash Benefit and The Fixed Surgical Care Benefit:** For Fixed Daily Hospitalization Cash Benefit and Fixed Surgical Care benefit exclusions refer to Annexure B of the Certificate of Insurance.

b. **Exclusions Applicable to Accidental Total Permanent Disability Benefit and optional Accidental Death Benefit Option:** For Accidental Total Permanent Disability Benefit and optional Accidental Death Benefit Option specific exclusions refer to Annexure C of the Certificate of Insurance.

c. **Exclusions Applicable to the Critical Illness (CI) Benefit Option:** For Critical Illness cover specific exclusions refer to Annexure D of the Certificate of Insurance.

d. **Exclusions Applicable for Cancer Cover Benefit Option:** For 'Cancer Cover' specific exclusions refer to Annexure H of the Certificate of Insurance.

e. **Exclusions Applicable for 'Cardiac Cover' Benefit Options:** For 'Cardiac Cover' specific exclusions refer to Annexure E, respectively, of the Certificate of Insurance.

14. FREE LOOK OPTION

A Member has the option to cancel the Certificate of Insurance in case of any disagreement with the terms and conditions of the Certificate of Insurance or otherwise. The request for cancellation must be sent to Us in writing, stating the reasons for such objections. This request must be sent within the Free Look period of 30 (thirty) days beginning from the date of receipt of the Certificate of Insurance, except for the Certificate of Insurance with tenure of less than a year. Upon receipt of request, if no claim has been made under the Certificate of Insurance, the Certificate of Insurance shall terminate forthwith and all rights, benefits and interests shall cease immediately. The Member will

be entitled to refund of the Premiums paid less proportionate risk Premium for the period of cover, the expenses, if any incurred on medical examination of the Member(s) and stamp duty paid, if any.

15. TERM and RENEWAL (only in case of one-year renewable group health insurance)

a. The Certificate of Insurance shall continue to be in force for a period of 1 (One) year from the Effective Date of Coverage or any subsequent Annual Date of Renewal provided that the Policy/ Certificate of Insurance (as applicable) continues to be renewed with Us. The Certificate of Insurance shall become renewable on each Annual Date of Renewal provided that We receive updated details in respect of all Members for whom the Policy/ Certificate of Insurance (as applicable) is proposed to be renewed. We will specify the Premium payable to renew the Policy/ Certificate of Insurance (as applicable) which must be received by Us before the Annual Date of Renewal for the Policy/ Certificate of Insurance (as applicable) to be renewed.

b. If We do not receive the Premium payable on the Annual Date of Renewal in full, master policyholder/Member shall be deemed to have discontinued payment of Premiums and this Policy/Certificate of Insurance (as the case may be) shall terminate. Member/master policyholder shall not subsequently be entitled to resume payment of Premiums except with Our prior written consent.

16. DECLARATION OF THE CORRECT AGE AND GENDER

The Premiums are calculated on the basis of the Age and/ or gender of the Member(s). If the Age and/or gender declared in the Proposal Form and/or Member enrolment application form is found to be incorrect anytime within three (3) years from the date of issuance of Certificate of Insurance, the Effective Date of Coverage, the date of Revival of the Certificate of Insurance whichever is later, then We may exercise Our rights under Section 45 of the Insurance Act, 1938, as amended from time to time or revise/adjust the Premium payable by master policyholder/ the Member with interest and/or from applicable benefits payable under the Policy in accordance with the Premium and benefits that would have been payable, if the correct Age and/ or gender would have made the Member eligible to be covered under the Policy on the Effective Date of Coverage.

17. **FRAUD, MIS-STATEMENT ANDFORFEITURE**

Fraud, mis-statement and forfeiture would be dealt with in accordance with provisions of Section 45 of the Insurance Act, 1938 as amended from time to time.

18. TRAVEL AND OCCUPATION

There are no restrictions on travel or occupation under this Certificate of Insurance.

19. **NOMINATION**

Nomination is allowed as per Section 39 of the Insurance Act, 1938 as amended from time to time. Member may request for a cancellation or change of nomination(s) for a Certificate of Insurance along with necessary details of substituted nominee. Additional charges, not exceeding Rs. 100/- on each occasion may be applicable for cancellation or change of nominee.

20. ASSIGNMENT

Assignment shall be applicable in accordance with provisions of Section 38 of the Insurance Act, 1938 as amended from time to time. Member may request for a cancellation or change of nomination(s) for a Certificate of Insurance along with necessary details of substituted nominee. Additional charges, not exceeding Rs. 100/- on each occasion may be applicable for cancellation or change of nominee.

21. ELECTRONIC TRANSACTIONS

Member has to comply with all the terms and conditions with respect to all transactions effected by or through facilities for conducting remote transactions including the internet, world wide web, electronic data interchange, call center, tele-service operations or by other means of telecommunication established by Us or on Our behalf, for and in respect of the Certificate of Insurance or services, which will constitute legally binding and valid transactions when executed in adherence to and incompliance with the terms and conditions for such facilities.

22. DUPLICATE CERTIFICATE OF INSURANCE

In case of loss of this Certificate of Insurance, Member may contact our nearest branch office to know the requirements for issuance of a duplicate Certificate of Insurance. The duplicate Certificate of Insurance shall be issued without any charge.

23. AMENDMENT

No amendments to the Certificate of Insurance will be effective, unless such amendments are expressly approved in writing by Us and by IRDAI wherever applicable.

24. REGULATORY AND JUDICIAL INTERVENTION

If any competent regulatory body or judicial body imposes any condition on the Certificate of Insurance for any reason, We are bound to follow the same which may include suspension of all benefits and obligations under the Policy.

25. **COMMUNICATION & NOTICES**

a. All notices meant for Us should be in writing and delivered to Our address as mentioned in or such other address as We may notify from time to time. Member should mention the correct Certificate of Insurance number in all communications including communications with respect to Premium remittances made by master Policyholder.

b. All notices meant for Member will be in writing and will be sent by Us to Member's address as shown in the Schedule or as communicated by Member and registered by Us. We may send a notices by post, courier, hand delivery, fax ore-mail/electronic mode or by any other means as determined by Us. If any change in address, or if the address of the nominee changes, it must be notified to Us immediately. Failure in timely notification of change of address could result in a delay in processing of benefits payable under the Policy.

c. For any updates, please visit Our website https://www.axismaxlife.com.

26. **GOVERNING LAW AND JURISDICTION**

The Certificate of Insurance will be governed by and enforced in accordance with the laws of India. The competent courts in India will have exclusive jurisdiction in all matters and causes arising out of the Certificate of Insurance.

27. **TRANSLATION**

In the event of any conflict or discrepancy between any translated version and the English language version of this Policy contract, the English language version of this Policy contract shall prevail.

28. **GRIEVANCE REDRESSAL MECHANISM &OMBUDSMAN DETAILS DISPUTE REDRESSAL PROCESS UNDER THEPOLICY:**

a. All consumer grievances and/or queries may be first addressed to the agent or Our customer helpdesk as mentioned below: Axis Max Life Insurance Limited ~~Max Life Insurance Company Limited~~ Plot 90C, Udyog Vihar, Sector 18, Gurugram, 122015, Haryana, India Helpline No: 1860 120 5577Email: service.helpdesk@axismaxlife.com

b. In case Our response is not satisfactory or there is no response within 14 (Fourteen) days:

   a. the complainant may file a written complaint with full details of the complaint and the complainant's contact information to the following official for resolution: Grievance Redressal Officer, Axis Max Life Insurance Limited ~~Max Life Insurance Company Limited~~ Plot No. 90C, Udyog Vihar, Sector 18, Gurugram, 122015,Haryana, India Helpline No: 1860 120 5577 Email: manager.services@axismaxlife.com;
   the complainant or his legal heirs may approach the Grievance Cell of the IRDAI on the following contact details: IRDA Grievance Call Centre (Bima Bharosa Shikayat Nivaran Kendra) Toll Free No:155255 or 1800 4254 732 Website:- bimabharosa.irdai.gov.in. You can also register your complaint online at http://www.igms.irda.gov.in/.
   You can also register your complaint through fax/paper by submitting your complaint to: Policyholder Protection & Grievance Redressal Department (PPGR) Insurance Regulatory and Development Authority of India Sy. No. 115/1, Financial District, Nanakramguda, Gachibowli, Hyderabad - 500 032, India, Ph: (040) 20204000

   b. In case you are not satisfied with the redressal or there is no response within a period of 1(One) month or within 1 year after rejection of complaint by Us, the complainant may approach Insurance Ombudsman at the address mentioned in Annexure A or on the IRDAI website www.irda.gov.in or on Council of Insurance Ombudsmen website at www.cioins.co.in, if the grievance pertains to:
      (i) delay in settlement of a claim beyond the time specified by Us;
      (ii) any partial or total repudiation of a claim by Us;

(iii) any dispute with regard to the Premium paid or payable in terms of the Policy; or
(iv) any misrepresentation of policy terms and conditions at any time in the policy document or policy contract;
(v) any dispute on the legal construction of the Policy in so far as such dispute relate to a claim;
(vi) policy servicing by Us, Our agents or intermediaries;
(vii) issuance of insurance policy, which is not inconformity with the proposal form submitted by you;
(viii) non issuance of any insurance document after receipt of the Premium.
(ix) any other matter resulting from violation of provisions of Insurance Act, 1938or the regulation, circulars, Guidelines or instructions issued by the IRDAI from time to time on the terms and conditions of the policy contract, in so far as they relate to issues mentioned in this para 5.2.5 above.

c. As per Rule 14 of the Insurance Ombudsman Rules, 2017, a complaint to the Insurance Ombudsman can be made only within a period of 1 (One) year after receipt of Our rejection of the representation or after receipt of Our decision which is not to your satisfaction or if We fail to furnish reply after expiry of a period of one month from the date of receipt of the written representation of the complainant ,provided the complaint is not on the same matter, for which any proceedings before any court, or consumer forum or arbitrator is pending.

Annexure 1

Section 45 – Policy shall not be called in question on the ground of mis-statement after three years

Provisions regarding policy not being called into question in terms of Section 45 of the Insurance Act, 1938, as amended from time to time are as follows:

1. No Policy of Life Insurance shall be called in question on any ground whatsoever after expiry of 3 yrs from
   a. the date of issuance of policy or
   b. the date of commencement of risk or
   c. the date of revival of policy or
   d. the date of rider to the policy

   whichever is later.
2. On the ground of fraud, a policy of Life Insurance may be called in question within 3 years from
   a. the date of issuance of policy or
   b. the date of commencement of risk or
   c. the date of revival of policy or
   d. the date of rider to the policy

   whichever is later.

   For this, the insurer should communicate in writing to the insured or legal representative or nominee or Assignees of insured, as applicable, mentioning the ground and materials on which such decision is based.
3. Fraud means any of the following acts committed by insured or by his agent, with the intent to deceive the insurer or to induce the insurer to issue a life insurance policy:
   a. The suggestion, as a fact of that which is not true and which the insured does not believe to be true;
   b. The active concealment of a fact by the insured having knowledge or belief of the fact;
   c. Any other act fitted to deceive; and
   d. Any such act or omission as the law specifically declares to be fraudulent.

4. Mere silence is not fraud unless, depending on circumstances of the case, it is the duty of the insured or his agent keeping silence to speak or silence is in itself equivalent to speak.
5. No Insurer shall repudiate a life insurance Policy on the ground of Fraud, if the Insured / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such mis-statement of or suppression of material fact are within the knowledge of the insurer. Onus of disproving is upon the policyholder, if alive, or beneficiaries.
6. Life insurance Policy can be called in question within 3 years on the ground that any statement of or suppression of a fact material to expectancy of life of the insured was incorrectly made in the proposal or other document basis which policy was issued or revived or rider issued. For this, the insurer should communicate in writing to the insured or legal representative or nominee or Assignees of insured, as applicable, mentioning the ground and materials on which decision to repudiate the policy of life insurance is based.
7. In case repudiation is on ground of mis-statement and not on fraud, the premium collected on policy till the date of repudiation shall be paid to the insured or legal representative or nominee or Assignees of insured, within a period of 90 days from the date of repudiation.
8. Fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer. The onus is on insurer to show that if the insurer had been aware of the said fact, no life insurance policy would have been issued to the insured.
9. The insurer can call for proof of age at any time if he is entitled to do so and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof of age of life insured. So, this Section will not be applicable for questioning age or adjustment based on proof of age submitted subsequently.

[Disclaimer: This is only a simplified version prepared for general information. You are advised to refer to the Insurance Act 1938 as amended from time to time for complete and accurate details.]

Annexure 2

Section 39 - Nomination by Policyholder

Nomination of a life insurance Policy is as below in accordance with Section 39 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows:

1. The policyholder of a life insurance policy on his own life may nominate a person or persons to whom money secured by the policy shall be paid in the event of his death.
2. Where the nominee is a minor, the policyholder may appoint any person to receive the money secured by the policy in the event of policyholder's death during the minority of the nominee. The manner of appointment to be laid down by the insurer.
3. Nomination can be made at any time before the maturity of the policy.
4. Nomination may be incorporated in the text of the policy itself or may be endorsed on the policy communicated to the insurer and can be registered by the insurer in the records relating to the policy.
5. Nomination can be cancelled or changed at any time before policy matures, by an endorsement or a further endorsement or a will as the case may be.
6. A notice in writing of Change or Cancellation of Nomination must be delivered to the insurer for the insurer to be liable to such nominee. Otherwise, insurer will not be liable if a bonafide payment is made to the person named in the text of the policy or in the registered records of the insurer.
7. Fee to be paid to the insurer for registering change or cancellation of a Nomination can be specified by the Authority through Regulations.
8. On receipt of notice with fee, the insurer should grant a written acknowledgement to the policyholder of having registered a Nomination or cancellation or change thereof.
9. A transfer or Assignment made in accordance with Section 38 shall automatically cancel the Nomination except in case of Assignment to the insurer or other transferee or Assignee for purpose of loan or against security or its reassignment after repayment. In such case, the Nomination will get affected to the extent of insurer's or transferee's or Assignee's interest in the policy. The Nomination will get revived on repayment of the loan.
10. The right of any creditor to be paid out of the proceeds of any policy of life insurance shall not be affected by the Nomination.
11. In case of Nomination by policyholder whose life is insured, if the nominees die before the policyholder, the proceeds are payable to policyholder or his heirs or legal representatives or holder of succession certificate.
12. In case nominee(s) survive the person whose life is insured, the amount secured by the policy shall be paid to such survivor(s).
13. Where the policyholder whose life is insured nominates his (a) parents, (b) spouse, (c) children, (d) spouse and children or (e) any of them. The nominees are beneficially entitled to the amount payable by the insurer to the policyholder unless it is proved that policyholder could not have conferred such beneficial title on the nominee having regard to the nature of his title.
14. If nominee(s) die after the policyholder but before his share of the amount secured under the policy is paid, the share of the expired nominee(s) shall be payable to the heirs or legal representative of the nominee or holder of succession certificate of such nominee(s).
15. The provisions of sub-section 7 and 8 (13 and 14 above) shall apply to all life insurance policies maturing for payment after the commencement of Insurance Laws (Amendment) Act, 2015.
16. If policyholder dies after maturity but the proceeds and benefit of the policy has not been paid to him because of his death, his nominee(s) shall be entitled to the proceeds and benefit of the policy.
17. The provisions of Section 39 are not applicable to any life insurance policy to which Section 6 of Married Women's Property Act, 1874 applies or has at any time applied except where before or after Insurance Laws ***(Amendment) Act 2015,*** a Nomination is made in favour of spouse or children or spouse and children whether or not on the face of the policy it is mentioned that it is made under Section 39. Where Nomination is intended to be made to spouse or children or spouse and children under Section 6 of MWP Act, it should be specifically mentioned on the policy. In such a case only, the provisions of Section 39 will not apply.

[Disclaimer: This is only a simplified version prepared for general information. You are advised to refer to the Insurance Act 1938 as amended from time to time for complete and accurate details.]

Annexure 3

Section 38 - Assignment and Transfer of Insurance Policies

Assignment or transfer of a policy should be in accordance with Section 38 of the Insurance Act, 1938 as amended from time to time. The extant provisions in this regard are as follows: 1.This policy may be transferred/assigned, wholly or in part, with or without consideration. 2. An Assignment may be effected in a policy by an endorsement upon the policy itself or by a separate instrument under notice to the Insurer. 3. The instrument of assignment should indicate the fact of transfer or assignment and the reasons for the assignment or transfer, antecedents of the assignee and terms on which assignment is made. 4. The assignment must be signed by the transferor or assignor or duly authorized agent and attested by at least one witness. 5. The transfer or assignment shall not be operative as against an insurer until a notice in writing of the transfer or assignment and either the said endorsement or instrument itself or copy there of certified to be correct by both transferor and transferee or their duly authorised agents have been delivered to the insurer. 6. Fee to be paid for assignment or transfer can be specified by the Authority through Regulations. 7. On receipt of notice with fee, the insurer should Grant a written acknowledgement of receipt of notice. Such notice shall be conclusive evidence against the insurer of duly receiving the notice. 8. If the insurer maintains one or more places of business, such notices shall be delivered only at the place where the policy is being serviced. 9. The insurer may accept or decline to act upon any transfer or assignment or endorsement, if it has sufficient reasons to believe that it is a.not bonafide;b.not in the interest of the policyholder;c.not in public interest; or d.is for the purpose of trading of the insurance policy.10. Before refusing to act upon endorsement, the insurer should record the reasons in writing and communicate the same in writing to policyholder within 30 days from the date of policyholder giving a notice of transfer or assignment.11. In case of refusal to act upon the endorsement by the insurer, any person aggrieved by the refusal may prefer a claim to IRDAI within 30 days of receipt of the refusal letter from the insurer. 12. The priority of claims of persons interested in an insurance policy would depend on the date on which the notices of assignment or transfer is delivered to the insurer; where there are more than one instruments of transfer or assignment, the priority will depend on dates of delivery of such notices. Any dispute in this regard as to priority should be referred to the Authority. 13. Every assignment or transfer shall be deemed to be absolute assignment or transfer and the assignee or transferee shall be deemed to be absolute assignee or transferee, except a.where assignment or transfer is subject to terms and conditions of transfer or assignment OR b.where the transfer or assignment is made upon condition that i. the proceeds under the policy shall become payable to policyholder or nominee(s) in the event of assignee or transferee dying before the insured; or ii. the insured surviving the term of the policy. Such conditional assignee will not be entitled to obtain a loan on policy or surrender the policy. This provision will prevail notwithstanding any law or custom having force of law which is contrary to the above position.14. In other cases, the insurer shall, subject to terms and conditions of assignment, recognize the transferee or assignee named in the notice as the absolute transferee or assignee and such persona shall be subject to all liabilities and equities to which the transferor or assignor was subject to at the date of transfer or assignment;b.may institute any proceedings in relation to the policy; andc.obtain loan under the policy or surrender the policy without obtaining the consent of the transferor or assignor or making him a party to the proceedings.15. Any rights and remedies of an assignee or transferee of a life insurance policy under an assignment or transfer effected before commencement of the Insurance Laws (Amendment) Act, 2015 shall not be affected by this section.

[Disclaimer: This is only a simplified version prepared for general information. You are advised to refer to the Insurance Act, 1938 as amended from time to time for complete and accurate details.

Annexure A: List of Insurance Ombudsman

AHMEDABAD - Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Building, Tilak Marg, Relief Road, Ahmedabad- 380 001. Tel.:- 079-25501201/02 Email: bimalokpal.ahmedabad@cioins.co.in. (State of Gujarat and Union Territories of Dadra & Nagar Haveli and Daman and Diu.)

BENGALURU - Office of the Insurance Ombudsman, Jeevan Soudha Bldg., PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560078. Tel.: 080-26652048/26652049 Email: bimalokpal.bengaluru@cioins.co.in. (State of Karnataka)

BHOPAL- Office of the Insurance Ombudsman, 1st Floor, Jeevan Shikha, 60-B, Hoshangabad Road, Opp. Gayatri Mandir, Arera Hills, Bhopal-462 011. Tel.:- 0755-2769201/2769202/2769203 Email: bimalokpal.bhopal@cioins.co.in (States of Madhya Pradesh and Chhattisgarh.)

BHUBANESHWAR - Office of the Insurance Ombudsman, 62, Forest Park, Bhubaneswar - 751009. Tel.:- 0674-2596461/2596455/2596429/2596003. Email: bimalokpal.bhubaneswar@cioins.co.in. (State of Odisha.)

CHANDIGARH - Office of the Insurance Ombudsman, S.C.O. No. 20-27, Ground Floor, Jeevan Deep Building, Sector 17-A, Chandigarh-160017. Tel.:- 0172 - 2706468 Email: bimalokpal.chandigarh@cioins.co.in [States of Punjab, Haryana (excluding 4 districts viz, Gurugram, Faridabad, Sonepat and Bahadurgarh) Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh]

CHENNAI- Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, Chennai-600 018. Tel.:- 044-24333668 / 24333678 Email: bimalokpal.chennai@cioins.co.in [State of Tamil Nadu and Union Territories - Puducherry Town and Karaikal (which are part of Union Territory of Puducherry).]

DELHI- Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi- 110002. Tel.:- 011– 46013992/ 23213504/ 23232481 Email: bimalokpal.delhi@cioins.co.in (State of Delhi, 4 districts of Haryana viz, Gurugram, Faridabad, Sonepat and Bahadurgarh)

KOCHI- Office of the Insurance Ombudsman, 10th Floor, Jeevan Prakash, LIC Building, Opp to Maharaja's College Ground, M.G. Road, Kochi 682011. Tel : 0484-2358759 Email: bimalokpal.ernakulam@cioins.co.in (State of Kerala and Union Territory of (a) Lakshadweep (b) Mahe - a part of Union Territory of Puducherry.)

GUWAHATI - Office of the Insurance Ombudsman, "Jeevan Nivesh", 5th Floor, Near. Panbazar, S.S. Road, Guwahati- 781001(ASSAM) Tel.:- 0361-2632204/ 2602205/ 2631307 Email: bimalokpal.guwahati@cioins.co.in (States of Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.)

HYDERABAD - Office of the Insurance Ombudsman, 6-2-46, 1st Floor, "Moin Court", Lane Opp. Hyundai Showroom, A.C. Guards, Lakdi-Ka-Pool, Hyderabad-500 004. Tel : 040-23312122/ 23376991 / 23376599 / 23328709 / 23325325 Email: bimalokpal.hyderabad@cioins.co.in (State of Andhra Pradesh, Telangana and Yanam and part of the Union Territory of Puducherry.)

JAIPUR- Office of the Insurance Ombudsman, Ground Floor, Jeevan Nidhi II Bldg, Bhawani Singh Marg, Jaipur – 302005 Tel : 0141-2740363 Email: bimalokpal.jaipur@cioins.co.in (State of Rajasthan)

KOLKATA Office of the Insurance Ombudsman, Hindustan Building. Annexe, 7th Floor, 4, C.R. Avenue, Kolkata-700 072. Tel : 033-22124339/22124341 Email: bimalokpal.kolkata@cioins.co.in (States of West Bengal, Sikkim, and Union Territories of Andaman and Nicobar Islands.)

LUCKNOW- Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-2, Nawal Kishore Road, Hazratganj, Lucknow- 226001. Tel.: 0522 - 4002082 / 3500613 Email: bimalokpal.lucknow@cioins.co.in (Following Districts of Uttar Pradesh: Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.)

MUMBAI - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S.V. Road, Santacruz(W), Mumbai 400054. Tel : 022- 69038800/27/29/31/32/33 Email: bimalokpal.mumbai@cioins.co.in (List of wards under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.)

NOIDA - Office of the Insurance Ombudsman, 4th Floor, Bhagwan Sahai Palace, Main Road, Naya Bans, Sector-15, Distt: Gautam Buddh Nagar, U.P. - 201301. Tel: 0120-2514252/2514253 Email: bimalokpal.noida@cioins.co.in (State of Uttarakhand and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.)

PATNA - Office of the Insurance Ombudsman, 2nd floor, Lalit Bhawan, Bailey Road, Patna - 800001 Tel No: 0612-2547068, Email id : bimalokpal.patna@cioins.co.in (State of Bihar, Jharkhand.)

PUNE - Office of the Insurance Ombudsman, 3rd Floor, Jeevan Darshan Bldg, C.T.S. Nos. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411030. Tel.: 020-24471175 Email: bimalokpal.pune@cioins.co.in (State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district,Palghar District, Raigad district & Mumbai Metropolitan Region.)

THANE - Office of the Insurance Ombudsman, 2nd Floor, Jeevan Chintamani Building, Vasantrao Naik Mahamarg, Thane (West), Thane – 400604 Email id: bimalokpal.thane@cioins.co.in (Area of Navi Mumbai, Thane District, Raigad District, Palghar District and wards of Mumbai, M/East, M/West, N, S and T".)

Annexure B

Exclusions for Fixed Daily Hospitalization Cash Benefit and Fixed Surgical Care Benefit:

We will not be liable to make any payments under these plan variants in respect of any expenses incurred by any Member(s) in connection with or in respect of the following:

The Member shall not be eligible for claiming any benefit if it is directly or indirectly - caused by, arises from or is in any way attributable to any of the following:

1. External Congenital anomaly: Treatment for external congenital disease or deformity, including physical defects present from birth will not be covered by the policy.
2. Hospitalization and/or Surgery is/are not in accordance with the Diagnosis and treatment of the condition for which the Hospital confinement or Surgery was required.
3. Diagnosis and/or Hospitalization and/or treatment (availed or advised) within the Waiting Period for the respective covered benefit.
4. Hospitalization following the Diagnosis in the Waiting Period.
5. Elective Surgery or treatment which is not medically necessary.
6. Weight reduction or weight improvement regardless of whether the same is caused (directly or indirectly) by a medical condition.
7. Study and treatment of sleep apnoea.
8. Routine eye tests, any dental treatment or Surgery of cosmetic nature, extraction of impacted tooth/teeth, orthodontics or orthognathic Surgery, or tempero-mandibular joint disorder except as necessitated by an Accidental Injury and warranting hospitalization.
9. Outpatient treatment.
10. Hospitalization and/or Surgery relating to infertility or impotency, sex change or any treatment related to it, abortion, sterilization and contraception including any complications relating thereto.
11. Hospitalization and/or Surgery for treatment arising from pregnancy and it's complications which shall include childbirth or miscarriage.
12. Hospitalization primarily for any purpose which in routine could have been carried out on an out-patient basis and which is not followed by an active treatment or intervention during the period of Hospitalization.
13. Experimental or unproven procedures or treatments, devices or pharmacological regimens of any description (not recognized by National Medical Commission) or Hospitalization for treatment under any system other than allopathy.
14. Admission to a nursing home or home for the care of the aged unless related to the treatment of an acute medical condition.
15. Convalescence, rest cure, sanatorium treatment, rehabilitation measures, respite care, long term nursing care or custodial care and general debility or exhaustion (run down condition).
16. The influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a Medical Practitioner.
17. Directly or indirectly arising from or consequent upon war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, terrorism, rebellion, active participation in strikes, riots or civil commotion, revolution, insurrection or military or usurped power;
18. Sexually transmitted diseases. (except HIV & AIDS)
19. Cosmetic or plastic surgery except to the extent that such Surgery is necessary for the repair of damage caused solely by Accidental Injuries, cancer or burns.
20. Treatment of xanthelesema, syringoma, acne and alopecia; circumcision unless Medically Necessary Treatment of a disease or necessitated due to an Accident.
21. Nuclear disaster, radioactive contamination and/or release of nuclear or atomic energy.
22. Intentional self-inflicted injuries; or any attempts of suicide while sane or insane; or deliberate exposure to exceptional danger (except in an attempt to save human life).
23. Violation or attempted violation of the law or resistance to arrest or by active participation in an act with criminal intent.
24. Participation in professional sports, racing of any kind, scuba diving, aerial sports, activities such as hand-gliding, ballooning, and any other hazardous activities or sports unless agreed by special endorsement.

25. Hospitalization where the Member is a donor for any organ transplant.
26. Aviation, gliding or any form of aerial flight other than other than on a scheduled commercial airline as a bona fide passenger (whether fare paying or not), pilot or crew member.
27. Any sickness classified as an epidemic by the Central or State government.
28. Non-allopathic modes of treatment which are not approved by a medical practitioner.
29. Treatment to relieve symptoms caused by ageing, puberty or other natural physiological cause, such as menopause and hearing loss caused by maturing or ageing.
30. Artificial life maintenance, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of health.
31. Treatment of abnormalities, deformities, or Illnesses present only because they have been passed down through the generations of the family.
32. Treatment for, or related to developmental problems, including learning difficulties, such as dyslexia and behavioral problems, including Attention Deficit Hyperactivity Disorder (ADHD).
33. Delaying of medical treatment in order to circumvent the Waiting Period.
34. No benefits will be payable for any condition(s) which is a direct or indirect result of any Pre-Existing Diseases conditions unless the Member has disclosed the same at the time of proposal or date of Revival, whichever is later, and We have accepted the same.

Annexure C

Permanent Exclusions for Accidental Total and Permanent Disability and Optional Accidental Death Benefit Option

The Member / nominee will not be entitled to any Accidental Total and Permanent Disability and optional Accidental Death Benefit directly or indirectly due to or caused, occasioned, accelerated or aggravated by any of the following:

1. Intentional self-inflicted injury, suicide or attempted suicide, while sane or insane
2. Member being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered Medical Practitioner
3. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, terrorist act, revolution, insurrection, military or usurped power, riot or civil commotion, strikes
4. Service in any naval, military, police, air force or similar service
5. Participation by the Member in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable
6. Participation by the Member in a criminal or unlawful act
7. Any injury incurred before the effective date of the cover
8. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to, diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping
9. Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature

Annexure D

Permanent Exclusions for Critical Illness Benefit Option

The following are the minimum exclusions for the Critical Illness Benefit Option. Additional exclusions are disease-specific and are incorporated into the definition of the disease. If any of the exclusion is found at underwriting stage, then the Policy/COI will not be issued. However, if any exclusion is accepted as substandard as per the Underwriting Policy, the claim will not be rejected on ground of that exclusion. Unless expressly stated to the contrary in this Policy, we shall not make any payment for any claim under this Policy in respect of any Member if it is directly or indirectly- caused by, arises from or is in any way attributable to any of the following:

1. 90 days of the start of coverage or date of reinstatement (i.e. during the Waiting Period). In case of Diagnosis of a Critical Illness condition contracted during the Waiting Period, 100% of the premium paid will be refunded and the benefit option will terminate.
2. Any external Congenital Anomaly (known and/or visible at the time of proposal), which is not as a consequence of Genetic disorder, unless the Member has disclosed at the time of proposal and the We have specifically accepted the same ;
3. Sickness or Critical Illness which was a Pre-Existing Condition or Sickness or Critical Illness which was induced by or as a result of a Pre-Existing condition
4. Intentional self-inflicted injury, attempted suicide, while sane or insane;
5. Insured person being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner;
6. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, strikes;
7. Taking part in any naval, military or air force operation during peace time or during service in any police, paramilitary or any similar organization; Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable;
8. Participation by the insured person in a criminal or unlawful act with illegal or criminal intent;
9. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to, diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping;
10. Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature;
11. In addition to the above, no Critical Illness Benefit will be payable for any of the following:
    - i Date of Diagnosis within 90 days from Effective Date of Coverage or Revival of cover
    - ii Critical Illness Benefit, where death occurs within 30 days of the date of diagnosis
    - iii Policy in the lapsed condition as on the date of diagnosis
    - iv Any more than one claim in respect of Critical Illness Benefit

Non-fulfillment of eligibility criteria for Critical Illness Benefit covered under the Policy.

Annexure E

Permanent Exclusions for Cardiac Cover Benefit options:

Cardiac Cover Benefit:

Unless expressly stated to the contrary in this Policy, We will not make any payment for any claim in respect of any Member if it is directly or indirectly- caused by, arises from or is in any way attributable to any of the following:

1. 180 days of the start of coverage or date of reinstatement (i.e. during the Waiting Period). In case of Diagnosis of a Cardiac condition contracted during the Waiting Period, We will pay 100% of the Premium received for this Benefit Option and it will be terminated.
2. Sickness or Cardiac condition which was a Pre-Existing Condition or Sickness or Cardiac condition which was induced by or as a result of a Pre-Existing condition
3. Intentional self-inflicted injury, attempted suicide, while sane or insane;
4. Insured person being under the influence of drugs, alcohol, narcotics or psychotropic substances unless taken in accordance with the lawful directions and prescription of a registered medical practitioner;
5. War, invasion, act of foreign enemy, hostilities (whether war be declared or not), armed or unarmed truce, civil war, mutiny, rebellion, revolution, insurrection, military or usurped power, riot or civil commotion, strikes;
6. Taking part in any naval, military or air force operation during peace time or during service in any police, paramilitary or any similar organization; Participation by the insured person in any flying activity, except as a bona fide, fare-paying passenger of a recognized airline on regular routes and on a scheduled timetable;
7. Participation by the insured person in a criminal or unlawful act with illegal or criminal intent;
8. Engaging in or taking part in professional sport(s) or any hazardous pursuits, including but not limited to, diving or riding or any kind of race; underwater activities involving the use of breathing apparatus or not; martial arts; hunting; mountaineering; parachuting; bungee-jumping;
9. Nuclear Contamination; the radio-active, explosive or hazardous nature of nuclear fuel materials or property contaminated by nuclear fuel materials or accident arising from such nature;

In addition to the above, no Cardiac benefit will be payable for any of the following:

- Date of diagnosis within 180 days from Effective Date of Coverage or Revival of cover
- Cardiac Benefit, where death occurs within 30 days of the date of diagnosis
- Policy in the lapsed condition as on the date of diagnosis
- Non-fulfillment of eligibility criteria for cardiac conditions covered under the policy

Annexure F

List of Major Surgeries payable under Fixed Surgical Care Benefit

Organ / System	Sr No	Surgery/Procedure
Operations on Blood Vessels	1	Surgery of the Aorta
	2	Proximal Aortic Aneurysmal repair by coronary artery transplantation
	3	Repair of Cerebral or Spinal Arterio- Venous Malformations or aneurysms
	4	Surgery of Carotid Artery
	5	Major vein repair with or without grafting for traumatic & nontraumatic lesions
Operations on the Heart	6	CABG (two or more coronary arteries) via open thoracotomy
	7	Prosthetic replacement of Heart Valve
	8	Coronary Angioplasty with Stent implantation
	9	Pericardiotomy / Pericardectomy
	10	Implantation of Cardioverter Defebrillator
	11	Permanent pacemaker Implantation in heart
	12	Mitral valve repair
	13	Aortic valve repair
	14	Tricuspid valve repair
Operations on Lung and Bronchus	15	Pneumenectomy
	16	Pleurectomy or Pleural decortication
	17	Open Lobectomy of Lung
	18	Partial Extirpation of Bronchus
Operations on the skull, brain and meninges	19	Craniotomy for malignant Cerebral tumors
	20	Craniotomy for non malignant space occupying lesions
	21	Operations on Subarachnoid space of brain
	22	Craniotomy- Surgery on meninges of Brain
	23	Other operations on the meninges of the Brain
	24	Micro vascular decompression of cranial nerves/nervectomy

	25	Craniotomy for Drainage of Extradural, subdural or intracerebral space
	26	Therapeutic Burr Hole on skull- Drainage of Extra-Dural, intra-Dural or intracerebral space
	27	Pineal Gland excision
	28	Pituitary Gland excision
Operations on Liver	29	Partial Resection of Liver
	30	TIPS procedure for portal Hypertension

Annexure G

List of Critical Illness along with their Definitions

List of Critical Illness conditions

Sr No.	Name of Critical Illness Benefit
1	Myocardial Infarction (First Heart Attack of specified severity)
2	Open Heart Replacement or Repair of Heart Valves
3	Cancer of Specified Severity
4	Kidney Failure requiring Regular Dialysis
5	Stroke resulting into permanent symptoms
6	Alzheimer's Disease
7	Apallic Syndrome
8	Coma of Specified Severity
9	End Stage Liver Failure
10	End Stage Lung Failure
11	Loss of Independent Existence
12	Blindness
13	Third Degree Burns
14	Major Head Trauma
15	Parkinson's Disease
16	Permanent Paralysis of Limbs
17	Multiple Sclerosis with Persisting Symptoms
18	Motor Neuron Disease with Permanent Symptoms
19	Benign Brain Tumor
20	Major Organ / Bone Marrow Transplant
21	Progressive Scleroderma
22	Muscular Dystrophy

23	Poliomyelitis
24	Loss of limbs
25	Deafness
26	Loss of Speech
27	Medullary Cystic Disease
28	Systemic Lupus Erythematosus with Renal Involvement
29	Aplastic Anemia

B. Definitions of Critical Illness Benefit conditions

1. Cancer of Specified Severity

A malignant tumor 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. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

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

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. Myocardial Infarction (First Heart Attack Of Specific Severity)

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

i. A history of typical clinical symptoms consistent with the Diagnosis of acute myocardial infarction (For e.g. typical chest pain)

ii. New characteristic electrocardiogram changes

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

The following are excluded:

• Other acute Coronary Syndromes

• Any type of angina pectoris

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

3. Stroke Resulting In Permanent Symptoms

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

The following are excluded:

i. Transient ischemic attacks (TIA)

ii. Traumatic injury of the brain

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

iv. Kidney Failure Requiring Regular Dialysis

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

5. Major Organ /Bone Marrow Transplant

The actual undergoing of a transplant of:

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

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

The following are excluded:

i. Other stem-cell transplants

ii. Where only islets of langerhans are transplanted

6. Permanent Paralysis Of Limbs

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

7. Blindness

Total, permanent and irreversible loss of all vision in both eyes as a result of Illness or Accident.

The Blindness is evidenced by:

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

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

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

8. Open Heart Replacement Or Repair Of Heart Valves

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

9. Multiple Sclerosis With Persisting Symptoms

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

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

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

iii. Neurological damage due to SLE is excluded.

10. Alzheimer's Disease [up to age 65 last birthday] – requiring constant supervision

A definite Diagnosis of Alzheimer's disease evidenced by all of the following:

i. Loss of intellectual capacity involving impairment of memory and executive functions (sequencing, organizing, abstracting, and planning), which results in a significant reduction in mental and social functioning

ii. Personality change

iii. Gradual onset and continuing decline of cognitive functions

iv. No disturbance of consciousness

v. Typical neuropsychological and neuroimaging findings (e.g. CT scan)

The disease must require constant supervision (24 hours daily) [up to age 65 last birthday]. The Diagnosis and the need for supervision must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:

i. Other forms of dementia due to brain or systemic disorders or conditions

11. Apallic Syndrome

A vegetative state is absence of responsiveness and awareness due to dysfunction of the cerebral hemispheres, with the brain stem, controlling respiration and cardiac functions, remaining intact.

The definite Diagnosis must be evidenced by all of the following:

i. Complete unawareness of the self and the environment

ii. Inability to communicate with others

iii. No evidence of sustained or reproducible behavioral responses to external stimuli

iv. Preserved brain stem functions

v. Exclusion of other treatable neurological or psychiatric disorders with appropriate neurophysiological or neuropsychological tests or imaging procedures

vi. The Diagnosis must be confirmed by a Consultant Neurologist and the condition must be medically documented for at least one month without any clinical improvement.

12. Aplastic Anaemia

A definite Diagnosis of aplastic anaemia resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition must be treated with blood transfusions and, in addition, with at least one of the following:

i. Bone marrow stimulating agents

ii. Immunosuppressants

iii. Bone marrow transplantation

iv. The Diagnosis must be confirmed by a Consultant Haematologist and evidenced by bone marrow histology.

13. Benign Brain Tumor

Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed imaging studies such as CT scan or MRI. This brain tumor must result in at least one of the following and must be confirmed by the relevant Medical Practitioner.

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

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

The following conditions are excluded: Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

14. End Stage Liver Failure

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

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

Liver failure secondary to drug or alcohol abuse is excluded.

15. End Stage Lung Failure

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

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

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

iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less ($PaO_2 < 55mmHg$); and

iv. Dyspnea at rest.

16. Coma of Specified Severity

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

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

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

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

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

17. Deafness

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

18. Major Head Trauma

Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the Accident. This Diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging,

Computerized Tomography, or other reliable imaging techniques. The Accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

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

The following are excluded: Spinal cord injury.

19. Loss of Limbs

The physical separation of two or more limbs, at or above the wrist or ankle level limbs as a result of injury or disease. This will include medically necessary amputation necessitated by Injury or disease. The separation has to be permanent without any chance of Surgical correction. Loss of Limbs resulting directly or indirectly from self-inflicted injury, alcohol or drug abuse is excluded.

20. Loss of Speech

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

21. Third Degree Burns

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

22. Medullary Cystic Disease

A definite Diagnosis of medullary cystic disease evidenced by all of the following:

i. Ultrasound, MRI or CT scan showing multiple cysts in the medulla and corticomedullary region of both kidneys

ii. Typical histological findings with tubular atrophy, basement membrane thickening and cyst formation in the corticomedullary junction

iii. Glomerular filtration rate (GFR) of less than 40 ml/min (MDRD formula)

The diagnosis must be confirmed by a Consultant Nephrologist.

For the above definition, the following are not covered:

i. Polycystic kidney disease
ii. Multicystic renal dysplasia and medullary sponge kidney
iii. Any other cystic kidney disease

23. Motor Neuron Disease With Permanent Symptoms

Motor neuron 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.

24. Muscular Dystrophy

A definite diagnosis of one of the following muscular dystrophies:

i. Duchenne Muscular Dystrophy (DMD)
ii. Becker Muscular Dystrophy (BMD)
iii. Emery-Dreifuss Muscular Dystrophy (EDMD)
iv. Limb-Girdle Muscular Dystrophy (LGMD)
v. Facioscapulohumeral Muscular Dystrophy (FSHD)
vi. Myotonic Dystrophy Type 1 (MMD or Steinert's Disease)
vii. Oculopharyngeal Muscular Dystrophy (OPMD)
The disease must result in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

The Diagnosis must be confirmed by a Consultant Neurologist and supported by electromyography (EMG) and muscle biopsy findings.

For the above definition, the following are not covered:

Myotonic Dystrophy Type 2 (PROMM) and all forms of myotonia.

25. Poliomyelitis - resulting in paralysis

A definite Diagnosis of acute poliovirus infection resulting in paralysis of the limb muscles or respiratory muscles. The paralysis must be medically documented for at least 3 months from the date of Diagnosis.

The Diagnosis must be confirmed by a Consultant Neurologist and supported by laboratory tests proving the presence of the poliovirus.

For the above definition, the following are not covered:

i. Poliovirus infections without paralysis

ii. Other enterovirus infections

iii. Guillain-Barré syndrome or transverse myelitis

26. Parkinson's Disease

A definite Diagnosis of primary idiopathic Parkinson's disease, which is evidenced by at least two out of the following clinical manifestations:

i. Muscle rigidity

ii. Tremor

iii. Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses)

Idiopathic Parkinson's disease must result [Up to age 65 last birthday] in a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily

Living for a continuous period of at least 3 months despite adequate drug treatment.

The Diagnosis must be confirmed by a Consultant Neurologist.

The implantation of a neurostimulator to control symptoms by deep brain stimulation is, independent of the Activities of Daily Living, covered under this definition. The implantation must be determined to be medically necessary by a Consultant Neurologist or Neurosurgeon.

For the above definition, the following are not covered:

i. Secondary parkinsonism (including drug- or toxin-induced parkinsonism)

ii. Essential tremor

iii. Parkinsonism related to other neurodegenerative disorders

27. Systemic Sclerosis (Scleroderma) – with organ involvement

A definite Diagnosis of systemic sclerosis evidenced by all of the following:

i. Typical laboratory findings (e.g.anti-Scl-70 antibodies)

ii. Typical clinical signs (e.g. Raynaud's phenomenon, skin sclerosis, erosions)

iii. Continuous treatment with corticosteroids or other immunosuppressants

Additionally, one of the following organ involvements must be Diagnosed:

i. Lung fibrosis with a diffusing capacity (DCO) of less than 70% of predicted
ii. Pulmonary hypertension with a mean pulmonary artery pressure of more than 25 mmHg at rest measured by right heart catheterisation
iii. Chronic kidney disease with a glomerular filtration rate of less than 60 ml/min (MDRD-formula)
iv. Echocardiographic signs of significant left ventricular diastolic dysfunction
The Diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist.

For the above definition, the following are not covered:

i. Localized scleroderma without organ involvement
ii. Eosinophilic fasciitis
iii. CREST-Syndrome

28. Systemic Lupus Erythematosus - with involvement of heart, kidneys or brain

A definite Diagnosis of systemic lupus erythematosus evidenced by all of the following:

i. Typical laboratory findings, such as presence of antinuclear antibodies (ANA) or anti-dsDNA antibodies.
ii. Symptoms associated with lupus erythematosus (butterfly rash, photosensitivity, serositis).
iii. Continuous treatment with corticosteroids or other immunosuppressants.
Additionally, one of the following organ involvements must be diagnosed:

i. Lupus nephritis with proteinuria of at least 0.5 g/day and a glomerular filtration rate of less than 60 ml/min (MDRD formula).
ii. Libman-Sacks endocarditis or myocarditis.

iii. Neurological deficits or seizures over a period of at least 3 months and supported by cerebrospinal fluid or EEG findings. Headaches, cognitive and psychiatric abnormalities are specifically excluded.
The Diagnosis must be confirmed by a Consultant Rheumatologist or Nephrologist.

For the above definition, the following are not covered:

i. Discoid lupus erythematosus or subacute cutaneous lupus erythematosus

29. Loss of Independent Existence

A definite Diagnosis [before age 65] of a total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months with no reasonable chance of recovery.

The diagnosis has to be confirmed by a specialist Medical Practitioner.

Annexure H

Definitions and Exclusions of Cancer Cover conditions

1. Early Stage Cancer:

Early Stage Cancer shall mean the presence of one of the following malignant conditions:

1. Papillary thyroid cancer less than 1 cm in diameter and histologically described as T1N0M0
2. Prostate cancer stage T1N0M0 OR Gleason score 2-6.
3. Chronic lymphocytic leukemia stage A (according to the Binet classification system)
4. Any carcinomas of the skin (size no less than 2mm) except Malignant melanoma and metastatic carcinoma.
5. Hodgkin's Disease, stage 1(according to the Ann-Arbor classification system).
6. Micro carcinoma of the bladder stage Tis or pTa.

The Diagnosis must be based on histopathological features and confirmed by a specialist. Pre-malignant lesions and conditions, unless listed above, are **excluded**. The insured shall have received appropriate and necessary treatment.

2. Carcinoma-in-situ

1. Carcinoma-in-situ: Tis according to the AJCC 7th Edition TNM classification. Carcinoma-in-situ is defined as a focal autonomous new group of carcinomatous cells which has not yet resulted in the invasion of normal tissue. Invasion means an infiltration and/or active destruction of normal tissue beyond the basement membrane in any one of the following organ groups.

a. Breast where the tumour is classified as Tis according to the TNM Staging method
b. Corpus uteri, cervix uteri, vagina, vulva or fallopian tubes where the tumour is classified as Tis according to the TNM Staging method.
c. Ovary -include borderline ovarian tumours with intact capsule, no tumour on the ovarian surface, classified as T1aN0M0,T1bN0M0 (TNM Staging) or FIGO 1A,FIGO 1B
d. Colon and rectum
e. Penis
f. Testis
g. Lung
h. Liver
i. Stomach, duodenum and Oesophagus
j. Kidney
k. Carcinoma ENT (ear, nose, throat)

For purposes of this Policy, Carcinoma-in-situ must be confirmed by a biopsy.

* FIGO refers to the staging method of the Federation Internationale de Gynecologie et d'Obstetrique.

Exclusions:

• Pre-malignant lesions and Carcinoma-in-situ of any organ unless listed above are excluded.

3. Cancer of Specified Severity

A malignant tumor 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. The term cancer includes leukemia, lymphoma and sarcoma.

The following are **excluded** –

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

ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

iii. Malignant melanoma that has not caused invasion beyond the epidermis;

iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

Permanent exclusions of Cancer Cover Benefit:

The following are the minimum exclusions for the Cancer only benefit. Additional exclusions are cancer-specific and are incorporated into the definition of the disease. Benefits shall not be paid in case of claims arising as a result of any of the following:

1. Diseases occurring within 180 days of the start of coverage (i.e. during the Waiting Period). In case of Diagnosis of a Cancer contracted during the Waiting Period, We will pay 100% of the Premium received for this Benefit Option and it will be terminated.
2. Any Pre-Existing Condition or
3. Intentional self-inflicted injury, attempted suicide, while sane or insane.

1. Participation by the insured person in a criminal or unlawful act with illegal or criminal intent. For example:

a. Using impersonation, tampering / forging Histopathology / Biopsy samples and / or reports, connivance with doctors, laboratories, and imaging centres to generate falsified reports
b. Fake Identity to Obtain Insurance or submission of falsified information to apply for cancer claim.

4. Caused or contributed by (in whole or in part) any of the following:
   a. Intoxication by alcohol or narcotics or drugs not prescribed by a registered Medical Practitioner.
   b. Nuclear, biological or chemical contamination (NBC)

Annexure –I

Major Cardiac (High Severity) conditions with 100% payout:

1. Myocardial Infarction (First Heart Attack of Specific Severity)

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

i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
ii. New characteristic electrocardiogram changes
iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers,
iv. The following are excluded:
v. Other acute Coronary Syndromes
vi. Any type of angina pectoris
vii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

2. Open Chest CABG (Coronary Artery Bypass Graft)

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

The following are excluded:

- Angioplasty and/or
- Any other intra-arterial procedures.

3. Open Heart Replacement Or Repair Of Heart Valves

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

4. Surgery to Aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches (including aortofemoral or aortoiliac bypass grafts). The surgery must be determined to be medically necessary by a Consultant Cardiologist / Surgeon and supported by imaging findings.

Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

5. Cardiomyopathy

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a Registered Medical Practitioner who is a cardiologist, and which results in permanent physical impairment to the degree of New York Heart Association classification Class IV, or its equivalent, for at least six (6) months based on the following classification criteria:

• Class IV - Inability to carry out any activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced and

• Echocardiography findings confirming presence of cardiomyopathy and Left Ventricular Ejection Fraction (LVEF %) of 40% or less

The following are excluded:

Cardiomyopathy directly related to alcohol or drug abuse.

6. Heart Transplant

The actual undergoing of a transplant of human heart that resulted from irreversible end stage heart failure. The undergoing of a heart transplant has to be confirmed by a specialist medical practitioner.

7. Primary (Idiopathic) Pulmonary Hypertension

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

The NYHA Classification of Cardiac Impairment are as follows:

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

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

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

Minor Cardiac (Mild Severity conditions) with 25% Payout:

1. Implantation of Pacemaker of Heart

Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia evidenced by 24 Holter monitoring report which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be medically necessary by a specialist in the relevant field.

The following are excluded:

• Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of cover or revival of coverage, whichever occurs later.

2. Balloon Valvotomy or Valvuloplasty

The actual undergoing of Valvotomy or Valvuloplasty necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram or any other appropriate diagnostic test that is available.

The following are excluded:

• Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of cover or revival of coverage, whichever occurs later.

3. Angioplasty

Coronary Angioplasty is defined as percutaneous coronary intervention by way of balloon angioplasty with or without stenting for treatment of the narrowing or blockage of minimum 50 % of one or more major coronary arteries. The intervention must be determined to be medically necessary by a cardiologist and supported by a coronary angiogram (CAG).

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography or investigation procedures without angioplasty/stent insertion are excluded.

4. Surgery for Cardiac Arrhythmia

Procedures like Maze surgery, RF Ablation therapy or any relevant procedure/surgery deemed absolutely necessary by a cardiologist to treat life threatening arrhythmias. Diagnosis must be evidenced by monitoring through a Holter monitor, event monitor or loop recorder and should be confirmed by a consultant cardiologist.

The following are excluded:

• Cardioversion and any other form of non-surgical treatments
• Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of cover or revival of coverage, whichever occurs later.

5. Minimally Invasive surgery of Aorta

The actual undergoing of minimally invasive surgical repair (i.e. via percutaneous intra-arterial route) of a diseased portion of an aorta to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

The following are excluded:

• Claim arising due to Internal Congenital Anomalies within 4 years from the date of commencement of cover or revival of coverage, whichever occurs later.

6. Pericardiectomy

The undergoing of a pericardiectomy performed by open heart surgery or keyhole techniques as a result of pericardial disease. The surgical procedures must be certified to be medically necessary by a consultant cardiologist.

The following are excluded:

Other procedures on the pericardium including pericardial biopsies and pericardial drainage procedures by needle aspiration.

7. Infective Endocarditis

Inflammation of the inner lining of the heart caused by infectious organisms, where all of the following criteria are met:

• Positive result of the blood culture proving presence of the infectious organism(s)

• Presence of at least moderate heart valve incompetence (meaning regurgitate fraction of twenty percent (20%) or above) or moderate heart valve stenosis (resulting in heart valve area of thirty percent (30%) or less of normal value) attributable to Infective Endocarditis; and

The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a cardiologist.

8. Pulmonary Thrombo Embolism

The blockage of an artery in the lung by a clot or other tissue from another part of the body. The Pulmonary Embolus must be unequivocally diagnosed by a specialist on either a V/Q scan (the isotope investigation which shows the ventilation and perfusion of the lungs), angiography or echocardiography, with evidence of right ventricular dysfunction and requiring medical or surgical treatment on an inpatient basis.