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

ABOUT AXIS MAX LIFE INSURANCE

Axis Max Life Insurance Limited, formerly known as Max Life Insurance Company Ltd., is a Joint Venture between Max Financial Services Limited ("MFSL") and Axis Bank Limited. Axis Max Life Insurance offers comprehensive protection and long-term savings life insurance solutions through its multi-channel distribution, including agency and third-party distribution partners. It has built its operations over two decades through a need-based sales process, a customer-centric approach to engagement and service delivery and trained human capital. As per the annual audited financials for FY2024-25, Axis Max Life has achieved a gross written premium of INR 33,223 Cr.

For more information, please visit the company website at https://www.axismaxlife.com

AXIS MAX LIFE GROUP SMART HEALTH INSURANCE PLAN

We, at Axis Max Life Insurance Company, understand your priorities and challenges. **Axis Max Life Group Smart Health Insurance Plan is a comprehensive Group Health Plan** designed to meet the diverse needs of your employees and valued customers. We bring you a flexible group health insurance solution tailored to meet diverse healthcare needs - you can now provide meaningful protection and support that goes beyond the basics**.**

KEY BENEFITS

The key benefits of **Axis Max Life Group Smart Health Insurance Plan** are two folds and extend to both the Master Policyholder and the member:

Benefits for the Master Policyholder

- **Retention Tool:** Incentive as employee retention tool and retain your loyal customers
- **Comprehensive benefits**: Covers member/employees through 6 benefit options along with optional Accidental Death Benefit
- **Tax Benefit:** Premium paid by the master policyholder is deductible as business expense as per the prevailing tax laws

Benefits for the Employee/Member

- **Mitigates Financial Risk:** Helps contain out-of-pocket medical expenses, minimizing disruptions caused by health-related financial burdens
- **Tax Benefit:** Tax benefits as per current tax laws as applicable

KEY HIGHLIGHTS

- Fixed benefit health plan, no ambiguity
- Flexibility to choose from 6 Benefit options
- Tax benefits as per current tax laws as applicable

SPECIAL FEATURES

Axis Max Life Group Smart Health Insurance Plan is a Non-linked, Non-participating, Group Pure Risk Health Plan, that provides its available benefits under two categories:

a) One Year Renewable Group Health Insurance
b) Single Premium Group Health Insurance

This product shall be offered to employer – employee and non- employer – employee groups. Non-employer – employee groups are groups other than employer – employee groups where a clearly evident relationship between the member and the policyholder for services/activities other than insurance exists.

In case the Master Policy is issued under Lender Borrower category, the Insured member shall have an option to issue an authorization in favor of the Company to the effect that in case of an Insured event during the Coverage Term, the claim amount, if any payable under the Master Policy shall first be utilized for payment to Master Policyholder for the

outstanding loan amount as specified in Master Policyholder's Credit Account Statement and the balance amount, if any, payable under the Master Policy will be payable to Insured member / Nominees / legal heirs or legal representatives (as applicable). In case of absence of such authorization the entire claim amount would be paid to the insured member/nominee(s)/ beneficiary. Please Note: Members of a group are considered for cover up to applicable maximum maturity age.

PRODUCT AT A GLANCE

The product offers 6 benefit options (plan variants) along with one optional add-on benefit for the Policyholder to choose from (as listed below) at policy inception and cannot be changed later. The Group policyholder or the individual member chooses benefit option, Policy Term (PT), premium frequency, sum insured and sum insured cover option at inception. The customer can choose one or more benefit options and would need to select the PT, premium frequency and sum insured for each variant. These choices can be exercised by both the master policyholder as well as the member. This choice shall be governed by the provisions of scheme rules.

S.No.	Benefit options
1	Fixed Daily Hospitalization Cash Benefit (FDHCB)
2	Fixed Surgical Care Benefit (FSCB)
3	Accidental Total Permanent Disability (ATPD)
4	Critical Illness Benefit (CI Benefit)
5	Cardiac Cover
6	Cancer Cover

An optional Accidental Death Benefit (ADB) Cover shall be available, which can be opted with any of the above-mentioned Benefit options, at the inception of the policy.

Where multiple benefit options are chosen, the benefits payable under each benefit option shall be independent of the benefits payable under other benefit options. The premium would vary based on the benefit option(s) chosen.

ELIGIBILITY CRITERIA

<table>
<tr><th>Item</th><th>Particular</th></tr>
<tr><td>Minimum Group Size</td><td>Employer employee: 5 Members
Non- employer employee: 50 Members
In case of employer-employee groups, the minimum membership criteria will be applicable at Group Company level.</td></tr>
<tr><td>Maximum Group Size</td><td>No limit on the maximum membership criteria applicable</td></tr>
<tr><td>Maximum Cover Ceasing Age (age last birthday)</td><td>70 years
Maximum Renewal Age under One-Year Renewable Group Health Insurance: 65 years</td></tr>
<tr><td>Premium Payment Mode/Variant</td><td>This product offers a Single Pay premium payment option.
Under One-Year Renewable Group Health Insurance, the following premium payment modes and modal factors shall be applicable.
<table>
<tr><th>Premium Mode</th><th>Factor</th></tr>
<tr><td>Annual</td><td>1.000</td></tr>
<tr><td>Semi-Annual</td><td>0.520</td></tr>
<tr><td>Quarterly</td><td>0.265</td></tr>
<tr><td>Monthly</td><td>0.090</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td rowspan="9">Sum Insured#</td><td>Benefit Option</td><td>Minimum</td><td>Maximum</td></tr>
<tr><td>Fixed Daily Hospitalization Cash Benefit</td><td>10,000</td><td rowspan="8">Subject to limits determined in accordance with the Board approved underwriting policy of the Company.</td></tr>
<tr><td>Fixed Surgical Care Benefit</td><td>30,000</td></tr>
<tr><td>Accidental Total Permanent Disability</td><td rowspan="6">10,000</td></tr>
<tr><td>Critical Illness Benefit</td></tr>
<tr><td>Cardiac Cover</td></tr>
<tr><td>Cancer Cover</td></tr>
<tr><td>Optional – Accidental Death Benefit</td></tr>
<tr><td colspan="3">Note 1: Wherever the coverage is provided against any loan obligations, Sum Insured for each benefit option (as well as Optional add-on benefit) shall also be consistent with the original loan amount sanctioned for level cover or with the loan schedule at inception. Note that the Sum Insured at inception for each benefit option (as well as Optional add-on benefit) shall not exceed the loan amount where the coverage is provided against the loan.
Note 2: The Sum Insured at inception under the Optional Accidental Death Benefit (ADB)shall not exceed the Sum Insured at inception under the selected Benefit Option. In case multiple Benefit Options are opted by the Master Policyholder/Member, the ADB Sum Insured at inception shall not exceed the highest Sum Insured at inception among the selected Benefit Options. For instance, if the Master Policyholder/Member opts for Accidental Total and Permanent Disability (ATPD), Critical Illness (CI) Benefit, and Optional ADB, then the Optional ADB Sum Insured at inception shall not exceed the higher of the ATPD or CI Sum Insured selected at inception.</td></tr>
<tr><td rowspan="4">Target Group</td><td colspan="3">Employer-Employee- Yes</td></tr>
<tr><td colspan="3">Non-Employer-Employee- Yes</td></tr>
<tr><td colspan="3">Social Sector- Yes</td></tr>
<tr><td colspan="3">Others (Please specify):
a) Members of co-operative societies
b) Members of Government agencies
c) Customers of an online service provider
d) Customers of any other service provider
e) Customers of a Bank or any other Financial Institution or Society
f) Vendors & Distributors of a company
g) Parents/Guardians of school students
h) Associations, where the members represent a particular profession/trade/domestic workers/Anganwadi workers
i) Any other homogenous group</td></tr>
</table>

Name of Benefit Option	Age at Entry (age last birthday)##		Policy Term^	
	Minimum	Maximum	Minimum	Maximum*
Fixed Daily Hospitalization Cash Benefit	18 years	65 years	1 year	5 years
Fixed Surgical Care Benefit			1 year	5 years

Accidental Total Permanent Disability			1 month	20 years
Critical Illness Benefit			1 year	15 years
Cardiac Cover			1 year	5 years
Cancer Cover			1 year	5 years
Optional Accidental Death Benefit			1 month	20 years

^Under One-Year Renewable Group Health Insurance, Policy Term applicable is 1 year only.

*If the product is offered in conjunction with a loan, policy term shall be subject to a maximum of five years, irrespective of the benefit option chosen. Additionally, the coverage term shall be less than or equal to the loan tenure.

"Sum assured 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 policy under health cover. The "Sum Assured under health cover" is here on referred to as "Sum Assured" or "Sum Insured" for each of the benefit option applicable for individual member.

The terms "Age at entry" refer to individual members covered under the Group Master Policy.

SUM INSURED COVER OPTIONS

The master policyholder or insured member must opt for either of the two Sum Insured cover options: Decreasing Cover or Level Cover. This option must be chosen at inception of the policy, if applicable. These are explained below:

A. Decreasing Cover: Under this option, the Sum Insured chosen at inception reduces at a fixed rate over the policy term, based on the frequency selected i.e. Annually or Monthly. The master policyholder or member must choose one of these two options at inception of the policy.

The "Fixed Reduction Rate" is calculated as:

- Annual Decreasing Cover: 1 divided by Policy Term (in years)
- Monthly Decreasing Cover: 1 divided by Policy Term (in months)

The resulting percentage is rounded down to five decimal places and applied accordingly on each policy anniversary (yearly or monthly) on Sum Insured chosen at inception. In the event of a covered contingency, the benefit payable will correspond to the Sum Insured applicable at the time of the event. 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 Cover option, and the current policy month for the Monthly Decreasing Cover option.

Example 1: Annual Decreasing Cover

If the Policy Term is 10 years with Sum Insured of 10,00,000 at inception, the Fixed Reduction Rate for an Annual Decreasing Cover will be equal to 1/10 = 10% rounded down to 5 decimal places. This reduction will be applied on the Sum Insured chosen at inception at each policy anniversary, starting from the beginning of the second year of the policy. The annual reduction schedule along with the corresponding Sum Insured applicable as detailed below:

Policy Year	**Fixed Reduction Rate**	**Sum Insured Proportion at the start of each policy year**	**Sum Insured applicable at the start of each policy year**
1st Year	10%	100%	1,000,000
2nd Year	10%	90%	900,000
3rd Year	10%	80%	800,000

4th Year	10%	70%	700,000
5th Year	10%	60%	600,000
6th Year	10%	50%	500,000
7th Year	10%	40%	400,000
8th Year	10%	30%	300,000
9th Year	10%	20%	200,000
10th Year	10%	10%	100,000

Example 2: Monthly Decreasing Cover

If the Policy Term is 10 years with Sum Insured of 10,00,000 at inception, the Fixed Reduction Rate for a Monthly Decreasing Cover will be equal to 1/120 = ~0.833% rounded down to 5 decimal places. This reduction will be applied on the Sum Insured chosen at inception at each monthly anniversary, starting from the beginning of the second month of the policy. The monthly reduction schedule along with the corresponding Sum Insured applicable as detailed below:

Policy Month	**Fixed Reduction Rate**	**Sum Insured Proportion at the start of each Policy month**	**Sum Insured applicable at the start of each policy month**
1st Month	0.8330%	100%	1,000,000
2nd Month	0.8330%	99%	991,670
3rd Month	0.8330%	98%	983,340
4th Month	0.8330%	98%	975,010
5th Month	0.8330%	97%	966,680
6th Month	0.8330%	96%	958,350
7th Month	0.8330%	95%	950,020
8th Month	0.8330%	94%	941,690
9th Month	0.8330%	93%	933,360
10th Month	0.8330%	93%	925,030
11th Month	0.8330%	92%	916,700
12th Month	0.8330%	91%	908,370
13th Month	0.8330%	90%	900,040
14th Month	0.8330%	89%	891,710
15th Month	0.8330%	88%	883,380
16th Month	0.8330%	88%	875,050
17th Month	0.8330%	87%	866,720

18th Month	0.8330%	86%	858,390
19th Month	0.8330%	85%	850,060
20th Month	0.8330%	84%	841,730
21st Month	0.8330%	83%	833,400
22nd Month	0.8330%	83%	825,070
23rd Month	0.8330%	82%	816,740
24th Month	0.8330%	81%	808,410
25th Month	0.8330%	80%	800,080
26th Month	0.8330%	79%	791,750
27th Month	0.8330%	78%	783,420
28th Month	0.8330%	78%	775,090
29th Month	0.8330%	77%	766,760
30th Month	0.8330%	76%	758,430
31st Month	0.8330%	75%	750,100
32nd Month	0.8330%	74%	741,770
33rd Month	0.8330%	73%	733,440
34th Month	0.8330%	73%	725,110
35th Month	0.8330%	72%	716,780
36th Month	0.8330%	71%	708,450
37th Month	0.8330%	70%	700,120
38th Month	0.8330%	69%	691,790
39th Month	0.8330%	68%	683,460
40th Month	0.8330%	68%	675,130
41st Month	0.8330%	67%	666,800
42nd Month	0.8330%	66%	658,470
43rd Month	0.8330%	65%	650,140
44th Month	0.8330%	64%	641,810
45th Month	0.8330%	63%	633,480
46th Month	0.8330%	63%	625,150
47th Month	0.8330%	62%	616,820

48th Month	0.8330%	61%	608,490
49th Month	0.8330%	60%	600,160
50th Month	0.8330%	59%	591,830
51st Month	0.8330%	58%	583,500
52nd Month	0.8330%	58%	575,170
53rd Month	0.8330%	57%	566,840
54th Month	0.8330%	56%	558,510
55th Month	0.8330%	55%	550,180
56th Month	0.8330%	54%	541,850
57th Month	0.8330%	53%	533,520
58th Month	0.8330%	53%	525,190
59th Month	0.8330%	52%	516,860
60th Month	0.8330%	51%	508,530
61st Month	0.8330%	50%	500,200
62nd Month	0.8330%	49%	491,870
63rd Month	0.8330%	48%	483,540
64th Month	0.8330%	48%	475,210
65th Month	0.8330%	47%	466,880
66th Month	0.8330%	46%	458,550
67th Month	0.8330%	45%	450,220
68th Month	0.8330%	44%	441,890
69th Month	0.8330%	43%	433,560
70th Month	0.8330%	43%	425,230
71st Month	0.8330%	42%	416,900
72nd Month	0.8330%	41%	408,570
73rd Month	0.8330%	40%	400,240
74th Month	0.8330%	39%	391,910
75th Month	0.8330%	38%	383,580
76th Month	0.8330%	38%	375,250
77th Month	0.8330%	37%	366,920

78th Month	0.8330%	36%	358,590
79th Month	0.8330%	35%	350,260
80th Month	0.8330%	34%	341,930
81st Month	0.8330%	33%	333,600
82nd Month	0.8330%	33%	325,270
83rd Month	0.8330%	32%	316,940
84th Month	0.8330%	31%	308,610
85th Month	0.8330%	30%	300,280
86th Month	0.8330%	29%	291,950
87th Month	0.8330%	28%	283,620
88th Month	0.8330%	28%	275,290
89th Month	0.8330%	27%	266,960
90th Month	0.8330%	26%	258,630
91st Month	0.8330%	25%	250,300
92nd Month	0.8330%	24%	241,970
93rd Month	0.8330%	23%	233,640
94th Month	0.8330%	23%	225,310
95th Month	0.8330%	22%	216,980
96th Month	0.8330%	21%	208,650
97th Month	0.8330%	20%	200,320
98th Month	0.8330%	19%	191,990
99th Month	0.8330%	18%	183,660
100th Month	0.8330%	18%	175,330
101st Month	0.8330%	17%	167,000
102nd Month	0.8330%	16%	158,670
103rd Month	0.8330%	15%	150,340
104th Month	0.8330%	14%	142,010
105th Month	0.8330%	13%	133,680
106th Month	0.8330%	13%	125,350
107th Month	0.8330%	12%	117,020

108th Month	0.8330%	11%	108,690
109th Month	0.8330%	10%	100,360
110th Month	0.8330%	9%	92,030
111th Month	0.8330%	8%	83,700
112th Month	0.8330%	8%	75,370
113th Month	0.8330%	7%	67,040
114th Month	0.8330%	6%	58,710
115th Month	0.8330%	5%	50,380
116th Month	0.8330%	4%	42,050
117th Month	0.8330%	3%	33,720
118th Month	0.8330%	3%	25,390
119th Month	0.8330%	2%	17,060
120th Month	0.8330%	1%	8,730

Please note, the Decreasing 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.

B. Level Cover: Under this cover option, the Sum Insured payable upon the occurrence of a covered contingency shall be equal to the initial amount of cover selected by the Master Policyholder or the insured member. The Sum Insured remains constant throughout the policy term. This cover option is available for all benefit options.

BENEFIT OPTIONS:

Benefit Option 1 - Fixed Daily Hospitalization Cash (FDHC) Benefit

1. The Fixed Daily Hospitalization Cash Benefit (FDHCB) Sum Insured along with the Sum Insured Cover option is chosen by the master policyholder or member at the policy inception.
2. FDHCB Sum Insured is payable in case of hospitalization due to any injury, sickness or disease.
3. The benefit shall be payable after the completion of each medically necessary continuous hospitalization for more than 24 hours as a result of injury, sickness or disease.
4. In case of Hospitalization, the Member shall receive 1% of FDHCB Sum Insured per day in case admitted in a non-ICU room or 2% of FDHCB Sum Insured per day in case admitted in an ICU room for each day of hospitalization beginning from the first day. The applicable amount payable on a per-day basis under the FDHCB benefit shall be referred to as the ‘Per Day FDHCB Sum Insured’.
5. The customer has the option to allocate a portion of their Per Day FDHCB Sum Insured as the "Fixed Recuperation Cash Support Benefit”. The Fixed Recuperation Cash Support Benefit is part of the Per Day FDHCB Sum Insured and is not payable in addition to it.
6. For example, if the policyholder is hospitalized in a non-ICU room for 3 days and the FDHCB Sum Insured is Rs. 100,000, then the benefits as provided in the below table will be payable provided that the customer has opted to allocate 60% of the Per Day FDHCB Sum Insured as the Fixed Recuperation Cash Support Benefit:

Description	Amount

FDHCB Sum Insured	Rs. 100,000
Total Per Day FDHCB Sum Insured (3% of FDHCB Sum Insured)	Rs. 3,000
Fixed Recuperation Cash Support Benefit (60% of Per Day FDHCB Sum Insured)	Rs. 1,800
FDHCB Component (40% of Per Day FDHCB Sum Insured)	Rs. 1,200
Total Benefit Payable	Rs. 3,000

7. The FDHCB Sum Insured payable towards any claim shall not exceed Unclaimed Benefit Sum Insured, which is defined as the Benefit Option Sum Insured as reduced by any claims already made for the Benefit Option since the date of Commencement of risk or date of revival of risk, whichever is later.
8. Once a valid claim under this benefit option has been made, then on renewal the sum assured will be the Unclaimed Benefit Sum Insured.
9. This benefit is a fixed per-day benefit and will be calculated on the basis of the number of continuous and completed days of Hospitalization.
10. This will be paid as a lump sum amount, irrespective of the actual hospitalization expenses.
11. The coverage for the Member shall cease for the remaining Member Cover Term in case 100% of FDHCB Sum Insured is exhausted against claims. The FDHCB will cease at the end of policy term.
12. However, coverage under other benefit options (if any) shall continue to be in force till the end of Member Cover Term
13. Renewal of this benefit shall be as per the Board Approved Underwriting Policy (BAUP)

This benefit shall be payable subject to the following:

1. Liability to make any payment under this benefit shall commence only after at least a continuous and completed 24 hours of Hospitalization in ICU or Non-ICU room of the life insured for each claim.
2. The Hospitalization is for Medically Necessary Treatment for an Illness/Accident and is commenced and continued on the written advice of the treating Medical Professional/Medical Practitioner.
3. A waiting period of 60 days is applicable from date of commencement of risk or date of revival of risk, whichever is later, for FDHCB, if the cause of claim is not due to an accident.
4. No waiting period shall be applicable between two successive hospitalizations.
5. Geographical coverage is applicable only for hospitalization within India.
6. No benefit shall be payable for any hospitalization due to illness during the waiting period. Such a waiting period is not applicable to claims arising due to accident provided the accident occurs after the date of commencement of risk or date of revival of risk, whichever is later, as the case may be.
7. More than one claim can be considered in respect of the Insured Person under this benefit, subject to the maximum payment of 100% of FDHCB Sum Insured. On exhaustion of the 100% of FDHCB Sum Insured payable, the cover under this benefit will terminate in relation to such life insured.
8. Once claim is considered admissible as per the terms and condition under this benefit, the member is eligible for the fixed daily amount from the first day of Hospitalization, provided that the life insured is hospitalized for a continuous period of 24 hours.
9. The amount payable under this benefit will be calculated on the basis of the number of continuous and completed days of Hospitalization and will be given as a single lump-sum payment.
10. Any procedure / treatment which leads to Hospitalization of less than 24 hours is not covered.
11. Out-patient treatment is not covered under this benefit option. Additionally, day-care procedures / treatments are categorically excluded.
12. The applicable waiting period, exclusions and definitions are provided in Annexure 1 and 3 respectively.

Benefit Option 2 - Fixed Surgical Care Benefit (FSCB)

1. The Fixed Surgical Care Benefit (FSCB) Sum Insured along with the Sum Insured Cover option is chosen by the master policyholder or member at the policy inception.

2. The FSCB Sum Insured is payable on hospitalization for undergoing any medically necessary surgery in India for a minimum period for 24 hours and actually undergoing that surgery. The surgery must be for medically necessary treatment of any illness or injury due to an accident and should have been advised in writing by a Medical Professional/Medical Practitioner.
3. FSCB Sum Insured shall be payable if the Member has undergone any medically necessary surgery, during the Member Cover Term and the surgery has been performed:
   A). by a qualified surgeon for a surgical operation
   B). at a hospital due to injury or sickness for covered surgical procedures advised by medical practitioner
4. In case the Member has undergone any of the specified surgeries, a fixed percentage of FSCB Sum Insured shall be payable on the basis of the surgery type as shown below:

Surgery Type	Benefit payable as % of FSCB Sum Insured
Major Surgery	100%
Minor Surgery	50%

5. "Major Surgery" is defined as any surgery directly involving the brain, heart (including arteries), liver or lung, as per the list provided in **Annexure 2**
6. "Minor Surgery" is any other valid surgery not categorized as Major Surgery.
7. 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.
8. 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 Life Insured during the same Hospitalization. E.g. In the event of a major and minor surgery both being performed on the life insured during the same Hospitalization, the claim will be paid for Major surgery only.
9. This benefit is a fixed lump sum benefit, irrespective of the actual surgery expenses.
10. 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 policy term irrespective of any previous claims paid subject to the maximum of 100% of FSCB Sum Insured.
11. The FSCB Sum Insured payable towards any claim shall not exceed the Unclaimed Benefit Sum Insured.
12. Once a valid claim under this benefit option has been made, then on renewal the sum assured will be the Unclaimed Benefit Sum Insured.
13. The FSCB ceases on earlier of:
    a. Claiming 100% of the chosen FSCB Sum Insured or
    b. End of Member Cover Term
14. Coverage under other benefit options (if any) shall continue to be in force till the end of Member Cover Term
15. Renewal of this benefit shall be as per the Board Approved Underwriting Policy (BAUP)

This benefit shall be payable subject to the following:

1. Liability to make any payment under this benefit shall commence only after at least a continuous and completed 24 hours of Hospitalization of the Life Insured for each claim.
2. The Company shall not be liable to pay the FSCB Sum Insured for more than the maximum limit as specified.
3. A waiting period of 60 days is applicable from date of commencement of risk or date of revival of risk, whichever is later, for FSCB claims relating to sickness. No benefit shall be payable for any FSCB claim due to illness during the waiting period. Such a waiting period is not applicable to claims arising due to accident provided the accident occurs after the date of commencement of risk or date of revival of risk, whichever is later, as the case may be.
4. More than one claim can be considered in respect of the Insured Person under this benefit, subject to the maximum limit specified and terms and conditions as applicable. On exhaustion of the maximum limit allowed, the cover under this benefit will terminate in relation to such Life Insured.
5. Out-patient treatment is not covered under this benefit option. Additionally, day-care procedures / treatments are categorically excluded.
6. The applicable waiting period, exclusions and definitions are provided in **Annexure 1 and 3** respectively.

Benefit Option 3 - Accidental Total Permanent Disability (ATPD)

The Accidental Total Permanent Disability (ATPD) Sum Insured along with the Sum Insured Cover option is chosen by the master policyholder or member at the policy inception. In the event of ATPD of a member during the Member Cover Term, 100% of the applicable ATPD Sum Insured shall be payable to the Member, based on the Sum Insured cover opted at inception of the policy. In case Decreasing Cover Sum Insured option is chosen, the applicable ATPD Sum Insured shall be equivalent to the "Sum Insured at time 't'" as defined above.

Accidental Total and Permanent Disability means when the insured Member is totally, continuously and permanently disabled due to accident and meets the definitions below:

Physical Impairments:
The Member suffers an injury/accident due to which there is total and irrecoverable loss of:

A. The use of two limbs; or
B. The sight of both eyes; or
C. The use of one limb and the sight of one eye; or
D. Loss by severance of two or more limbs at or above wrists or ankles; or
E. Sight of one eye and loss by severance of one limb at or above wrist or ankle

Injury means accidental physical bodily harm excluding illness and disease. It must be solely and directly caused by external, violent, visible and evident means which are verified and certified by a Medical Practitioner.

This benefit shall be payable subject to the following:

1. To be regarded as totally and permanently disabled, the life assured must be unable to perform (whether aided or unaided) at least 3 of the "Activities of Daily Living".
2. The "Activities of Daily Living" include:
   - 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.
   - Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
   - Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa.
   - Mobility: the ability to move indoors from room to room on level surfaces.
   - Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
   - Feeding: the ability to feed oneself once food has been prepared and made available.
3. The disabilities as stated above must last, without interruption, for at least 6 consecutive months and must, in the opinion of a Medical Practitioner, be deemed permanent.
4. This benefit shall commence upon the completion of this uninterrupted period of 6 months. However, for the disabilities mentioned in (D) and (E) above, such 6 months period would not be applicable, and the benefit shall commence immediately

Please note:

1. Two Settlement options are available for the benefit amount payable. The same are detailed in Plan Benefits (Settlement Option) section
2. Coverage under other benefit options (if any) shall continue to be in force till the end of Member Cover Term
3. Renewal of this benefit shall be as per the Board Approved Underwriting Policy (BAUP)

The applicable waiting period, exclusions and definitions are provided in **Annexure 1 and 3** respectively.

Benefit Option 4 - Critical Illness (CI) Benefit

1. The Critical Illness (CI) Benefit Sum Insured along with the Sum Insured Cover option is chosen by the master policyholder or member at the policy inception.
2. Critical Illness means the first time Diagnosis of the Member with any of the illnesses or the first performance of any of the certain medical procedures/surgeries, as enlisted in **Annexure 3**, by a Medical Practitioner in respect of the Member during his/her lifetime. In case a Member is diagnosed on first occurrence of the critical illness conditions covered, subject to satisfaction of definitions, policy conditions and exclusions,

100% of the applicable CI Benefit Sum Insured shall be payable, provided the illness/ condition has occurred for the first time.

3. An amount equal to 100% of the CI Benefit Sum Insured is payable on diagnosis of any of the covered CI conditions, as applicable. In case Decreasing Cover Sum Insured option is chosen, the applicable CI Benefit Sum Insured shall be equivalent to the "Sum Insured at time 't'" as defined above.
4. The cover under this CI benefit terminates on the first occurrence of any of the applicable Major CI. The list of Major CI conditions is listed in the Table below:

Sr No.	Name of CI
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

5. For all the above-mentioned 29 Major CI Conditions, an initial waiting period of 90 days applies from the date of commencement of risk or date of revival of risk, whichever is later, as the case may be. In case the insured

event happens during this period, no benefit shall be payable. However, 100% of the premiums paid will be refunded and the benefit option will terminate.

6. Additionally, no waiting period applies for Critical Illness claims arising solely and directly due to an accident
7. The survival period of 30 days from the date of first diagnosis is applicable for this benefit to be payable for claims arising out of critical illnesses under consideration and mentioned above.
8. The survival period is defined as the period of time after the date of first diagnosis of a critical illness that the member has to survive to become eligible for the benefit payment under the Critical Illness benefit.
9. 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.
10. Claim payment will only be made with confirmatory diagnosis of the conditions covered while the insured is alive (i.e., a claim would not be admitted if the diagnosis is made post-mortem).
11. Two Settlement options are available for the benefit amount payable. The same are detailed in Plan Benefits (Settlement Option) section
12. No benefit shall be available on renewal once a valid claim under this benefit option has been admitted.
13. Renewal of this benefit shall be as per the Board Approved Underwriting Policy (BAUP)
14. The benefit shall be payable upon the first occurrence of the CI conditions covered, subject to satisfaction of definitions, policy conditions and exclusions.
15. This implies that this benefit will not be offered to lives with any of the above listed and covered 29 critical illnesses/conditions existing or occurred previously.
16. Member coverage under this benefit shall terminate post 100% of the CI Benefit Sum Insured has been paid against the valid claim during the Member Cover Term.
17. However, coverage under other Benefit Options (if any) shall continue for the remaining Member Cover Term

Benefit Option 5 – Cancer Cover

The Cancer Cover Sum Insured along with the Sum Insured Cover option is chosen by the master policyholder or member at the policy inception. Cancer Cover offers a lump sum payout, as applicable, on diagnosis of listed Cancer, during the Member Cover Term, provided the Member survives for a period of 7 days from the date of diagnosis of the condition. In case Decreasing Cover Sum Insured option is chosen, the applicable Cancer Cover Sum Insured shall be equivalent to the "Sum Insured at time 't'" as defined above.

The Cancer Cover Sum Insured payable under this benefit option is as follows:

In the event of Diagnosis of	% Cancer Cover Sum Insured (SI) payable
Minor Cancer	25% of Cancer Cover SI
Major Cancer	100% of Cancer Cover SI less Minor Cancer claim, if any

The list of Cancer conditions covered, and their category is as below:

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

Please note:

1. Any payout for a Minor Cancer claim will accelerate the payout for Major Cancer benefit.
2. Only 1 Minor claim is payable under this benefit. That is, only one claim can be made for diagnosis of Early-Stage Cancer or Carcinoma-in-situ (CIS).
3. For Major Cancer or Minor Cancer Conditions, an initial waiting period of 180 days applies from date of commencement of risk or date of revival of risk, whichever is later, is applicable for this benefit to be payable for claims arising out of cancer. The waiting period is defined as the period starting from policy inception or reinstatement during which no benefits are payable under the plan. In case the insured event happens during

this period, no benefit shall be payable. However, 100% of the premiums paid will be refunded and the benefit option will terminate.

4. A survival period of 7 days from the date of first diagnosis is applicable for this benefit to be payable for claims arising out of Cancer Cover benefit. The survival period is defined as the period of time after the date of diagnosis of a cancer condition that the member has to survive to become eligible for the benefit payment under the Cancer Cover benefit.
5. 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
6. Claim payment will only be made with confirmatory diagnosis of the conditions covered while the insured is alive (i.e., a claim would not be admitted if the diagnosis is made post-mortem).
7. In the event that the Master Policyholder/Member has opted for a Decreasing Sum Insured cover option and a minor claim is made first, 25% of Sum Insured applicable at that time 't' will be paid to the member. Subsequently, the claim amount already paid shall be deducted from the applicable Sum Insured at each future time period. 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 with regard to this benefit, then this benefit option will cease. Refer to **Annexure 6** for an example on the Decreasing Sum Insured cover in case of a minor claim.
8. Two Settlement options are available for the benefit amount payable. The same are detailed in Plan Benefits (Settlement Option) section
9. Cancer Cover Sum Insured payable towards any claim shall not exceed the Unclaimed Benefit Sum Insured.
10. Once a valid claim under this benefit option has been made, then on renewal the sum assured will be the Unclaimed Benefit Sum Insured.
11. Renewal of this benefit shall be as per the Board Approved Underwriting Policy (BAUP)
12. 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.
13. However, coverage under other Benefit Options (if any) shall continue for the remaining Member Cover Term

Benefit Option 6 – Cardiac Cover

The Cardiac Cover Sum Insured along with the Sum Insured Cover option is chosen by the master policyholder or member at the policy inception. In the event of the first occurrence/diagnosis/undergoing of covered conditions/surgeries, as listed below, during the Member Cover Term while the coverage is in force, a lump sum payout (as a % of Cardiac Cover Sum Insured) shall be payable to the Member, as applicable. In case Decreasing Cover Sum Insured option is chosen, the applicable Cardiac Cover Benefit Sum Insured shall be equivalent to the "Sum Insured at time 't'" as defined above. The percentage of Cardiac Cover Sum Insured payable under this benefit option shall be as specified in the table below:

In the event of Diagnosis of	% Cardiac Cover Sum Insured payable
Minor Cardiac	25% Cardiac Cover SI
Major Cardiac	100% of Cardiac Cover SI less Minor Cardiac claim, if any

The list of Cardiac conditions covered, and their categorization is as below:

Name of Cardiac Cover	Major / Minor
Myocardial Infarction (First Heart Attack of specified severity)	Major
Open Chest CABG (Coronary Artery Bypass Graft)^	Major
Open Heart Replacement or Repair of Heart Valves^	Major
Major Surgery of Aorta^	Major
Cardiomyopathy	Major
Heart Transplant^	Major
Primary (Idiopathic) Pulmonary Hypertension	Major

Insertion of Pacemaker^	Minor
Balloon Valvotomy or Valvuloplasty^	Minor
Angioplasty^	Minor
Minimally invasive Surgery of Aorta^	Minor
Pericardiectomy^	Minor
Infective Endocarditis^	Minor
Surgery for Cardiac Arrhythmia^	Minor
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.

Please note:

1. Any payout for a Minor Cardiac claim will accelerate the payout for Major Cardiac benefit.
2. Only 1 Minor claim is payable under this benefit.
3. For Major Cardiac or Minor Cardiac Conditions, an initial waiting period of 180 days applies from date of commencement of risk or date of revival of risk, whichever is later, is applicable for this benefit to be payable for claims arising out of Cardiac Cover benefit. The waiting period is defined as the period starting from policy inception or reinstatement during which no benefits are payable under this benefit. In case the insured event happens during this period, no benefit shall be payable. However, 100% of the premiums paid will be refunded and the benefit option will terminate.
4. Additionally, no waiting period applies for Cardiac Cover claims arising solely and directly due to an accident
5. A survival period of 30 days from the date of first diagnosis is applicable for this benefit to be payable for claims arising out of Cardiac Cover benefit. The survival period is defined as the period from the date of first diagnosis of the cardiac condition(s) which the policyholder must survive to become eligible for the benefit payment under the Cardiac Cover benefit.
6. 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
7. Claim payment will only be made with confirmatory diagnosis of the conditions covered while the insured is alive (i.e., a claim would not be admitted if the diagnosis is made post-mortem).
8. In the event that the Master Policyholder/Member has opted for a Decreasing Sum Insured cover option and a minor claim is made first, 25% of Sum Insured applicable at that time 't' will be paid to the member. Subsequently, the claim amount already paid shall be deducted from the applicable Sum Insured at each future time period. In case, the Cardiac Cover Sum Insured applicable for any member at any time 't' becomes less than the minor claim amount already paid off with regard to this benefit, then this benefit option will cease. Refer to **Annexure 6** for an example on the Decreasing Sum Insured cover in case of a minor claim.
9. Two Settlement options are available for the benefit amount payable. The same are detailed in Plan Benefits (Settlement Option) section
10. Cardiac Cover Sum Insured payable under each claim shall not exceed the Unclaimed Benefit Sum Insured.
11. Once a valid claim under this benefit option has been made, then on renewal the sum assured will be the Unclaimed Benefit Sum Insured.
12. Renewal of this benefit shall be as per the Board Approved Underwriting Policy (BAUP)
13. 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.
14. However, coverage under other Benefit Options (if any) shall continue for the remaining Member Cover Term

Optional Benefit – Accidental Death Benefit (ADB)

The member or master policyholder has the flexibility to add an optional Accidental Death Benefit with any of the available benefit options only at the time of the inception of the policy. This optional ADB shall not be offered on a stand-alone basis and can only be attached in conjunction with available benefit options.
The Accidental Death Benefit (ADB) Sum Insured along with the Sum Insured Cover option is chosen by the master policyholder or member at the policy inception. In the event of Accidental Death of a Member, during the Member Cover Term, 100% of the applicable ADB Sum Insured shall be payable as lumpsum to the Nominee. In case Decreasing Cover Sum Insured option is chosen, the applicable ADB Sum Insured shall be equivalent to the "Sum Insured at time 't'" as defined above.

Accidental Death means the death of the Insured which results directly, solely and independently of any other causes from Bodily Injury caused by accident and occurs within 180 days of the date of Accident. Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.
Accidental Death must be caused within 180 days of any bodily injury. If the bodily injury occurred within the coverage period and the Accidental Death happens after the end of coverage period but within 180 days of bodily injury, a valid claim arising as a result of such Accidental Death shall not be denied.

1. Two Settlement options are available for the benefit amount payable. The same are detailed in Plan Benefits (Settlement Option) section
2. Under this add-on benefit option, both Level Cover Sum Insured and Decreasing Cover Sum Insured options are available.
3. Coverage under other benefit options (if any) shall continue to be in force till the end of Member Cover Term
4. Renewal of this benefit shall be as per the Board Approved Underwriting Policy (BAUP)

Refer to **Annexure 1** for Exclusions and applicable waiting periods of the respective variants.

Additionally, refer to **Annexure 3** for the detailed definitions of the Covered Critical Illnesses, including conditions related to Major/Minor Cancer and Major/Minor Cardiac conditions, as well as definitions pertaining to various benefit/add-on options: ADB, ATPD, FDHCB, and FSCB.

PLAN BENEFITS

Maturity Benefit	No Maturity benefit is payable under this Master policy
Death Benefit	No benefit is payable on Death other than Optional Accidental Death Benefit (ADB) as specified earlier. In case the Member passes away where the Income Benefit, subject to the Settlement option opted, is still being paid, the outstanding benefit payments shall continue to be paid to the nominee.

Settlement Option:

Two Settlement options are available to receive the applicable Sum Insured Benefit:

a) **Option 1 (Lump Sum Benefit)**: Under this option, benefit amount payable will be paid immediately on happening of the incidence.

b) **Option 2 (Lump sum and Level Income)**: Under this option, X% of the benefit amount payable will be paid as lump sum immediately on happening of the incidence where X% lies between 0% and 100% (0% included) and can be selected in multiples of 10% only. The balance amount, i.e. (1-X%) of the benefit amount payable 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 the incidence basis the chosen income pay-out frequency.

Level Modal Income = [(1-X%) * Benefit amount payable/Income Period (in years)] * Income Factor*Modal Factor where income factors based on income period are provided in annexure A. The income factors will be reviewed periodically, subject to the completion of the applicable approval process. The available options for income

frequencies during an income period include **Annual**, **Semi-Annual**, **Quarterly**, and **Monthly**. The modal factors for the available income frequencies are as follows:

Income Mode	Income Frequency	Factor
Annual	1	1
Semi-Annual	2	0.5061
Quarterly	4	0.2546
Monthly	12	0.0852

Settlement option can be selected at inception only by the policyholder (for all the members as default) or by the individual member. Additionally, the benefit income frequency can be changed by the member/ nominee anytime during the benefit payout duration by submitting a written request at least 30 days before the next claim anniversary.

At any time during the income period, commutation of remaining incomes can be done after submitting a written request for the same to the Company. The company shall pay the present value of all future incomes discounted at the rate of 5% p.a. Please note that the rate of 5% p.a. used here is based on Company's long-term expectation of interest rates. This will be reviewed from time to time, contingent upon the completion of the applicable approval process.

Thus, Lumpsum Amount = Commutation Factor x Level Modal Income

Commutation Factor = $\frac{\boldsymbol{Level\ Modal\ Income} \times (\mathbf{1} - \frac{\mathbf{1}}{(\mathbf{1}+\boldsymbol{i})^{\boldsymbol{t}}}) \times (\mathbf{1}+\boldsymbol{i})}{\boldsymbol{i}}$

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

Non-forfeiture Benefits

Lapse:
In case of non-receipt of premium for any chosen Benefit Option, the policy will lapse at the end of the grace period and no benefits shall be payable. In cases where a member/master policyholder has opted for multiple Benefit Options under the One-Year Renewable Group Health Insurance, no individual Benefit Option shall be permitted to lapse independently. The policy shall lapse in its entirety if the premium for any of the selected Benefit Options is not received. The policy can be revived during the revival period only upon payment of the full due premiums, as applicable, corresponding to all the originally selected Benefit Options. The details on revival procedure are provided in Policy discontinuance and revival section.

Surrender Benefit:
Provided the policyholder has paid all due premiums, a surrender value will be applicable under the policy in case the policyholder surrenders the policy for all plan variants. No surrender value shall be payable with respect to the Scheme Member for whom valid claims are made during the Coverage Term.

The policy shall acquire a surrender value once all premiums have been paid.

<u>On Surrender of One-Year Renewable Group Health Insurance</u>:
In case of employer-employee scheme, if an individual member exits from the group, premium for the unexpired risk cover will be refunded to the policyholder as per the scheme rules. In case of non-employer-employee scheme, if an individual member exits from the group, cover will continue till the end of the period of coverage for which the premium has been received unless specifically a request is received for the refund of premium for the unexpired risk cover.

In both employer employee schemes and non-employer employee schemes, on surrender of the master policy, an option to the individual members of the group shall be provided whether to continue the cover for the unexpired

period of risk or to exit from the scheme in which case we shall be providing the refund of premium for the unexpired risk cover.

On Surrender of Single Premium Group Health Insurance:
The Surrender Value shall be computed using the formula mentioned below:

70% of the (Total Premiums Paid[#] plus underwriting extra premiums paid plus loading for modal premiums, if any in respect of Member) *(Unexpired risk period in months[1])/(Total period of Cover in months)*(Sum Insured applicable at the time of surrender[2])/ (Sum Insured at inception).
The risk cover under the policy will cease after the surrender request has been processed. No surrender value shall be payable with respect to Insured Member for whom valid claims are made during coverage term. In case of termination of Master Policy, the individual Members of the group shall be given an option to continue the coverage as an individual policy till the expiry of individual Member Cover Term.

In case multiple plan variants are opted by the master policyholder or members, surrender of only one particular plan variant will not be allowed. All plan variants will need to be surrendered together.

[1] Ignoring fraction of a month
[2] As per the schedule mentioned in certificate of insurance at the outset

[#] "Total Premiums Paid" means total of all the premiums paid under the base product, excluding any extra premium and taxes, if collected explicitly.

Paid-Up Benefit
Not applicable

Termination
This Policy will terminate on the occurrence of the earliest of the following events:

- The date on which a free look cancellation request is received by Axis Max Life
- At the end of 3 months from the date of receipt of notice of termination by any party
- Termination of member's cover under the policy
- In case of multiple plan variants opted by the master policyholder or members, termination of one plan variant due to the applicable reason will not terminate the policy.

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

- On the coverage expiry date;
- On the date of payment of a request for surrender of the insurance cover from the member by Axis Max Life;
- On the date of payment of a request for Free Look cancelation of the insurance cover from the member by Axis Max Life; or
- On the benefit amount becoming payable in respect of the member.
- On the expiry of the revival period, if the lapsed cover has not been revived
- On date on which the cover is cancelled or terminated for any reason

General Conditions

- The One-year renewal group health plan is a one-year contract and can be renewed at the premium rates, terms and conditions mutually agreed by the Master Policyholder and Axis Max Life Insurance

Grace Period: A grace period of thirty (30) days (fifteen (15) days in case of monthly premium payment mode) from the due date for payment of each premium will be allowed to the Policyholder for payment of contractual premium. During the grace period in the event of any member suffering an insured event, consideration of the claim is subject to payment of premiums due. During the grace period, the Company will accept the premium without interest.

The insurance coverage / benefit continues during the grace period but if there is any claim during the grace period, the Company will deduct the due premium (if any) from the benefits payable under the Policy.

Policy Loan Provisions
No loan is available under the policy

ANNEXURE 1: WAITING PERIOD AND EXCLUSIONS

Annexure 1.1a: Permanent Exclusions for optional Accidental Death Benefit (ADB) and Accidental Total Permanent Disability (ATPD) Benefit option:

The life assured / nominee will not be entitled to any accidental benefits 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. 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
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 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
6. Participation by the insured person 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 1.1b: Permanent Exclusions for Critical Illness (CI) Benefit option:

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 Life Assured 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 Life Assured has disclosed at the time of proposal and the Company has 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
   Pre-existing disease (PED) means any condition, ailment, injury or disease:

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

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

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:
    - Date of diagnosis within 90 days from date of commencement or reinstatement of cover
    - Critical Illness Benefit, where death occurs within 30 days of the date of diagnosis
    - Policy in the lapsed condition as on the date of diagnosis
    - Any more than one claim in respect of Critical Illness Benefit
12. Non-fulfillment of eligibility criteria for Critical Illness Benefit covered under the policy

Annexure 1.1c: Permanent Exclusions for Cancer Cover and Cardiac Cover Benefit options

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, the 100% of the premium paid will be refunded and the benefit option will terminate.
2. Any Pre-Existing Condition or
3. Intentional self-inflicted injury, attempted suicide, while sane or insane.
4. 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.

5. 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)

Cardiac Cover Benefit:

Unless expressly stated to the contrary in this Policy, the Company will not make any payment for any claim in respect of any Life Assured 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, 100% of the premium paid will be refunded and the benefit option will terminate.
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 date of commencement or reinstatement of cover
- Cardiac Cover 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 1.1d: Exclusions for Fixed Daily Hospitalization Cash Benefit (FDHCB) and Fixed Surgical Care Benefit (FSCB):

The company will not be liable to make any payments under these plan variants in respect of any expenses incurred by any insured person(s) in connection with or in respect of the following: The life assured 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 registered 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 for 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 Life Assured 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 conditions unless Life Assured has disclosed the same at the time of proposal or date of revival, whichever is later, and the company has accepted the same.

Annexure 1.2a: Waiting Period Clause for Accidental Death Benefit (ADB) and Accidental Total Permanent Disability (ATPD) benefit options

- No waiting period applies for ADB and ATPD claims.

Annexure 1.2b: Waiting Period Clause for Critical Illness (CI) Benefit option

- The waiting period shall apply to all the members of a new group or to new members of the existing group.
- The waiting period shall not apply to those existing members of a renewing 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. If there is a break in the policy, then the waiting period shall start afresh.
- The waiting period of 90 days from policy inception is applicable for this benefit to be payable for claims arising out of critical illnesses under consideration.
- The waiting period is defined as the period starting from policy inception, during which no benefits are payable under the respective benefits.
- No waiting period applies for Critical Illness claims arising solely due to an accident.
- On revival under One-Year Renewable Group Health Insurance,
    - If the policy is revived within 90 days, only the remaining part of waiting period will apply.
    - If the policy is revived after 90 days, full waiting period will apply afresh.

Annexure 1.2c: Waiting Period Clause for Cancer Cover and Cardiac Cover Benefit options:

- The waiting period shall apply to all the members of a new group or to new members of the existing group.
- The waiting period shall not apply to those existing members of a renewing 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. If there is a break in the policy, then the waiting period shall start afresh.
- A waiting period of 180 days from policy inception and from date of policy reinstatement is applicable for this benefit to be payable for claims arising out of Cancer Cover benefit.
- A waiting period of 180 days from policy inception and from date of policy reinstatement is applicable for this benefit to be payable for claims arising out of Cardiac Cover benefit.
- The waiting period is defined as the period starting from policy inception or reinstatement during which no benefits are payable under the plan.
- No waiting period applies for Cardiac Cover claims arising solely due to an accident.
- On revival under One-Year Renewable Group Health Insurance,
    - If the policy is revived within 180 days, only the remaining part of waiting period will apply.
    - If the policy is revived after 180 days, full waiting period will apply afresh.

Annexure 1.2d: Waiting Period Clause for Fixed Daily Hospitalization Cash Benefit (FDHCB) and Fixed Surgical Care Benefit (FSCB):

- The waiting period shall apply to all the members of a new group or to new members of the existing group.
- The waiting period shall not apply to those existing members of a renewing 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. If there is a break in the policy, then the waiting period shall start afresh.

- Waiting Period of 60 days from the date of policy commencement or date of reinstatement, whichever is later, if cause of claim is not due to an accident.
- There is no waiting period between two successive hospitalizations.
- On revival under One-Year Renewable Group Health Insurance,
    - If the policy is revived within 60 days, only the remaining part of waiting period will apply.
    - If the policy is revived after 60 days, full waiting period will apply afresh.
- A 1-year waiting period will apply, from the date of policy commencement or date of reinstatement, whichever is later. Please refer to Appendix A for the list of surgeries falling under 1-year waiting period.
- A 2-year waiting period will apply, from the date of policy commencement or date of reinstatement, whichever is later. Please refer to Appendix A for the list of surgeries falling under 2-year waiting period.

Appendix A: Waiting Periods Applicable

Unless expressly stated to the contrary, the Company shall not be liable to make any payment for any claim in respect of any Insured Person, when that claim is directly or indirectly caused by or arises from or is in any way related to any of the following:

Surgeries and Procedures classified under One-Year and Two-Year exclusion clause

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 the date of commencement of cover of the Daily Hospital cash benefit or Surgical 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 policy has been continuously in force without any break.

Sr. No	Injury / Sickness / Disease / Surgical Procedure (1 year Waiting List)
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

Sr. No	Injury / Sickness / Disease / Surgical Procedure (2 year Waiting List)
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

ANNEXURE 2: LIST OF MAJOR SURGERIES PAYABLE UNDER FIXED SURGICAL CARE BENEFIT (FSCB)

Organ / System	Sr No	Surgery/Procedure
	1	Surgery of the Aorta

Operations on Blood Vessels	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 3: DEFINITIONS

Applicable Definitions for Optional Accidental Death Benefit (ADB) and Accidental Total Permanent Disability (ATPD) Benefit option (Annexure 3a)

Accident means sudden, unforeseen and involuntary event caused by external, visible and violent means.

Accidental Death means death by or due to a bodily injury caused by an Accident, independent of all other causes of death.

Accidental Death must be caused within 180 days of any bodily injury. If the bodily injury occurred within the coverage period and the Accidental Death happens after the end of coverage period but within 180 days of bodily injury, a valid claim arising as a result of such Accidental Death shall not be denied.

Accidental Total and Permanent Disability means when the insured Member is totally, continuously and permanently disabled due to accident and meets the definitions below:

Physical Impairments:

The Member suffers an injury/accident due to which there is total and irrecoverable loss of:

A. The use of two limbs; or

B. The sight of both eyes; or

C. The use of one limb and the sight of one eye; or

D. Loss by severance of two or more limbs at or above wrists or ankles; or

E. Sight of one eye and loss by severance of one limb at or above wrist or ankle

Note:

- To be regarded as totally and permanently disabled, the life assured must be unable to perform (whether aided or unaided) at least 3 of the "Activities of Daily Living".
- The "Activities of Daily Living" include:
  1. 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.
  2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
  3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa.
  4. Mobility: the ability to move indoors from room to room on level surfaces.
  5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.
  6. Feeding: the ability to feed oneself once food has been prepared and made available.
- The disabilities as stated above must last, without interruption, for at least 6 consecutive months and must, in the opinion of a Medical Practitioner, be deemed permanent.
- This benefit shall commence upon the completion of this uninterrupted period of 6 months. However, for the disabilities mentioned in (D) and (E) above, such 6 months period would not be applicable, and the benefit shall commence immediately

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

Injury means accidental physical bodily harm excluding illness and disease. It must be solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

Applicable Definitions for Critical Illness (CI) Benefit option (Annexure 3b):

Critical Illness means the first time Diagnosis of the Member with any of the illnesses or the first performance of any of the certain medical procedures/surgeries, as enlisted below, by a Medical Practitioner in respect of the Member during his/her lifetime.

A. List of CI conditions

Sr No.	Name of CI
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 CI 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.
4. Kidney Failure Requiring Regular Dialysis

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (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 specialist.
i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

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) specialist. Total means “the loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies of hearing” in both ears.

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 following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word “permanent” shall mean beyond the scope of recovery with current medical knowledge and technology.

The Activities of Daily Living are:
1. 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;

2. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
4. Mobility: the ability to move indoors from room to room on level surfaces;
5. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
6. Feeding: the ability to feed oneself once food has been prepared and made available. 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) specialist.

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.

Activities of Daily Living are:
1. 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.
2. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
5. Getting between rooms – the ability to get from room to room on a level floor.
6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

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.

Activities of Daily Living are:
1. 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.
2. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.

5. Getting between rooms – the ability to get from room to room on a level floor.
6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

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.

Activities of Daily Living are:
1. 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.
2. Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
3. Feeding oneself – the ability to feed oneself when food has been prepared and made available.
4. Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
5. Getting between rooms – the ability to get from room to room on a level floor.
6. Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.

The diagnosis has to be confirmed by a Specialist.

Applicable Definitions for Cancer Cover and Cardiac Cover Benefit options (Annexure 3c):

The definitions and exclusions given in this appendix are applicable to Major and Minor Cancer/Cardiac benefits.

A1. List of Cancer Cover conditions

Sr No.	Type of Cancer	Major/Minor
1	Early-Stage cancer	Minor
2	Carcinoma in situ (CIS)	Minor
3	Cancer of Specified Severity	Major

A2. Definitions 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;

B1. List of Cardiac-only conditions

Sr No.	Type of Cardiac Condition	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

B2. Definitions of Cardiac Cover conditions

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.

Applicable Definitions for Fixed Daily Hospitalization Benefit (FDHCB) and Fixed Surgical Care Benefit (FSCB) (Annexure 3d):

The definitions and exclusions given in this appendix are applicable to Fixed Daily Hospitalization Cash Benefit and Fixed Surgical Care Benefit.

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.

Hospital means any institution established for in-patient care and day care treatment of disease/ injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under Schedule of Section 56(1) of the said Act, OR complies with all minimum criteria as under:
i. has qualified nursing staff under its employment round the clock;
ii. has at least ten inpatient beds in towns having a population of less than ten lakhs and at least fifteen inpatient beds in all other places;
iii. has qualified medical practitioner (s) in charge round the clock;
iv. has a fully equipped operation theatre of its own where surgical procedures are carried out
v. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.

Hospitalization means admission in a hospital for a minimum period of twenty-four (24) consecutive 'In-patient care' hours except for specified procedures/ treatments, where such admission could be for a period of less than twenty-four (24) consecutive hours.

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

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.

Surgery / Surgical Procedure means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a hospital or day care centre by a medical practitioner.

Medically Necessary Treatment is defined as 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 insured;
- 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.

Accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a medical practitioner.

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

Medical Practitioner means a person who holds a valid registration from the Medical Council of any state or National Medical Commission or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his / her license. The medical practitioner should not be the insured or a close relative of the insured.

Pre-existing Disease means any condition, ailment, injury or disease:
a) that is/are diagnosed by a physician not more than 36 months prior to the date of commencement of the policy issued by the insurer; or

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

ANNEXURE 6: EXAMPLE OF DECREASING SUM INSURED COVER IN CASE OF A MINOR CLAIM

Example 1: Annual Decreasing Cover with minor claim at the end of 8th Policy Year.

If the Policy Term is 10 years with Sum Insured of 10,00,000 at inception and the minor claim is arising at the end of 8th Year, the Fixed Reduction Rate for an Annual Decreasing Cover will be equal to 1/10 = 10% rounded down to 5 decimal places. This reduction will be applied on the Sum Insured chosen at inception at each policy anniversary, starting from the beginning of the second year of the policy. The annual reduction schedule along with the corresponding Sum Insured applicable as detailed below:

Policy Year	Fixed Reduction Rate	Sum Insured Proportion at the start of each policy year	Sum Insured applicable at the start of each policy year
1st Year	10%	100%	1,000,000
2nd Year	10%	90%	900,000
3rd Year	10%	80%	800,000
4th Year	10%	70%	700,000
5th Year	10%	60%	600,000
6th Year	10%	50%	500,000
7th Year	10%	40%	400,000
8th Year	10%	30%	300,000
9th Year	10%	20%	125,000
10th Year	10%	10%	25,000

25% of 8th year Sum Insured is payable in case of minor claim, which is 3,00,000 * 25%= ‘75,000/-, once the claim is made the applicable Sum Insured thereafter will be 2,25,000 for the remaining 8th Policy Year and Sum Insured following the claim next year would reduce by the claim amount and then further decrease by 10%.

Sum Insured at the start of 9th year = 2,25,000 (Remaining Sum Insured from 8th year) - 10%*10,00,000 (Reduction at 10%) = 1,25,000

Example 2: Monthly decreasing cover with minor claim at the end of 96th Policy Month.

If the Policy Term is 10 years with Sum Insured of 10,00,000 at inception, the Fixed Reduction Rate for a Monthly Decreasing Cover will be equal to 1/120 = ~0.833% rounded down to 5 decimal places. This reduction will be applied on the Sum Insured chosen at inception at each monthly anniversary, starting from the beginning of the second month of the policy. The monthly reduction schedule along with the corresponding Sum Insured applicable as detailed below:

Policy Year	Policy Month	Fixed Reduction Rate	Sum Insured Proportion at the start of each Policy month	Sum Insured applicable at the start of each policy month
1st Year	1st Month	0.8330%	100%	1,000,000
1st Year	2nd Month	0.8330%	99%	991,670
1st Year	3rd Month	0.8330%	98%	983,340
1st Year	4th Month	0.8330%	98%	975,010
1st Year	5th Month	0.8330%	97%	966,680
1st Year	6th Month	0.8330%	96%	958,350
1st Year	7th Month	0.8330%	95%	950,020

1st Year	8th Month	0.8330%	94%	941,690
1st Year	9th Month	0.8330%	93%	933,360
1st Year	10th Month	0.8330%	93%	925,030
1st Year	11th Month	0.8330%	92%	916,700
1st Year	12th Month	0.8330%	91%	908,370
2nd Year	13th Month	0.8330%	90%	900,040
2nd Year	14th Month	0.8330%	89%	891,710
2nd Year	15th Month	0.8330%	88%	883,380
2nd Year	16th Month	0.8330%	88%	875,050
2nd Year	17th Month	0.8330%	87%	866,720
2nd Year	18th Month	0.8330%	86%	858,390
2nd Year	19th Month	0.8330%	85%	850,060
2nd Year	20th Month	0.8330%	84%	841,730
2nd Year	21st Month	0.8330%	83%	833,400
2nd Year	22nd Month	0.8330%	83%	825,070
2nd Year	23rd Month	0.8330%	82%	816,740
2nd Year	24th Month	0.8330%	81%	808,410
3rd Year	25th Month	0.8330%	80%	800,080
3rd Year	26th Month	0.8330%	79%	791,750
3rd Year	27th Month	0.8330%	78%	783,420
3rd Year	28th Month	0.8330%	78%	775,090
3rd Year	29th Month	0.8330%	77%	766,760
3rd Year	30th Month	0.8330%	76%	758,430
3rd Year	31st Month	0.8330%	75%	750,100
3rd Year	32nd Month	0.8330%	74%	741,770
3rd Year	33rd Month	0.8330%	73%	733,440
3rd Year	34th Month	0.8330%	73%	725,110
3rd Year	35th Month	0.8330%	72%	716,780
3rd Year	36th Month	0.8330%	71%	708,450
4th Year	37th Month	0.8330%	70%	700,120
4th Year	38th Month	0.8330%	69%	691,790
4th Year	39th Month	0.8330%	68%	683,460
4th Year	40th Month	0.8330%	68%	675,130
4th Year	41st Month	0.8330%	67%	666,800
4th Year	42nd Month	0.8330%	66%	658,470
4th Year	43rd Month	0.8330%	65%	650,140
4th Year	44th Month	0.8330%	64%	641,810
4th Year	45th Month	0.8330%	63%	633,480
4th Year	46th Month	0.8330%	63%	625,150
4th Year	47th Month	0.8330%	62%	616,820
4th Year	48th Month	0.8330%	61%	608,490
5th Year	49th Month	0.8330%	60%	600,160
5th Year	50th Month	0.8330%	59%	591,830
5th Year	51st Month	0.8330%	58%	583,500
5th Year	52nd Month	0.8330%	58%	575,170

5th Year	53rd Month	0.8330%	57%	566,840
5th Year	54th Month	0.8330%	56%	558,510
5th Year	55th Month	0.8330%	55%	550,180
5th Year	56th Month	0.8330%	54%	541,850
5th Year	57th Month	0.8330%	53%	533,520
5th Year	58th Month	0.8330%	53%	525,190
5th Year	59th Month	0.8330%	52%	516,860
5th Year	60th Month	0.8330%	51%	508,530
6th Year	61st Month	0.8330%	50%	500,200
6th Year	62nd Month	0.8330%	49%	491,870
6th Year	63rd Month	0.8330%	48%	483,540
6th Year	64th Month	0.8330%	48%	475,210
6th Year	65th Month	0.8330%	47%	466,880
6th Year	66th Month	0.8330%	46%	458,550
6th Year	67th Month	0.8330%	45%	450,220
6th Year	68th Month	0.8330%	44%	441,890
6th Year	69th Month	0.8330%	43%	433,560
6th Year	70th Month	0.8330%	43%	425,230
6th Year	71st Month	0.8330%	42%	416,900
6th Year	72nd Month	0.8330%	41%	408,570
7th Year	73rd Month	0.8330%	40%	400,240
7th Year	74th Month	0.8330%	39%	391,910
7th Year	75th Month	0.8330%	38%	383,580
7th Year	76th Month	0.8330%	38%	375,250
7th Year	77th Month	0.8330%	37%	366,920
7th Year	78th Month	0.8330%	36%	358,590
7th Year	79th Month	0.8330%	35%	350,260
7th Year	80th Month	0.8330%	34%	341,930
7th Year	81st Month	0.8330%	33%	333,600
7th Year	82nd Month	0.8330%	33%	325,270
7th Year	83rd Month	0.8330%	32%	316,940
7th Year	84th Month	0.8330%	31%	308,610
8th Year	85th Month	0.8330%	30%	300,280
8th Year	86th Month	0.8330%	29%	291,950
8th Year	87th Month	0.8330%	28%	283,620
8th Year	88th Month	0.8330%	28%	275,290
8th Year	89th Month	0.8330%	27%	266,960
8th Year	90th Month	0.8330%	26%	258,630
8th Year	91st Month	0.8330%	25%	250,300
8th Year	92nd Month	0.8330%	24%	241,970
8th Year	93rd Month	0.8330%	23%	233,640
8th Year	94th Month	0.8330%	23%	225,310
8th Year	95th Month	0.8330%	22%	216,980
8th Year	96th Month	0.8330%	21%	208,650
9th Year	97th Month	0.8330%	20%	148,158

9th Year	98th Month	0.8330%	19%	139,828
9th Year	99th Month	0.8330%	18%	131,498
9th Year	100th Month	0.8330%	18%	123,168
9th Year	101st Month	0.8330%	17%	114,838
9th Year	102nd Month	0.8330%	16%	106,508
9th Year	103rd Month	0.8330%	15%	98,177
9th Year	104th Month	0.8330%	14%	89,848
9th Year	105th Month	0.8330%	13%	81,517
9th Year	106th Month	0.8330%	13%	73,188
9th Year	107th Month	0.8330%	12%	64,857
9th Year	108th Month	0.8330%	11%	56,528
10th Year	109th Month	0.8330%	10%	48,197
10th Year	110th Month	0.8330%	9%	39,868
10th Year	111th Month	0.8330%	8%	31,537
10th Year	112th Month	0.8330%	8%	23,208
10th Year	113th Month	0.8330%	7%	14,878
10th Year	114th Month	0.8330%	6%	6,547
10th Year	115th Month	0.8330%	5%	0
10th Year	116th Month	0.8330%	4%	0
10th Year	117th Month	0.8330%	3%	0
10th Year	118th Month	0.8330%	3%	0
10th Year	119th Month	0.8330%	2%	0
10th Year	120th Month	0.8330%	1%	0

25% of 96th month Sum Insured is payable in case of minor claim, which is 208,650 * 25%= '52,163/-. Once the claim is made Sum Insured following the claim, next month would reduce by the claim amount and then further decrease by 0.8330%.

Sum Insured at the start of 97th month = 1,56,487 (Remaining Sum Insured from 96th month) - 0.8330%*10,00,000 (Reduction at 0.8330%) = 1,48,158

ANNEXURE A

Income Factors

Term	Income Factor	Term	Income Factor
1	100.00%	6	112.57%
2	102.56%	7	115.13%
3	104.90%	8	117.82%
4	107.53%	9	120.64%
5	109.89%	10	123.30%

OTHER TERMS & CONDITIONS

Tax Benefit

Tax benefits and liabilities under the Policy are subject to prevailing tax laws. Tax laws and the benefits arising there under are subject to change. You are advised to seek an opinion of a tax advisor in relation to applicable tax benefits and liabilities.

Free Look Period

The Master Policyholder and/or the Life Insured/Scheme Member, except for the Policy / Certificate of Insurance with tenure of less than a year, have a period of 30 days beginning from the date of receipt of the Policy/Certificate of Insurance, whether received electronically or otherwise, to review the terms and conditions of the Policy/Certificate of Insurance. If the Master Policyholder/ the member disagrees to any of the terms or conditions of the Policy/Certificate of Insurance and if no claim has been made under the Policy/Certificate of Insurance, the Master Policyholder/the Member has an option to return the original Policy/Certificate of Insurance by stating the objections/reasons for such disagreement in writing.

In case of Employer-Employee groups, where free look cancellation can only be exercised by the Master Policyholder and once exercised, the Policy shall terminate forthwith and all rights, benefits and interests under the coverage shall cease immediately and the cover in respect of all existing members will also cease immediately. If no claim has been made under the Policy, the Company will refund the premiums paid, after deducting the proportionate risk premium for the period of cover, charges of stamp duty and the expenses incurred on medical examination of the member(s), if any.

In case of Non-Employer-Employee groups, where free look cancellation is exercised by the Master Policyholder, the Policy shall terminate forthwith and all rights, benefits and interests under the coverage shall cease immediately. However, the cover in respect of existing members will continue as per the terms of Certificate of Insurance as applicable. No new members will be enrolled under the Policy. Where free look cancellation is exercised by member, Certificate of Insurance shall terminate forthwith and all rights, benefits and interests shall cease immediately. If no claim has been made under the Policy/Certificate of Insurance, the Company will refund the Premiums received, after deducting the proportionate risk premium for the period of cover, charges of stamp duty paid and the expenses incurred on medical examination of the member(s), if any.

Policy Discontinuance and Revival

Under One-Year Renewable Group Health Insurance, revival may be allowed within the policy term of one year. A policy lapsed within the policy term of one year due to non-payment of modal premium can be revived provided:

- Policyholder makes a written request for reinstatement to the Company.
- The policyholder producing an evidence of insurability (in form of declaration of health condition and/or relevant medical reports) of the Life Insured at his/her own cost which is acceptable to the Company as per Board approved underwriting policy.
- Policyholder pays all overdue premiums, together with late fee applicable on the date of revival and as determined by the Company from time to time depending upon the number of days between the date of lapse and the date of revival of the policy. The current revival interest rate structure is mentioned below:

No. of Days between lapse and revival of policy	Revival Interest Rate
0-60	Nil
61-180	RBI Bank Rate + 1% p.a. compounded annually on due premiums.
>180	RBI Bank Rate + 3% p.a. compounded annually on due premiums.

The revival will take effect only after it is approved by the Company as per the board approved underwriting policy and communicated to the policyholder in writing. The Company may not be liable to cover the claims occurring during the period for which the master policy is in lapsed condition.

The 'RBI Bank Rate' for the financial year ending 31st March (every year) will be considered for determining the revival interest rate.

On grounds of simplicity and operational ease, the revival interest rate is revised only if the RBI Bank Rate changes by 100 bps or more from the RBI Bank rate used to determine the prevailing revival interest rate (reviewed on every 31st March).

As the interest rate will be reviewed at the beginning of each financial year, any change in revival interest rate will be

applicable from 1st July to 30th June to allow sufficient time for making changes in the policy administration system.

The current 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 revival will take effect only after it is approved by the Company as per the Board approved underwriting policy and communicated to the policyholder in writing. The Company may not be liable to cover the claims occurring during the period for which the master policy is in lapsed condition.

Full Disclosure & Incontestability:
We draw your attention to Section 45 and statutory warning under Section 41 of the Insurance Act 1938 as amended from time to time – which reads as follows:

SECTION 45 OF THE INSURANCE ACT, 1938 AS AMENDED FROM TIME TO TIME STATES THAT:

(1) No policy of life insurance shall be called in question on any ground whatsoever after the expiry of three years from the date of the policy, i.e. from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy whichever is later.

(2) A policy of life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground of fraud:

Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees of the insured the grounds and materials on which such decisions are based.

Explanation I – For the purposes of this sub-section, the expression "fraud" means any of the following acts committed by the 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 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 specially declares to be fraudulent.

Explanation II – Mere silence as to facts likely to affect the assessment of the risk by the insurer is not fraud, unless the circumstances of the case are such that regard being had to them, it is the duty of the insured or his agent, keeping silence to speak, or unless his silence is, in itself, equivalent to speak.

(3) Notwithstanding anything contained in sub-section (2) no insurer shall repudiate a life insurance policy on the ground of fraud if the insured can prove that the mis-statement of or suppression of a material fact was true to the best of his knowledge and belief or that such mis-statement of or suppression of a material fact are within the knowledge of the insurer:

Provided that in case of fraud, the onus of disproving lies upon the beneficiaries, in case the member is not alive.

Explanation – A person who solicits and negotiates a contract of insurance shall be deemed for the purpose of the formation of the contract, to be the agent of the insurer.

(4) A policy of the life insurance may be called in question at any time within three years from the date of issuance of the policy or the date of commencement of risk or the date of revival of the policy or the date of the rider to the policy, whichever is later, on the ground that any statement of or suppression of a fact material to the

expectancy of the life of the insured was incorrectly made in the proposal or other document on the basis of which the policy was issued or revived or rider issued:

Provided that the insurer shall have to communicate in writing to the insured or the legal representatives or nominees of the insured the grounds and material on which such decision to repudiate the policy of life insurance is based:

Provided further that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation shall be paid to the insured or the legal representatives or nominees of the insured within a period of ninety days from the date of such repudiation

Explanation – For the purposes of this sub-section, the mis-statement of or suppression of fact shall not be considered material unless it has a direct bearing on the risk undertaken by the insurer, the onus is on the insurer to show that had the insurer been aware of the said fact no life insurance policy would have been issued to the insured.

(5) Nothing in this section shall prevent the insurer from calling 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 that the age of the life insured was incorrectly stated in the proposal.

PROHIBITION OF REBATES: SECTION 41 OF THE INSURANCE ACT, 1938 AS AMENDED FROM TIME TO TIME STATES:

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

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

NOMINATION

Nomination shall be applicable in accordance with provisions of Section 39 of the Insurance Act 1938 respectively, as amended from time to time.

ASSIGNMENT

Assignment shall be applicable in accordance with provisions of Section 38 of the Insurance Act 1938 respectively, as amended from time to time.

Expert Advice at Your Doorstep:

Our distributors have been professionally trained to understand and evaluate your unique financial requirements and recommend a policy which best meets your needs. With experienced and trained distributors, we are fully resourced to help you achieve your life's financial objectives. Please call us today. We would be delighted to meet you.

CLAIM PAYMENT PROCEDURE

Handling of claims

1. For processing a claim request under this Policy, we will require all of the following documents based on Benefit Option chosen:

Documents required for Fixed Daily Hospitalization Cash Benefit and Fixed Surgical Care Benefit:

a) Duly filled and signed 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) Photo copy 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) Proof of undergoing Surgery with surgical notes and its necessary documents;
h) In addition to the above mandatory documents, if the admission is more than 48 hrs , please provide the below
    I. Copy of all Indoor Case Papers/ In hospital records.
    II. Copy of all medical tests done during hospitalization
    III. All Pre and Post Hospitalization records.
    IV. first consultation report confirming the disease or condition by registered Medical Practitioner;
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.

Documents required for Critical Illness:

a) Duly filled and signed Claimant's statement in the prescribed form;
b) Copy of photo ID / KYC documents of Insured if applicable;
c) PAN card of claimant / Insured;
d) Photo copy of Hospital Discharge summary and final bill or Hospital bill summary;
e) Original cancelled cheque with pre- printed name and account number of claimant on it;
f) All confirmatory diagnostic reports confirming the diagnosis of critical illness;
g) Copy of all Indoor Case Papers/ In hospital records;
h) 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.

Documents required for Accidental Total Permanent Disability and optional Accidental Death 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 and Insured;
e) Disability Certificate issued by the Medical CMO;
f) Copy of Driving License (In case of Road traffic accident);
g) Original cancelled cheque with pre- printed name 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 optional Accidental Death Benefit) issued by the local/municipal authority.

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 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) 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;

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 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

2 Notwithstanding anything contained in this Policy, the following shall apply:

2.1 We may make the payment of outstanding loan balance amount to the Master policyholder by deducting from the claim proceeds payable under the Policy, in accordance with IRDAI guidelines as amended from time to time provided the Members provide authorization to do so. The Members may provide the said authorization either on the Entry Date or at a later date;

2.2 You 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;

2.3 We reserve the right to:

2.3.1 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 You; or

2.3.2 You shall provide a certification from Your 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.

2.4 In case of absence of authorization, the entire claim amount shall be payable to the nominee/ beneficiary.

2.5 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.
For claims related to Fixed Daily Hospitalisation Cash Benefit and Fixed Surgical Care Benefit, a Claimant may contact the TPA at the details mentioned on Our website https://www.axismaxlife.com

2.6 Subject to the provisions of Section 45 of the Insurance Act, 1938, as amended from time to time, we shall pay the benefits under this Policy subject to Our satisfaction:

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

2.6.2 of the bonafides and credentials of the Claimant.

2.7 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 this Policy.

2.8 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.

Important Notes:

- This is only a prospectus. It does not purport to be a contract of insurance and does not in any way create any rights and/or obligations. All the benefits are payable subject to the terms and conditions of the Policy.
- Extra Premium may be charged for substandard lives.
- Benefits are available provided all premiums are paid, as and when they are due.

- Taxes, cesses & levies as imposed by Government from time to time would be levied as per applicable laws.
- All Policy benefits are subject to policy being in force.
- "We", "Us", "Our" or the "Company" means Axis Max Life Insurance Limited.
- "You" or "Your" means the Policyholder.

Should you/member(s) need(s) any further information from us, please do not hesitate to contact on the below mentioned address and numbers. We look forward to have you as a part of the Axis Max Life family.

For other terms and conditions, request your Agent Advisor or our distributor for giving a detailed presentation of the product before concluding the sale.

CONTACT DETAILS OF THE COMPANY

Company Website
https://www.axismaxlife.com

Registered Office
Axis Max Life Insurance Limited
419, Bhai Mohan Singh Nagar, Railmajra, Tehsil Balachaur, District Nawanshahr,
Punjab -144 533 Tel: (01881) 462000

Communication Address
Axis Max Life Insurance Limited
Plot No. 90C, Sector 18,
Gurugram – 122015, Haryana, India.
Tel No.: (0124) 4219090

Customer Helpline Number: 1860 120 5577
Customer Service Timings: 9:00 AM - 6:00 PM Monday to Saturday (except National holidays) or SMS 'Life' to 5616188

Disclaimers:
Axis Max Life Insurance Limited, formerly known as Max Life Insurance Company Ltd , is a Joint Venture between Max Financial Services Limited ("MFSL") and Axis Bank Limited. Corporate Office: 11th Floor, DLF Square Building, Jacaranda Marg, DLF City Phase II, Gurugram (Haryana)-122002. For more details on risk factors, terms and conditions, please read the prospectus carefully before concluding a sale. You may be entitled to certain applicable tax benefits on your premiums and policy benefits. Please note all the tax benefits are subject to tax laws prevailing at the time of payment of premium or receipt of benefits by you. Tax benefits are subject to changes in tax laws. Insurance is the Subject matter of solicitation. You can call us on our Customer Helpline No. 1860 120 5577.

Website: https://www.axismaxlife.com

ARN: AxisMaxLife/Group SHIP/V01/July 2025
IRDAI Regn. No – 104

BEWARE OF SPURIOUS / FRAUD PHONE CALLS!

- IRDAI is not involved in activities like selling insurance policies, announcing bonus or investment of premiums.
- Public receiving such phone calls are requested to lodge a police complaint