HDFC ERGO General Insurance Company Limited

Policy Wordings

my: Sampoorna Suraksha

PREAMBLE

We will provide Insurance coverage to the **Insured Person**(s) under this Policy up to **Sum Insured** including **Cumulative Bonus** as applicable and subject to waiting periods, limits, Sub-limits, **Co-payment**, Time Deductible, **Deductible**, and **Aggregate Deductible** as specified in Schedule of Coverage on the Policy Schedule. The Policy is based on statements, disclosures, declarations made in the Proposal form/Enrollment form and Medical reports.

Certain words used in the Coverage description have specific meanings which are mentioned in Definitions and which impacts the Coverage. All such words, are mentioned in **Bold** to enable **You** to identify that the particular word has a specific meaning for which You need to refer Section – A, Definitions.

Section A- Definitions

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

1. Standard General Definitions Applicable to my:health Suraksha , my:health Critical Suraksha Plus , my:health Medisure Super Top up Insurance , my:health Hospital cash Benefit Add on , my:health Koti Suraksha-Personal Accident & Travel Insurance

Def. 1. **Accident or Accidental** means a sudden, unforeseen andinvoluntary event caused by external, visible and violent means.

Def. 2. **Any one illness** means continuous period of **Illness** and includes relapse within 45 daysfrom the date of last consultation with the Hospital/Nursing Home where treatment was taken.

Def. 3. **AYUSH HOSPITAL** means an AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital; or

b. Teaching hospital attached to AYUSH College recognized by the Central Government /Central Council of Indian Medicine/Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located within-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 4. **AYUSH Day Care Centre** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner (s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

Def. 5. **Cashless Facility** means a facility extended by the **Insurer** to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the **Network Provider** by the **insurer** to the extent pre-authorization is approved.

Def. 6. **Condition Precedent** means a policy term or condition upon which the **Insurer's** liability under the policy is conditional upon

Def. 7. **Congenital Anomaly** means a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

a) **Internal Congenital Anomaly**: Congenital Anomaly which is not in the visible and accessible parts of the body.

b) **External Congenital Anomaly**: Congenital Anomaly which is in the visible and accessible parts of the body

Def. 8. **Co-Payment** means a cost sharing requirement under a health insurance policy that provides that the policyholder/ insured will bear a specified percentage of the admissible claims amount. A **Co-Payment** does not reduce the Sum Insured

Def. 9. **Cumulative Bonus** means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.

Def. 10. **Day care Centre** means any institution established for **Day Care Treatment** of **Illness** and / or injuries or a medical set -up with a **Hospital** and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criterionas 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

Def. 11. **Day Care Treatment/ Procedures** means those medical treatment, and/or surgical procedure which is

i) undertaken under General or Local Anaesthesia in a **Hospital/Day Care Centre** in less than 24 hours because of technological advancement, and

ii) which would have otherwise required **Hospitalization** of more than 24 hours,

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

Def. 12. **Deductible** means a cost sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount in case of indemnity policies and for a specified number of days/hours in case of Hospital cash policies, which will apply before any benefits are payable by the insurer. A Deductible does not reduce the sum insured.

Def. 13. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery

Def. 14. **Disclosure of information norm** means the policy shall be void and all premiums paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

Def. 15. **Domiciliary Hospitalization** means medical treatment for an Illness/disease/Injury which in the normal course would require care and treatment at a Hospital but is actually taken while confined at home under any of the following circumstances:

I. the condition of the patient is such that he/she is not in a condition to be removed to a Hospital, or

II. the patient takes treatment at home on account of non-availability of room in a Hospital

Def. 16. **Emergency Care** means management for an **Illness** or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment of the insured person's health.

Def. 17. **Grace Period** means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of pre –existingdiseases. Coverage is not available for the period for which no premium is received.

Def. 18. **Hospital** means any institution established for In-patient Care and **Day Care Treatment** of **Illness** and/or injuries and which has been registered as a **Hospital** with the local authorities under the clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

- has at least 10 in-patient beds, in towns having a population of less than 10,00,000 and 15 in-patient beds in all other places,
- has qualified nursing staff under its employment round the clock,
- has qualified Medical Practitioner(s) in charge round the clock,
- has a fully equipped operation theatre of its own where surgical procedures are carried out,
- maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Def. 19. **Hospitalization** means admission in a **Hospital** for a minimum period of 24 consecutive 'In-patient Care' hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Def. 20. **Illness/ Illnesses** 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

(a) **Acute condition** - Acute condition is a disease, **Illness or Injury** that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ **Illness/ Injury** which leads to full recovery

(b) **Chronic condition** - A chronic condition is defined as a disease, **Illness, or Injury** that has one or more of the following characteristics:

1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Def. 21. **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.

Def. 22. **In-patient Care** means treatment for which the Insured Person has to stay in a **Hospital** for more than 24 hours for a covered event.

Def. 23. **Intensive Care Unit** means an identified section, ward or wing of a **Hospital** which is under the constant supervision of a dedicated Medical Practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

Def. 24. **ICU (Intensive Care Unit)Charges** means the amount charged by a **Hospital** towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensive charges

Def. 25. **Maternity Expenses** means

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean Section Bncurred during Hospitalization).

b. Expenses towards lawful medical termination of pregnancy during the policy Period.

Def. 26. **Major Illness means:**

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

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 Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;**2. Open Chest CABG**

I. 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.

II. The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures

3. Myocardial Infarction (First Heart Attack of specific severity)

I. 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:

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

   b. New characteristic electrocardiogram changes

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

II. The following are excluded:

   a. Other acute Coronary Syndromes

   b. Any type of angina pectoris

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

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 (hemodialysis 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 Transplantation

The actual undergoing of a transplant of:

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

   b. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

he following are excluded:

   a. Other stem-cell transplants

   b. Where only islets of langerhans are transplanted

6. Multiple Sclerosis with persisting symptoms

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

   a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

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

II. Neurological damage due to SLE is excluded.

7. 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.

8. Stroke resulting in permanent symptoms

I. Any cerebrovascular incident producing permanent neurological sequelae.

   a. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.

   b. 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.

II. The following are excluded:

   a. Transient ischemic attacks (TIA)
   b. Traumatic injury of the brain
   c. Vascular disease affecting only the eye or optic nerve or vestibular functions.

9. Surgery of Aorta

The actual undergoing of medically necessary surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Traumatic injury of the aorta is excluded.

10. Primary (Idiopathic) Pulmonary Hypertension

I. 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.

II. 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.

III. 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.

11. 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.

Def. 27. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow upprescription.

Def. 28. **Medical Expenses** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of **Illness** or **Accident** on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or Medical practitioners in the same locality would have charged for the same medical treatment.

Def. 29. **Medically Necessary treatment** means any treatment, test, medication, or stay in **Hospital** or part of stay in Hospital which

- Is required for the medical management of the I**llness or Injury** suffered by the Insured Person;
- 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.

Def. 30. **Medical Practitioner** means a person who holds a valid registration from the Medical Council of any State or Medical Council of India 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 license.Medical Practitioner who is sharing the same residence with the Insured person`s and is a member of Insured Person's family are not considered as Medical Practitioner under the scope of this Policy.

Medical practitioner for mental illnesses means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Act;

Medical Practitioner (Definition applicable for the treatment taken outside India)

Means a licensed medical practitioner acting within the scope of hislicense and who holds a degree of a recognized institution and isregistered by the Authorized Medical Council of the respectivecountry.

Def. 31. **New-born Baby** means baby born during the Policy Period and is Aged up to 90 days

Def. 32. **Network Provider** means **Hospitals** or health care

providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a Cashless facility.

Def. 33. **Non Network** means any **Hospital**, **Day Care Centre** or other provider that is not part of the Network

Def. 34. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication

Def. 35. **Portability** means, the right accorded to individual health insurance policyholders (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer.

Def. 36. **Pre-existing disease** means any condition, ailment, **injury or disease**:

i. That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement or

ii. For which Medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy or its reinstatement.

Def. 37. **Preventive Health Check-up** - Preventive Health Check-up means a package of medical test(s) undertaken for general assessment of health status, it does not include any diagnostic or investigative medical tests for evaluation of illness or a disease.

Def. 38. **OPD Treatment.** OPD treatment means the one in which the Insured visits a clinic / Hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Def. 39. **Pre-hospitalization Medical Expenses** means **Medical Expenses** incurred during pre-defined number of days

preceding the Hospitalization of the Insured Person, provided that:

i. Such **Medical Expenses** are incurred for the same condition for which the Insured Person's **Hospitalization** was required, and

ii. The In-patient **Hospitalization** claim for such **Hospitalization** is admissible by the Insurance Company

Def. 40. **Post-hospitalization Medical Expenses** means **Medical Expenses** incurred during pre-defined number of days immediately after the insured person is discharged from the Hospital provided that:

i. Such **Medical Expenses** are for the same condition for which the insured person's **Hospitalization** was required, and

ii. The inpatient **Hospitalization** claim for such **Hospitalization** is admissible by the insurance company.

Def. 41. **Qualified Nurse** is a person who holds a valid registration from the nursing council of India or the nursing council of any state in India

Def. 42. **Renewal** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of Grace Period for treating the Renewal continuous for the purpose of gaining credit for **Pre-Existing Diseases**, time-bound exclusions and for all **waiting periods**

Def. 43. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the Associated Medical Expenses

Def. 44. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for a specific provider and consistent with the prevailing charges in the geographical area for identical or similar services ,taking into account the nature of Illness/ Injury involved.

Def. 45. **Surgery or Surgical Procedure** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering and prolongation of life, performed in a **Hospital** or **Day Care Centre** by a medical practitioner.

Def. 46. **Unproven/Experimental Treatment** is a treatment including drug experimental therapy which is not based on established medical practice in India, is a treatment experimental or unproven.

2. Specific Definitions

Def. 1. **Adventurous/Hazardous Sports** means any sport or activity involving physical exertion and skill in which an Insured Person participates or competes for entertainment or as part of his Profession whether he / she is trained or not.

Def. 2. **Age or Aged** means completed years as at the Policy Commencement Date.

Def. 3. **Alternative treatments** means forms of treatments other than treatment "Allopathic" or "modern medicine" and includes Ayurveda, Unani, Sidha,Homeopathy, Yoga & Naturopathy in the Indian context.

Def. 4. **Aggregate Deductible:** Aggregate deductible is a cost-sharing requirement under a health insurance policy that provides that the Company will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the Company. An Aggregate deductible does not reduce the Sum Insured. The deductible is applicable in aggregate towards hospitalization expenses incurred which are admissible under this Policy (and not excluded) during the policy year by insured person (individual Sum Insured policy) or insured family (in case of floater sum insured policy).

Def. 5. **Associated Medical Expenses** means Consultation fees, charges on Operation theatre, surgical appliances & nursing, and expenses on Anesthesia, blood, oxygen incurred during Hospitalization of the Insured Person

Def. 6. **Base Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for respective Cover during the life time of the Policy.

Def. 7. **Bank Rate** means the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.

Def. 8. **Biological attack or weapons** the emission, discharge, dispersal, release or escape of any pathogenic (disease

producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

Def. 9. **Break in Policy** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof

Def. 10. **Catastrophic Event** means and includes Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Tsunami, Flood, Inundation and Earthquake.

Def. 11. **Chemical attack or weapons** means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

Def. 12. **Commencement Date** means the commencement date of the Policy as specified in the Policy Schedule.

Def. 13. **Coma/Comatose State** means 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.

v. Coma resulting directly from alcohol or drug abuse is excluded.

Def. 14. **Common Carrier** means any land, sea or air conveyance operated under a licence issued by a governmental authority having jurisdiction, for the transportation of fare paying passengers and which has fixed, established routes only.

Def. 15. **Dependent Child/Children** means living dependent child or children of **Insured Person** up to age of 25 years as on date of Injury, including legally adopted and step- children.

Def. 16. **Dependents** means only the family members listed below:

a) Your legally married spouse as long as she continues to be married to You

b) Your children Aged between 91 days and 25 years if they are unmarried, still financially dependent on You and have not established their own independent households;

c) Your natural parents or parents that have legally adopted You, and Your parents in law

Def. 17. **Dependent Parents** means Your natural parents, parents that have legally adopted you or Your parents in law.

Def. 18. **Family Floater** means a Policy described as such in the Policy Schedule where under You and Your Dependents (Spouse, dependent children, dependent parents/parents in laws) named in the Policy Schedule are insured under this Policy as at the Commencement Date.

Def. 19. **Insured Person** means the persons named in the Policy Schedule and insured under the Policy.

Def. 20. **Life threatening situation shall** mean a serious medical condition or symptom resulting from Injury or Illness which is not **pre-existing** disease, which arises suddenly and unexpectedly, and requires immediate care and treatment by a **Medical Practitioner,** generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an Emergency anymore.

Def. 21. **Material Facts** means all relevant information sought by the Company in the Proposal Form and other connected documents to enable it to take informed decision in the context of underwriting the risk.

Def. 22. **Mental illness** means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence;

Def. 23. **Mental health establishment** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental Illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental **Illness** are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general **Hospital** or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental **Illness** resides with his relatives or friends;

Def. 24. **Migration** means, the right accorded to the health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer.

Def. 25. **HDFC ERGO Mobile App** is a proprietary App of HDFC ERGO General Insurance Company. With this App you can:

o Access **Your** Policy Details

- Manage **Your** policy, download **Your** policy schedule and access to Your e-card will always be at Your fingertips, 24 x 7.

o Policy Endorsement made easy

- By submitting a request to us through my: Health App, you can make any modifications in **Your** policy, for e.g. change in spelling of the name, contact number etc.

o Effortless Claims Management

- Now you can Submit Your claims from the app for faster

processing and track the status at Your fingertips. You can also intimate a claim using the app. You can also view Network hospitals in **Your** area with directions.

o Stay Active – Short Walks, Big Benefits

- The App tracks **Your** steps, fitness session and lets you earn incentive on renewal discount on Your policy.

Def. 26. **Non-Medical Expenses** – Are expenses other than those defined as Medical Expenses and which are listed on our website www.hdfcergo.com

Def. 27. **Nuclear attack** means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

Def. 28. **Permanent Total Disablement** means that the Insured Person is totally disabled from undertaking all the material duties of his/her usual occupation for which the **Insured Person** is reasonably fitted by training, education or experience for a continuous period of 365 days and, at the expiration of the 365 days period, it is reasonably certain that such disability will persist throughout the Insured Person's lifetime.

Def. 29. **Policy** means Your statements in the proposal form (which are the basis of this Policy), this **policy** wording (including endorsements, if any), and the Policy Schedule (as the same may be amended from time to time).

Def. 30. **Policy Period** means the period between the Commencement Date and the Expiry Date specified in the Policy Schedule

Def. 31. **Policy Holder** means Person who has proposed the Policy and in whose name the Policy is issued

Def. 32. **Policy Schedule** means Schedule attached to and forming part of this Policy mentioning the details of the **Insured Persons**, the Sum Insured, the period and the limits to which benefits under the **Policy** are subject to (Schedule of coverage), including any Annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.

Def. 33. **Policy Year** means a year following the Commencement Date and its subsequent annual anniversary.

Def. 34. **Sum Insured** means the sum shown in the Policy Schedule which represents Our maximum liability for each **Insured Person** for any and all benefits claimed for during the Policy Year, and in relation to a Family Floater represents Our maximum liability for any and all claims made by You and all of Your Dependents during the Policy Year.

Def. 35. **Sub-limit** means a cost sharing requirement under a health insurance **policy** in which an insurer would not be liable to pay any amount in excess of the pre-defined limit

Def. 36. **Time Deductible** means a cost sharing requirement under a health insurance **Policy** that provides that the Insurer will not be liable for a specified number of days, which will apply before any benefits are payable by the insurer. A **Time Deductible** does not reduce the **Sum Insured**

Def. 37. **Temporary Total Disablement** means disablement which temporarily and entirely prevents an Insured Person from engaging in or giving attention to the Insured Person's usual occupation for a continuous period mentioned in the Schedule of Coverage on the Policy Schedule.

Def. 38. **Temporary Partial Disablement** means disablement which temporarily and partially prevents an Insured Person from engaging in or giving attention to the Insured Person's usual occupation.

Def. 39. **We/Our/Us** means the HDFC ERGO General Insurance Company Limited

Def. 40. You/Your/Policyholder means the person named in the Policy Schedule who is insured under the Policy or has proposed and concluded this Policy with Us.

3. Standard Definitions of Critical Illnesses/ Surgical Procedures Applicable to Section B-2: my:health Critical Suraksha Plus

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:

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

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

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

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

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

xv. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

2. Major Organ Transplant – Bone Marrow

I. The actual undergoing of a transplant of Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

3. Open Chest CABG

I. 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.

II. The following are excluded:

a. Angioplasty and/or any other intra-arterial procedures

4. Myocardial Infarction (First Heart Attack of specific severity)

III. 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:

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

e. New characteristic electrocardiogram changes

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

IV. The following are excluded:

d. Other acute Coronary Syndromes

e. Any type of angina pectoris

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

5. 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.

6. Primary (Idiopathic) Pulmonary Hypertension

IV. 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.

V. The NYHA Classification of Cardiac Impairment are as follows:

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

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

VI. 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.

7. Angioplasty

i. 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).

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

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

8. Multiple Sclerosis with persisting symptoms

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

a. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and

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

IV. Neurological damage due to SLE is excluded.

9. Permanent Paralysis of Limbs

a. 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.

10. Stroke resulting in permanent symptoms

III. Any cerebrovascular incident producing permanent neurological sequelae.

a. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source.

b. 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.

IV. The following are excluded:

a. Transient ischemic attacks (TIA)

b. Traumatic injury of the brain

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

11. Benign Brain Tumor

I. 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 by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the elevant medical specialist.

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

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

III. 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.

12. Coma of specified severity

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   a. no response to external stimuli continuously for at least 96 hours;
   b. life support measures are necessary to sustain life; and
   c. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner.
   a. Coma resulting directly from alcohol or drug abuse is excluded.

13. 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.

14. Major Head Trauma

I. 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.

II. 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.

III. The Activities of Daily Living are:
   i. 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;
   ii. Dressing: the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
   iii. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
   iv. Mobility: the ability to move indoors from room to room on level surfaces;
   v. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   vi. Feeding: the ability to feed oneself once food has been prepared and made available.

IV. The following are excluded:
   i. Spinal cord injury;

15. Loss of Speech

I. 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.

16. Kidney failure requiring regular dialysis

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

17. End Stage Liver Failure

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:
   a. Permanent jaundice; and
   b. Ascites; and
   c. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

18. Deafness

I. 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.

19. Blindness

I. Total, permanent and irreversible loss of all vision in both eyes as a result of illness or accident.

II. The Blindness is evidenced by:
   a. corrected visual acuity being 3/60 or less in both eyes or;
   b. the field of vision being less than 10 degrees in both eyes.

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

20. 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.

4. Specific Definitions of Critical Illnesses/ Surgical Procedures Applicable to Section B-2: my:health Critical Suraksha Plus

1) Major Organ Transplant – Heart

I. The actual undergoing of a transplant of heart, that resulted from irreversible end-stage failure of the relevant organ

a. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

2) Malignant Cancer of Specified sites (Female) – Breast, Cervix, Uterus, Fallopian Tube, Ovary, Vagina/Vulva

A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

The following are excluded:

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

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 Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. Tumors of any other sites except Breast, Cervix, Uterus, Fallopian Tube, Ovary, Vagina/Vulva

3) Malignant Cancer of Specified sites (Male)-Head and Neck, Lung, Stomach, Colorectum, Prostate

A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

The following are excluded:

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

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 Tumours histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

ix. Tumors of any other sites except Head and Neck, Lung, Stomach, Colorectum, Prostate

4) Carcinoma In Situ (CiS)

Carcinoma-in-situ shall mean first ever histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma in any one of the following covered organ groups, and subject to any classification stated:

i. Breast, where the tumour is classified as Tis according to the TNM Staging method;

ii. Corpus uteri, vagina, vulva or fallopian tubes where the tumour is classified as Tis according to the TNM Staging method or FIGO (staging method of the Federation Internationale de Gynecologie et d'Obstetrique) Stage 0;

iii. Cervix uteri, classified as cervical intraepithelial neoplasia grade III (CIN III) or as Tis according to the TNM Staging method or FIGO Stage 0;

iv. Ovary –include borderline ovarian tumours with intact capsule, no tumour on the ovarian surface, classified as T1aN0M0, T1bN0M0 (TMN Staging) or FIGO 1A, FIGO 1B

v. Colon and rectum; Penis; Testis; Lung; Liver; Stomach, Nasopharynx and oesophagus;

vi. Urinary tract, for the purpose of in-situ cancers of the bladder, stage Ta of papillary Carcinoma is included.

The diagnosis of the Carcinoma in situ must always be supported by a histopathological report. Furthermore, the diagnosis of Carcinoma in situ must always be positively diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical diagnosis does not meet this standard.

5) Early Stage Cancer

Early stage Cancers shall mean first ever presence of one of the following malignant conditions:

i. Prostate Cancer that is histologically described using the TNM Classification as T1N0M0 or Prostate cancers

described using another equivalent classification.

ii. Thyroid Cancer that is histologically described using the TNM Classification as T1N0M0.

iii. Tumours of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification).

iv. Chronic Lymphocytic Leukaemia (CLL) RAI Stage 1 or 2. CLL RAI Stage 0 or lower is excluded.

v. Malignant melanoma that has not caused invasion beyond the epidermis. Other skin carcinoma are excluded.

vi. Hodgkin's lymphoma Stage I by the Cotswolds classification staging system.

The Diagnosis must be based on histopathological features and confirmed by a Pathologist.

6) Aplastic Anaemia

Def. 1. **Chronic persistent** bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

I. Blood product transfusion;

II. Marrow stimulating agents;

III. Immunosuppressive agents; or

IV. Bone marrow transplantation.

Def. 2. **The diagnosis** must be confirmed by a hematologist using relevant laboratory investigations including Bone Marrow Biopsy resulting in bone marrow cellularity of less than 25% which is evidenced by any two of the following:

(a) Absolute neutrophil count of less than 500/mm^3 or less

(b) Platelets count less than 20,000/mm^3 or less

(c) Reticulocyte count of less than 20,000/mm^3 or less

Def. 3. Temporary or reversible Aplastic Anaemia is excluded.

7) Surgery of Aorta

The actual undergoing of medically necessary surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. Traumatic injury of the aorta is excluded.

8) Other serious coronary artery disease

I. Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only (non-invasive diagnostic procedures excluded).

II. For purposes of this definition, "major coronary artery" refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches).

9) Dissecting Aortic Aneurysm

I. A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a Registered Medical practitioner who is a specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.

10) 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:

i. Class IV – inability to carry out an activity without discomfort. Symptoms of congestive cardiac failure are present even at rest. With any increase in physical activity, discomfort will be experienced.

ii. The Diagnosis of Cardiomyopathy has to be supported by echographic findings of compromised ventricular performance.

iii. Irrespective of the above, Cardiomyopathy directly related to alcohol or drug abuse is excluded.

11) Infective Endocarditis

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

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

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

(f) The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a Registered Medical practitioner who is a cardiologist.

12) Eisenmenger's Syndrome

Development of severe pulmonary hypertension and shunt reversal resulting from heart condition. The diagnosis must be made by a Registered Medical practitioner who is a specialist with echocardiography and cardiac catheterization and supported by the following criteria:

1. Mean pulmonary artery pressure > 40 mm Hg;

2. Pulmonary vascular resistance > 3mm/L/min (Wood units); and

3. Normal pulmonary wedge pressure < 15 mm Hg.

13) Balloon Valvotomy or Valvuloplasty

An interventional procedure involving Percutaneous heart valve repair by balloon valvotomy or valvuloplasty to repair narrowing of heart valves using a catheter.

Payout will be based on the actual undergoing of surgery. The need for surgery should be certified by a cardiologist and supported by an echocardiography

14) Insertion of Pacemaker

Insertion of a permanent cardiac pacemaker that is required as a result of life threatening cardiac arrhythmias, cardiomyopathy

or any other condition which cannot be treated via other means.

The insertion of the cardiac pacemaker must be certified to be absolutely necessary by a specialist in the relevant field.

15) Parkinson's Disease

I. The occurrence of Parkinson's Disease where there is an associated Neurological Deficit that results in Permanent Inability to perform independently at least three of the activities of daily living as defined below.

1. **Transfer:** Getting in and out of bed without requiring external physical assistance
2. **Mobility:** The ability to move from one room to another without requiring any external physical assistance
3. **Dressing:** Putting on and taking of all necessary items of clothing without requiring any external physical assistance
4. **Bathing/Washing:** The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by other means
5. **Eating:** All tasks of getting food into the body once it has been prepared

II. Parkinson's disease secondary to drug and/or alcohol abuse is excluded.

16) Alzheimer's Disease

Clinically established diagnosis of Alzheimer's Disease (presenile dementia) resulting in a permanent inability to perform independently three or more activities of daily living – bathing, dressing/undressing, getting to and using the toilet, transferring from bed to chair or chair to bed, continence, eating/drinking and taking medication – or resulting in need of supervision and permanent presence of care staff due to the disease. These conditions have to be medically documented for at least 3 months.

17) Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The diagnosis of muscular dystrophy must be unequivocal and made by a Registered Medical practitioner who is a consultant neurologist. The condition must result in the inability of the Insured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

Activities of daily living:

a. **Washing:** the ability to wash in the bath or shower (including getting into and out of the shower) or wash satisfactorily by other means and maintain an adequate level of cleanliness and personal hygiene;

b. **Dressing:** the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

c. **Transferring:** The ability to move from a lying position in a bed to a sitting position in an upright chair or wheel chair and vice versa;

d. **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;

e. **Feeding:** the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.

f. **Mobility:** The ability to move indoors from room to room on level surfaces at the normal place of residence

18) Apallic Syndrome

Universal necrosis of the brain cortex with the brainstem remaining intact. The diagnosis must be confirmed by a Neurologist acceptable to Us and the condition must be documented for at least one month.

19) Bacterial Meningitis

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

i. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and

ii. A consultant neurologist.

20) Creutzfeldt-Jakob Disease (CJD)

Creutzfeldt-Jacob disease is an incurable brain infection that causes rapidly progressive deterioration of mental function and movement. A Registered Medical practitioner who is a neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging. There must be objective neurological abnormalities on exam along with severe progressive dementia.

21) Encephalitis

I. Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This diagnosis must be certified by a Registered Medical practitioner who is a consultant neurologist and the permanent neurological deficit must be documented for at least 6 weeks.

22) Progressive Supranuclear Palsy

Confirmed by a Registered Medical practitioner who is a specialist in neurology of a definite diagnosis of progressive supranuclear palsy. There must be permanent clinical impairment of motor function, eye movement disorder and postural instability.

23) Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included however, minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolizations, thrombolysis and stereotactic biopsy are all excluded. Brain surgery as a result of an Accident is also excluded. The procedure must be considered medically necessary by a Registered Medical practitioner who is a qualified specialist.

24) Major Organ Transplant – Kidney, Lung, Liver and Pancreas

The actual undergoing of a transplant of:

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

b. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

a. Other stem-cell transplants

b. Where only islets of langerhans are transplanted

25) Medullary Cystic Disease

I. Medullary Cystic Disease where the following criteria are met:

a. the presence in the kidney of multiple cysts in the renal medulla accompanied by the presence of tubular atrophy and interstitial fibrosis;

b. clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and

c. the Diagnosis of Medullary Cystic Disease is confirmed by renal biopsy.

II. Isolated or benign kidney cysts are specifically excluded from this benefit.

26) Systemic Lupus Erythematous with LupusNephritis

i. A multi-system autoimmune disorder characterised by the development of autoantibodies directed against various self-antigens. In respect of this Policy, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class V Lupus Nephritis, established by renal biopsy, and in accordance with the WHO Classification). The final diagnosis must be confirmed by a Registered Doctor specialising in

Rheumatology and Immunology.

ii. The WHO Classification of Lupus Nephritis:

- Class I Minimal Change Lupus Glomerulonephritis
- Class II Mesangial Lupus Glomerulonephritis
- Class III Focal Segmental Proliferative Lupus Glomerulonephritis
- Class IV Diffuse Proliferative Lupus Glomerulonephritis
- Class V Membranous Lupus Glomerulonephritis

27) End Stage Lung Failure

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

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

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

d. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 5mmHg); and

e. Dyspnoea at rest.

28) Fulminant Hepatitis

I. A sub-massive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

a. Rapid decreasing of liver size;

b. Necrosis involving entire lobules, leaving only a collapsed reticular framework;

c. Rapid deterioration of liver function tests;

d. Deepening jaundice; and

e. Hepatic encephalopathy.

II. Acute Hepatitis infection or carrier status alone does not meet the diagnostic criteria.

29) Chronic Adrenal Insufficiency (Addison's Disease)

I. An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Registered Medical practitioner who is a specialist in endocrinology through one of the following:

1. ACTH simulation tests;
2. insulin-induced hypoglycemia test;
3. plasma ACTH level measurement;
4. Plasma Renin Activity (PRA) level measurement.

II. Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.

30) Progressive Scleroderma

I. A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

II. The following are excluded:

1. Localised scleroderma (linear scleroderma or morphea);
2. Eosinophilic fasciitis; and
3. CREST syndrome.

31) Chronic Relapsing Pancreatitis

I. An unequivocal diagnosis of Chronic Relapsing Pancreatitis, made by a Registered Medical practitioner who is a specialist in gastroenterology and confirmed as a continuing inflammatory disease of the pancreas characterised by irreversible morphological change and typically causing pain and/or permanent impairment of function. The condition must be confirmed by pancreatic function tests and radiographic and imaging evidence.

II. Relapsing Pancreatitis caused directly or indirectly, wholly or partly, by alcohol is excluded.

32) Elephantiasis

I. Massive swelling in the tissues of the body as a result of destroyed regional lymphatic circulation by chronic filariasis infection. The unequivocal diagnosis of elephantiasis must be confirmed by a Registered Medical practitioner who is a specialist physician. There must be clinical evidence of permanent massive swelling of legs, arms, scrotum, vulva,

or breasts. There must also be laboratory confirmation of microfilariae infection.

II. Swelling or lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities is excluded.

33) Pneumonectomy

The undergoing of surgery on the advice of a specialist Medical Practitioner to remove an entire lung for disease or traumatic injury suffered by the Insured Person.

The following conditions are excluded:

I. Removal of a lobe of the lungs (lobectomy)

II. Lung resection or incision"

34) Terminal Illness

The conclusive diagnosis of an illness, which in the opinion of a Medical Practitionerwho is an attending Consultant and agreed by our appointed Registered Medical practitioner, life expectancy is no greater than twelve (12) months from the date of notification of claim, regardless of any treatment that might be undertaken.

35) Myelofibrosis

A disorder which can cause fibrous tissue to replace the normal bone marrow and results in anaemia, low levels of white blood cells and platelets and enlargement of the spleen. The condition must have progressed to the point that it is permanent and the severity is such that the Insured requires a blood transfusion at least monthly. The diagnosis of myelofibrosis must be supported by bone marrow biopsy and confirmed by a Registered Medical practitioner who is a specialist.

36) Pheochromocytoma

I. Presence of a neuroendocrine tumour of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumour.

II. The Diagnosis of Pheochromocytoma must be confirmed by a Registered Medical practitioner who is an endocrinologist.

37) Crohn's Disease

I. Crohn's Disease is a chronic, transmural inflammatory disorder of the bowel. To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:

1. Stricture formation causing intestinal obstruction requiring admission to hospital, and
2. Fistula formation between loops of bowel, and
3. At least one bowel segment resection.

II. The diagnosis must be made by a Registered Medical practitioner who is a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.

38) Severe Rheumatoid Arthritis

Unequivocal Diagnosis of systemic immune disorder of rheumatoid arthritis where all of the following criteria are met:

i. Diagnostic criteria of the American College of Rheumatology for Rheumatoid Arthritis;

ii. Permanent inability to perform at least two (2) "Activities of Daily Living";

iii. Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and

iv. The foregoing conditions have been present for at least six (6) months.

39) Severe Ulcerative Colitis

I. Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.

II. All of the following criteria must be met:

1. the entire colon is affected, with severe bloody diarrhoea; and
2. the necessary treatment is total colectomy and ileostomy; and
3. the diagnosis must be based on histopathological features and confirmed by a Registered Medical practitioner who is a specialist in gastroenterology.

5. Specific Definitions applicable to Section B3: my: health Medisure Super Top Up

Def 1 **For Super Top Up** : Dependents: mean only the family members listed below:

- Your legally married spouse ,
- Your dependent children – being your children (natural or legally adopted) aged between 3 months and 23 years, who is/are financially dependent on the primary insured or proposer and does not have his / her independent sources of income.
- Your parents or parents-in-law

Def 2 **Disease**: means an alteration in the state of the body or of some of its organs, interrupting or disturbing the performance of the functions, and causing or threatening pain and weakness or physical or mental disorder and certified by a Medical Practitioner to that effect.

6. Specific Definitions Applicable to Section B-6 : Travel Insurance

Def 1 **Any one illness** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

Def 2 **Insured Journey** means a trip commencing during the Period of Insurance. The Company agrees to continue the insurance for an Insured Person who commences an Insured Journey before the Policy Expiration Date, on the proviso that premium has been paid for such Insured Journey and the return trip is within One hundred Eighty (180) Days after the Insured Journey commences.

Def 3 **Medical Treatment** means a Physician's medical advice, treatment, consultations, and prescribed or remedial attention

Def 4 **Accumulation Limit** means the maximum amount payable by the Company in respect of any one Accident, irrespective of the number of Insured Persons involved in such Accident. In the event that an Accident occurs which results

in insurable losses under this Policy and which ordinarily would mean that the Accumulation Limit is exceeded, the Accumulation Limit amount will be distributed on a proportional basis to all Insured Persons, taking into account the maximum Sums Insured per Benefit and per **Insured Person**

Def 5 **Assistance Provider** means the assistance company with whom the Company contracts, as an independent contractor, to provide travel-related emergency assistance services.

Def 6 **Beneficiary**: In case of death of the Insured Person, the Beneficiary means, unless stipulated otherwise by the Insured Person, the surviving Spouse of the Insured Person, mentally capable and not divorced, followed by the children recognized or adopted followed by the Insured Person's legal heirs or nominees. For all other benefits, the Beneficiary means the Insured Person himself unless stipulated otherwise.

Def 7 **Civil War** means armed opposition, whether declared or not, between two or more parties belonging to the same country where the opposing parties are of different ethnic, religious or ideological groups. Included in the definition: armed rebellion, revolution, sedition, insurrection, Coup d' Etat, the consequences of Martial law.

Def 8 **Close Business Associate** means:

a. a business associate not a fellow employee of the **Insured Person** where the business relationship with the **Insured Person** is continuous and reliant on each other for the Insured Person's business, or

b. a business companion who travels with the **Insured Person** for the same business purpose, and whose presence is necessary for the Insured Person's business, or

c. a fellow employee of the **Insured Person**.

Def 9 **Common Carrier** means any land, sea or air conveyance operated under a licence issued by a governmental authority having jurisdiction, for the transportation of fare paying passengers and which has fixed, established routes only.

Def 10 **Compensation** means Sum Insured, Total Sum Insured or percentage of the Sum Insured, as appropriate.

Def 11 **Daily Activities** means activities such as, but not limited to, cooking and/or taking of food, discharging of urine and/or faeces, getting dressed or undressed, washing and taking a bath, walking and general living activities.

Def 12 **Daily Benefit** means the amount payable for every twenty-four (24) continuous hours an Insured Person is in Hospital as an in-patient up to the maximum number of Days stated in the Schedule

Def 13 **Date of Loss:**

- For Accident means the date of the Accident.
- for all other benefits means the date the event happened that leads to an alleged claim.
- For Sickness means the first date of diagnosis or the date the Insured Person first became aware of the Sickness.

Def 14 **Day** means a continuous period of twenty-four (24) hours.

Def 15 **Family Accumulation Limit** means the maximum amount payable by the Company in respect of any one Accident, irrespective of the number of Insured Persons from the same Immediate Family involved in such Accident. In the event that an Accident occurs which results in insurable losses under this Policy and which ordinarily would mean that the Family Accumulation Limit is exceeded, the Family Accumulation Limit amount will be distributed on a proportional basis to all Insured Persons from the same Immediate Family, taking into account the maximum Sums Insured per Benefit and per Insured Person.

Def 16 **Foreign War** means armed opposition, whether declared or not between two countries.

Def 17 **Franchise** means an amount stated in the Schedule as a percentage or a fixed amount for which the Company will not be responsible if the claim falls below such percentage or fixed amount, or a period of time for which the Company will not be responsible unless the period of time has expired.

Def 18 **Immediate Family / Immediate Family Member** means an Insured Person's Spouse; children; children-in-law; siblings; siblings-in-law; parents; parents-in-law; grandparents; grandchildren; legal guardian, ward; step or adopted children; step-parents; aunts, uncles; nieces, and nephews, who reside in the same country as the **Insured Person**.

Def 19 **Operative Time** means the time that the insurance is effective as stated on the Schedule

Def 20 **Permanent Total Disablement** means disablement, as the result of a Bodily Injury, which:

- continues for a period of twelve (12) consecutive months, and
- is confirmed as total, continuous and permanent by a Physician after the twelve (12) consecutive months, and
- entirely prevents an Insured Person from engaging in or giving attention to gainful occupation of any and every kind for the remainder of his/her life.

Def 21 **Primary Insured Person** means the Insured Person who elects insurance under the Policy and pays all the required premium for the insurance elected

Def 22 **Salary** means the total gross basic annual salary excluding payments for overtime, commission or bonus payable by the Policyholder to the Insured Person at the time of the Date of Loss. For weekly paid Insured Persons, the Salary will be calculated by taking the average gross weekly basic salary of the Insured Person for the thirteen (13) weeks prior to the Date of Loss and multiplying this amount by fifty-two (52).

Def 23 **Serious Injury or Serious Sickness** means Bodily Injury or Sickness certified as being dangerous to life by a Physician.

Def 24 Sickness means any fortuitous somatic illness or disease but excluding any disease or illness which is, arises out of or is caused by a condition or defect for which medical treatment was recognized, advised, sought out, or should have reasonably sought out, or received at any time before the Period of Insurance.

Def 25 **Spouse** means an Insured Person's husband or wife who is recognized as such by the laws of the jurisdiction in which they reside.

Def 26 **Subrogation shall** mean the right of the insurer to assume the rights of the insured person to recover expenses

paid out under the policy that may be recovered from any other source.

Def 27 **Terrorism** means activities against persons, organisations or property of any nature:

1) that involve the following or preparation for the following:

a) use or threat of force or violence; or

b) commission or threat of a dangerous act; or

c) commission or threat of an act that interferes with or disrupts an electronic, communication, information or mechanical system; and

2) when one or both of the following applies:

a) the effect is to intimidate or coerce a government or the civilian population or any segment thereof, or to disrupt any segment of the economy; or

b) it appears that the intent is to intimidate or coerce a government, or to further political, ideological, religious, social or economic objectives or to express (or express opposition to) a philosophy or ideology.

Def 28 **Total Number of Travel Days** means the maximum number of days insured under the Policy.

7. Specific Definitions applicable for Section B-7: –HDFC ERGO Bharat Griha Raksha

Bank means a bank or any financial institution

Def 2. Carpet Area means:

1. for the main building unit of Your Home, it is the net usable floor area, excluding the area covered by the external walls, areas under services shafts, exclusive balcony or verandah area and exclusive open terrace area, but including the area covered by the internal partition walls of the residential unit;

2. for any enclosed structure on the same site, it is the net usable floor area of such structure; and

3. for any balcony, verandah area, terrace area, parking area, or any enclosed structure that is part of Your Home, it is 25% of its net usable floor area.

Def 3. **Commencement Date** means the date and time from which the insurance cover under this Policy begins . It is shown in the Policy Schedule.

Def 4. **Cost of Construction** means the amount required to construct Your Home Building at the Commencement Date. This amount is calculated as follows:

1. For residential structure of Your Home including Fittings and Fixtures:

Carpet Area of the structure in square metres X Rate of Cost of Construction at the Commencement Date. The Rate of Cost of Construction is the prevailing rate of cost of construction of Your Home Building at the Commencement Date as declared by You and accepted by Us and shown in the Policy schedule.

2. **For additional structures** : the amount that is based on the prevailing rate of Cost of Construction at the Commencement Date as declared by You and accepted by Us.

Def 5. **Endorsement** means A written amendment to the Policy that We make (additions, deletions, modifications, exclusions or conditions of an insurance Policy) which may change the terms or scope of the original policy.

Def 6. **General Contents** are all the contents of household use in Your Home e.g. furniture, electronic items and goods, antennae, solar panels, water storage equipment, kitchen equipment, electrical equipment (including those fitted on walls), clothing and apparel and items of similar nature.

Def 7. **Personal Effects** means clothing, spectacles, umbrellas, footwear, etc.

Def 8. **Home Contents** means those articles or things in Your Home that are not permanently attached or fixed to the structure of Your Home. Home Contents may consist of General Contents and/or Valuable Contents.

Def 9. **Insured** means The Person/s who has/have purchased Insurance Cover under this Policy.

Def 10. **Insured Property** means Your Home Building and Home Contents, or any item of property covered by this Policy.

Def 11. **Kutcha Construction** means Building(s) having walls and/or roofs of wooden planks/thatched leaves and/or grass/ hay of any kind/bamboo/plastic cloth/asphalt/canvas/tarpaulin and the like.

Def 12. **Market Value** means Replacement Value less depreciation.

Def 13. **Policy Period** means Policy period means the period commencing from the effective date and time as shown in the Policy Schedule and terminating at Midnight on the expiry date as shown in the Policy Schedule or on the termination of or the cancellation of insurance as provided for in this Policy, whichever is earlier.

Def 14. **Policy Schedule** means the document accompanying and forming part of the Policy that gives Your details and of Your insurance cover of this Policy.

Def 15. **Premium** means the premium is the amount You pay Us for this insurance. The Policy Schedule shows the amount of premium for the Policy Period and all other taxes and levies.

Def 16. **Pucca Construction** means Construction other than Kutcha Construction.

Def 17. **Reinstatement Value** means the cost of replacing or reinstating on the same site, property of the same kind or type but not superior to or more extensive than the insured property when new.

Def 18. **Single Article** means one distinct physical object having an independent economic value.

Def 19. **Spouse** means your wife or husband

Def 20. **Sum Insured** means the amount shown as Sum Insured in the Policy Schedule and as described in Section B-7 A (4) and 7B (2) of this Policy. It represents Our maximum liability for each cover or part of cover and for each loss.

Def 21. **Total Loss** means a situation where the Insured Property or item is completely destroyed, lost or damaged beyond retrieval or repair or the cost of repairing it is more than the Sum Insured for that item or in total.

Def 22. **Valuable Contents** of Your Home consist of items such

as jewellery, silverware, paintings, works of art, antique items, curios and items of similar nature.

Def 23. **We, Us, Our, Insurer** means The HDFC ERGO General Insurance Company that has provided Insurance Cover under this Policy; of the Company.

Def 24. **You, Your, Insured** means The Insured Person/s who has/have purchased Insurance Cover under this Policy; of such Insured Person/s.

Def 25. **Your Home Building** means a building consisting of a residential unit, having an enclosed structure and a roof, basement (if any) and used as a dwelling place described in detail as per Section B-7, A (2) of this Policy.

8. Specific Definitions applicable for Section B-8:E@SECURE Insurance

Def 1 **Bank Account:** Your Bank Account details including personal e-banking login name, passwords or Bank Account number that are issued by banks operating in India.

Def 2 **Bank Rate:** Means Bank rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due

Def 3 **Credit/Debit Card:** Your physical Credit/Debit Card, Credit/Debit Card details or Credit/Debit Card numbers that are issued by banks operating in India.

Def 4 **Cyber Bullying or Harassment:** Means an aggressive, intentional act or behavior that is carried out by a group or an individual, using electronic forms of contact, repeatedly and over time against a victim who cannot easily defend himself or herself.

Cyber bullying or harassment includes any of the following but not limited to: posting rumors about a person, sexual remarks, threats to disclose victims' personal information, or pejorative labels, internet trolling and cyber stalking.

Def 5 **Computer System:** Means Your electronic data storage or computing devices including input and output support devices and excluding calculators which are not programmable and capable of being used in conjunction with external files, which contain Ccomputer Programmes, electronic instructions, input Data and output Data, that performs logic, arithmetic, Data storage and retrieval, communication control and other functions. Computer System shall include all kinds of digital devices including but is not limited to mobile phones, laptops, personal computers.

Def 6 **Endorsement:** An authorized amendment to this Policy

Def 7 **Extortion Loss:** means any:

i. monies paid by You with Our prior written consent to prevent or end an Extortion Threat; or

ii. Professional Fees for independent advisors to conduct an investigation to determine the cause of an Extortion Threat

Def 8 **Email Spoofing:** means forgery of an email header so that expected and awaited message appears to have originated from a legitimate source, instead was sent by someone from somewhere other than the actual legitimate and/or trusted source

Def 9 **Extortion Threat:** means any threat or connected series of threats, for the purpose of demanding monies, communicated to You to prevent or end a Security Threat

Def 10 **Flooding; Flood:** The process of creating various e-contents (on blog posts, social networking profiles etc) to roll back the harmful information in major search engines such as Google, Yahoo, MSN.

Def 11 **Harmful Publication:** Published information on the internet (including forums, blog postings, social media and any other websites) that undermines Your reputation such that the information is:

a. Defamatory–an allegation of a fact that is false and injurious;

b. Insulting–an offensive expression of contempt or invectiveness; orUnlawful disclosure of one's private life.

Def 12 **Journalist:** A person employed by traditional news media or any professional medium or agency to regularly gather, process and disseminate news and information to serve the public interest.

Def 13 Money: Any circulating medium of exchange, including but not limited to

a. coins & paper money,

b. gold, silver, or other metal in pieces of convenient form stamped by public authority and issued as a medium of exchange and measure of value

Any article or substance used as a medium of exchange, measure of wealth, or means of payment, such as cheques on demand or demand drafts.

Def 14 **Deemed Necessary:** Means Psychiatric services needed to prevent, diagnose, or treat a psychological illness, injury, condition, disease, or its symptoms and that meet accepted standards of psychiatry.

Def **15 Occupation:** Your full-time or part-time gainful employment or any other work for pay or profit.

Def 16 **Personal Information:** Your private details (including any online authentication information) relating to Your identity that will allow You to be identified, such as:

- Full name
- Passport number
- Aadhaar ID number
- Mailing and/or home address
- Driving license number
- Telephone number(s) registered under Your name
- Online login ID and password
- Credit/Debit Card number
- Bank Account number

Def 17 **Period of Insurance** The period of cover as stated in the Policy Schedule.

Def 18 **Phishing:** Fraudulent websites or emails, purporting to be from reputable companies or institutions in order to induce individuals to reveal personal information, such as usernames, passwords and credit card numbers and internet banking details.

Def 19 **Policyholder :** The name stated in the Policy Schedule.

Def 20 **Specified Event:** An occurrence of one or more of these

covered events which arises out of the use of the internet and that is attributed to the conduct of a Third Party and is not due to Your fault:

- Damage to E-reputation
- Identity Theft
- Unauthorized Online Transactions
- E-Extortion
- Cyber Bullying
- Phishing and E-mail Spoofing

Def 21 **Security Threat:** means any threat conveyed over internet to demand money or goods or services from You by threatening to inflict harm to Your person, Your reputation, or Your property by making public, Your Personal Information/ data stored in your Computer System while still in your physical possession and custody or by denying You the access to data or information in such Computer Systems.

Def 22 **Third Party:** Any person or entity who deals at arm's length with You and which neither controls nor is controlled by You. Third Party shall not be:

- Any person covered under this Policy; or
- Any person or entity who is in an employer-employee relationship with You; or
- Any member of Your Family (regardless residing with You or not) and/or their authorized representatives.

Def 23 **We/Us/Our** HDFC ERGO General Insurance Company Limited

Def 24. **You/Your/Yourself** - The name stated in the Policy Schedule.

Section B. Benefits

Section 1: my:health Suraksha

A: Hospitalization Cover

We will pay under below listed Covers on Medically Necessary Hospitalization of an Insured Person due to Illness or Injury sustained or contracted during the Policy Period. The payment is subject to Sum Insured and limits including Cumulative Bonus if applicable as specified on the Schedule of Coverage in the Policy Schedule. Subject to otherwise terms and conditions of the Policy.

1. Medical Expenses

i. Room rent, boarding and Nursing charges

ii. Intensive Care Unit charges

iii. Consultation fees

iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances

v. Medicines, drugs and consumables

vi. Diagnostic procedures

vii. The Cost of prosthetic and other Medical devices or equipment if implanted internally during a Surgical Procedure.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

a) Mental Healthcare

The Coverage for Mental illness is applicable if done in Mental Health Establishment and is subject to the provisions contained in the Mental Health Care Act, 2017, as amended from time to time and other applicable laws and Regulations

2. Home Healthcare

Insured Person can avail Hospitalization at home under Home Healthcare for Medically Necessary Treatment of Illnesses, if prescribed by treating Medical Practitioner. We will pay Medical Expenses under Section A1 incurred for treatment of such Illness where opted.

This Cover can be availed through Cashless Facility only as procedure given under Claims Procedure – Section E

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

3. Domiciliary Hospitalization

We will pay the Medical Expenses incurred on Domiciliary Hospitalization of the Insured Person provided that:

i. It has been prescribed by the treating Medical Practitioner

and

ii. the condition of the Insured Person is such that he/she could not be removed to a Hospital

or

iii. the Medical Necessary Treatment is taken at Home on account of non-availability of room in Hospital

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

4. Pre-Hospitalization cover

We will pay for the Pre-hospitalization Medical Expenses incurred during the 60 days immediately before Hospitalization of an Insured Person provided that Claim under Section B.1A.1 or I.1.A.6 is admissible under the Policy.

Where Insured Person has opted for Home Healthcare treatment under Section B.1.A.2, Pre-Hospitalization Medical Expenses are payable up to 60 days prior to start of the Medical treatment.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

5. Post-Hospitalization cover

We will pay for the Post-Hospitalization Medical Expenses incurred upto180 days from the date Insured Person is discharged from Hospital provided that Claim under Section B.1.A1 or I.1.A 6 is admissible under the Policy

Where Insured Person has opted for Home Healthcare treatment under Section B.1.A2, Post Hospitalization Medical

Expenses are payable up to 180 days post completion of the medical treatment.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

6. Day Care Procedures

We will pay for the Medical Expenses under Section B-1-A1 on Hospitalization of Insured Person in Hospital or Day Care Centre forDay Care Treatment.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

7. Road Ambulance

We will pay for expenses incurred on Road Ambulance Services if Insured Person is required;

i. to be transferred to the nearest Hospital following an emergency (namely a sudden, urgent, unexpected occurrence or event, bodily alteration or occasion requiring immediate medical attention)

ii. or from one Hospital to another Hospital

iii. of from Hospital to Home (within same City) following Hospitalization

provided that Claim under Section B.1.A1 and I.1.A6 is admissible under the Policy.

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

8. Organ Donor Expenses

We will pay Medical Expenses as listed under Section B.1.A1 towards organ donor's Hospitalization for harvesting of the donated organ where an **Insured Person** is the recipient, provided that;

i. The organ donor is any person whose organ has been made available in accordance and in compliance with The Transplantation of Human Organ (amendment) Act, 2011,Transplantation of Human Organs and Tissues Rules, 2014and other applicable laws and rules.

ii. Hospitalization Claim under Section B.1.A1 is admissible under the Policy

iii. The Organ Donor's Pre-Hospitalization and Post-Hospitalization expenses are excluded under the Policy

iv. Any other Medical Expenses or Hospitalization consequent to the harvesting is excluded under the Policy

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

9. Alternative Treatments

We will pay Medical Expenses as listed under Section B.1.A1 only on In-patient care treatment of Insured Person in an AYUSH Hospital for the below Alternative Treatments prescribed by the Medical Practitioner

- Ayurvedic
- Unani
- Siddha
- Homeopathy
- Yoga & Naturopathy

provided that;

i. The procedure performed on the Insured Person cannot be carried out on Outpatient basis

ii. In the event of admissible Claim under this Cover, no Claim shall be admissible under Section B.1.A 1 for Allopathic treatment of same Illness or Injury

Insured Person shall bear specified percentage of admissible Claim amount under each and every Claim If Co-payment under Section B.1.C-14 is opted and specified in the Schedule of Coverage in the Policy Schedule

B: Renewal Benefits

1. Preventive Health Check-Up

After every block of every four consecutive, continuous and Claim free Policy Years with Us, We will pay towards cost of Preventive Health Check-upto specified percentage (as mentioned on the Schedule of Coverage) of Sum Insured for those Insured Persons who were Insured under the previous 4 Policy years with Us.

Other terms and Conditions applicable to this Benefit

- This benefit will not be carried forward if not utilized.
- Eligibility to avail Health Check-up will be in accordance to lower of expiring Policy Sum Insured or Renewed Policy Sum Insured.
- This cover is applicable only to Insured Person covered under all four Policy Years and who continue to remain insured in the subsequent Policy Year/Renewal.
- Availing of Claim under this Cover will not impact the Sum Insured or the eligibility for Cumulative Bonus

2. Cumulative Bonus

On each Renewal of the Policy with Us, We will apply 5% of Basic Sum Insured under expiring Policy as Cumulative Bonus in the Policy provided that;

i. There has been no claim under the Policy in expiring year under Section B.1.A

ii. Cumulative Bonus will be reduced at the same rate as accrued in the event of admissible Claim under Section B.1.A of the Policy.

iii. Cumulative Bonus can be accumulated upto 50% of Basic Sum Insured.

iv. Cumulative Bonus applied will be applicable only to Insured Person covered under expiring Policy and who continue to remain insured on Renewal.

v. In case of multiyear policies, Cumulative Bonusthat has accrued for the second and third Policy Year will be credited

on Renewal. Accrued Cumulative Bonus may be utilized in case of any Claim during Policy tenure

3. my: Health Active

A. Fitness discount @ Renewal

Insured Person can avail discount on Renewal Premium by accumulating Healthy Weeks as per table given below.

One Healthy Week can be accumulated by;

- Recording minimum 50,000 steps in a week subject to maximum 15,000 steps per day, tracked through Your wearable device linked to Our **HDFC ERGO Mobile App** and Your Policy number

OR

- burning total of 900 calories upto maximum of 300 calories in one exercise session per day, tracked Your wearable device linked to Our **HDFC ERGO Mobile App** and Your Policy number
- Fitness discount @ Renewal is applicable for Adult Insured Persons only. Any Person covered as Child Dependent, irrespective of the Age is excluded.

Healthy Weeks Discounts

No. of Healthy Weeks Accumulated	Discount on Renewal Premium
1-4	0.50%
5-8	1.00%
9-12	2.00%
13-16	3.00%
17-26	6.00%
27-36	7.50%
Above 36	10.00%

Steps to accumulate Healthy Weeks

Step 1 - The **HDFC ERGO Mobile App** must be downloaded on the mobile.

Step 2 - You can start accumulating Healthy Weeks by tracking physical activity trough the Wearable device linked

To Our **HDFC ERGO Mobile App** app and **Your** Policy number

We encourage and recognize all types of exercise/fitness activities by making use of wearable devices to track and record the activities Insured Person engages in.

Application of Fitness discount @ Renewal

- **Annual Policy:** Discount amount accrued based on Number of accumulated Healthy Weeks during the expiring Policy Year will be applied on the Renewal Premium for expiring Policy Sum Insured and for Insured Person covered under expiring Policy
- **Multi Year Policy:**

o Fitness discount earned on yearly basis will be accumulated till Policy End date.

o On Renewal of the Policy, total discount amount accrued each Policy Year will be applied on Renewal Premium of subsequent year and for Insured Person covered under expiring Policy

- For Policies covering more than one Insured Person, Healthy Weeks for each Insured Person will be tracked and accrued. Such discount will be applicable on individual Renewal Premium for both Individual and Floater Sum Insured basis Policies.
- Premium will be discounted to the extent applicable to coverage corresponding to expiring Policy.
- In case of Increase in Sum Insured at Renewal, discount amount will be applied on the premium corresponding to expiring Policy Sum Insured.
- Fitness discount @ Renewal will be applied only on Renewal of Policy with Us and only if accrued.

B. Health Incentive

This Program encourages **Insured Persons** to maintain good health and avail incentives as listed below.

Under this Program, **Insured Person** having Pre-Existing Diseases or Obesity (BMI above 30) as listed under table A below, will be eligible for reduction in Medical Underwriting Loading applied on first inception of the Policy with Us provided that;

i. Insured Person shall undergo medical tests and/or BMI check-up as listed below minimum 3 months prior to expiry of Policy Year (For Multiyear Policies) or before Renewal (For Annual Policies).

ii. Medical test shall be done at Your own cost through our Network Provider on Our **HDFC ERGO Mobile App** If the test parameters are within normal limits, We will apply 50% discount on the Medical Underwriting loading applied for corresponding Pre-Existing Disease or Obesity as applicable on Renewal of the Policy with Us.

iii. If the test parameters at subsequent Renewal are not within normal limits or Medical test reports are not submitted in accordance with i and ii above, the discount amount applied on Medical Underwriting loading will be zero

Table A

Pre-existing Diseases	Test
Diabetes	HbA1c
Hypertension	Blood Pressure reading
Hyperlipidemia	Total Cholesterol
Cardiovascular Diseases	ECG
Hypothyroidism	Thyroid function tests
Obesity	BMI

Application of Health Incentive

- **Annual Policy:** Discount amount accrued during the expiring Policy year will be applied on the Renewal Premium corresponding to expiring Policy Sum Insured and for Insured Person covered under expiring Policy
- **Multi Year Policy:**

o Discount amount earned on yearly basis will be accumulated

till Policy End date.

- On Renewal of the Policy, total discount amount accrued each year will be applied on Renewal Premium of subsequent year and for Insured Person covered under expiring Policy
- For Policies covering more than one **Insure Person**, tests shall be done for each Insured Person basis which such reduction in loading where ever applicable will be applied on individual Renewal Premium for both Individual and Floater Sum Insured basis Policies.
- Medical Underwriting loading will be discounted only on Renewal of Policy with Us and only for **Insured Person** covered under such expiring Policy
- Discount on Medical Underwriting loading under this cover is applicable only on next Renewal and cannot be utilized if Policy not renewed with us.

C. Wellness services:

The services listed below are available to all Insured Person through Our **Network Provider** on **Our HDFC ERGO Mobile App** only. Availing of services under this Section will not impact the Sum Insured or the eligibility for Cumulative Bonus.

i. Health Coach:

An **Insured Person** will have access to Health Coaching services in areas given below:

- Disease management
- Activity and fitness
- Nutrition
- Weight management
- Psychological Counselling
- Depression Counselling

These services will be available through Our **HDFC ERGO Mobile App** as a chat service or as a call back facility.

ii. Wellness services

- **Discounts:** on OPD, Pharmaceuticals, pharmacy, diagnostic centres.
- **Customer Engagement:** Monthly newsletters, Diet consultation, health tips
- **Specialized programs:** Stress management, Pregnancy Care, Work life balance management.

These services will be available through Our **HDFC ERGO Mobile App** Disclaimer applicable to **HDFC ERGO Mobile App** and associated services

*It is agreed and understood that Our **HDFC ERGO Mobile App** and Wellness services intention is not to provide specific medical advice but rather to provide users with information to better understand their health and their diagnosed disorders. The information is not a substitute for professional medical care by a qualified doctor or other health care professional.*

The information provided is general in nature and is not specific to you. You must never rely on any information obtained using this app for any medical diagnosis or recommendation for medical treatment or as an alternative to medical advice from your physician or other professional healthcare provider. If you think you may be suffering from any medical condition you should seek immediate medical attention.

*Reliance on any information on this App is solely at your own risk. **HDFC EGRO General Insurance Company Limited** do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations, any decision made or action taken or not taken in reliance upon the information.*

C: Optional Covers

Insuring Clause

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that We will pay/restrict the expenses under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and upto the Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule.

1. Preventive Health Check-Up - Booster

On opting this Cover, **Insured Person** will be entitled for Health Check-up after each Policy Year with Us irrespective of Claims made under the Policy in accordance with options given below.

i. We will reimburse the cost of Preventive **Health Check-up** to limits mentioned on the Schedule of Coverage.

Or

ii. **Insured Person** shall have the option to undergo Health Check-Up at our Network Service Provider in accordance to criteria given below.

Sum Insured	Tests
Upto 2 Lacs	Medical Examination Report, Complete Blood Count Urine R, Fasting Blood Sugar, Serum Creatinine, Lipid Profile, Electro Cardio Gram
3 Lac and above	Chest X Ray , 2D echo/ Stress test, PSA for Males, PAP smear for Females, Medical Examination Report, Complete Blood Count Urine R, Fasting Blood Sugar, Serum Creatinine, Lipid Profile, Electro Cardio Gram

Other Terms and Conditions applicable to this Cover

- This benefit will not be carried forward if not utilized within 60 days of Policy Anniversary/Renewal date.
- On opting this Cover, Renewal Benefit 1, Preventive Health Check-up under Section B stands deleted.

2. Parent and Child care Cover - Basic

We will pay to the Insured Person subject to waiting period as mentioned in the Schedule of Coverage on the Policy Schedule under Covers as given below.

I. Parent Care

i. **Medical Expenses** under Section B.1.A1 for Maternity Expenses limited up to 2 deliveries or 1 delivery and 1 termination or 2 terminations during the lifetime of the Insured Person

ii. **OPD Treatment** in Pre-natal and Post-natal period provided Claim under Maternity Expenses is admissible under the Policy.

II. Child Care

We will pay/cover following expenses towards Child Care for New Born Baby under this cover if Claim for Maternity Expenses is admissible under the Policy.

i. We will pay **Medical Expenses** listed under Section B.1.A1 within Sum Insured for Parent Care towards treatment of a New Born Baby as per limit mentioned on Schedule of Coverage.

ii. **New Born Baby Cover**–We will cover New Born Baby immediately after the birth as per original terms of the Policy on receipt of completed proposal form and Premium received within 90 days of birth of Baby and subject to acceptance by Us.

If this Cover is opted, General exclusion xv) under **General Exclusions**, Section BII.b.1, stands deleted.

Exclusions applicable to this Cover.

i. Pre-Hospitalization and post-Hospitalization expenses are not payable under this cover

ii. We will not pay any expenses related to ectopic pregnancy under this cover. Ectopic pregnancy will be covered as a part of expenses under Section B.1.A1 only.

iii. Treatment for impotency, treatment to effect infertility, surrogate or vicarious pregnancy, voluntary termination of pregnancy, procedures to assist birth control, contraceptive supplies.

3. Parent and Child care Cover – Booster

We will pay to the Insured Person subject to waiting period and limits as mentioned in the Schedule of Coverage on the Policy Schedule under Covers as given below.

I. Parent Care

i. **Maternity Expenses** - Medical Expenses for a delivery (including caesarean section) on Hospitalization or the lawful medical termination of pregnancy during the Policy Period.

ii. **OPD Treatment** in Pre-natal and post-natal period up to the limit of this cover, provided Claim under i. Maternity Expenses is admissible under the Policy

iii. **Infertility Treatment**: Medical Expenses listed under Section B.1.A1 incurred for infertility treatment, assisted reproductive treatments undertaken on advice of a Medical Practitioner, up to 50% of Normal Delivery Sum Insured under this Cover. This cover is applicable for both Male and Female Insured Person

II. Child Care

We will pay following expenses towards Child Care for New Born Baby under this cover if Claim for Maternity Expenses is admissible under the Policy.

i) New Born baby cover:

We will pay **Medical Expenses** listed under Section B.1.A1 towards treatment of a New Born Baby within the limit of Sum Insured under this Cover as mentioned in Schedule of Coverage on the Policy Schedule

ii) Vaccination Charges:

We will pay expenses incurred on vaccination for **New Born Baby** as per National Immunization Schedule until New Born Baby completes 1 year of age subject to maximum of sub limit of Sum Insured under this Cover.

If opted, this cover General exclusion xiv), xv), xxvi) under General Exclusions, Section BII.b.1 and Optional Cover 2 "Parent and Child Cover – Basic" under Section C stands deleted.

III. Waiting Period modification Option

On availing this option, Waiting Period listed under Section BII.a.iv, will stand modified as mentioned in the Schedule of Coverage on the Policy Schedule.

All other terms and conditions of the Parent & Child Care Cover - Booster shall remain unaltered.

Exclusions applicable to this Cover.

i. Pre-Hospitalization and post-Hospitalization expenses are not payable under this cover

ii. We will not pay any expenses related to ectopic pregnancy under this cover. Ectopic pregnancy will be covered as a part of expenses under Section B.1.A1 only.

iii. Treatment for impotency, treatment to effect infertility, surrogate or vicarious pregnancy, voluntary termination of pregnancy, procedures to assist birth control, contraceptive supplies.

4. Air Ambulance Cover

We will pay for Air Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid ambulance transportation as prescribed by a Medical Practitioner, from the site of first occurrence of the Illness/ Accident to the nearest Hospital, that ground transportation cannot provide. Claim would be reimbursed up to the actual

expenses subject to a maximum of Sum Insured as specified on the Schedule of Coverage in the Policy Schedule.

Exclusion:

We will not pay for return transportation to the Insured Person's home by air ambulance

5. Recovery Benefit

We will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule upon Medically Necessary Hospitalization of an Insured Person exceeding 10 consecutive and continuous days and for which Claim is admissible under Section B.1.A– Hospitalization Cover.

This benefit is not applicable if Medical treatment is taken under Section B.1.A2 – Home Healthcare and I.1.A3 – Domiciliary Hospitalization

6. Sum Insured Rebound

We will add to the Sum Insured, an amount equivalent to the Claim amount paid under Basic Sum Insured, subject to maximum of Basic Sum Insured, on subsequent Hospitalization of the Insured Person during Policy Year subject to;

i. The Total **Sum Insured** added under this cover will not exceed the Basic Sum Insured in a Policy Year

ii. Total of Basic **Sum Inured** under **Hospitalization** Cover, Cumulative/Extended Cumulative Bonus (if applicable) earned and **Sum Insured** Rebound will be available to all Insured Persons for all claims under Section A during the current Policy Year and subject to the condition that a single claim in a Policy Year cannot exceed the sum of Basic Sum Insured and the Cumulative/Extended Cumulative Bonus (if opted) earned

iii. In case of treatment for Chemotherapy and Dialysis, Sum Insured Rebound will be applicable only once in lifetime of Policy

i. This cover will be applicable annually for policies with term more than one year.

ii. Any unutilized amount of **Sum Insured** Rebound cannot be carried over to next Policy Year or Renewal Policy

iii. The Sum Insured Rebound can be utilized for Claims under Section A only.

Illustration 1

Time	Claim no.	Sum Insured available	Cumulative Bonus available	Admissible Claim amount	SI Rebound Available	Total SI Rebound till date	Payable amount
3 months	1	3,00,000	30,000	2,50,000	0	0	2,50,000
5 months		50,000	30,000	1,40,000	0	0	80,000
9 months	2	0	0	2,50,000	3,00,000	3,00,000	2,50,000
11 months	4	0	0	70,000	50,000	3,00,000	50,000

Illustration 2

Time	Claim no.	Sum Insured available	Cumulative Bonus	Admissible Claim amount	SI Rebound	Total SI Rebound till date	Payable amount
3 months	1	3,00,000	30,000	2,50,000	0	0	2,50,000
6 months	2	50,000	30,000	1,40,000	2,50,000	2,50,000	1,40,000
9 months	3	0	0	2,50,000	=250,000-60,000+50,000 =240,000	3,00,000	2,40,000
11 months	4	0	0	70,000	0	3,00,000	0

7. Outpatient Dental Treatment

After three consecutive and continuous Policy Years with Us, We will pay 50% of Medical Expenses incurred by Insured Person towards Dental Treatment prescribed by Medical Practitioner up to the amount as mentioned in the Schedule of Coverage on the Policy Schedule. Claim under this Section can be availed only through our Network Provider. The Cover is applicable only to Insured Person covered under three consecutive and continuous Policy Years and who continue to remain insured in the subsequent Policy Year/Renewal

The Coverage is applicable only towards cost of X-rays, extractions, amalgam or composite fillings, root canal treatments and prescribed drugs for the same.

Claim under this Section will not affect Cumulative Bonus under Section B.1.B2, condition ii.

Exclusions specific to Outpatient Dental Treatment

i. Cosmetic surgery, dentures, dental prosthesis, dental implants, orthodontics, orthognathic surgery, jaw alignment or treatment for the temporomandibular (jaw) joint, or upper and lower jaw bone surgery and surgery related to the temporomandibular (jaw) unless necessitated by an acute traumatic injury due to an accident or cancer

8. External Medical Aids

After every two consecutive and continuous Policy Year with Us, We will pay up to 50% of cost incurred towards following Medical Expenses subject to maximum of Sum Insured as mentioned in the Schedule of Coverage, on the Policy Schedule;

i. One pair of spectacles or one pair of contact lenses,

ii. A hearing aid

Other terms

- The Cover is applicable only to **Insured Person** covered under two consecutive and continuous Policy Years and who continue to remain insured in the subsequent Policy Year/Renewal
- Under a Family Floater Policy, Our liability shall be limited to either one pair of spectacles or contact lenses or hearing aid per family.
- Medical Expenses incurred under this Cover shall be prescribed by our Network Provider and is payable only once after block of every two consecutive and continuous Policy Year with Us.
- Claim under this Section will not affect Cumulative Bonus under Section B.1.B2, condition ii

9. Major Illness Hospitalization Expenses

We will pay for Medical Expenses incurred and admissible under Section B.1.A1,up to additional Sum Insured equivalent to Basic **Sum Insured** on Medically necessary Hospitalization of **Insured Person** for Major illnesses listed below whose diagnosis first commence/occurs after the applicable waiting period from commencement of the first Policy with Us, subject to the following;

i. **Waiting Period** – The coverage is subject to Waiting Period as mentioned on Schedule of Coverage on the Policy Schedule

ii. **Claim for each Major Illness** is payable only once during the lifetime of Policy with Us. However, Insured Person will continue to be covered under this Section for other Major Illnesses.

iii. **Claim** under this Cover is admissible only when total of Basic Sum Insured is completely utilized.

iv. The additional **Sum Insured** under this Cover is exclusive and specific for the treatment of the first occurrence of the above Critical Illness undertaken in a Hospital/Nursing Home as an in-patient and will not be available for other **illnesses/hospitalization**.

Major Illness Covered			
1	Cancer of specified severity	6	Major Organ/Bone Marrow Transplant
2	Open Chest CABG	7	Stroke resulting in permanent symptoms
3	Myocardial Infarction (First Heart Attack of specific severity)	8	Surgery of Aorta
4	Kidney Failure requiring regular dialysis	9	Primary (Idiopathic) Pulmonary Hypertension
5	Multiple Sclerosis with Persisting Symptoms		

10. Non-Medical Expenses cover

We will pay for Non-Medical Expenses upto the limit mentioned in Schedule of Coverage in the Policy Schedule on Medically necessary Hospitalization of Insured Person for claims admissible under Section B.1.A1, 2 and 3.

In view of this Cover, Exclusion xxvii) of Section BII.b.1, shall stand covered upto the extent mentioned above.

11. Waiting period Modification Option

On availing this option, Waiting Periods listed under Section BII.a – i, ii and iii will stand modified as mentioned in Schedule of Coverage on the Policy Schedule for following Sections;

Section B.1.A – Hospitalization Cover

Section B.1.C4 – Air Ambulance

Section B.1.C5 – Recovery Benefit

Section B.1.C9 – Major Illness Hospitalization Expenses

Section B.1.C17 –Hospital Cash

Section B.1.C18 – Global Health Cover

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

12. Extended Cumulative Bonus

On availing this cover, Cumulative Bonus percentage mentioned under Section B.1.B2 – Cumulative Bonus will stand modified as mentioned in Schedule of Coverage on the Policy Schedule subject to;

i. Once the Extended Cumulative Bonus benefit is availed by the Insured Person, it cannot be opted out at subsequent Renewal.

ii. All other terms and Conditions of Renewal Benefits Section B.1.B, ii shall remain unaltered.

13. Room Rent Modification Option

On availing this option, limits specified under Section B.1.A1 i and I.1.Aii will stand modified as below.

i. **Room Rent, boarding and Nursing** – limit of 1% of the Basic Sum Insured subject to maximum of Rs. 5,000 per day

ii. **Intensive care unit** – limit of 2% of the Basic Sum Insured subject to maximum of Rs. 10,000 per day

Proportionate deduction:

In case Room Rent during Hospitalization of **Insured Person** exceeds the aforesaid limits, the reimbursement/payment of Room Rent charges including all Associated Medical Expenses incurred at **Hospital** shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. This condition is not applicable in respect of Hospitals where differential billing for Associated Medical Expenses is not followed based on Room Rent.

14. Co-Payment

On availing this option, Co-Payment as mentioned on the Schedule of Coverage in the Policy Schedule will be applied on each and every admissible claim after Deductible/Excess wherever applicable under the Policy. Once the Co-Payment option is availed by the Insured Person, it cannot be opted out of at subsequent Renewal.

15. Major Illness – Benefit

If the eldest **Insured Person** covered under the Policy suffers from Major Illness as listed below, whose diagnosis first commence/occurs after the applicable Waiting Period from commencement of first Policy with Us, We will pay Sum Insured as mentioned on the Schedule of Coverage.

The Coverage under this benefit shall cease to exist upon occurrence of any one Major Illness covered for which Claim is admitted by the Company.

Major Illness Covered			
1	Cancer of specified severity	8	Stroke resulting in Permanent Symptoms
2	Open Chest CABG	9	Surgery of Aorta
3	Myocardial Infarction (First Heart Attack of specific severity)	10	Primary (Idiopathic) Pulmonary Hypertension
4	Kidney Failure requiring regular dialysis	11	Open Heart Replacement or Repair of Heart Valves
5	Major Organ/Bone Marrow Transplant		
6	Multiple Sclerosis with Persisting Symptoms		
7	Permanent Paralysis of Limbs		

Survival Period

Claim under this Cover is payable only if **Insured Person** survives 30 days from the diagnosis, fulfillment of the definition of the Major illness covered and with confirmatory diagnosis of the conditions covered while the Insured Person is alive (A claim would not be admitted if the diagnosis is made post mortem)

16. E-Opinion

We will pay expenses incurred towards second Medical Opinion availed from **Medical Practitioner** in respect of Major Illness covered and listed below under the Policy through our Network Provider.

The Coverage under this benefit shall cease to exist upon availing Second Opinion for any one Major Illness as listed below.

Major Illness Covered			
1	Cancer of specified severity	8	Stroke resulting in Permanent Symptoms
2	Open Chest CABG	9	Surgery of Aorta
3	Myocardial Infarction (First Heart Attack of specific severity)	10	Primary (Idiopathic) Pulmonary Hypertension
4	Kidney Failure requiring regular dialysis	11	Open Heart Replacement or Repair of Heart Valves
5	Major Organ/Bone Marrow Transplant		
6	Multiple Sclerosis with Persisting Symptoms		
7	Permanent Paralysis of Limbs		

Disclaimer - *E- Opinion Services are being offered by Network providers through its portal/mail/App or what so ever electronic form to Policyholders/Insured of HDFC ERGO GENERAL INSURANCE COMPANY LIMITED. In no event shall HDFC ERGO be liable for any direct, indirect, punitive, incidental, special consequential damages or any other damages whatsoever caused to the Policyholders/Insured of HDFC ERGO while receiving the services from Network providers.*

17. Hospital Cash

We will pay per day **Sum Insured** up to maximum Number of days and in manner as specified in Schedule of Coverage on the **Policy Schedule**, for each continuous and completed period of 24 hours of Medically Necessary Hospitalization of an eldest Insured Person in the Policy and for which Claim is admissible under Section B.1.A – Hospitalization Cover.

18. Global Health Cover

On availing this Cover, We will pay the **Medical Expenses** incurred outside India under below given Sections and Covers wherever opted and as mentioned on the Schedule of Coverage in the Policy Schedule

Section B.1.A: Hospitalization Cover	
I.1.A1	Medical Expenses
I.1.A4	Pre-Hospitalization cover
I.1.A5	Post-Hospitalization cover
I.1.A6	Day Care Procedures
I.1.A7	Road Ambulance
I.1.A8	Organ Donor Expenses
I.1.A9	Alternative Treatments

Section B.1.C: Optional Covers	
I.1.C1	Preventive Health Check-Up - Booster
I.1.C2	Parent and Child care Cover - Basic
I.1.C3	Parent and Child care Cover – Booster
I.1.C4	Air Ambulance Cover
I.1.C5	Recovery Benefit
I.1.C6	Sum Insured Rebound
I.1.C7	Outpatient Dental Treatment

I.1.C8	External Medical Aids
I.1.C9	Major Illness Hospitalization Expenses
I.1.C10	Non-Medical Expenses cover
I.1.C15	Major Illness – Benefit
I.1.C16	E-Opinion
I.1.C17	Hospital Cash

Global Cover is applicable subject to following terms and conditions

i. Global coverage for expenses towards all the listed covers is applicable and effective only if mentioned on the Schedule of Coverage in the Policy Schedule.

ii. A Deductible of USD 100 will apply for expenses under all the respective covers separately for each and every claim.

iii. Claims on Reimbursement basis will be payable in INR only.

iv. All other terms and conditions of the respective Section and Covers under the policy shall remain unaltered

Section 2: my: health Critical Suraksha Plus

A. Base Covers

I. Critical Illnesses Cover

1. Cancer Cover

If Insured Person suffers from Critical illness or undergoes Surgical Procedure as listed below, whose diagnosis first commence/occurs after the applicable Waiting Period from commencement of first Policy with Us, We will pay Sum Insured or percentage of Sum Insured in accordance with table below:

	Critical illness /Surgical Procedure	Stage	Percentage of Sum Insured Payable	Waiting Period Applicable
1	Malignant Cancer of specified Sites	Major	100% of Sum Insured	90 days
	Specified Sites-Female			
	Breast			
	Cervix			
	Uterus			
	Fallopian Tube			
	Ovary			
	Vagina/Vulva			
	Specified Sites-Male			
	Head and Neck	Major	100% of Sum Insured	90 days
	Lung			
	Stomach			
	Colorectum			
	Prostate			
2	Cancer of specified severity	Major	100% of Sum Insured	90 days
3	Aplastic Anemia	Major	100% of Sum Insured	90 days
4	Major Organ Transplant – Bone Marrow	Major	100% of Sum Insured	90 days
5	Early Stage Cancer	Minor	25% of Sum Insured subject to maximum of Rs. 1,000,000	180 days
6	Carcinoma in situ	Minor		

1. Heart Cover

If Insured Person suffers from Critical illness or undergoes Surgical Procedure as listed below, whose diagnosis first commence/occurs after the applicable Waiting Period from commencement of first Policy with Us, We will pay Sum Insured or percentage of Sum Insured in accordance with table below:

	Critical Ailments/ Procedures	Stage	Percentage of Sum Insured Payable	Waiting Period Applicable
1	Open Chest CABG	Major	100% of Sum Insured	90 days
2	Myocardial Infarction (First Heart Attack of specified severity)	Major		
3	Open Heart Replacement or Repair of Heart Valves	Major		
4	Major Organ Transplant – Heart	Major		
5	Surgery of Aorta	Major		
6	Primary (Idiopathic) Pulmonary Hypertension	Major		
7	Other serious coronary artery disease	Major		
8	Dissecting Aortic Aneurysm	Major		
9	Cardiomyopathy	Major		
10	Eisenmenger's Syndrome	Major		
11	Infective Endocarditis	Major		
12	Angioplasty	Minor	25% subject to maximum payout of INR 1,000,000	180 days
13	Balloon Valvotomy or Valvuloplasty	Minor		
14	Insertion of Pacemaker	Minor		

2. Nervous System Cover

If Insured Person suffers from Critical illness or undergoes Surgical Procedure listed below after the applicable Waiting Period from commencement of first Policy with Us, We will pay Sum Insured in accordance with table below:

	Critical Ailments/ Procedures	Stage	Percentage of Sum Insured Payable	Waiting Period Applicable
1	Multiple Sclerosis with persisting symptoms	Major	100% of Sum Insured	90 days
2	Permanent Paralysis of Limbs	Major		
3	Stroke resulting in permanent symptoms	Major		
4	Benign Brain Tumour	Major		
5	Coma of specified severity	Major		
6	Parkinson's Disease	Major		
7	Alzheimer's Disease	Major		
8	Motor Neurone Disease with permanent symptoms	Major		
9	Muscular Dystrophy	Major		
10	Apallic Syndrome	Major		
11	Bacterial Meningitis	Major		
12	Creutzfeldt-Jakob Disease (CJD)	Major		
13	Encephalitis	Major		
14	Major Head Trauma	Major		
15	Progressive Supranuclear Palsy	Major		
16	Brain Surgery	Major		
17	Loss of Speech	Major		

3. Other Major Organ Cover

If **Insured Person** suffers from **Critical illness** or undergoes Surgical Procedure listed below after the applicable Waiting Period from commencement of first Policy with Us, We will pay percentage of **Sum Insured** in accordance with table below:

	Critical Ailments/ Procedures	Stage	Percentage of Sum Insured Payable	Waiting Period Applicable
1	Kidney failure requiring regular dialysis	Major	100% of Sum Insured	90 days
2	Major Organ Transplant – Kidney, Lung, Liver and Pancreas	Major		
3	End Stage Liver Failure	Major		
4	Medullary Cystic Disease	Major		
5	Systemic Lupus Erythematous with Lupus Nephritis	Major		
6	End Stage Lung Failure	Major		
7	Fulminant Hepatitis	Major		
8	Chronic Adrenal Insufficiency (Addison's Disease)	Major		
9	Progressive Scleroderma	Major		
10	Chronic Relapsing Pancreatitis	Major		
11	Elephantiasis	Major		
12	HIV due to blood transfusion and occupationally acquired HIV	Major		
13	Terminal Illness	Major		
14	Myelofibrosis	Major		
15	Pheochromocytoma	Major		
16	Crohn's Disease	Major		
17	Severe Rheumatoid Arthritis	Major		
18	Severe Ulcerative Colitis	Major		
19	Deafness	Major		
20	Blindness	Major		
21	Third Degree Burns	Major		
22	Severe Osteoporosis	Major	25% subject to maximum payout of INR 1,000,000	180 days

Covers and General Conditions applicable to Section B.2.AI, 1 to 4

1. Reduced Premium Benefit

If **Insured Person** is diagnosed with any covered Minor condition covered under this section and for which Claim

is admissible under the Policy, We will waive 50% of the applicable Annual Renewal Premium on subsequent Renewal of Policy with Us subject to:

i. Premium will be waived for the Renewal of **Insured Person** for whom the claim has been made, to the extent applicable to Coverage, terms and conditions corresponding to expiring year Policy.

ii. Premium will be waived for subsequent Renewal of 5 Policy Years only.

2. Survival Period

Claim under Section B.2.AI, 1 to 4 is payable only if Insured Person survives 7 days from the diagnosis and fulfillment of the definition of the **Critical Illness** or Surgical Procedure covered.

The Claim is admissible only with confirmatory diagnosis of the conditions covered while the **Insured Person** is alive (A claim would not be admitted if the diagnosis is made post mortem)

3. Number of Claims and Benefits payable

Only one claim is payable under each of the stages given below during lifetime of the Policy under this Section subject to maximum 100% of **Sum Insured** mentioned on the Policy Schedule irrespective of Number of Sections opted and Number of Policies held by the Insured Person.

Minor Stage - On the admissibility of Claim under Minor Stage condition under the Policy, coverage for all other Minor stage Conditions shall cease to exist. The Policy shall continue to Cover Major Stage condition for the Balance Sum Insured.

Major Stage – On the admissibility of Claim under Major Stage condition, coverage under this Policy shall cease to exist.

In the event where an **Insured Person** holds multiple Policies insuring different Covers under this Section of this product, Claim will be admissible under one Cover only and Total Sum Insured as applicable under such Cover across all policies of this product will be paid by the Company. Insurance for other Covers, if applicable, shall cease to exist.

II. Multipay Critical Illnesses Cover

1. Cancer Cover

If Insured Person suffers from Critical illness or undergoes Surgical Procedure as listed below, whose diagnosis first commence/occurs after the applicable Waiting Period from commencement of first Policy with Us, We will pay Sum Insured or percentage of Sum Insured in accordance with table below:

	Critical illness /Surgical Procedure	Stage	Percentage of Sum Insured Payable	Waiting Period Applicable
1	Cancer of Specified Severity	Major	100% of Sum Insured	90 days
2	Aplastic Anemia	Major		
3	Major Organ Transplant – Bone Marrow	Major		

1 Heart Cover

If Insured Person suffers from Critical illness or undergoes Surgical Procedure as listed below, whose diagnosis first commence/occurs after the applicable Waiting Period from commencement of first Policy with Us, We will pay Sum Insured or percentage of Sum Insured in accordance with table below:

A	Critical Ailments / Surgical Procedures	Stage	Percentage of Sum Insured Payable	Waiting Period Applicable
1	Open Chest CABG	Major	100% of Sum Insured	90 days
2	Myocardial Infarction (First Heart Attack of specified severity)	Major		
3	Open Heart Replacement or Repair of Heart Valves	Major		
4	Major Organ Transplant – Heart	Major		
5	Surgery of Aorta	Major		
6	Primary (Idiopathic) Pulmonary Hypertension	Major		
7	Other serious coronary artery disease	Major		
8	Dissecting Aortic Aneurysm	Major		
9	Cardiomyopathy	Major		
10	Eisenmenger's Syndrome	Major		
11	Infective Endocarditis	Major		
B*	Angioplasty	Minor	25% subject to maximum payout of INR1,000,000	180 days

***B - Angioplasty**

We will pay 25% of **Sum Insured** subject to maximum of INR 10,00,000 if **Insured Person** undergoes Angioplasty, whose diagnosis first commence/occurs more than 180 days after the commencement of first Policy with Us.

On the admissibility of Claim under Angioplasty, coverage for Angioplasty shall cease to exist. The Policy shall continue to cover other **Critical illness** or Surgical Procedure under this cover, for Balance Sum Insured in accordance with table above.

2. Nervous System Cover

If **Insured Person** suffers from Critical illness or undergoes Surgical Procedure listed below after the applicable Waiting Period from commencement of first Policy with Us, We will pay percentage of **Sum Insured** in accordance with table below:

A	Critical Ailments / Surgical Procedures	Stage	Percentage of Sum Insured Payable	Waiting Period Applicable
1	Multiple Sclerosis with persisting symptoms	Major	100% of Sum Insured	90 days
2	Permanent Paralysis of Limbs	Major		
3	Stroke resulting in permanent symptoms	Major		
4	Benign Brain Tumour	Major		
5	Coma of specified severity	Major		
6	Parkinson's Disease	Major		
7	Alzheimer's Disease	Major		
8	Motor Neurone Disease with permanent symptoms	Major		
9	Muscular Dystrophy	Major		
10	Apallic Syndrome	Major		
11	Bacterial Meningitis	Major		
12	Creutzfeldt-Jakob Disease (CJD)	Major		
13	Encephalitis	Major		
14	Major Head Trauma	Major		
15	Progressive Supranuclear Palsy	Major	100% of Sum Insured	90 days
16	Brain Surgery	Major		
17	Loss of Speech	Major		

3. Other Major Organ Cover

If **Insured Person** suffers from **Critical illness** or undergoes Surgical Procedure listed below after the applicable Waiting Period from commencement of first Policy with Us, We will pay percentage of **Sum Insured** in accordance with table below:

A	Critical Ailments / Surgical Procedures	Stage	Percentage of Sum Insured Payable	Waiting Period Applicable
1	Kidney failure requiring regular dialysis	Major	100% of Sum Insured	90 days
2	Major Organ Transplant – Kidney, Lung, Liver and Pancreas	Major		
3	End Stage Liver Failure	Major		
4	Medullary Cystic Disease	Major		
5	Systemic Lupus Erythematous with Lupus Nephritis	Major		
6	End Stage Lung Failure	Major		
7	Fulminant Hepatitis	Major		
8	Chronic Adrenal Insufficiency (Addison's Disease)	Major		
9	Progressive Scleroderma	Major		
10	Chronic Relapsing Pancreatitis	Major		
11	Elephantiasis	Major		
12	HIV due to blood transfusion and occupationally acquired HIV	Major		
13	Terminal Illness	Major		
14	Myelofibrosis	Major		
15	Pheochromocytoma	Major		
16	Crohn's Disease	Major		
17	Severe Rheumatoid Arthritis	Major		
18	Severe Ulcerative Colitis	Major	100% of Sum Insured	90 days
19	Deafness	Major		
20	Blindness	Major		
21	Third Degree Burns	Major		

Covers and General Conditions applicable to Section B.2.All, 1 to 4

1. Reduced Premium Benefit

If **Insured Person** is diagnosed with any covered Critical Illness under any Cover from Section B.2.All, 1 to 4 and for which Claim is admissible under the Policy, We will waive 50% of the applicable Annual Renewal Premium on subsequent Renewal of Policy subject to:

i. Premium will be waived for the renewal of Insured person for whom the claim has been made, to the extent applicable to Coverage, terms and conditions corresponding to expiring Policy.

ii. Premium will be waived for subsequent Renewal of 5 Policy Years, following every admissible claim under each Cover.

2. Survival Period

Each Claim under Section B.2. All, 1 to 4 is payable only if Insured Person survives 7 days from the diagnosis and fulfillment of the definition of the Critical Illness or Surgical Procedure covered.

The Claim is admissible only with confirmatory diagnosis of the conditions covered while the Insured Person is alive (A claim would not be admitted if the diagnosis is made post mortem)

3. Number of Claims and Waiting Period

Coverage under this Section shall cease to exist; once a Claim has been admitted under each of the Covers as opted by the **Insured Person** and maximum 100% of the **Sum Insured** is paid by the Company under such Covers subject to 12 months waiting period between Claims under any two Covers.

In the event where an **Insured Person** holds multiple Policies under this Section of this product, Total Sum Insured under this section across all policies of this product will be paid by the Company for each admissible claim subject to 12 months waiting period between Claims under any two Covers.

For Example: If an **Insured Person** suffers a Stroke resulting in permanent symptoms and at any time within 12 months also suffers from Myocardial Infraction (First Heart Attack of specified severity) thereby triggering claims under both Nervous System Cover and Cardiac Cover, the Company will pay maximum 100% of Sum Insured under one Cover only. However, if the two incidences were separated by more than 12 months' time period, the Company will pay maximum 100% of Sum Insured under each Cover.

B. my: health Active

1. Fitness discount @ Renewal

Insured Person can avail discount on Renewal Premium by accumulating Healthy Weeks as per table given below.

One Healthy Week can be accumulated by;

- Recording minimum 50,000 steps in a week subject to maximum 15,000 steps per day, tracked through Your wearable device linked to Our **HDFC ERGO Mobile App** and Your Policy number

OR

- burning total of 900 calories up to maximum of 300 calories in one exercise session per day, tracked Your wearable device linked to Our **HDFC ERGO Mobile App** app end Your Policy number

Healthy Weeks Discounts

No. of Healthy Weeks Accumulated	Discount on Renewal Premium
1-4	0.50%
5-8	1.00%
9-12	2.00%
13-16	3.00%
17-26	6.00%
27-36	7.50%
Above 36	10.00%

Steps to accumulate Healthy Weeks

Step 1 - The **HDFC ERGO Mobile App** must be downloaded on the mobile.

Step 2 - You can start accumulating Healthy Weeks by tracking physical activity trough the Wearable device linked to **HDFC ERGO Mobile App**

We encourage and recognize all types of exercise/fitness activities by making use of wearable devices to track and record the activities Insured Person engages in.

Application of Fitness discount @ Renewal

- **Annual Policy:** Discount amount accrued based on Number of accumulated Healthy Weeks during the expiring Policy year will be applied on the Renewal Premium for expiring Policy Sum Insured.
- Multi Year Policy:
  - o Fitness discount earned on yearly basis will be accumulated till Policy End date.
  - o On Renewal of the Policy, total discount amount accrued each year will be applied on Renewal Premium of subsequent year.
- For Policies covering more than one Insured Person, Healthy Weeks for each Insured Person will be tracked and accumulated. Such discount will be applicable on individual Renewal Premium. Premium will be discounted to the extent applicable to coverage corresponding to expiring Policy.
- In case of Increase in Sum Insured at Renewal, discount percentage will be applied on the Sum Insured applicable under expiring Policy.
- Fitness discount @ Renewal will be applied only on Renewal of Policy with Us.

2. Health Incentive

This Program encourages **Insured Person** to maintain good health and avail incentives as listed below.

Under this Program, **Insured Person** having Pre-Existing Diseases or Obesity (BMI above 30)as listed under table A below, will be eligible for reduction in Medical Underwriting Loading applied at first inception of the Policy with Us provided that;

i. **Insured Person** shall undergo medical tests and/or BMI check-up below minimum 3 months prior to expiry of Policy Year (For Multiyear Policies) or before Renewal (For Annual Policies).

ii. Medical test shall be done at Your own cost through our Network Provider through Our **HDFC ERGO Mobile App** If the test parameters are within normal limits, We will apply 50% discount on the Medical Underwriting loading applied for corresponding Obesity as applicable on Renewal of the Policy with Us.

iii. If the test parameters at subsequent renewal is not within normal limits or Medical test reports are not submitted in accordance with i and ii above, the discount amount applied on Medical Underwriting loading will be zero

Table A

Pre-existing Diseases	Test
Diabetes	HbA1c
Hypertension	Blood Pressure reading
Hyperlipidemia	Total Cholesterol
Hypothyroidism	Thyroid function tests
Obesity	BMI

Application of Health Incentive

- **Annual Policy:** Discount amount accrued during the expiring Policy year will be applied on the Renewal Premium for expiring Policy Sum Insured.
- Multi Year Policy:

o Discount amount earned on yearly basis will be accumulated till Policy End date.

o On Renewal of the Policy, total discount amount accrued each year will be applied on Renewal Premium of subsequent renewal.

- For Policies covering more than one **Insure Person**, tests shall be done for each **Insured Person** basis which such reduction in loading will be applicable on individual Renewal Premium.
- Medical Underwriting loading will be discounted only on Renewal of Policy with Us
- Discount on Medical Underwriting loading under this cover is applicable only on next Renewal and cannot be utilized if Policy is not renewed with Us.

3. Wellness services:

The services listed below are available to all Insured Person through Our Network Provider on Our **HDFC ERGO Mobile App** only.

i. Health Coach:

An **Insured Person** will have access to Health Coaching services in areas given below:

- Disease management
- Activity and fitness
- Nutrition
- Weight management.

These services will be available through Our **HDFC ERGO Mobile App** as a chat service or as a call back facility.

ii. Wellness services

- **Discounts**: on OPD, Pharmaceuticals, pharmacy, diagnostic centers.
- **Customer Engagement**: Monthly newsletters, Diet consultation, health tips
- **Specialized programs**: stress management, Pregnancy Care, Work life balance management

These services will be available through Our **HDFC ERGO Mobile App**

Disclaimer applicable to **HDFC ERGO Mobile App** and associated services

It is agreed and understood that Our **HDFC ERGO Mobile App** and Wellness services are not providing and shall not be deemed to be providing any Medical Advice, they shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this benefit.

C. Renewal Benefit

1. Preventive Health Check Up

Insured Person will be entitled for Preventive **Health Check-up** on Renewal of the Policy with Us, at our Network Diagnostic centers or hospitals in accordance to r list of tests, eligibility criteria and waiting period as specified below

Health Checkup- on each Policy Renewal

Age / Expiring Policy Sum Insured	1Lac to 10Lacs	11Lacs to 50 Lacs	Above 50 Lacs
18 to 40 Years	Set 1	Set 1, Thyroid, USG abdomen and pelvis	Set 1, Thyroid , USG abdomen and pelvis, Lipid Profile, Renal Profile
41 Yrs and Above	Set 1,Sr Creat	Set 1,SrCreat, Thyroid, USG abdomen and pelvis	Set 1, Thyroid, USG abdomen and pelvis, Lipid Profile,Renal profile, ECG

Set 1 -Comprises of, Complete Blood Count, Urine R,FBS,Sr Cholesterol

Health Checkup – Additional Tests

Age	Gender	Type of Test	Waiting Period	Sum Insured
Below 40 years	Female	PAP Smear & Mammography	Once in two years	All Sum Insured
	Male	PSA		
Above 40 years	Female	PAP Smear & Mammography	Once in four years	All Sum Insured
	Male	PSA		

Other terms and Conditions applicable to this Benefit

- This benefit will not be carried forward if not utilized within 60 days of Renewal Policy Inception date.
- Eligibility to avail Health Check-up will be in accordance to expiring Policy Sum Insured.
- The test reports received under this benefit shall not be utilized for re-underwriting the Policy

Procedure for availing this benefit

i. Insured person will be intimated to undergo the health check-up at our Network Provider, through **HDFC ERGO Mobile App**.

ii. Test reports from our Network Provider will be made available to You on Our **HDFC ERGO Mobile App** You have

the option to avail this benefit at our Network Provider through Phone/Email or other modes of communication available time to time.

D. Optional Covers

Insuring Clause

In consideration of payment of additional Premium by You, We will provide insurance to the **Insured Person(s)** under below listed Covers, up to Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule. These Covers are optional and applicable only if opted for.

1. Pre Diagnosis Cover

If a Claim is admissible under Section B.2.A I or I.2.A II as opted, We will pay the expenses incurred towards diagnostic tests/ procedures incurred up to 30 days prior to the diagnosis of such Critical Illness or Undergoing of such Surgical Procedure.

Indicative list of Procedures covered

Sr No	List of Diagnostic tests/ Procedures
1	Renal/Cardiac Angiogram.
2	Intravenous Pyelogram.
3	Ultrasonagraphy.
4	Ultrasound Guided FNAC.
5	Colour Doppler.
6	Mammography.
7	CT Scan.
8	MRI Scan.
9	Treadmill Test ECHO.
10	Cardiogram.
11	Electrophysiology.
12	Endoscopic Procedures.
13	Special Radiological Procedures such as barium meal investigations
14	Arthrogram, ERCP, Intravenous Urogram, Cystourethrogram,
15	Nephrostogram.
16	Special Blood Investigations such as Assay of Various Blood Factors.
17	Virology Markers, Complete Coagulation Work up

2. Post Diagnosis Support

a. Second Medical Opinion

We will pay expenses incurred towards second Medical Opinion availed from Medical Practitioner in respect of Critical Illness/Surgical Procedure for which Claim is admissible under the Policy.

b. Molecular Gene Expression Profiling Test

We will pay the expenses incurred towards the expenses for Molecular Gene Expression Profiling Test for Treatment Guidance on diagnosis of any Major stage Cancer for which Claim is admissible under Section B.2.A I.1or I.2.A II.1, Cancer Cover as opted. The benefit under this cover can be availed only once during lifetime of the Policy.

c. Post Diagnosis Assistance

We will pay **Sum Insured** towards outpatient counseling required upon diagnosis of **Critical Illnesses** and Surgical Procedures for which Claim is admissible under Section B.2.A I or I.2.A II as opted. The Cover is subject to maximum number of sessions as specified on Schedule of Coverage.

Applicability of Cover (Applicable to a. and c.)

Section B.2.A I – if Base Coverage is opted under Section B.2.A I, the Claim under this cover is admissible only once in life time of the Policy

Section B.2.A II – if Base Coverage is opted under Section B.2.A II, the Claim under this cover is admissible after every admissible Claim under the Policy

3. Loss of Job

We will pay **Sum Insured** if **Insured Person** suffers from Loss of Job due to his/her Voluntary Resignation or Termination from the employment within six months of diagnosis of any of the Major stage Critical Illnesses or undergoing any of the Major stage Surgical Procedures for which Claim is admissible under Section B.2.A I or I.2.A II of the Policy.

Section 3: my: health Medisure Super Top Up Insurance

If during the Policy Period, You suffer from any Illness or Accident which requires Hospitalization as an inpatient, We will reimburse the amount of such **Medical Expenses** as per the benefits given under Scope of Covers, in excess of Aggregate Deductible and subject to a maximum of the **Sum Insured** as stated in the Schedule. The liability of the Company to pay the admissible Claim under that Policy Year will commence only once Aggregate Deductible has been exhausted.

A. Scope of Cover

1. In-patient Hospitalization Expenses:

If any **Insured Person** suffers an Illness or Accident during the Policy Period requiring Inpatient Hospitalization, We will pay the Medical Expenses incurred for

1.1 Room Rent/ Boarding & Nursing;

1.2 ICU Rent/Boarding & Nursing;

1.3 Fees of Surgeon, Anaesthetist, Nurses and Specialists;

1.4 Cost of Operation Theatre, diagnostic tests, medicines, blood, oxygen and cost of prosthetic and other Medical devices or equipment if implanted internally like pacemaker during a surgical procedure.

Note pertaining specifically to AYUSH Treatments only:

Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'In-patient Hospitalization expenses' cover if undertaken in an AYUSH Hospital. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this cover.

2. Pre-Hospitalization Medical Expenses –

The Pre Hospitalization Medical Expenses incurred in the 30 days immediately before You were Hospitalized, provided that:

i. Such Medical Expenses were in fact incurred for the same condition requiring subsequent Hospitalization, and;

ii. We have accepted the Claim under Scope of Cover. "In-patient Hospitalization expenses".

3. Post Hospitalization Medical Expenses –

The Post Hospitalization **Medical Expenses** incurred in the 60 days immediately after You were discharged, provided that:

i. Such Medical Expenses were in fact incurred for the same condition for which Your Hospitalization was required, and;

ii. We have accepted the Claim under Scope of Cover . "In-patient Hospitalization expenses".

4. Day Care treatment –

We will pay for the **Medical Expenses** under Section B.3.A.1 on Hospitalization of **Insured Person** in Hospital or Day Care Centre for Day Care Treatment.

Section 4: my: health Hospital Cash Benefit Add on

A: Coverage

1. Hospital Cash Benefit

We will pay Sum Insured on Medically Necessary Hospitalization (including In-patient care AYUSH treatment taken in an AYUSH Hospital) of an Insured Person due to Illness or Injury sustained or contracted during the Policy Period. The payment is subject to per day benefit Sum Insured as specified on the Schedule of Coverage in the Policy Schedule for up to maximum of 30 days.

2. Companion Benefit

We will pay additional amount upto the limit specified on the Schedule of Coverage in the Policy Schedule towards expenses of an accompanying person during Hospitalization for up to maximum of 30 days.

B: Optional Cover

Insuring Clause

In consideration of payment of additional Premium, it is hereby declared and agreed that We will pay under below listed Cover subject to all other terms, conditions, exclusions and waiting periods applicable to the add on and Policy on which this add on is attached.

The Cover is optional and applicable only if opted for and up to the Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule.

1. Hospital Cash benefit - Global

On availing this option, We will pay Sum Insured on Medically Necessary Hospitalization of an Insured Person outside India due to Illness or Injury sustained or contracted during the Policy Period.

2. Waiting period Modification Option

On availing this option, Waiting Periods listed under Section BII.a.I: Waiting Periods will stand modified as mentioned in Schedule of Coverage on the Policy Schedule.

All other terms and Conditions of the respective Section and Policy shall remain unaltered.

C: Renewal Benefits

A. Fitness discount @ Renewal

Insured Person can avail discount on Renewal Premium by accumulating Healthy Weeks as per table given below.

One Healthy Week can be accumulated by;

- Recording minimum 50,000 steps in a week subject to maximum 15,000 steps per day, tracked through Your wearable device linked to Our **HDFC ERGO Mobile App** and Your Policy number

OR

- burning total of 900 calories upto maximum of 300 calories in one exercise session per day, tracked Your wearable device linked to Our **HDFC ERGO Mobile App** and Your Policy number

- Fitness discount @ Renewal is applicable for Adult Insured Persons only. Any Person covered as Child Dependent, irrespective of the Age is excluded

Healthy Weeks Discounts

No. of Healthy Weeks Accumulated	Discount on Renewal Premium
01-04	0.50%
05-08	1.00%
09-12	2.00%
13-16	3.00%
17-26	6.00%
27-36	7.50%
Above 36	10.00%

Steps to accumulate Healthy Weeks

Step 1 - The **HDFC ERGO Mobile App** must be downloaded on the mobile.

- Step 2 - You can start accumulating Healthy Weeks by tracking physical activity trough the Wearable device linked to Our **HDFC ERGO Mobile App** and Your Policy number

We encourage and recognize all types of exercise/fitness activities by making use of wearable devices to track and record the activities Insured Person engages in.

Application of Fitness discount @ Renewal

- **Annual Policy:** Discount amount accrued based on Number of accumulated Healthy Weeks during the expiring Policy year will be applied on the Renewal Premium for expiring Policy Sum Insured.

- **Multi Year Policy:**

o Fitness discount earned on yearly basis will be accumulated till Policy End date.

o On Renewal of the Policy, total discount amount accrued each year will be applied on Renewal Premium of subsequent year.

- For Policies covering more than one **Insure Person**, Healthy Weeks for each Insured Person will be tracked

and accumulated. Such discount will be applicable on individual Renewal Premium for both Individual and Floater **Sum Insured** basis Policies.

- Premium will be discounted to the extent applicable to terms corresponding to expiring Policy.
- In case of Increase in Sum Insured at Renewal, discount amount will be applied on the **Sum Insured** applicable under expiring Policy.
- Fitness discount @ Renewal will be applied only on Renewal of Policy with Us.

B. Health Incentive

This Program encourages Insured Persons to maintain good health and avail incentives as listed below.

Under this Program, **Insured Person** having Pre-Existing Diseases or Obesity (BMI above 30) as listed under table A below, will be eligible for reduction in Medical Underwriting Loading applied from first inception of the Policy with Us provided that;

iv. Insured Person shall undergo medical tests and/or BMI check-up as listed below minimum 3 months prior to expiry of Policy Year (For Multiyear Policies) or before Renewal (For Annual Policies).

v. Medical test shall be done at Your own cost through our Network Provider on **my: Health mobile App**.

vi. If the test parameters are within normal limits, We will apply 50% discount on the Medical Underwriting loading applied for corresponding Pre-Existing Disease or Obesity as applicable on Renewal of the Policy with Us.

vii. If the test parameters at subsequent renewal are not within normal limits or Medical test reports are not submitted in accordance with i and ii above, the discount amount applied on Medical Underwriting loading will be zero

viii. The test reports received to avail the health incentive benefit shall not be utilised for re underwriting the policy

Table A

Pre-existing Diseases	Test
Diabetes	HbA1c
Hypertension	Blood Pressure reading
Hyperlipidemia	Total Cholesterol
Cardiovascular Diseases	ECG
Hypothyroidism	Thyroid function tests
Obesity	BMI

Application of Health Incentive

- **Annual Policy:** Discount amount accrued during the expiring Policy year will be applied on the Renewal Premium for expiring Policy Sum Insured.
- **Multi Year Policy:**

o Discount amount earned on yearly basis will be accumulated till Policy End date.

o On Renewal of the Policy, total discount amount accrued each year will be applied on Renewal Premium of subsequent year.

- For Policies covering more than one **Insure Person**, tests shall be done for each Insured Person basis which such reduction in loading will be applicable on individual Renewal Premium for both Individual and Floater **Sum Insured** basis Policies.
- Discount on Medical Underwriting loading under this cover is applicable only on next Renewal and cannot be utilized if Policy not renewed with us.

C. Wellness services:

The services listed below are available to all Insured persons through Our **Network Provider** on Our mobile application only. Availing of services under this Section will not impact the **Sum Insured** or the eligibility for Cumulative Bonus.

i. Health Coach:

An **Insured Person** will have access to Health Coaching services in areas given below:

- Disease management
- Activity and fitness
- Nutrition
- Weight management.

These services will be available through Our mobile application as a chat service or as a call back facility.

ii. Online Wellness services

- **Discounts:** on OPD, Pharmaceuticals, pharmacy, diagnostic centres
- **Customer Engagement:** Monthly newsletters, Diet consultation, health tips
- **Specialized programs**: stress management, Pregnancy Care, Work life balance management.

Disclaimer applicable to **HDFC ERGO Mobile App** and associated services

It is agreed and understood that Our **HDFC ERGO Mobile App** and Wellness services are not providing and shall not be deemed to be providing any Medical Advice, they shall only provide a suggestion for the Insured Person's consideration and it is the Insured Person's sole and absolute choice to follow the suggestion for any health related advice. We do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations suggested under this benefit.

Section 5: my: health Koti Suraksha – Personal Accident Cover

I. Coverage

I. Accidental Death

We will pay the **Sum Insured**, as specified in the Schedule of Coverage on Policy Schedule, if **Insured Person** sustains Injury due to Accident during the Policy Period, which shall within twelve months of its occurrence be the sole and direct cause of Death of **Insured Person**.

i. Disappearance

We will pay the **Sum Insured** in the event if Insured Person's body cannot be located within 365 Days;

a. after the forced landing, stranding, sinking or wrecking of a conveyance in which **Insured Person** was known to be a passenger during Policy Period or;

b. after and as a result of any Catastrophic Event during Policy Period

it shall be deemed, subject to all other terms and provisions of the Policy, that Insured Person shall have suffered Death due to Accident under the Policy.

If at any time, after the payment of the **Accidental death benefit**, it is discovered that the **Insured Person** is still alive, claims settled in respect of Disappearance benefit shall be reimbursed in full to the Company.

ii. Comatose

If **Insured Person** sustains Injury during **Policy Period** which directly and independently of all other causes results in the Insured Person being in Hospital in a Comatose State within one month of the date of Injury for continuous period of more than three months, We will pay **Sum Insured** as mentioned in the Schedule of Coverage on Policy Schedule.

Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims. The Company's liability during the lifetime of the Policy will not exceed the Base **Sum Insured** in respect of the Cover

I. Specific Conditions applicable to Cover 1 – Accidental Death

The Coverage under this Section terminates on admissibility of Claim equal to the **Sum Insured**

II. Optional Cover applicable to Cover 1 – Accidental Death

i. Burns

If **Insured Person** sustains Injury during Policy Period, which solely and directly results into burns, We will pay in accordance with benefit table below subject to maximum of Sum Insuredas mentioned in the Schedule of Coverage on Policy Schedule;

Description	% of Base Sum Insured payable
a. Head	
i. Third degree burns of 8% or more of the total head surface area	100%
ii. Second degree burns of 8% or more of the total head surface	50%
iii. Third degree burns of 5% or more, but less than 8% of the total head surface area	80%
iv. Second degree burns of 5% or more, but less than 8% of the total head surface area	40%
v. Third degree burns of 2% or more, but less than 5% of thetotal head surface area	60%
vi. Second degree burns of 2% or more, but less than 5% of the total head surface area	0%
b. Rest of the Body	
i. Third degree burns of 20% or more of the total body surface area	100%
ii. Second degree burns of 20% or more of the total body surface area	50%
iii. Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
iv. Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
v. Third degree burns of 10% or more, but less than 15% of the total body surface area	60%
vi. Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
vii. Third degree burns of 5% or more, but less than 10% of the total body surface area	20%
viii. Second degree burns of 5% or more, but less than 10% of the total body surface area	10%

Specific conditions applicable to Burns

i. If the Injury results in more than one of the Descriptions above, then the Company shall be liable for the largest **Sum Insured** (as per defined Description) only.

ii. Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims.

iii. This Cover terminates on admissibility of Claim(s) equal to the **Sum Insured**. The Company's liability during the lifetime of the Policy will not exceed the Base **Sum Insured** in respect of the Cover.

2 – Permanent Disablement

I. Permanent Disablement

If **Insured Person** sustains Injury during **Policy Period**, which shall within twelve (12) months of its occurrence be the sole and direct cause of Permanent Disablement, We will pay in accordance to the Benefit table below upto maximum of **Sum Insured** as mentioned in the Schedule of Coverage on Policy Schedule provided such disablement is certified by the Medical Practitioner

i. Benefit Table A

The Disablement		% of Base Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance of Limbs)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance of Limbs)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%

9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance of Limbs)	50%
12	Permanent Total Loss of Sight of one eye	50%

ii. Benefit Table B

	The Disablement	% of Base Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use of such Limb)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use of such Limb)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use of such Limb)	50%
12	Permanent Total Loss of Sight of one eye	50%

iii. Benefit Table C

	The Disablement	% of Base Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use)	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb (physical severance or the total and permanent loss of use)	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total Loss of Sight of one eye	50%
13	Permanent Total Loss of Hearing in one ear	15%
14	Permanent Total Loss of the lens in one eye	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand:	
a	Both joints	20%
b	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a	Three joints	5%
b	Two joints	4%
c	One joint	2%
19	Permanent Total Loss of use of toes:	
a	All – one foot	15%
b	Big – both joints	5%
c	Big – one joint	2%
d	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%

iv. Benefit Table D

	The Disablement	% of Base Sum Insured Payable
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs (physical severance or the total and permanent loss of use)	100%

4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb (physical severance or the total and permanent loss of use)	50%
12	Permanent Total Loss of Sight of one eye	50%
13	Permanent Total Loss of Hearing in one ear	15%
14	Permanent Total Loss of the lens in one eye	25%
15	Permanent Total Loss of use of four fingers and thumb of either hand	40%
16	Permanent Total Loss of use of four fingers of either hand	20%
17	Permanent Total Loss of use of one thumb of either hand:	
a	Both joints	20%
b	One joint	10%
18	Permanent Total Loss of one finger of either hand:	
a	Three joints	5%
b	Two joints	4%
c	One joint	2%
19	Permanent Total Loss of use of toes:	
a	All – one foot	15%
b	Big – both joints	5%
c	Big – one joint	2%
d	Other than Big – each toe	2%
20	Established non-union of fractured leg or kneecap	10%
21	Shortening of leg by at least 5 cms.	8%
22	Ankylosis of the elbow, hip or knee	20%
23	Permanent disablement not otherwise provided for under Items 2-22 inclusive up to a maximum of	75%

Terms and Conditions applicable to Cover 2 – Permanent Disabelemt

i. Ankylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall be limited to fifty percent (50%) of the Base **Sum Insured** subject to maximum of **Sum Insured** payable for the loss of the said members.

ii. Benefit under item 23 of Table D shall be determined by the independent Medical Practitioner who will certify the percentage of Base **Sum Insured** payable taking into consideration the nature of the Injury and disability in conjunction with the stated percentages Base Sum Insured for more specific injuries shown in the Table of Benefits.

iii. Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims.

iv. The Coverage under this Section terminates on admissibility of Claim(s) equal to the **Sum Insured**. The Company's liability during the lifetime of the Policy will not exceed the Base **Sum Insured** in respect of the Cover.

v. The total amount payable in respect of more than one disablement due to the same Injury is arrived at by adding together the various percentages of Base Sum Insured shown in the Table of Benefits subject to maximum of **Sum Insured**.

3 – Temporary Total Disablement

I. Temporary Total Disablement – **Accident Only**

If Insured Person sustains Injury during Policy Period, which solely and directly results in Temporary Total Disablement ,We will pay the weekly benefit upto maximum of Sum Insured as specified in the Schedule of Coverage on the Policy Schedule for each continuous period of Temporary Total Disablement.

II. Temporary Total Disablement – **Accident and Illness**

If during Policy Period, Insured Person;

a) Sustain injury

b) Contracts Illness

Which solely and directly results in Temporary Total Disablement, We will pay the weekly benefit up to maximum of Sum Insured as specified in the Schedule of Coverage on the Policy Schedule for each continuous period of Temporary Total Disablement.

This coverage is subject to specific exclusions applicable to Temporary Total Disablement due to illness as listed under IV –What is not covered

III. Specific Conditions applicable to **Temporary Total Disablement (I) and (II)**

i. If Injury sustained or Illness (as applicable) suffered is in relation to the spine and its muscular girdle, ligamentous system, cartilage, nervous system and blood supply to the spine which is not detectable by means of radiological scanning, imaging, or neurological fallout testing, then the Company shall only be liable in respect of this Section for a maximum period of five (5) weeks and only once in lifetime of the Policy.

ii. In the event of a dispute arising as to when Temporary Total Disablement ceased, the date shall be finally determined by an independent **Medical Practitioner** who certifies:

a. the date upon which the **Insured Person** recovered; or

b. the date upon which the **Insured Person** recovered as far

as he/she ever will; or

c. the date from which the **Insured Person** is declared to have suffered Permanent Total Disablement

iii. Any claim amount admissible/paid during the year will reduce the **Sum Insured** payable for the Cover in respect of subsequent claims.

iv. The Coverage under this Cover terminates on admissibility of Claim(s) equal to **Sum Insured**. The Company's liability during the lifetime of the Policy will not exceed the Base Sum Insured in respect of the Cover.

4 – Broken Bones

I. Broken Bones

If **Insured Person** sustains Injury during Policy Period, which solely and directly results into Fracture, certified by Medical Practitioner, We will pay in accordance to the Benefit table below upto maximum **Sum Insured** as mentioned in the Schedule of Coverage on Policy Schedule;

	Fracture	% of Base Sum Insured payable
1	Fractures of the Skull: a) Compound fracture with damage to the brain tissue b) Compound fracture without damage to the brain tissue c) All other fractures	 100 75 50
2	Fractures of hip or pelvis (excluding thigh or coccyx): a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 100 50 30 20
3	Fracture of thigh or heel: a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 50 40 30 20
4	Fracture of Lower Leg, Clavicle, Ankle, Elbow, Upper or Lower Arm (including wrist, but excluding Colles-type fracture): a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 40 30 20 12
5	Fractures of Lower Jaw: a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 30 20 16 8
6	Fractures of Shoulder Blade, Kneecap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes and heel): a) All compound fractures b) All other fractures	 20 10
7	Colles type fracture to the Lower Arm: a) Compound b) Other	 20 10
8	Fractures of Spinal Column (Vertebrae but excluding coccyx): a) All compression fractures b) All spinous, transverse process or pedicle fractures c) All other vertebral fractures	 20 20 10
9	Fractures of Rib or Ribs, Cheekbone, Coccyx, Upper Jaw, Nose, Toe and toes, finger or fingers: a) Multiple fractures (at least one compound & one complete) b) All other compound fractures c) Multiple fractures, at least one complete d) All other fractures	 16 12 8 4

II. Specific Conditions applicable to Broken Bones

The Claims under this Section are payable subject to:

i. Extent and nature of fracture as certified by **Medical Practitioner**.

ii. The total amount payable under this Cover, in respect of more than one fracture due to the same Injury, will be calculated by adding the various benefits together, but shall not exceed the **Sum Insured** under this Cover.

iii. This Cover terminates on admissibility of Claim(s) equal to the **Sum Insured**. The Company's liability during the lifetime of the Policy will not exceed the Base **Sum Insured** in respect of the Cover.

5 – Emergency Medical Expenses

I. Emergency Medical Expenses

We will pay **Medical Expenses** listed below for an Emergency Care of an **Insured Person** due to an Injury sustained during the Policy Period up to Sum Insured as mentioned in the Schedule of Coverage on the **Policy Schedule**, subject to Co-Payment, Deductible and Sub-limit as applicable and within India only.

Medical Expenses

1. Room Rent and boarding charges in the event of Hospitalization of **Insured Person**
2. Intensive Care Unit charges in the event of Hospitalization of **Insured Person**
3. Post Hospitalization expenses up to 30 days
4. Consultation fees & Nursing charges
5. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances charges
6. Medicines, drugs and consumables
7. Diagnostic procedures
8. The Cost of prosthetic and other devices or equipment if implanted internally during a Surgical Procedure.
9. Medical Expenses listed above for Domiciliary Hospitalization in India only
10. **Road Ambulance:** if following an Injury, Insurance Person is required to be Hospitalized, we will indemnify the cost of Road Ambulance;

- to the nearest Hospital
- from one Hospital to another Hospital
- or from Hospital to Home (within same City)

Note pertaining specifically to AYUSH Treatments only:

Medical expenses pertaining only to In-patient care AYUSH treatment are also covered under 'Emergency Medical Expenses' cover if undertaken in an AYUSH Hospital. Any medical expense other than In-patient care AYUSH treatment expenses are not covered under this cover.

i. **Room Rent & Proportionate deduction:** In the event of Hospitalization, Insured Person is eligible for Room Rent category of up to Single Standard AC Room. In case of admission to a room exceeding the aforesaid category, the reimbursement/payment of Room Rent charges including all Associated Medical Expenses(excluding Medicines and drugs)incurred at Hospital shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent charges. This condition is not applicable in respect of Hospitals where differential billing for Associated Medical Expenses is not followed based on Room Rent.

II. Optional Covers under Emergency Medical Expenses

i. Emergency Medical Expenses - Global

On availing this option, We will pay Medical Expenses under I. Emergency Medical Expenses, incurred anywhere in world.

ii. Co-payment

On availing this option, Co-Payment will be applicable as mentioned in the Schedule of Coverage on the Policy Schedule on all Claims under Cover 6 – Emergency Medical Expenses

6 – Hospital Cash – Accident only

I. Hospital Cash – Accident Only

If **Insured Person** sustains Injury, which with in month of its occurrence, results in Medically Necessary;

i. Hospitalization

ii. Domiciliary Hospitalization

iii. Hospitalization for Alternative Treatments

of an **Insured Person** within India, We will pay per day Sum Insured subject to maximum number of benefit days as specified on the Schedule of Coverage in the Policy Schedule for each continuous and completed period of 24 hours of such Hospitalization.

II. Specific Conditions applicable to Cover Hospital Cash – Accident only

For the purpose of application of Time Deductible, successive Hospital stays with less than sixty days between each one for a same cause, shall be deemed as one Hospitalization event.

III. Optional Covers applicable to Cover Hospital Cash – Accident only

i. Companion Benefit

In the event of admissible Claim under this Cover, We will pay additional Sum Insured as specified on the Schedule of Coverage in the Policy Schedule towards expenses of an accompanying person during Hospitalization of the Insured Person.

ii. Hospital Cash –ICU

We will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule for each continuous and completed period of 24 hours of Hospitalization of Insured Person in the Intensive Care Unit.

iii. Time Deductible Modification Option

On availing this option, Time Deductible as mentioned on the Schedule of Coverage in the Policy Schedule will be applied on each and every admissible Claim under the Policy.

iv. Hospital Cash – Global

On availing this option, we will pay Sum Insured as specified on the Schedule of Coverage in the Policy Schedule on Medically Necessary Hospitalization of an Insured Person outside India due to Injury sustained during Policy Period.

7- Chauffeur Benefit

I. Chauffeur Benefit

If Insured Person sustains Injury during the Policy Period which results in Temporary Total Disablement or Temporary Partial Disablement, We will indemnify the Insured Person towards daily cost of hire of a transportation or driver to maintain the mobility of Insured Person. The Coverage is applicable for period of disablement subject to maximum number of days and Sum Insured specified in the Schedule of Coverage on the Policy Schedule.

II. Specific Conditions applicable to Chauffeur Benefit

i. This cover is applicable only on certification of Travel by Medical Practitioner.

ii. In the event of Claim admissible under this Cover, no claim shall be payable under Cover 3 – Temporary Total Disablement

iii. Any claim amount admissible/paid during the year will reduce the Sum Insured payable for the Cover in respect of subsequent claims.

iv. The Coverage under this Cover terminates on admissibility of Claim(s) equal to the Sum Insured. The Company's liability during the lifetime of the Policy will not exceed the Base Sum Insured in respect of the Cover.

II. Value added Services under Section B – Personal Accident

i. Health Coach:

Insured Person will have access to Health Coaching services in areas given below :

- Disease management
- Activity and fitness
- Nutrition
- Weight management
- Psychological counselling
- Depression counselling

These services will be available through Our **HDFC ERGO Mobile App** as a chat service or as a call back facility.

ii. Wellness services

- **Discounts:** on OPD, Pharmaceuticals, pharmacy and diagnostic centres
- **Customer Engagement:** Monthly newsletters, Diet consultation, health tips
- **Specialized programs:** stress management, Pregnancy Care, Work life balance management.

III. Optional Covers under Personal Accident Cover

In consideration of payment of additional Premium or reduction in the Premium as applicable, it is hereby declared and agreed that We will pay/restrict the expenses under below listed Covers subject to all other terms, conditions, exclusions and waiting periods applicable to the Policy.

These Covers are optional and applicable only if opted for and upto the Sum Insured or limits mentioned on the Schedule of Coverage in the Policy Schedule.

i. Preventive Health Check-up

Insured Person will be entitled for below list of tests after completion of each Policy Year/Renewal at our Network Provider ;

- Chest X Ray
- 2D echo/ Stress test
- PSA for Males
- PAP smear for Females
- Medical Examination Report
- Complete Blood Count Urine R
- Fasting Blood Sugar
- Serum Creatinine
- Lipid Profile
- Electro Cardio Gram

Other terms and Conditions applicable to this Benefit

- This benefit will not be carried forward if not utilized within 60 days of Policy anniversary date.
- The test reports received under this benefit will not be utilized for re-underwriting the coverage of Insured Person

Procedure for availing this benefit

i. You will be intimated to undergo the health check-up at our Network Provider, through Our HDFC ERGO Mobile App Test reports from our Network Provider will be made available to You on Our HDFC ERGO Mobile App You have the option to avail this benefit at our Network Provider through Phone/Email or other modes of communication as available from time to time.

ii. Last Rites

On availing this option, We will pay the Sum Insured towards Last Rites of Insured Person in the event of admissible Claim under Cover I.5.B.1 – Accidental Death.

The Coverage for this Optional cover terminates on admissibility of Claim equal to the Sum Insured

iii. Dependent Children Education Benefit

We will pay the Sum Insured towards education of Dependent Children, in the event of Claim admissible under Cover I.5.B.1 – Accidental Death.

Conditions applicable to Dependent Children Education Benefit

1) This Coverage is applicable only to living Dependent Children

2) The **Sum Insured** for this Cover is the total claim amount payable for all Dependent Children combined

3) The Coverage for this Optional cover terminates on admissibility of Claim equal to the Sum Insured

iv. Renewal Premium Benefit

In the event, Claim for Insured Policy Holder becomes admissible under Cover I.5.B.1 – Accidental Death, We will pay the amount equivalent to the Renewal premium of the Coverage for all other **Insured Person** covered in the same policy as mentioned in the Schedule of Coverage on the Policy Schedule.

Conditions applicable to Renewal Premium Benefit

(I) Renewal Premium benefit will only be in respect of Coverage under Section B – Personal Accident

(II) The Benefit will be payable irrespective of whether Policy is renewed or not.

v. Parental Care Benefit

We will pay the Sum Insured towards parental care of Dependent Parents, in the event of Claim admissible under Cover I.5.B.1 – Accidental Death.

Conditions applicable to Parental Care Benefit

1) This Coverage is applicable only to living Dependent Parents

2) The Sum Insured for this Cover is the total claim amount payable for both Dependent Parents combined

3) The Coverage for this Optional cover terminates on admissibility of Claim equal to the Sum Insured

vi. Medical Evacuation

We will indemnify the **Insured Person** for Air Ambulance transportation in an airplane or helicopter for Emergency Care which requires immediate and rapid ambulance transportation as prescribed by Medical Practitioner, from the site of first occurrence of the Accident to the nearest Hospital, that ground transportation cannot provide provided Claim is admissible under any of the Cover 1 to 9 of this Section.

Conditions applicable to Medical Evacuation

The Claim under this cover is admissible only once in a Policy Year irrespective of number of Claims becoming admissible under any of the Cover 1 to 9 of this Section.

Section 6: Travel Insurance

1. Accidental Death

If during the Period of Insurance an Insured Person sustains Bodily Injury which directly and independently of all other causes results in Death within twelve (12) months of the Date of

Loss, then the Company agrees to pay to the Insured Person's Beneficiary or legal representative the Compensation stated in the Schedule.

Specific Extensions

1) Disappearance: In the event of the disappearance of the Insured Person, following a forced landing, stranding, sinking or wrecking of a conveyance in which such Insured Person was known to have been travelling as an occupant, it shall be deemed after twelve (12) months, subject to all other terms and conditions of this Policy, that such Insured Person shall have died as the result of an Accident. If at any time, after the payment of the Accidental death benefit, it is discovered that the Insured Person is still alive, all payments shall be reimbursed in full to the Company.

2) Exposure: Death as a direct result of exposure to the elements shall be deemed to be Bodily Injury.

Specific Conditions

If applicable and if payment has been made under the Permanent Disablement Section, any amounts paid under that Section would be deducted from payment of a claim under this Section of the Policy.

2. Permanent Disablement

If during the Period of Insurance an Insured Person sustains Bodily Injury which directly and independently of all other causes results in disablement within twelve (12) months of the Date of Loss, then the Company agrees to pay to the Insured Person the Compensation stated in the specific Table of Benefits below, which is shown as the Table of Benefits in the Schedule. The Deductible or Franchise, if applicable, shall be deducted from the Compensation payable.

Specific Extensions

Exposure: Permanent disablement as a direct result of exposure to the elements shall be deemed to be Bodily Injury.

Specific Provisions

1) Ankylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall be limited to fifty percent (50%) of the Compensation payable for the loss of the said members.

2) Any benefit payable under item 23 of Table (C) shall be at the complete discretion of the Company taking into consideration the nature of the Bodily Injury in conjunction with the stated Compensation percentages for more specific injuries shown in the Table of Benefits.

Specific Conditions

1) The insurance shall terminate for an Insured Person under this Section upon payment of a benefit equal to the Total Sum Insured.

2) The total amount payable in respect of more than one disablement due to the same Accident is arrived at by adding together the various percentages shown in the Table of Benefits, but shall not exceed the Total Sum Insured.

3) The Deductible or Franchise, if applicable, shall apply to the total amount payable, irrespective of the number of benefits an Insured Person is entitled to.

4) If an Insured Person dies as the result of the Bodily Injury any amount claimed and paid to an Insured Person under the Permanent Disablement Section will be deducted from any payment under the Accidental Death Section.

Specific Definitions for all Tables of Benefits

1) Limb means the hand above the wrist joint or foot above the ankle joint.

2) Loss of Hearing means the total and irrecoverable Loss of Hearing.

3) Loss of Mastication means the total and irrecoverable loss of ability to chew food.

4) Loss of Sight means the total and irrecoverable Loss of Sight. This is considered to have occurred if the degree of sight remaining after correction is 3/60 or less on the Snellen Scale.

5) Loss of Speech means the total and irrecoverable Loss of Speech.

Specific Definitions for Table (A)

Loss used with reference to Limb means the loss by physical severance of such Limb.

Specific Definitions for Table (B)

Loss used with reference to Limb means the loss by physical severance or the total and permanent loss of use of such Limb.

Specific Definitions for Table (C) & Table (D)

Loss used with reference to Limb and / or fingers, thumbs or toes, means the loss by physical severance or the total and permanent loss of use of said member.

Table Of Benefits – Table (A)

The Disablement	Compensation Expressed as a Percentage of Total Sum Insured
1) Permanent Total Disablement	100%
2) Permanent and incurable insanity	100%
3) Permanent Total Loss of two Limbs	100%
4) Permanent Total Loss of Sight in both eyes	100%
5) Permanent Total Loss of Sight of one eye and one Limb	100%
6) Permanent Total Loss of Speech	100%
7) Complete removal of the lower jaw	100%
8) Permanent Total Loss of Mastication	100%
9) Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10) Permanent Total Loss of Hearing in both ears	75%
11) Permanent Total Loss of one Limb	50%
12) Permanent Total Loss of Sight of one eye	50%

Table Of Benefits – Table (B)

The Disablement	Compensation Expressed as a Percentage of Total Sum Insured
1) Permanent Total Disablement	100%
2) Permanent and incurable insanity	100%
3) Permanent Total Loss of two Limbs	100%
4) Permanent Total Loss of Sight in both eyes	100%
5) Permanent Total Loss of Sight of one eye and one Limb	100%
6) Permanent Total Loss of Speech	100%
7) Complete removal of the lower jaw	100%
8) Permanent Total Loss of Mastication	100%
9) Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10) Permanent Total Loss of Hearing in both ears	75%
11) Permanent Total Loss of one Limb	50%
12) Permanent Total Loss of Sight of one eye	50%

Table Of Benefits – Table (C)

The Disablement	Compensation Expressed as a Percentage of Total Sum Insured
1) Permanent Total Disablement	100%
2) Permanent and incurable insanity	100%
3) Permanent Total Loss of two Limbs	100%
4) Permanent Total Loss of Sight in both eyes	100%
5) Permanent Total Loss of Sight of one eye and one Limb	100%
6) Permanent Total Loss of Speech	100%
7) Complete removal of the lower jaw	100%
8) Permanent Total Loss of Mastication	100%
9) Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10) Permanent Total Loss of Hearing in both ears	75%
11) Permanent Total Loss of one Limb	50%
12) Permanent Total Loss of Sight of one eye	50%
13) Permanent Total Loss of Hearing in one ear	15%
14) Permanent Total Loss of the lens in one eye	25%
15) Permanent Total Loss of use of four fingers and thumb of either hand	40%
16) Permanent Total Loss of use of four fingers of either hand	20%
17) Permanent Total Loss of use of one thumb of either hand: a) Both joints b) One joint	 20% 10%
18) Permanent Total Loss of one finger of either hand: a) Three joints b) Two joints c) One joint	 5% 3.5% 2%
19) Permanent Total Loss of use of toes: a) All – one foot b) Big – both joints c) Big – one joint d) Other than Big – each toe	 15% 5% 2% 2%
20) Established non-union of fractured leg or kneecap	10%
21) Shortening of leg by at least 5 cms.	7.50%
22) Ankylosis of the elbow, hip or knee	20%
23) Permanent disablement not otherwise provided for under Items 2-22 inclusive up to a maximum of	75%

Table Of Benefits – Table (D)

The Disablement	Compensation Expressed as a Percentage of Total Sum Insured
1) Permanent Total Disablement	100%
2) Permanent and incurable insanity	100%
3) Permanent Total Loss of two Limbs	100%
4) Permanent Total Loss of Sight in both eyes	100%
5) Permanent Total Loss of Sight of one eye and one Limb	100%
6) Permanent Total Loss of Speech	100%
7) Complete removal of the lower jaw	100%
8) Permanent Total Loss of Mastication	100%
9) Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance	100%
10) Permanent Total Loss of Hearing in both ears	75%
11) Permanent Total Loss of one Limb	50%
12) Permanent Total Loss of Sight of one eye	50%

13) Permanent Total Loss of Hearing in one ear	15%
14) Permanent Total Loss of the lens in one eye	25%
15) Permanent Total Loss of use of four fingers and thumb of either hand 1)	40%
16) Permanent Total Loss of use of four fingers of either hand	20%
17) Permanent Total Loss of use of one thumb of either hand: a) Both joints b) One joint	 20% 10%
18) Permanent Total Loss of one finger of either hand: a) Three joints b) Two joints c) One joint	 5% 3.5% 2%
19) Permanent Total Loss of use of toes: a) All – one foot b) Big – both joints c) Big – one joint d) Other than Big – each toe	 15% 5% 2% 2%
20) Established non-union of fractured leg or kneecap	10%
21) Shortening of leg by at least 5 cms.	7.50%
22) Ankylosis of the elbow, hip or knee	20%

3. Emergency Medical Expenses

If, during the Period of Insurance, an Insured Person sustains Bodily Injury or sudden unexpected Sickness, then the Company will reimburse the Insured Person the necessary Usual and Reasonable Medical Expenses, incurred within two (2) months from the Date of Loss up to the Sum Insured stated in the Schedule. The Deductible or Franchise, if applicable, shall be deducted from the Compensation payable.

Note pertaining specifically to AYUSH Treatments only:

Medical expenses pertaining only to Emergency In-patient care AYUSH treatment sustained due to Bodily Injury or sudden unexpected sickness are also covered under 'Emergency Medical Expenses' cover if undertaken in an AYUSH Hospital. However, any medical expense other than In-patient care AYUSH treatment expenses are not covered under this Policy.

Specific Conditions

1) Medical Expenses shall include and be limited to the following services:

a) charges for semi private Hospital room and board, use of the operating room, emergency room, and Ambulatory Medical Centre.

b) fees of Physicians.

c) Medical Expenses, in or out of Hospital, including: laboratory tests, ambulance service (to or from the Hospital), prescription medicines or drugs, therapeutics, anaesthetics (including administration of anaesthetics), transfusions, artificial Limbs or eyes (excluding repair or replacement of these items), x-rays, prosthetic appliances.

d) charges for a registered nurse (R.N).

2) If a Policyholder or Insured Person has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

Specific Definitions

1) Ambulatory Medical Centre means a licensed facility providing ambulatory surgical or medical treatment, other than a Hospital, clinic or Physician' s office.

2) Usual and Reasonable Medical Expenses means fees and prices generally charged in the locality where performed for medically necessary services and supplies required for treatment of cases of comparable severity and nature, but not to include charges that would not have been made if no insurance existed.

Specific Exclusions

The Company shall not be liable to pay any benefit in respect of any Insured Person for:

1) Any Medical Expenses incurred where an Insured Journey is undertaken against the advice of a qualified licensed medical practitioner.

2) Any Medical Expenses incurred when the specific purpose of a journey is to receive medical treatment or advice.

3) Any Medical Expenses incurred within the territorial limits that are not stated in the Schedule.

4) any medical treatment, drugs or medicines, prescribed or applied, before the Period of Insurance.

5) any dental work.

4. Emergency Dental Treatment

If during the Period of Insurance an Insured Person sustains Bodily Injury or Acute Pain which directly and independently of all other causes results in necessary emergency dental work, then the Company agrees to pay for such costs up to the Total Sum Insured stated in the Schedule. The Deductible or Franchise, if applicable, shall be deducted from the Compensation payable.

Specific Conditions

If a Policyholder or Insured Person has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

Specific Definitions

Acute Pain means unexpected and sudden pain that requires immediate treatment.

Specific Exclusions

The Company shall not be liable to pay any benefit in respect of any Insured Person for permanent crowns or artificial teeth.

5. Emergency Travel Benefits

The benefits below will only be insured as part of the Policy if the Assistance Provider Services Section has been purchased and contact has been made with the Assistance Provider. Contact must be made prior to any arrangements being made for such benefits.

1) **Medical Repatriation:** If the **Insured Person** is unable to continue his/her journey after a Hospital stay or medical treatment due to Bodily Injury or Sickness, then the Company agrees to pay the actual costs or the Total Sum Insured stated in the Schedule, whichever is the lesser, for the repatriation of the **Insured Person** back to the Insured Person's Country of Residence or Country of Citizenship (for Operative Times within the country of residence, the Insured Person will be returned to his / her home town). If the gravity of the situation so dictates, then the Company will pay for appropriate medical authorities to accompany the Insured Person during the return journey.

2) **Body Repatriation:** If during the Period of Insurance, an Insured Person dies as the result of Bodily Injury or Sickness then the Company agrees to pay the actual costs or the Total **Sum Insured** stated in the Schedule, whichever is the lesser, for the repatriation of the corpse of the Insured Person to his / her Country of Residence or Country of Citizenship (for Operative Times within the country of residence, the corpse will be returned to his / her home town).

Specific Conditions

1) The decision on the most appropriate means, timing and course of action belongs to the Assistance Provider only.

2) If a Policyholder or **Insured Person** has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

Specific Exclusions

The Company shall not be liable to pay any benefit in respect of any Insured Person:

1) if an **Insured Person** or anyone acting on behalf of an Insured Person has not contacted the Assistance Provider, prior to any arrangements that may give rise to a claim under this Section.

2) Any Medical Expenses incurred where an Insured Journey is undertaken against the advice of a qualified licensed medical practitioner.

3) Any Medical Expenses incurred when the specific purpose of a journey is to receive medical treatment or advice.

6. Contingency Travel Benefits

The benefits below will only be insured as part of the Policy if the Assistance Provider Services Section has been purchased and contact has been made with the Assistance Provider. Contact must be made prior to any arrangements being made for such benefits.

Emergency Hotel Extension: If during the Period of Insurance an Insured Person sustains Bodily Injury or Sickness which directly and independently of all other causes results in a Hospital stay as an in-patient for more than five (5) Days and misses his / her scheduled flight back to the country of residence, then the Company agrees to pay for the costs of Hotel accommodation up to the Total Sum Insured stated in the Schedule, or until a return flight becomes available, whichever is the earlier.

Specific Conditions

1) The decision on the most appropriate means, timing and course of action belongs to the Assistance Provider only.

2) If a Policyholder or **Insured Person** has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

Specific Exclusions

The Company shall not be liable to pay any benefit in respect of any **Insured Person**:

1) if an **Insured Person** or anyone acting on behalf of an Insured Person has not contacted the Assistance Provider, prior to an event that may give rise to a claim under this Section.

2) Any **Medical Expenses** incurred where an Insured Journey is undertaken against the advice of a qualified licensed medical practitioner.

3) Any **Medical Expenses** incurred when the specific purpose of a journey is to receive medical treatment or advice.

7. Accidental Death - Common Carrier

If during the Period of Insurance an Insured Person is riding as a passenger in or on, boarding or alighting from a Common Carrier and sustains Bodily Injury which directly and independently of all other causes results within twelve (12) calendar months of the Accident in death, then the Company agrees to pay to the Insured Person's Beneficiary or legal representative Compensation stated in the Schedule.

Specific Conditions

If applicable and if payment has been made under the Permanent Disablement or Permanent Disablement – Common Carrier Section, any amounts paid under that Section would be deducted from payment of a claim under this Section of the Policy.

8. Permanent Disablement – Common Carrier

If during the Period of Insurance an Insured Person is riding as a passenger in or on, boarding or alighting from a Common Carrier and sustains Bodily Injury which directly and independently of all other causes results in disablement within twelve (12) months of the Date of Loss, then the Company agrees to pay to the Insured Person the Compensation stated in the specific Table of Benefits below, which is shown as the Table of Benefits in the Schedule. The Deductible or Franchise, if applicable, shall be deducted from the Compensation payable.

Specific Conditions

1) This insurance shall terminate for an **Insured Person** under this Section upon payment of a benefit equal to the Total **Sum Insured**.

2) The total amount payable in respect of more than one disablement due to the same Accident is arrived at by adding together the various percentages shown in the Table of Benefits, but shall not exceed the Total **Sum Insured**.

3) The Deductible or Franchise, if applicable, shall apply to the total amount payable, irrespective of the number of benefits an Insured Person is entitled to.

4) If an **Insured Person** dies as the result of the Bodily Injury any amount claimed and paid to an Insured Person under

the Permanent Disablement or Permanent Disablement – Common Carrier Section will be deducted from any payment under the Accidental Death – Common Carrier Section.

Specific Provisions

Ankylosis of the fingers (other than thumb and forefinger) and of the toes (other than the big toe) shall be limited to fifty percent (50%) of the Compensation payable for the loss of the said members.

Specific Definitions for all Tables of Benefits

1) Limb means the hand above the wrist joint or foot above the ankle joint.
2) Loss of Hearing means the total and irrecoverable Loss of Hearing.
3) Loss of Mastication means the total and irrecoverable ability to chew food.
4) Loss of Sight means the total and irrecoverable Loss of Sight. This is considered to have occurred if the degree of sight remaining after correction is 3/60 or less on the Snellen Scale.
5) Loss of Speech means the total and irrecoverable Loss of Speech.

Specific Definitions for Table (B)

Loss used with reference to Limb and / or fingers, thumbs or toes, means the loss by physical severance or the total and permanent loss of use of said member.

Table Of Benefits – Table (B)

The Disablement		Compensation Expressed as a Percentage of Total Sum Insured
1	Permanent Total Disablement	100%
2	Permanent and incurable insanity	100%
3	Permanent Total Loss of two Limbs	100%
4	Permanent Total Loss of Sight in both eyes	100%
5	Permanent Total Loss of Sight of one eye and one Limb	100%
6	Permanent Total Loss of Speech	100%
7	Complete removal of the lower jaw	100%
8	Permanent Total Loss of Mastication	100%
9	Permanent Total Loss of the central nervous system or the thorax and all abdominal organs resulting in the complete inability to engage in any job and the inability to carry out Daily Activities essential to life without full time assistance.	100%
10	Permanent Total Loss of Hearing in both ears	75%
11	Permanent Total Loss of one Limb	50%
12	Permanent Total Loss of Sight of one eye	50%

9. Hospital Cash – Accident & Sickness

If during the Period of Insurance an Insured Person sustains Bodily Injury or Sickness which directly and independently of all other causes results in the Insured Person being in a Hospital as an in-patient (including In-patient care AYUSH treatment taken in an AYUSH Hospital) within one (1) calendar month the Date of Loss, then the Company agrees to pay to the Insured Person the Daily Benefit stated in the Schedule. The Deductible or Franchise, if applicable, shall be deducted from the Compensation payable.

Specific Provisions

In case of successive Hospital stays with less than sixty (60) Days between each one for a same cause, the Deductible or Franchise will only apply once, as the Hospital stays will be deemed as one event.

Specific Conditions

Once the Company has paid the Daily Benefit up to the maximum number of Days stated in the Schedule, cover under this Section will cease for such Insured Person.

10. Loss Of Baggage & Personal Documents

If, during the Period of Insurance, the Baggage, Personal Documents and/or Personal Effects owned by or in the custody of an Insured Person are damaged or lost, then the Company will reimburse the Insured Person the cost of replacement of the articles for any amount up to the Total Sum Insured stated in the Schedule. The Deductible, if applicable, shall be deducted from the Compensation payable.

Specific Conditions

1) Any valid claim involving a motor vehicle, and at all time subject to Specific Exclusion (5), will be limited to a maximum of fifty percent (50%) of the **Sum Insured** stated in the Schedule.
2) All claims will be subject to the Company at its own discretion assessing the value of the claim based on the age and estimated wear and tear of the article that forms the basis of the claim.
3) If applicable and if payment has been made under the Baggage Delay Section, any amounts paid would be deducted from payment of a claim under this Section of the Policy.
4) If a Policyholder or **Insured Person** has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

Specific Definitions

Personal Documents means an Insured Person's identity card (if applicable), ration card, voter identity card, passport, driving license and car license.

Specific Claims Provisions

In the event of a claim the **Insured Person** must:

1) give immediate written notice:

a) to the relevant Common Carrier in the event of loss or damage in transit;

b) to the relevant police authority in the event of loss or theft;

2) submit a copy of the relevant Common Carrier or police report when a claim is made;

3) obtain a Common Carrier or police report where the loss occurred;

4) in the event of loss by a Common Carrier, retain original tickets and baggage slips and submit them when a claim is made;

5) submit original purchase receipts in the event of claims regarding goods purchased during the Insured Journey; and

6) for claims involving jewellery, submit original or certified copies of valuation certificates issued prior to the commencement of the Period of Insurance, when a claim is made.

For purposes of any claim hereunder:

1) a pair of skis, ski boots and accessories shall be regarded as one item;

2) bottles of perfume, aftershave, and make up shall together be regarded as one item;

3) the equipment and accessories of any sport that an Insured Person takes on a trip shall be regarded as one item.

Specific Exclusions

The Company shall not be liable to pay any benefit in respect of any Insured

Person for:

1) loss of cash, bank or currency notes, cheques, debit or credit cards or unauthorised use thereof, postal orders, travellers cheques, travel, tickets, securities of any kind and petrol or other coupons.

2) mechanical or electrical breakdown or derangement or breakage of fragile or brittle articles, or damage caused by such breakage unless caused by fire or by Accident to the conveying vehicle.

3) Destruction or damage due to wear and tear, moth or vermin.

4) baggage, clothing and personal effects despatched as unaccompanied baggage.

5) theft from a motor vehicle unless the property is securely locked in the boot and entry to such vehicle is gained by visible, violent and forcible means.

6) loss or damage to sports equipment whilst in use, contact lenses, samples, tools.

7) for loss, destruction, or damage due to delay, confiscation or detention by order of any government or Public Authority.

8) for loss, destruction or damage directly occasioned by pressure waves, caused by aircraft or other aerial devices travelling at sonic or supersonic speeds.

9) for loss, destruction or damage caused by any process of cleaning, dyeing, repairing or restoring.

10) for loss, destruction, or damage caused by atmospheric or climatic conditions or any other gradually deteriorating cause.

11) a claim involving animals.

12) loss, including but not limited to loss by theft, or damage to vehicles or other accessories.

13) for any loss that is not reported either to the appropriate police authority or transport carrier within twenty four (24) hours of discovery or if the carrier is an airline if a property irregularity report is not obtained.

14) baggage and/or personal effects sent under an airway-bill or bill of lading.

15) computer equipment, cameras, musical instruments, radios and portable radio /cassette/compact disc players.

16) contact lenses, glasses, hearing aids or bridges or dentures for a tooth or teeth.

11. Loss Of Checked Baggage

If, during the Period of Insurance, the Baggage, Personal Documents and/or Personal Effects that have been checked in on the same Common Carrier as a travelling **Insured Person**, are damaged or lost, then the Company will reimburse the Insured Person the cost of replacement of the articles for any amount up to the Total **Sum Insured** stated in the Schedule. The Deductible, if applicable, shall be deducted from the Compensation payable.

Specific Conditions

1) All claims will be subject to the Company at its own discretion assessing the value of the claim based on the age and estimated wear and tear of the article that forms the basis of the claim.

2) If applicable and if payment has been made under the Baggage Delay Section, any amounts paid would be deducted from payment of a claim under this Section of the Policy.

3) If a Policyholder or **Insured Person** has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

Specific Definitions

Personal Documents means an Insured Person's identity card (if applicable), ration card, voter identity card, passport, driving licence and car licence.

Specific Claims Provisions

In the event of a claim the Insured Person must:

1) give immediate written notice:

a) to the relevant Common Carrier in the event of loss or damage in transit;

b) to the relevant police authority in the event of loss or theft;

2) submit a copy of the relevant Common Carrier or police report when a claim is made;

3) obtain a Common Carrier or police report where the loss occurred;

4) in the event of loss by a carrier, retain original tickets and baggage slips and submit them when a claim is made;

5) submit original purchase receipts in the event of claims regarding goods purchased during the Insured Journey; and

6) for claims involving jewellery, submit original or certified copies of valuation certificates issued prior to the commencement of the Period of Insurance, when a claim is made.

For purposes of any claim hereunder:

1) a pair of skis, ski boots and accessories shall be regarded as one item;

2) bottles of perfume, aftershave, and make up shall together be regarded as one item;

3) the equipment and accessories of any sport that an Insured Person takes on a trip shall be regarded as one item.

Specific Exclusions

The Company shall not be liable to pay any benefit in respect of any Insured Person for:

1) loss of cash, bank or currency notes, cheques, debit or credit cards or unauthorised use thereof, postal orders, travellers cheques, travel, tickets, securities of any kind and petrol or other coupons.

2) mechanical or electrical breakdown or derangement or breakage of fragile or brittle articles, or damage caused by such breakage unless caused by fire or by Accident to the conveying vehicle.

3) destruction or damage due to wear and tear, moth or vermin.

4) baggage, clothing and personal effects despatched as unaccompanied baggage.

5) theft from a motor vehicle unless the property is securely locked in the boot and entry to such vehicle is gained by visible, violent and forcible means.

6) loss or damage to sports equipment whilst in use, contact lenses, samples, tools.

7) for loss, destruction, or damage due to delay, confiscation or detention by order of any government or Public Authority.

8) for loss, destruction or damage directly occasioned by pressure waves, caused by aircraft or other aerial devices travelling at sonic or supersonic speeds.

9) for loss, destruction or damage caused by any process of cleaning, dyeing, repairing or restoring.

10) for loss, destruction, or damage caused by atmospheric or climatic conditions or any other gradually deteriorating cause.

11) a claim involving animals.

12) loss, including but not limited to loss by theft, or damage to vehicles or other accessories.

13) for any loss that is not reported either to the appropriate police authority or transport carrier within twenty four (24) hours of discovery or if the carrier is an airline if a property irregularity report is not obtained.

14) baggage and/or personal effects sent under an airway-bill or bill of lading.

15) computer equipment, cameras, musical instruments, radios and portable radio /cassette/compact disc players.

16) contact lenses, glasses, hearing aids or bridges or dentures for a tooth or teeth.

12. Baggage Delay

If, during the Period of Insurance, the baggage and/or personal effects owned by or in the custody of an Insured Person is delayed or misdirected for more than the Deductible stated in the Schedule, then the Company will reimburse the Insured Person the cost of necessary personal effects up to the Sum Insured stated in the Schedule.

Specific Conditions

1) The baggage and/or personal effects must have been checked in as registered baggage by the airline operating under a licence issued by a governmental authority having jurisdiction for the transportation of fare paying passengers on fixed established routes, for any benefit to be payable under this Section.

2) If upon further investigation it is later determined that the baggage and/or personal effects has been lost, then any amount claimed and paid to an Insured Person under the Baggage Delay Section will be deducted from any payment under the Baggage Loss Section.

3) An Insured Person shall exercise all reasonable measures and precautions for the safety of, and recovery of, any property insured hereunder. Notification of any apparent delay to baggage must be made immediately to the airline concerned.

4) If a Policyholder or Insured Person has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

5) If the Insured Person receives any form of compensation from the Common Carrier in the form of vouchers, tickets or coupons, then these items will be surrendered to the Company.

Specific Exclusions

The Company will not indemnify the Insured Person for delayed baggage as a result of the following:

1) chartered flights, unless such flights are registered in the International Data System.

2) confiscation of baggage by customs or any government authority.

3) purchases made after arriving in the final destination mentioned on the airline ticket.

4) baggage and/or personal effects sent under an airway-bill or bill of lading.

5) delays due to a strike or industrial action existing or announced before the start of the journey.

6) delays due to withdrawal of aircraft from service by any civil aviation authority of which notice had been given before the start of the journey.

7) any delays of the return journey.

13. Flight Delay

If during the Period of Insurance, the flight on which an Insured Person is due to travel is delayed in excess of the Deductible, then the Company agrees to reimburse up to the

amount stated in the Schedule per hour, or up to the Total Sum Insured, whichever is the lesser, for essential purchases, such as meals, refreshments or other related expenses directly resulting from the:

1) delay or cancellation of the Insured Person's booked and confirmed flight.

2) late arrival of the Insured Person's connecting flight causing the Insured Person to miss his or her onward connection.

3) or a late arrival (of more than 1 hour) of public transport causing the Insured Person to miss the flight.

Specific Conditions

1) If a Policyholder or Insured Person has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

2) If the Insured Person receives any form of compensation from the Common Carrier in the form of vouchers, tickets or coupons, then these items will be surrendered to the Company.

Specific Claims Provisions

All claims must be submitted in writing to the Company by the Insured Person, or his/her legal representative and all information, documents, and evidence required by the Company shall be furnished at no expense to the Company and shall be in such form and of such nature as the Company may prescribe. All claims must be reported to the Company within twenty- one (21) Days of a delay occurring, and must contain:

a) the Policy number.

b) detailed circumstances of the delay.

c) a copy of declaration of delay made by the public transport company (other than an airline).

d) all receipts, all invoices serving as proof of purchases made in connection with the flight delay, as well as proof of the delay and the flight number and place where the delay occurred.

Specific Exclusions

The Company shall not be liable for any claim:

1) arising or as the result of chartered flights, unless such flights are registered in the International Data System.

2) if comparable alternative transport has been made available within six (6) hours after scheduled departure time or within six (6) hours of an actual connecting flight arrival time.

3) if an Insured Person fails to check-in according to the itinerary supplied, unless it is due to a strike.

4) if the delay is due to a strike or industrial action existing or announced before the start of the journey.

5) if the delay is due to withdrawal of aircraft from service by any civil aviation authority of which notice had been given before the start of the journey.

14. Hijacking

If during the Period of Insurance an Insured Person is travelling on board a Common Carrier which is Hijacked, then the Company agrees to pay to the Insured Person the Compensation stated in the Schedule for every six (6) continuous hours in excess of the Deductible up to the Total Sum Insured.

Specific Definitions

Hijacked means the unlawful seizure or wrongful exercise of control of a Common Carrier, or the crew thereof.

Specific Exclusions

The Company shall not be liable to pay any benefit in respect of any Insured Person for any claim caused by civil authority.

15. Personal Liability

Property Damage

If while this Policy is in force a claim is made or a suit brought against an Insured Person for Property Damage that occurred during the Period of Insurance, then the Company agrees to pay to the Insured Person the Compensation stated in the Schedule, up to the Total Sum Insured, for the damages for which the Insured Person is legally liable.

Medical Payments to Others

If while this Policy is in force a claim is made or a suit brought against an Insured Person for Medical Expenses as the result of an Accident that occurred during the Period of Insurance caused by the **Insured Person** and resulting in Bodily Injury to another person, then the Company agrees to pay to the Insured Person the Compensation stated in the Schedule, up to the Total Sum Insured, for the damages for which the Insured Person is legally liable.

In no event with the Company pay more than the Total Sum Insured for all Property Damage or Medical Expenses arising out of one event.

Specific Conditions

1) If a Policyholder or **Insured Person** has other insurance against a loss covered by this Section, then the Company shall not be liable for a greater proportion of the loss than the applicable benefit under this Section bears to the total applicable benefit under all such insurance.

2) The Total **Sum Insured** is the total amount payable for Property Damage and Medical Payments to Others combined, not for each one.

Specific Definitions

1) **Medical Expenses** means reasonable charges for medical, surgical, X-ray, dental, ambulance, Hospital, professional nursing, prosthetic devices and funeral services.

2) **Property Damage** means physical injury to, destruction of or loss of use of tangible property.

Specific Exclusions

The Company will not be liable for any claims caused by or resulting either directly or indirectly from:

1) liability which is expected or intended by an Insured Person.

2) liability arising out of or in connection with a business engaged in by an Insured Person. This exclusion applies

but is not limited to an act or omission,

3) regardless of its nature or circumstance, involving a service or duty rendered, promised, owed, or implied to be provided because of the nature of the business.

4) liability arising out of the rental or holding for rental of any part of any premises or a motor vehicle of any kind by an Insured Person.

5) liability arising out of the rendering of or failure to render professional services.

6) liability arising out of a premises, watercraft or aircraft that is owned by, rented to or rented by an Insured Person.

7) liability arising out of the ownership, maintenance, use, loading or unloading of motor vehicles, all other motorised land conveyances, water craft or aircraft.

8) liability arising out of the transmission of a communicable disease by an Insured Person.

9) liability arising out of sexual molestation, corporal punishment, or physical or mental abuse.

10) liability arising out of the use, sale, manufacture, delivery, transfer or possession by any person of a controlled substance or contraband as defined by the appropriate authority or government agency.

11) liability under any contract or agreement.

12) Property Damage to property owned by an Insured Person.

13) Property Damage to property rented to, occupied, or used by or in the care of an Insured Person.

14) Bodily Injury to any person eligible to receive any benefits voluntarily provided or required to be provided by an Insured Person under any worker's compensation law, non-occupational disablement law or occupational diseases law.

15) any claims or suits arising from any Immediate Family Member, Close Business Associate or an Immediate Family Member of a Close Business Associate against an Insured Person.

16. Financial Emergency Assistance

The deductible excess in respect of this benefit will be applicable for each separate claim, and shall be of an amount as specified in the Schedule of this Policy. For the purpose of this benefit, 'financial emergency' shall mean a situation wherein the Insured loses all or a substantial amount of his/her travel funds due to theft, robbery, mugging or dacoity, such that there is a detrimental effect on his/her travel plans.

The Company shall have the sole discretion to determine whether a 'financial emergency' has occurred in any instance.

This is an assistance provided by the company through service provider. The assistance would be provided subject to the terms and conditions of the service provider, as stated below.

Exclusions Applicable - Financial Emergency Assistance

The Company shall not be liable to make any payment under this benefit in connection with or in respect of any expenses whatsoever incurred by the Insured in connection with or in respect of

1) A shortage or loss of funds due to currency fluctuation, errors omissions, exchange, loss or depreciation in value.

2) Any loss not reported to the police authorities having jurisdiction at the place of loss within 24 hours of the occurrence of the incident and a written report being obtained for the same.

3) Any claim in respect of a loss of traveller's cheques not immediately reported to the local branches or agents of the issuing authority.

4) Loss of funds not kept in the personal custody of the Insured.

5) Any reimbursement under Financial Emergency Assistance is excluded if the claim is put up after arrival of the Insured to the Republic of India

6) Any exclusion mentioned in the '**General Exclusions**' section of this Policy

Section 7: HDFC ERGO Bharat Griha Raksha

We give insurance cover for physical loss or damage, or destruction caused to Insured Property by the following unforeseen events occurring during the **Policy Period**.

The events covered are given in Column A and those not covered in respect of these events are given in Column B.

	Column A	Column B
	We cover physical loss or damage, or destruction caused to the Insured Property by	We do not cover any loss or damage, or destruction caused to the Insured Property
1	Fire	caused by burning of Insured Property by order of any Public Authority.
2	Explosion or Implosion	-
3	Lightning	-
4	Earthquake, volcanic eruption, or other convulsions of nature	-
5	Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Tsunami, Flood and Inundation	-
6	Subsidence of the land on which Your Home Building stands, Landslide, Rockslide	caused by a. normal cracking, settlement or bedding down of new structures, b. the settlement or movement of made up ground, coastal or river erosion, c. defective design or workmanship or use of defective materials, or d. demolition, construction, structural alterations or repair of any property, or e. groundworks or excavations.
7	Bush fire, Forest fire, Jungle fire	-

8	Impact damage of any kind, i.e., damage caused by impact of, or collision caused by any external physical object (e.g. vehicle, falling trees, aircraft, wall etc.)	caused by pressure waves caused by aircraft or other aerial or space devices travelling at sonic or supersonic speeds.
9	Missile testing operations	-
10	Riot, Strikes, Malicious Damages	caused by a. temporary or permanent dispossession, confiscation, commandeering, requisition or destruction by order of the government or any lawful authority, or b. temporary or permanent dispossession of Your Home by unlawful occupation by any person.
11	Acts of terrorism (Coverage as per Terrorism Clause attached)	Exclusions and Excess as per Terrorism Clause attached.
12	Bursting or overflowing of water tanks, apparatus and pipes.	-
13	Leakage from automatic sprinkler installations.	a. repairs or alterations in Your Home or the building in which Your Home is located, b. repairs, removal or extension of any sprinkler installation, or c. defects in the construction known to You.
14	Theft within 7 (seven)days from the occurrence of and proximately caused by any of the above Insured Events.	if it is a. of any article or thing outside Your Home, or b. of any article or thing attached from the outside of the outer walls or the roof of Your Home, unless securely mounted.

Clause A: Home Building Cover

1. What We cover

We cover physical loss or damage, or destruction of Your Home Building because of any Insured Event listed in this Policy. We also cover architect's, surveyor's, consulting engineer's fees, cost of removing debris as specified under Clause A (5) (f) of this Policy. Further, We pay for Loss of rent and Rent for Alternative Accommodation, which will be paid to the extent declared by You and agreed by Us as specified under Clause A (6) of this Policy while Your Home Building is not fit for living following loss or damage due to an insured event.

2. Your Home Building

a. Your Home Building is a building consisting of a residential unit, having an enclosed structure and a roof, basement (if any) and used as a dwelling place.

b. Your Home Building includes

i. fixtures and fittings permanently attached to the floor, walls or roof, like fixed sanitary fittings, electrical wiring and other permanent fittings.

ii. the following 'additional structures' if they are on the same site, and are used as part of Your Home Building:

a) garage, domestic out-houses used for residence, parking spaces or areas, if any

b) compound walls, fences, gates, retaining walls and internal roads,

c) verandah or porch and the like,

d) septic tanks, bio-gas plants, fixed water storage units or tanks,

e) solar panels, wind turbines and air conditioning systems, central heating systems and the like, if not included in Home Contents Cover,

iii. any other structure shown in the Policy Schedule.

c. Your Home Building does not include Contents of Your Home.

3. Use for residence

a. We will pay only if Your Home Building is used for the purpose of residence of Yourself and Your family, or of Your tenant, licensee or employee.

b. We will not pay if

i. Your Home Building is used as a holiday home, or for lodging and boarding, or

ii. Your Home Building or any part of Your Home Building is used for purposes other than residential except where it is used both for Your residence and for the purposes of earning Your livelihood if You are self- employed or You have shifted Your office to Your Home Building for a temporary period due to lockdown or closure of Your office ordered by a public authority.

4. Sum Insured

a. The Sum Insured for the Home Building Cover is the prevailing Cost of Construction of Your Home Building at the Commencement Date as declared by You and accepted by Us and will be the maximum amount payable in the event the Home Building is a Total Loss.

b. If the Policy Period is more than one year, We will automatically increase Your Sum Insured during the Policy Period by 10% per annum on each anniversary of Your Policy without additional premium for a maximum of 100% of the Sum Insured at the Policy Commencement Date.

c. The Sum Insured will be automatically increased each day by an amount representing 1/365th of 10% of Sum Insured at the Policy Commencement Date for annual policies.

d. Restoration of Sum Insured: Except as stated in Cancellation clause of this Policy, the insurance cover will at all times be maintained during the Policy Period to the full extent of the respective Sum Insured. This means that after We have paid for any loss, the policy shall be restored to the full original amount of Sum Insured. You must pay to Us proportionate premium for the unexpired Policy Period from the date of loss. We can also deduct this premium from the net claim that We must pay You.

5. What We pay

a. If You make a claim under the policy for damage to Your

Home Building due to any of the insured perils, We reimburse the cost to repair it to a condition substantially the same as its condition at the time of damage. You must spend for repairs, and claim that amount from Us.

b. We will calculate the amount of claim on the basis of the actual Carpet Area subject to the Carpet Area not exceeding that declared by You in the Proposal Form and stated in the **Policy Schedule**.

c. The maximum We will pay for all items together is the Sum Insured shown in the **Policy Schedule** for Home Building Cover. If the **Policy Schedule** shows any limit for any item, such limit is the maximum We will pay for that item.

d. If Your Home Building is a Total Loss, We will pay You the Sum Insured of the Home Building.

e. If only an additional structure is destroyed, We will pay You an amount equal to the Cost of Construction of the additional structure.

f. In addition to what Clause A (5) (c) of this Policy provides for, We will pay You the following expenses:

i. up to 5% of the claim amount for reasonable fees of architect, surveyor, consulting engineer;

ii. up to 2 % of the claim amount for reasonable costs of removing debris from the site.

6. Loss of Rent and Rent for Alternative Accommodation:

In addition to what Clause A (5) (c) of this Policy provides for, We will pay the amount of rent You lose or alternative rent You pay while Your Home Building is not fit for living because of physical loss arising out of an Insured Event as follows:

a. If You are living in Your Home as a tenant, and You are required to pay higher rent for the alternative accommodation, We will pay the difference between the rent for alternative accommodation and the rent of Your Home Building.

b. We will pay the loss under this cover for an accommodation that is not superior to Your Home Building in any way and in the same city as Your Home Building.

c. The amount of lost rent shall be calculated as follows: Sum Insured for Cover for Loss of Rent (as declared by You in the Proposal Form and specified by Us in the Policy Schedule) X Period necessary for repairs ÷ Loss of Rent Period opted for.

d. This cover will be available for the reasonable time required to repair Your Home Building to make it fit for living. The maximum period of this cover is three years from the date Your Home Building becomes unfit for living. You must submit a certificate from an architect or the local authority to show that Your Home Building is not fit for living.

e. Claim for loss of rent will be accepted only if We have accepted Your claim for loss for physical damage to Your Home under the Home Building Cover.

Clause B: Home Contents Cover

1. What We cover:

We cover the physical loss or damage to or destruction of the General Contents of Your Home caused by an Insured Event as listed in this Policy. Valuable Contents of Your Home are not covered under this Policy unless You have purchased the optional cover for the Valuable Contents.

2. Sum Insured:

a. The Sum Insured for the Home Contents Cover is shown in the Policy Schedule and will be the maximum amount payable in the event the Home Contents are destroyed / lost completely.

b. The policy has a built-in cover for the General Contents of Your home equal to 20% of the Sum Insured for Home Building Cover subject to a maximum of ₹10 Lakh (Rupees Ten Lakh) provided You have opted for both Home Building and Home Contents cover. If You choose to have a higher Sum Insured for Home Contents, You have to declare the Sum Insured in the Proposal Form and pay additional premium.

c. If You have purchased only Home Contents Cover, You have to declare the Sum Insured for the General Contents in the Proposal Form.

d. The Sum Insured You have chosen for General Contents must be enough to cover the cost of replacement of the General Contents.

e. If You want to cover the Valuable Contents in Your Home, You must opt for the Optional Cover for Valuable Contents as given in Clause C (1) (a) of this Policy.

f. Restoration of Sum Insured: Except as stated in Cancellation Clause, the insurance cover will at all times be maintained during the Policy Period to the full extent of the respective Sum Insured. This means that after We have paid for any loss, the policy shall be restored to the full original amount of Sum Insured. You must pay to Us proportionate premium for the unexpired Policy Period from the date of loss. We can also deduct this premium from the net claim that We must pay You.

3. What We pay

a. If the General Contents of Your Home are physically damaged by any Insured Event, We will at Our option,

i. reimburse to You the cost of repairs to a condition substantially the same as its condition at the time of damage, or

ii. pay You the cost of replacing that item with a same or similar item, or

iii. repair the damaged item to a condition substantially the same as its condition at the time of damage.

b. The maximum We will pay for Home Contents is the Sum Insured shown in the Policy Schedule for Home Contents Cover. If the Policy Schedule shows any limit for any item, or category or groups of items, such limit is the maximum We will pay for that item.

Clause C: Additional Covers

1. Optional Covers:

a. Cover for Valuable Contents on Agreed Value Basis (under Home Contents cover):

For Valuable Contents, a value may be agreed upon by You

and Us based on a valuation certificate submitted by You and accepted by Us. However, We shall waive the requirement of valuation certificate if the Sum Insured opted for is up to ₹5 Lakh (Rupees Five Lakh) and Individual item value does not exceed ₹1 Lakh (Rupees One Lakh).

i. If the Valuable Contents of Your Home are physically damaged by any Insured Event, We will pay the cost of repairing the item/s.

ii. If the Valuable Contents of Your Home are a Total Loss We will pay the Sum Insured shown in the Policy Schedule for the Valuable item/s. If the Policy Schedule shows any limit for any item, or category or groups of items, such limit is the maximum We will pay for that item. Loss to only one item of a pair or set does not constitute loss or damage to the entire pair or set.

b. Personal Accident Cover:

In the event an insured peril that caused damages to Your Home Building and/or Home Contents also results in the unfortunate death of either You or Your spouse, We will pay compensation of ₹5,00,000 (Rupees Five Lakh) per person.

In the event of the unfortunate death of the insured, the Personal Accident cover shall continue for the spouse until expiry of the policy.

Add-ons:

You can opt for an Add-on by choosing from the Add-ons, if any, offered by Us under this product and the ones that You have purchased will be mentioned in the Policy Schedule and the relevant clause/s and/or endorsements will be attached to this Policy.

Clause D. Conditions

(I) Your Obligations

1. Make true and full disclosure in the proposal and related documents

a. You have a duty of disclosure to tell Us everything You know, or could reasonably be expected to know, that is relevant to Us for deciding whether to give You insurance cover and on what terms. You owe this duty to disclose such relevant material information even if We have not specifically asked for it. This duty extends to any information or declaration given by anyone else on Your behalf.

b. We have agreed to give You insurance cover entirely on the basis of the information You, or anyone on Your behalf, have given Us in the proposal, statements and other declarations and documents (in writing or electronic) about Yourself, Your family, Your Home Building and Home Contents. The correct and complete information You give is the basis of Our contract with You. Our promise to pay is conditional upon the truth of these statements and on the assumption that You, or anyone on Your behalf, has not withheld any material information about Yourself, Your family, Your Home Building and Home Contents.

2. Obligation to take care : You must:

a. keep Your Home Building and Home Contents in good condition and well maintained, You must ensure that the structure of Your Home Building does not have any faults or defects that are visible and material that will aggravate loss or damage to the Home Building in the event an insured peril occurs.

b. take care to prevent theft, loss or damage to Your Home Building and Home Contents, and

c. ensure that unauthorized persons do not occupy Your Home Building.

3. Inform change in circumstances : You must inform Us immediately if

a. You change Your address,

b. You make any addition, alteration, extension to the structure of Your Home Building,

c. You let out Your Home Building, or Your Home Building will no longer be solely occupied by You,

d. You change the use of Your Home Building.

4. Allow inspection and investigation of claim:

You must allow, and give full cooperation to the survey/ investigation of Your claim by Us. You must allow Us, and any surveyor, officer or other representative that We authorise, to inspect Your Home Building and Home Contents including the interior wherever necessary, take photographs and where required, permit the scientific testing and investigation of any insured article affected by the insured peril. You must answer all questions asked regarding Your claim truthfully and completely, and submit all relevant documents that We will require.

5. Make true statements and full disclosure in the claim and related documents

You must also give true and full information in Your claim and submit true documents. If You give any false information or document in the claim, or if You withhold any information or document (written or electronic), We have a right to refuse payment of Your claim. We may also cancel Your policy.

Clause E. Changes to covers

a. You can choose to make changes to the covers of this Policy as may be permitted by Us, or increase or reduce any Sum Insured. You must make a proposal or request for any change. It will be effective only after We have accepted Your proposal, and You have paid the additional premium, where applicable.

b. This Policy (including the Policy Schedule, the proposal, declarations and Endorsements) consists of the entire contract between You and Us.

Clause F. Waiver of Underinsurance

Underinsurance does not apply to Sampoorna Suraksha. Thus, if Your Sum Insured calculated on the basis of the information that You provided, is less than the actual value at risk, the difference will not affect the amount We pay.

Clause G. Other Details

1. Notices

a. We will send any notice, letter or communication in writing to You at Your address mentioned in the Policy Schedule, and to Your email address that You have registered with Us.

b. You will send any notice, letter, intimation or communication in writing to Us at Our branch office where You purchased this Policy. You can also send it at the address mentioned in the Policy Schedule.

2. Nomination for this Policy

You can nominate a person to receive the claim amount under this Policy in the event of Your death. You can make such nomination at the time You take the Policy, or later. You can also change the nomination at any time. You can make the nomination on Our nomination form available in Our office or from Our website:

www.hdfcergo.com.

3. Applicable law and jurisdiction

This Policy will be subject to the laws of India, and to the jurisdiction of courts in India.

4. Arbitration

If any dispute or difference arises between You and Us regarding the amount of claim to be paid under this policy (liability having been admitted by Us), such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by You and Us or if You and We cannot agree upon a single arbitrator within 30 days of either of Us opting for arbitration, the same shall be referred to a panel of three arbitrators comprising of two arbitrators, one to be appointed by each of Us, to the dispute/difference and the third arbitrator to be appointed by two such arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

Specific Exclusions

We do not cover losses and expenses for any loss or damage or destruction of the Insured Property that is directly or indirectly as a result of or is caused by or arising from events, stated below:

1. Your deliberate, wilful or intentional act or ommission, or of anyone on Your behalf, or with Your connivance.
2. War, invasion, act of foreign enemy hostilities or war-like operations (whether war is declared or not), civil war, mutiny, civil commotion amounting to a popular rising, military rising, rebellion, revolution, insurrection or military or usurped power.
3. Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from combustion of nuclear fuel, or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component that is part of it.
4. Pollution or contamination, unless

i. the pollution or contamination itself has resulted from an Insured Event, or

ii. an Insured Event itself results from pollution or contamination.

5. Loss, damage or destruction to any electrical/electronic machine, apparatus, fixture, or fitting by over-running, excessive pressure, short circuiting, arcing, self- heating or leakage of electricity from whatever cause (lightning included). This exclusion applies only to the particular machine so lost, damaged or destroyed.
6. Loss or damage to bullion or unset precious stones, manuscripts, plans, drawings, securities, obligations or documents of any kind, coins or paper money, cheques, vehicles, and explosive substances unless otherwise expressly stated in the policy.
7. Loss of any Insured Property which is missing or has been mislaid, or its disappearance cannot be linked to any single identifiable event.
8. Loss or damage to any Insured Property removed from Your Home to any other place.
9. Loss of earnings, loss by delay, loss of market or other consequential or indirect loss or damage of any kind or description whatsoever.
10. Any reduction in market value of any Insured Property after its repair or reinstatement.
11. Any addition, extension, or alteration to any structure of Your Home Building that increases its Carpet Area by more than 10% of the Carpet Area existing at the Commencement Date or on the date of renewal of this Policy, unless You have paid additional premium and such addition, extension or alteration is added by Endorsement.
12. Costs, fees or expenses for preparing any claim.

Section 8: E@SECURE INSURANCE

1. Legal Protection

If You have a legal dispute over any of the Specified Events, We will provide You the necessary legal protection against the costs of pursuing and defending legal actions maximum up to the amount of the sub limit set forth under "Legal Protection" specified on the Policy Schedule:

a) Professional Legal Advice

We will pay for the legal advice sought by You based on the laws of India.

b) Legal Costs

We will cover Your legal costs to:

- Pursue or defend any legal actions against or by the Third Party;
- Remove any criminal or civil judgments wrongly entered against You; or
- Challenge the accuracy or completeness of any information in a credit report.

Provided that:

1. The Specified Event occurred on the internet during the Period of Insurance;
2. Our prior written consent must be obtained before any costs are incurred (which shall not be unreasonably withheld or delayed);
3. The legal action pursued / defended is within the jurisdiction of the Indian courts.

B. Specified Events

2. Damage to e-Reputation

If You suffer damage to Your personal reputation which arises directly from a Harmful Publication(whether in the form of videos, photographs or published statements) by any Third Party on the internet, We will reimburse for the costs incurred by You:

a) For the services of an IT specialist to remove and / or Flood such Harmful Publication from the internet maximum up to the amount of the sub limit set forth under "Damage to e-Reputation " on the Policy Schedule; and

For the Face – to – face consultation with a Psychologist / an accredited Psychiatrist for post – traumatic stress disorder, suicidal tendencies, self-harm, depression, anxiety disorder, insomnia, eating disorders or similar serious medical condition that makes consultation Deemed Necessary, maximum up to the amount of the sub limit set forth under "Psychological counseling" on the Policy schedule. Any sub limit of liability available for counseling service under this is part of, and not in addition to, the sub limit of liability set forth under limit mentioned in "Damage to e-reputation" on Policy Schedule; the payment by Us of any such sub limit of liability erodes the sub limit of liability set forth in "Damage to e-reputation" of the Policy Schedule.

Provided that:

1. This Specified Event occurred on the internet during the Period of Insurance;
2. You lodge an FIR within Seventy – two (72) hours upon discovering the Harmful Publication, giving details of the contents and specific internet sites where the Harmful Publication is published.

What We will not cover under this Section:

In addition to the General Exclusions, We will also not pay any claim in respect of:

1. Loss that occurs within the first forty – five (45) days of the inception date of this insurance cover.
2. Any non-digital media (e.g. in print), radio and television broadcast
3. Damage caused by a Journalist.
4. Any legal proceedings (pending or settled) with a Third Party prior to the commencement of this cover.

3. Identity Theft

If Your Personal Information is stolen over the internet, and a Third Party knowingly and unlawfully uses it subsequently without Your express consent to obtain money, goods or services, We will provide for reimbursement of the costs / expenses that You incurred maximum up to the amount of the sub limit set forth under "Identity Theft" on the Policy Schedule for /to :

a) amend or rectify records regarding Your true name or identity, including but not limited to:

- To notarize affidavits for financial institutions or credit bureau agencies to restore Your Bank Accounts and credit rating;
- To re-submit loan applications which were declined solely because the lender received incorrect credit information; and
- Costs of telephone calls, postage and bank charges to resolve the Identity Theft.

b) Any lost wages due to time taken off from work, not exceeding 7days solely for the purpose of meeting with the relevant organizations and/or authorities to amend or rectify records as a result of an Identity Theft

- If You are self - employed, lost wages will be calculated based on Your tax returns in the prior year and limited to wages lost within 12 months upon discovery of the Identity Theft.

b) For the Face – to – face consultation with a Psychologist / an accredited Psychiatrist for post – traumatic stress disorder, suicidal tendencies, self-harm, depression, anxiety disorder, insomnia, eating disorders or similar serious medical condition that makes consultation Deemed Necessary, maximum up to the amount of the sub limit set forth under "Psychological counseling" on the Policy schedule. Any sub limit of liability available for counseling service under this is part of, and not in addition to, the sub limit of liability set forth under limit mentioned in "Identity Theft" on Policy Schedule; the payment by Us of any such sub limit of liability erodes the sub limit of liability set forth in "Identity Theft" of the Policy Schedule.

Provided that:

1. This Specified Event occurred on the internet during the Period of Insurance;
2. You lodge an FIR detailing the Identify Theft within 72 hours upon discovery of Identity Theft by You;
3. You notify Your bank or Credit / Debit Card issuer(s) of the Identity Theft by Youwithin72 hours upon discovery of the Identity Theft by You(if applicable).
4. You provide evidence of lost wages.

All losses resulting from the same, continuous, related or repeated acts shall be treated as arising out of a single Identity Theft occurrence.

What We will not cover under this Section:

In addition to the General Exclusions, Wewillalso not pay any claim in respect of:

1. Expenses incurred (e.g. loan application fees, telephone charges etc.) six (6) months after the expiry of the cover.

4. Unauthorized Online Transactions

If You suffer loss as a direct result of the fraudulent use of Your Bank Account and / or Credit/Debit Cards and /or E-Wallets by a Third Party for purchases made over the internet, We will indemnify You maximum up to the amount of the sub limit set forth under "Unauthorized Online Transaction" on the Policy Schedule for:

a) Any Unauthorized Online Transactions that are charged to Your Credit/Debit Card or Bank Account or E-Wallets that are legally unrecoverable from any other sources.

b) Any lost wages due to time taken off from work, not exceeding 7days solely for the purpose of meeting with the relevant organizations and authority to amend or rectify records regarding Your true name or identity as a result of the Unauthorized Online Transactions.

- If You are self-employed, lost wages will be based on Your tax returns in the prior year and limited to wages lost within 12 months upon discovery of the theft.

c) Costs of telephone calls, postage and bank charges to resolve the breach of payment.

Provided that:

1. This Specified Event occurred on the internet during the Period of Insurance;
2. You lodge an FIR detailing the Unauthorized Online Transaction within 72 hours upon discovery of the breach by You;
3. You notify to the issuing bank and/or Credit/Debit Card and/or E-Wallet provider within 72 hours upon discovery of the breach by You;
4. You provide evidence that the bank is not reimbursing You for the fraudulent transactions;
5. You provide evidence of lost wages.

What We will not cover under this Section:

In addition to the General Exclusions, We will also not pay any claim in respect of:

1. Reimbursement by the bank for the transaction.
2. Cash advances (or cash withdrawn through an ATM or Bank Account) made through Your stolen Bank Accounts and/or Credit/Debit Cards.

5. E-Extortion

If You suffer financial loss solely and directly as a result of Extortion Threat, We will reimburse You or pay on Your behalf Extortion Loss that You incur solely and directly as result of Extortion Threat maximum up to the amount of the sub limit set forth under "E-Extortion" on the Policy Schedule

Provided that:

1. This Specified Event occurred on the internet during the Period of Insurance;
2. You lodge an FIR within seventy two (72) hours upon receiving the Extortion Threat;
3. You shall use your best efforts at all times to ensure that knowledge regarding the existence of the insurance for Extortion Loss afforded by this policy is kept confidential, unless disclosure to law enforcement authorities is required.
4. You shall allow Us(or the our nominated representatives) to notify the police or other responsible law enforcement authorities of any Extortion Threat.

What We will not cover under this Section:

In addition to the General Exclusions, We will also not pay any claim in respect of:

1. Loss that occurs within the first forty five (45) days of the inception date of this insurance cover.
2. Any claim or legitimate demand or even confiscation of the assets by bonafide governmental or judicial authority.

6. Cyber Bullying or Harassment

If You are the victim of Cyber Bullying or Harassment by a Third Party, resulting in or possibly leading to lower self-esteem, increased suicidal ideation, and a variety of emotional responses including retaliating, being scared, frustrated, angry, and depressed as certified by a qualified Psychologist / Psychiatrist being the direct result of Cyber Bullying or Harassment, We will reimburse You maximum up to the amount of the sub limit set forth under " Cyber Bullying" on the Policy Schedule for

a) Face – to – face consultation with a Psychologist / an accredited Psychiatrist for post – traumatic stress disorder, suicidal tendencies, self-harm, depression, anxiety disorder, insomnia, eating disorders or similar serious medical condition that makes consultation Deemed Necessary.

Provided that:

1. This Specified Event occurred on the internet during the Period of Insurance;
2. You lodge an FIR detailing the perpetrators or in event of victim being a minor, an FIR following a psychological consultation or a written complaint to the school authorities.

In addition to the General Exclusions, We will also not pay any claim in respect of:

1. Event that occurs within the first 45(forty five) days of the inception date of this insurance cover.
2. Any non-digital media (e.g. in print, radio or television broadcast)
3. Any act of government or authority putting You under surveillance or monitoring.
4. Any disciplinary act or related disciplinary action initiated by authorities against You at work place, clubs, social forums or school.
5. Any legal proceedings (pending or settled) with a Third Party prior to the commencement of this cover.

7. Phishing & Email Spoofing

If You suffer financial loss directly due to Phishing, we will indemnify You for the Money You lost as a direct result of Phishing maximum up to the amount of sub-limit set forth under "Phishing" on the Policy Schedule. In the event, the Phishing is of the nature of Email Spoofing as defined, We will indemnify You for the Money You lost, maximum up to the amount of sub-limit set forth under "Email Spoofing" on the Policy Schedule.

Provided that:

1. This Specified Event occurred on the internet during the Period of Insurance;
2. You lodge an FIR detailing the loss within 72 hours upon discovery of the loss by You
3. In event of Email Spoofing, the onus is on You to prove and establish that You had every reason to expect such email and You had the requirement to make payment against same

What We will not cover under this Section:

In addition to the General Exclusions, We will also not pay any claim in respect of:

1. Any Illegal transactions e.g bribes, commissions or illegal gratifications
2. Phishing resulting in revelation of personal information including passwords
3. Any payments or charges towards lottery, unexpected bequeath of wealth, or any other similar unsolicited promises or dishonest incentives

Limit Of Cover

(a) Limit of Liability: Our maximum limit of liability for any one Period of Insurance is limited to the amount specified in the Policy Schedule.

(b) Deductible: We shall be liable only in excess of the Deductible stated in the Policy Schedule. The Deductible shall apply to all claims resulting from one event (or a series of events) occurring at the same time or from the same originating cause.

Section C. Waiting Periods and Exclusions

A. Standard Waiting Periods applicable to Section 1: my: health Suraksha 4. my:health Hospital Cash Benefit and 5. My:health Koti Suraksha – Personal Accident Cover - Cover I.5.B.3, II – Temporary Total Disablement due to Illness and Cover I.5.B.5, Emergency Medical Expenses

Claims under the Policy are covered subject to waiting Period as specified below:

i) Pre-existing Diseases – Code – Excl01

a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.

b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum of Sum Insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the Policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

ii) Specified Disease/Procedure waiting period- Code – Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for Pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

a. Illnesses

Internal Congenital diseases	Non infective Arthritis
Diseases of gall bladder including cholecystitis	calculus diseases of Urogenital system e.g.Kidneystone,Urinary Bladder Stone
Pancreatitis	Ulcer and erosion of stomach and duodenum
All forms of Cirrhosis	Gastro Esophageal Reflux Disorder (GERD)
Perineal Abscesses	Perianal Abscesses
Cataract	Fissure/fistula in anus, Haemorrhoids including Gout and rheumatism
Pilonidal sinus	
Benign tumors, cysts, nodules, polyps including breast lumps	Osteoarthritis and osteoporosis
Polycystic ovarian diseases	Fibroids (fibromyoma)
Sinusitis, Rhinitis	Tonsillitis
Skin tumors	Benign Hyperplasia of Prostate

b. Surgical Procedures

Adenoidectomy, tonsillectomy	Tympanoplasty, Mastoidectomy
Dilatation and curettage (D&C)	Nasal concha resection
Myomectomy for fibroids	Surgery of Genito urinary system
Surgery on prostate	Cholecystectomy
Hernia	Hydrocele/Rectocele
Surgery for prolapsed inter vertebral disc	Joint replacement surgeries
Surgery for varicose veins and varicose ulcers	Surgery for Nasal septum deviation
Surgery for Perianal Abscesses	Fissurectomy, Haemorrhoidectomy, Fistulectomy, ENT surgeries

iii) 30-day waiting period – Code – Excl03

a) Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured

Person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

iv) A waiting period of 48 months shall apply for all Claims under Parent and Child Care Cover – Basic/Parent and Child Cover – Booster (Section B.1.C, 2 and 3)

B. Standard Waiting Periods applicable to Section 3: my:health Medisure Super Top Up Insurance

i) Pre-existing Diseases – Code – Excl01

a) Expenses related to the treatment of a pre-existing disease (PED) and its direct complications shall be excluded until the expiry of 36 months of continuous coverage after the date of inception of the first policy with insurer.

b) In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of sum of Sum Insured increase.

c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

d) Coverage under the Policy after the expiry of 36 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

ii) Specified Disease/Procedure waiting period- Code – Excl02

a) Expenses related to the treatment of the listed Conditions, surgeries/treatmentsshall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first Policy with us. This exclusion shall not be applicable for claims arising due to an Accident.

b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c) If any of the specified disease/procedure falls under the waiting period specified for Pre-existing diseases, then the longer of the two waiting periods shall apply.

d) The waiting period for listed conditions shall apply even if contracted after the Policy or declared and accepted without a specific exclusion.

e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.

- Cataract
- Hysterectomy other than for malignancy
- Uterine prolapse including any condition requiring Hysterectomy
- Polycystic Ovarian Diseases, Myomectomy for Fibroids
- Knee Replacement Surgery (other than caused by an accident)
- Osteoarthritis and Osteoporosis
- Arthritis, Arthroscopic Surgery, Rheumatism, Joint Replacement Surgery (other than caused by accident), Prolapse of Intervertibral discs(other than caused by accident)
- Varicose Veins and Varicose Ulcers, Hernia, Stones in the urinary, uro-genital and biliary systems, Benign Prostate Hypertrophy, Hydrocele
- Fistula in anus, Piles, Fissures
- Fibroids, Dilatation & Curettage for treatment purposes, Pilonidal sinus, Chronic Suppurative Otitis Media (CSOM)
- Deviated Nasal Septum, Sinusitis and related disorders
- Surgery on tonsils/Adenoids
- Gastric and duodenal ulcer, any type of Cysts/Nodules/ Polyps, and any type of Breast lumps, benign ear, Nose and Throat disorders and surgeries Chronic Nephritis and Nephropathy (Kidney diseases).

iii) 30-day waiting period – Code – Excl03

a) Expenses related to the treatment of any illness within 30 days from the first Policy commencement date shall be excluded except claims arising due to an Accident, provided the same are covered.

b) This exclusion shall not, however, apply if the Insured Person has continuous coverage for more than twelve months.

c) The within referred waiting period is made applicable to the enhanced Sum Insured in the event of granting higher Sum Insured subsequently.

C. Standard General Exclusions

C.i. General Exclusions applicable for Section B1: my: health Suraksha and Section B.4.my:health Hospital Cash Benefit – Add On

We will not make any payment for any claim in respect of any Insured Person caused by, arising from or attributable to any of the following unless expressly stated to the contrary in this Policy:

i. Investigation & Evaluation: **Code – Excl04**

a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

ii. Rest Cure, rehabilitation and respite care: **Code – Excl05** – Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. Obesity/Weight control: **Code – Excl06** – Expenses related

to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the doctor

b. The surgery/procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI)

i. Greater than or equal to 40 or,

ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

1. Obesity related cardiomyopathy

2. coronary heart disease

3. severe sleep apnoea

4. uncontrolled type2 diabetes

iv. Change-of-Gender treatments: **Code – Excl07** – Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v. Cosmetic or plastic surgery: **Code – Excl08** – Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to removea direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

vi. Hazardous or Adventure sports: **Code – Excl09** – Expenses related to any treatment necessitated due to participation as a professional in Hazardous or Adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.

vii. Breach of Law: **Code – Excl10** - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

viii. Excluded Providers: **Code11** - Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

ix. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code – Excl12**

x. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code – Excl13**

xi. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. **Code – Excl14**

xii. Refractive Error: **Code - Excl15** – Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

xiii. Unproven Treatments: **Code – Excl16** – Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

xiv. Sterility and Infertility: **Code- Excl17** – Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization

b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

c. Gestational Surrogacy

d. Reversal of sterilization

xv. Maternity: **Code – Excl18**

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.

C.ii. Specific General Exclusions

i. War or any act of war(whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

ii. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.

iii. Any Insured Person's participation or involvement in naval, military or air force operation.

iv. Investigative treatment for Sleep-apnoea, general debility or exhaustion ("run-down condition").

v. Congenital external diseases, defects or anomalies,

vi. Stem cell harvesting,.

vii. Investigative treatment for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).

viii. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).

ix. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

x. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

xi. Vaccination including inoculation and immunisations (Except post bite treatment),

xii. Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges etc. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com.

xiii. Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who is a member of an Insured Person's family, or stays with him,

xiv. Treatment taken on Outpatient basis

xv. The provision or fitting of hearing aids, spectacles or contact lenses.

xvi. Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement method. Optometric therapy.

xvii. Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.

xviii. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheel chairs crutches and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical Expenses is attached and also available on www.hdfcergo.com.

xix. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

D. Specific General Exclusions applicable for Section B.2: my:health Critical Illness Plus

We will not make any payment for any claim in respect of any Insured Person, caused by, arising from or attributable to any of the following unless expressly stated to the contrary in this Policy:

- A waiting period of 48 months shall apply for all Pre-existing Conditions declared and/or accepted at the time of applying first Policy with us. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.
- Treatment arising from or consequent upon war or any act of war (whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, , civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.
- Any Illness, sickness or disease other than those opted and specified as Critical Illnesses or Surgical Procedure under this Policy;
- Any claim with respect to any Critical Illness diagnosed prior to Policy Inception Date
- Any Critical Illness arising out of use, abuse or consequence or influence of any substance, intoxicant, drug, alcohol or hallucinogen unless prescribed by Medical Practitioner;
- Narcotics used by the Insured Person unless taken as prescribed by a registered Medical Practitioner,
- Any Claim caused due to intentional self-injury, suicide or attempted suicide.
- Any Critical Illness caused by or arising from or attributable to a foreign invasion, act of foreign enemies, hostilities, (whether war be declared or not or while performing duties in the armed forces of any country during war or at peace time), civil war, public defence, rebellion, revolution, insurrection, military or usurped power;
- Any claim caused by ionizing radiation or contamination by radioactivity from any nuclear fuel (explosive or hazardous form) or from any nuclear waste from the combustion of nuclear fuel, nuclear, chemical or biological attack.
- Working in underground mines, tunneling or involving electrical installations with high tension supply, or as jockeys or circus personnel;
- Congenital External Anomalies or any complications or conditions arising there from including any developmental conditions of the Insured;
- Whilst engaging in Adventure Sports.
- Involvement in naval, military or air force operation.
- Participation by the Insured Person in any flying activity, except as a bona fide passenger (fare paying and otherwise) of a recognized airline on regular routes and on a scheduled time table.

Specific General Exclusions applicable to Loss of Job:

i. Loss of job due to retirement whether voluntary or otherwise

ii. Resignation due to non-confirmation of employment after or during such period under which the Insured was under probation

E. Exclusions Applicable for Section B-3: my:health Medisure Super Top Up Insurance

E.i. Standard Exclusions

i) Investigation & Evaluation: **Code – Excl04**

d) Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.

e) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

ii) Rest Cure, rehabilitation and respite care: **Code – Excl05** – Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

f) Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

g) Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii) Obesity/Weight control: **Code – Excl06** – Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

h) Surgery to be conducted is upon the advice of the doctor

i) The surgery/procedure conducted should be supported by clinical protocols

j) The member has to be 18 years of age or older and

k) Body Mass Index (BMI)

i. Greater than or equal to 40 or,

ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

1. Obesity related cardiomyopathy
2. coronary heart disease
3. severe sleep apnoea
4. uncontrolled type2 diabetes

iv) Change-of-Gender treatments: **Code – Excl07** – Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v) Cosmetic or plastic surgery: **Code – Excl08** – Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

vi) Hazardous or Adventure sports: **Code – Excl09** – Expenses related to any treatment necessitated due to participation as a professional in Hazardous or Adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.

vii) Breach of Law: **Code – Excl10** - Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

viii) Excluded Providers: **Code11** - Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

ix) Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **Code – Excl12**

x) Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **Code – Excl13**

xi) Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure. **Code – Excl14**

xii) Refractive Error: **Code - Excl15** – Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

xiii) Unproven Treatments: **Code – Excl16** – Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

xiv) Sterility and Infertility: **Code- Excl17** – Expenses related to sterility and infertility. This includes:

l) Any type of contraception, sterilization

m) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

n) Gestational Surrogacy

o) Reversal of sterilization

xv) Maternity: **Code – Excl18**

p) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

q) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.

E.ii. Specific Exclusions

i. Domiciliary hospitalization expenses

ii) Co-payment: All person(s) named in the Schedule to this Policy above the age of 80 years (age last birthday) shall bear a co-pay of 10% for each and every claim.

iii) Aggregate Deductible: We are not liable for Claims/Claim amount falling within Aggregate Deductible limit as opted and mentioned on the Schedule

iv) War or any act of war(whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, civil war, public defence, rebellion, revolution, insurrection,military or usurped acts, nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

v) Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.

vi) Any Insured Person's participation or involvement in naval, military or air force operation.

vii) Investigative treatment for Sleep-apnoea, general debility or exhaustion ("run-down condition").

viii) Congenital external diseases, defects or anomalies,

ix) Stem cell harvesting

x) Investigative treatment for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).

xi) Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).

xii) Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

xiii) Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

xiv) Vaccination including inoculation and immunisations (Except post bite treatment),

xv) Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges etc. Full list of Non-Medical expenses is attached and also available at www.hdfcergo.com.

xvi) Treatment rendered by a Medical Practitioner which is outside his discipline or the discipline for which he is licensed; treatments rendered by a Medical Practitioner who is a member of an Insured Person's family, or stays with him,

xvii) Treatment taken on Outpatient basis

xviii) The provision or fitting of hearing aids, spectacles or contact lenses.

xix) Any treatment and associated expenses for alopecia, baldness including corticosteroids and topical immunotherapy wigs, toupees, hair pieces, any non-surgical hair replacement method. Optometric therapy.

xx) Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.

xxi) Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively). prosthesis, corrective devices external durable medical equipment of any kind,wheelchairs crutches and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical Expenses is attached and also available on www.hdfcergo.com.

xxii) Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

xxiii) Ambulance charges.

xxiv) Costs of donor screening and organ.

xxv)Expenses incurred on Alternative treatments exceptIn-patient care AYUSH treatments taken in an AYUSH Hospital'.

xxvi) Whilst You are flying or taking part in aerial activities (including as a cabin crew) except as a bona fide passenger (fare paying or otherwise) in a regular Scheduled airline or air Charter Company.

F. Specific Exclusions Applicable for Section B5: my: health Koti Suraksha – Personal Accident Cover

We will not make payment for any claim in respect of any Insured Person caused by, arising from or attributable to any of the following unless expressly stated to the contrary in the Policy;

i. The abuse or the consequences of the abuse of tobacco, intoxicants or hallucinogenic substances including all forms of narcotic drugs and alcohol unless prescribed by Medical Practitioner

ii. War or any act of war(whether war be declared or not or caused during service in the armed forces of any country), invasion, act of foreign enemy, , civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear, Chemical, Biological attack or weapons/materials or radiation of any kind

iii. Whilst travelling in aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world.

iv. Death or Disability suffered by the Insured Person on account of his participation as the driver, co-driver or passenger during trial runs (excluding Test Drives)using a motorized vehicle or bicycle.

v. Death or Disability caused by or arising from or in consequence of or contributed to Nuclear, Chemical or Biological attack/weapons, material by or arising from or in consequence of or contributed to by ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel (including any self-sustaining process of nuclear fission).

vi. Any Insured Person committing or attempting to commit intentional self-Injury (except in an attempt to save human life) or suicide while mentally sound or suffering from Mental illness

vii. From engaging in or participation in naval, military or air force operation.

viii. Injury sustained whilst or as a result of participation as a professional in Hazardous or Adventure sports

ix. Breach of Law: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

x. Injury sustained whilst or as a result of active participation in any violent labour disturbance, riot or civil commotion or public disorder.

xi. Injury sustained whilst on service or on duty with or undergoing training with any military or police force, or

militia or paramilitary organisation, notwithstanding that the Injury occurred whilst the Insured Person was on leave or not in uniform.

G. Exclusions applicable to Cover I.5.B.3, II – Temporary Total Disablement due to Illness and Cover I.5.B.5, Emergency Medical Expenses

G.i. Standard Exclusions

We will not make any payment for any claim in respect of any Insured Person, caused by, arising from or attributable to any of the following unless expressly stated to the contrary in this Policy:

i. Investigation & Evaluation: **Code Excl04**

a. Expenses related to any admission primarily for diagnostic and evaluation purposes only are excluded.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded.

ii. Rest Cure, rehabilitation and respite care **Code – Excl05** – Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

iii. Obesity/Weight control: **Code – Excl06** – Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the doctor

b. The surgery/procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI)

i. Greater than or equal to 40 or,

ii. Greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:

iii. Obesity related cardiomyopathy

iv. coronary heart disease

v. severe sleep apnoea

vi. uncontrolled type2 diabetes

iv. Change-of-Gender treatments: **Code – Excl07** - Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

v. Cosmetic or plastic surgery: **Code – Excl08** – Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of Medically Necessary Treatment to removea direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

vi. Hazardous or Adventure Sports - **Code – Excl09** :Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep sea diving.

vii. Breach of Law - **Code – Excl10**: Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

viii. Excluded Providers - **Code – Excl11**- Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website/notified to the policyholders are not admissible. However, in case of life threatening situations or following an Accident, expenses up to the stage of stabilization are payable but not the complete claim.

ix. Treatment for Alcoholism, drug or substance abuse or any addictive condition and consequences thereof Excl12

x. Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.Excl13

xi. Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a Medical Practitioner as part of Hospitalization claim or day care procedure.Excl14

xii. Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.Excl15

xiii. Unproven Treatments – Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.Excl16

xiv. Sterility and Infertility **Code – Excl17** - Expenses related to sterility and infertility. This includes:

e. Any type of contraception, sterilization

f. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI

g. Gestational Surrogacy

h. Reversal of sterilization

xv. Maternity - Code – Excl18

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;

b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the Policy period.

G.ii. Specific Exclusions

i. War or any act of war, invasion, act of foreign enemy, (whether war be declared or not or caused during service in the armed forces of any country), civil war, public defence, rebellion, revolution, insurrection, military or usurped acts, Nuclear weapons/materials, chemical and biological weapons, radiation of any kind.

ii. Any Insured Person committing or attempting to commit intentional self-injury or attempted suicide or suicide while mentally sound or unsound.

iii. Any Insured Person's participation or involvement in naval, military or air force operation.

iv. Investigative treatment for Sleep-apnoea, General debility or exhaustion ("run-down condition").

v. Congenital external diseases, defects or anomalies,

vi. Stem cell harvesting

vii. Investigative treatments for analysis and adjustments of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure or for muscle stimulation by any means except treatment of fractures (excluding hairline fractures) and dislocations of the mandible and extremities).

viii. Circumcisions (unless necessitated by Illness or Injury and forming part of treatment).

ix. Any Convalescence, sanatorium treatment, private duty nursing or long-term nursing care.

x. Preventive care, and other nutritional and electrolyte supplements, unless certified to be required by the attending Medical Practitioner as a direct consequence of an otherwise covered claim.

xi. Vaccination including inoculation and immunisations (Except post Animal bite treatment),

xii. Non-Medical expenses such as Food charges (other than patient's diet provided by hospital), laundry charges, attendant charges, ambulance collar, ambulance equipment, baby food, baby utility charges etc. Full list of Non-Medical expenses is attached and also available at **www.hdfcergo.com**.

xiii. The provision or fitting of hearing aids, spectacles or contact lenses.

xiv. Any treatment and associated expenses for alopecia, baldness, including corticosteroids and topical immunotherapy, wigs, toupees, hair pieces, any non-surgical hair replacement methods. Optometric therapy.

xv. Any treatment or part of a treatment that is not of a Reasonable and Customary charge, not Medically Necessary; treatments or drugs not supported by a prescription.

xvi. Expenses for Artificial limbs and/or device used for diagnosis or treatment (except when used intra-operatively).prosthesis, corrective devices external durable medical equipment of any kind, wheelchairs, crutches, and oxygen concentrator for bronchial asthma/ COPD conditions, cost of cochlear implant(s) unless necessitated by an Accident. Exhaustive list of Non-Medical expenses attached and also available on www.hdfcergo.com

xvii. Any Claim arising due to Non-disclosure of Pre-existing Illness or Material fact as sought to be declared on the Proposal form.

H. Specific Exclusions Applicable for Section B6: Travel Insurance

The Company shall not be liable to pay any benefit in respect of any Insured Person:

1) For Bodily Injury or Sickness occasioned by Civil War or Foreign War.

2) For Bodily Injury or Sickness caused or provoked intentionally by the Insured Person.

3) for Bodily Injury or Sickness due to willful or deliberate exposure to danger, (except in an attempt to save human life), intentional self-inflicted injury, suicide or attempt thereat, or arising out of non-adherence to Medical Advice.

4) For Bodily Injury or Sickness sustained or suffered whilst the Insured Person is or as a result of the Insured Person being under the influence of alcohol or drugs or narcotics unless professionally administered by a Physician or unless professionally prescribed by and taken in accordance with the directions of a Physician.

5) For Bodily Injury due to a gradually operating cause.

6) For Bodily Injury sustained whilst or as a result of participating in any sport as a professional player.

7) For Bodily Injury sustained whilst or as a result of participating in any competition involving the utilization of a motorized land, water or air vehicle.

8) For Bodily Injury sustained whilst or as a result of riding or driving a motorcycle or motor scooter over one hundred fifty (150) cc.

9) For Bodily Injury whilst the Insured Person is travelling by air other than as a fare paying passenger on an aircraft registered to an airline company for the transport of paying passengers on regular and published scheduled routes.

10) For Bodily Injury sustained whilst or as a result of participating in any criminal act.

11) For Bodily Injury or Sickness resulting from pregnancy within twenty-six (26) weeks of the expected date of birth.

12) For Bodily Injury or Sickness caused by or arising from or due to venereal or venereal related disease.

13) For Bodily Injury sustained whilst or as a result of active participation in any violent labour disturbance, riot or civil commotion or public disorder.

14) for Bodily Injury sustained whilst on service or on duty with or undergoing training with any military or police force, or militia or paramilitary organization, notwithstanding that the Bodily Injury occurred whilst the Insured Person was on leave or not in uniform.

15) Any pathological fracture.

16) For cures of any kind and all stay in long term care institutions (retirement homes, convalescence centres, centres of detoxification etc.).

17) For investigations, operations or treatment of a purely

cosmetic nature; or for obesity; or undertaken to facilitate pregnancy or to cure impotence or to improve potency.

28) for Bodily Injury sustained whilst or as a result of engaging in, practicing for, or taking part in training peculiar to any kind of hazardous sport such as parachuting, hangliding, parasailing, off-piste skiing or bungee jumping.

19) Any Medical Expenses incurred, the need of which arises out of a Pre-existing Condition

20) For Bodily Injury caused by or arising from or as a result of Terrorism.

I. Specific Terms Applicable for Section 8: E@Secure Insurance

1) Your failure to take due care and precaution to safe guard Your Personal Information, Bank Accounts and/or Credit/ Debit Cards information and internet communication.

2) Deliberate, fraudulent, Illegal or malicious acts or failure to act by You or intentional or knowing violation of any duty, obligation, contract, law or regulation by You.

3) Facts or circumstances existing prior to the commencement of this cover, which You knew or ought to have reasonably known to be facts or circumstances likely to give rise to a claim.

4) Your business activities (including but not limited to e-trading and blogging where You receive remuneration or benefits in any form), Occupation or political affiliations.

5) Loss that You have directly or indirectly and intentionally created or endorsed by You.

6) Any unexplained loss or mysterious disappearance.

7) Any loss or damage caused by the order of any government authority.

8) Consequential loss or damage of any kind including loss suffered by any Third Party.

9) Any claim in connection with the ownership, driving or use of a motor vehicle.

10) Fees and costs incurred before acceptance of a claim.

11) Any claims made in connection: failure or interruption, caused by whatsoever reason, of access to a Third Party infrastructure or service provider, including telecommunications, internet service, satellite, cable, electricity, gas, water or other utility service providers.

12) Losses arising from the theft, disappearance, loss of value or inaccessibility of any crypto currency"

13) Any claim reported to Us more than six (6) months after the occurrence of the Specified Event.

14) Any damage to or destruction of any tangible property, including loss of use thereof.

15) Any liability under any contract, agreement, guarantee or warranty assumed or accepted by except to the extent that such liability would have attached to You in the absence of such contract, agreement, guarantee or warranty.

16) Any actual or alleged plagiarism or infringement of any Trade Secrets, patents, trademarks, trade names, copyrights, licenses or any other form of intellectual property.

17) War, Terrorism, looting and Governmental Acts.

18) Any losses or liabilities connected with any inherent product defect/wear and tear or any types of purchase or sale transactions or other dealing in securities, commodities, derivatives, foreign or Federal Funds, currencies, foreign exchange, and the like.

19) Any distribution of unsolicited correspondence or communications (whether in physical or electronic form), wiretapping, audio or video recordings or telephone marketing.

SECTION D GENERAL CONDITIONS

A) General Conditions Applicable to Section B. 1: my: health Suraksha

A.i. Standard

1. Free Look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The Insured Person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the Policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

2. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

3. Multiple Policies

i. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

ii. Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other policy / policies even if the Sum Insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and

conditions of this Policy.

iii. If the amount to be claimed exceeds the Sum Insured under a single Policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

4. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

5. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

6. Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

7. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression “fraud” means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person 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

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

8. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

iii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

9. Grace Period

i. A Grace Period of 30 days is available for Renewal of the Policy. Any Illness, disease or condition contracted during Grace Period will not be covered and will be treated as Pre-existing diseases.

ii. Policies for which Premium is received after the Grace Period shall be considered as a fresh policy.

iii. For Policies on instalment basis, Grace Period is available as given below.

Installment Premium Option	Grace Period applicable
Yearly	30 days
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

10. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

11. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

12. Cancellation

i. The Policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

For Policies where instalment option is not availed and no claim has been made under the Policy, We will refund premium in accordance with the table below:

Month	Policy Tenure 1 Year	Policy Tenure 2 Year	Policy Tenure 3 Year
Up to 1 Month	85.0%	92.5%	95.0%
Up to 3 Month	70.0%	85.0%	90.0%
Up to 6 Month	45.0%	70.0%	80.0%
Up to 12 Month	0.0%	45.0%	60.0%
Up to 15 Month	NA	30.0%	50.0%
Up to 18 Month	NA	20.0%	45.0%
Up to 24 Month	NA	0.0%	30.0%
Up to 27 Month	NA	NA	20.0%
Up to 30 Month	NA	NA	12.5%
Up to 36 Month	NA	NA	0.0%

For Policies where Premium is paid by instalment, additional conditions as given below will be applicable.

- When yearly payment option is chosen, cancellation grid as per 1-Year Tenure policies will be applicable
- For all other options, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the policy year. For instalment after 6 months, no refund will be payable.
- In case of admissible claim under the Policy, future instalments for the current policy year will be adjusted in the claim amount and no refund of any premium will be applicable during policy year

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

13. Premium Payment in Instalments

If the Insured Person has opted for Payment of Premium on an installment basis i.e. Yearly, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period as mentioned in the table below would be given to pay the installment premium due for the Policy.

Options	Installment Premium Option	Grace Period applicable
Option 1	Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

ii. During such Grace Period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

iv. No interest will be charged If the installment premium is not paid on due date.

v. In case of installment premium due not received within the Grace Period, the Policy will get cancelled.

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Instalment Premium payment through Auto Debit/ECS Facility

i. If Option of Premium payment by Installment is opted through auto Debit/ECS facility, a separate authorization form shall be submitted by Insured Person where Premium to be debited at a chosen frequency will be mentioned upfront

ii. Where there is a change either in the terms and conditions of the Coverage or Policy or in the premium rate, the ECS

authorization shall be obtained afresh

iii. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable

iv. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode

14. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

15. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

16. Claim Settlement (Provision for Penal Interest)

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which We will send a closure letter or make a part-payment if We have not received the deficiency documents after 45 days from the date of the initial request for such documents

ii. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

iii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the Bank Rate.

iv. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

v. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the Bank Rate from the date of receipt of last necessary document to the date of payment of claim.

vi. If We, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to You in writing within 30 days of the receipt of documents.

vii. If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

viii. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim

17. Nomination:

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

A.ii. Specific Definitions

1. Geography

This Policy only covers Medical Treatment taken within India, except under the policies with Global Health Cover as may be specified in the on the Schedule of Coverage in the policy Schedule.

2. Non-Disclosure or Misrepresentation

i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person, is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

a) cancelled ab initio from the inception date or the Renewal date (as the case may be), or the Policy may be modified by Us at Our sole discretion, upon 15 days' notice by sending an endorsement to Your address shown in the Schedule and

b) the claim under such Policy if any, shall be prejudiced.

ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;

a) Permanently exclude the disease/condition and continue with the Policy

b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

3. The above options will not prejudice the rights of the Company to invoke cancellation under clause 4 i above. Loadings

i. We may apply Medical Underwriting loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past

medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.

ii. The maximum Medical Underwriting loading shall not exceed 35% for each diagnosis / medical condition and a total of 100% for each Insured Person

iii. Medical Underwriting loadings will be applied from Commencement date of the Policy including subsequent Renewal(s) with Us or on increased Sum Insured. We will not apply any additional loading on Your policy premium at Renewal based on claim experience in Your Policy. However increase or decrease of discount in Medical Underwriting loading is subject to terms mentioned under Section 3B – Health Incentives

iv. We will inform You about the applicable Medical underwriting loading with time bound exclusion (if any) through a counter offer letter and will issue the Policy only on Your acceptance within 15 days of the receipt of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.

4. Endorsements

The following endorsements are permissible during the Policy Period:

1. Non-Financial Endorsements – which do not affect the premium

i. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)

ii. Rectification in gender of the Insured Person (if this does not impact the premium)*

iii. Rectification in relationship of the Insured Person with the Proposer

iv. Rectification of date of birth of the Insured Person (if this does not impact the premium)*

v. Change in the correspondence address of the Proposer (if this does not impact the premium)*

vi. Change in Nominee Details

vii. Change in Height, weight, marital status (if this does not impact the premium) *

viii. Change in bank details

ix. Any other non-financial endorsement

2. Financial Endorsements – which result in alteration in premium

i. Change in Age/date of birth

ii. Change in Height, weight

iii. Addition of Insured Person (New Born Baby or newly wedded spouse)

iv. Deletion of Insured Person on death or Marital separation

v. Any other financial endorsement

The Policyholder shallapply in a proposal form along with birthCertificate / marriage certificate as the case may be for addition of Insured person.

5. Premium Tier :

For the purpose of policy issuance, the premium will be computed basis the city of residence provided by the Insured Person in the proposal form. Classification of cities would be as under:

- Tier 1a: Delhi and NCR region
- Tier 1b: Mumbai, Mumbai Suburban and Navi Mumbai, Pune, Surat, Ahmedabad, Varodara
- Tier 2: Rest of India

Conditions:

i. On payment of Tier 1a premiums, an Insured Person can avail treatment all over India without any co-payment.

ii. On payment of Tier 1b premium, an Insured Person can avail treatment at Tier1b cities and Tier 2 cities without any Co-Payment. However if an Insured Person avails a treatment in Tier 1a cities , 20% Co-Payment shall be applicable on admissible claim amount.

iii. On payment of Tier 2 premium, an Insured Person can avail treatment at Tier 2 cities without any Co-Payment. However if an Insured Person avails a treatment in Tier 1a or Tier1b cities, 20% Co-Payment shall be applicable on admissible claim amount.

iv. Co-Paymentunder ii and iii above will not be applied If an Insured Personopts for Hospitalization with Room Rent up to Rs 2,500 per day or on Hospitalizationfor Medically Necessary treatment following an Accident

B) General Conditions Applicable for Section B. 2: my:health Critical Suraksha Plus

B.i. Standard Conditions

1. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression “fraud” means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person 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

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

2. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

3. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

4. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that.

5. Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract amount for the particular claim.

6. Free Look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The Insured Person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the Policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

7. Grace Period

i. A grace period of 30 days for Renewals is permissible and the Policy will be considered as continuous for the purpose of all waiting periods. However, any treatment availed for an Illness contracted during the grace period will not be admissible under the Policy.

ii. For Renewal received after completion of 30 days grace period, the Policy would be considered as a fresh policy. All the discounts, modifications of loading earned on the previous policies shall not be extended in the fresh Policy

iii. All eligible claims reported in the installment grace period would be payable if otherwise admissible as per terms and conditions of the Policy For Policies on instalment basis, Grace Period is available as given below.

Installment Premium Option	Grace Period applicable
Yearly	30 days
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

8. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

iii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

9. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

10. Cancellation

i. The Policyholder may cancel this policy by giving 15days'

written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

For Policies where instalment option is not availed and no claim has been made under the Policy, We will refund premium in accordance with the table below:

Month	1 Year	2 Year	3 Year
Up to 1 Month	85.0%	92.5%	95.0%
Up to 3 Month	70.0%	85.0%	90.0%
Up to 6 Month	45.0%	70.0%	80.0%
Up to 12 Month	0.0%	45.0%	60.0%
Up to 15 Month	NA	30.0%	50.0%
Up to 18 Month	NA	20.0%	45.0%
Up to 24 Month	NA	0.0%	30.0%
Up to 27 Month	NA	NA	20.0%
Up to 30 Month	NA	NA	12.5%
Up to 36 Month	NA	NA	0.0%

For Policies where Premium is paid by instalment, additional conditions as given below will be applicable.

- When yearly payment option is chosen, cancellation grid as per 1-Year Tenure policies will be applicable
- For all other options, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the policy year. For instalment after 6 months, no refund will be payable.
- In case of admissible claim under the Policy, future instalments for the current policy year will be adjusted in the claim amount and no refund of any premium will be applicable during policy year

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 30 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

11. Premium Payment in Instalments

If the Insured Person has opted for Payment of Premium on an installment basis i.e. Yearly, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period as mentioned in the table below would be given to pay the installment premium due for the Policy.

Options	Installment Premium Option	Grace Period applicable
Option 1	Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

ii. During such Grace Period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

iv. No interest will be charged If the installment premium is not paid on due date.

v. In case of installment premium due not received within the Grace Period, the Policy will get cancelled.

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Instalment Premium payment through Auto Debit/ECS Facility

v. If Option of Premium payment by Installment is opted through auto Debit/ECS facility, a separate authorization form shall be submitted by Insured Person where Premium to be debited at a chosen frequency will be mentioned upfront

vi. Where there is a change either in the terms and conditions of the Coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh

vii. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable

viii. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode

12. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

13. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per

IRDAI guidelines, provided the policy has been maintained without a break.

14. Claim Settlement (provision for Penal Interest)

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which We will send a closure letter or make a part-payment if We have not received the deficiency documents after 45 days from the date of the initial request for such documents

ii. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

iii. Upon acceptance of an offer of settlement by the Insured person, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the Insured Person.

iv. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

v. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

vi. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

vii. If We, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to You in writing within 30 days of the receipt of documents.

viii. If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the treatment of Insured Person and to investigate the circumstances pertaining to the claim.

ix. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim

15. Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

B.ii. Specific General Conditions

1. Geography

The policy provides worldwide coverage, there is no territorial limit

2. Endorsements

The following endorsements are permissible during the Policy Period:

1.1 Non-Financial Endorsements – which do not affect the premium

a. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)

b. Rectification in gender of the Insured Person (if this does not impact the premium)*

c. Rectification in relationship of the Insured Person with the Proposer

d. Rectification of date of birth of the Insured Person (if this does not impact the premium)*

e. Change in the correspondence address of the Proposer

f. Change in Nominee Details

g. Change in Height, weight, marital status (if this does not impact the premium)

h. Change in bank details

i. Any other non-financial endorsement

1.2 Financial Endorsements – which result in alteration in premium

a. Change in Age/date of birth/ Gender

b. Change in Height, weight

c. Deletion of Insured Person on death or Marital separation

d. Any other financial endorsement

e. Enhancement of Sum Insured – Enhancement of Sum Insured is subject to Medical Underwriting

- Endorsements, a and b above shall be effective from the date of receipt of premium withUsand we shall be effective from Date of Commencement/Renewal of the Policy.
- The Policyholder should provide a fresh application in a proposal form for addition of Insured person.

C) General Conditions Applicable for Section B. 3: my:health Medisure Super Top Up Insurance

C.i. Standard Conditions

1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

2. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

3. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

4. Multiple Policies

i. In case of multiple policies taken by an Insured Person during a period from one or more insurers to indemnify treatment costs, the Insured Person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the Insurer chosen by the Insured Person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen Policy.

ii. Insured Person having multiple policies shall also have the right to prefer claims under this Policy for the amounts disallowed under any other policy / policies even if the Sum Insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of thisPolicy.

iii. If the amount to be claimed exceeds the Sum Insured under a single Policy, the Insured Person shall have the right to choose Insurer from whom he/she wants to claim the balance amount.

iv. Where an Insured Person has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured Person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen Policy.

5. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression “fraud” means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

e) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

f) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

g) any other act fitted to deceive; and

h) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

6. Premium Payment in Instalments

If the Insured Person has opted for Payment of Premium on an installment basis i.e. Yearly, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy.

viii. Grace Period as mentioned in the table below would be given to pay the installment premium due for the Policy.

Options	Installment Premium Option	Grace Period applicable
Option 1	Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

ix. During such Grace Period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.

x. The Insured Person will get the accrued continuity benefit in respect of the “Waiting Periods”, “Specific Waiting Periods” in the event of payment of premium within the stipulated Grace Period.

xi. No interest will be charged If the installment premium is not paid on due date.

xii. In case of installment premium due not received within the Grace Period, the Policy will get cancelled.

xiii. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

xiv. The Company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Instalment Premium payment through Auto Debit/ECS Facilit

ix. If Option of Premium payment by Installment is opted through auto Debit/ECS facility, a separate authorization form shall be submitted by Insured Person where Premium to be debited at a chosen frequency will be mentioned upfront

x. Where there is a change either in the terms and conditions of the Coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh

xi. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable

xii. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode

7. Cancellation

The Policyholder may cancel this policy by giving 15days’ written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

For Policies where instalment option is not availed and no claim has been made under the Policy, We will refund premium in accordance with the table below:

Period On Risk	Rate of Premium Refunded
Up to 1 month	75% of annual Premium
Up to 3 months	50% of annual Premium
Up to 6 months	25% of annual Premium
Exceeding six months upto 365 days	Nil

In case of 2 year Policy;

If cancellation done before completion of 1 year: same grid as given above is applicable on first year Premium and second year Premium will be completely refunded.

If cancellation is done after completion of 1 year: same grid as given above is applicable however retention Premium onsecond year premium will be calculated on Annual Premium without long term Policy discount.

For Policies where Premium is paid by instalment, additional conditions as given below will be applicable.

- When yearly payment option is chosen, cancellation grid as per 1-Year Tenure policies will be applicable
- For all other options, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the policy year. For instalment after 6 months, no refund will be payable.
- In case of admissible claim under the Policy, future instalments for the current policy year will be adjusted in the claim amount and no refund of any premium will be applicable during policy year

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

iii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Free look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The Insured Person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the insured shall be entitled to

iv. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or

v. where the risk has already commenced and the option of return of the Policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or

vi. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

9. Claim Settlement (Provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the Bank Rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the Bank Rate from the date of receipt of last necessary document to the date of payment of claim.

10. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

vi. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

vii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

viii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

ix. At the end of the policy period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

x. No loading shall apply on renewals based on individual claims experience.

11. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting

periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

12. Migration

The Insured Person will have the option to migrate the Policy to other health insurance products/plans offered by the Company by applying for Migration of the policyatleast30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the Company, the Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on Migration.

For Detailed Guidelines on Migration, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

13. Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract.

14. Withdrawal of Policy

iii. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

iv. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

15. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

16. Nomination:

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

C.ii. Specific Terms & Conditions

1. Observance of Terms and Conditions

The due observance and fulfilment of the terms, conditions and endorsements of this Policy insofar as they relate to anything to be done or complied with You shall be a condition precedent to any liability on Us to make any payment under this Policy.

2. Reasonable Care

You shall take all reasonable steps to safeguard against any accident or illnesses that may give rise to any claim under this Policy.

3. Notice of Charge

We shall not be bound to take notice or be affected by any notice of any trust, charge, lien, assignment or other dealing with or relating to this Policy, but Our payment to You or Your nominees or Your legal representative or to the Hospital/ Nursing Home, as the case may be, of any benefit under the Policy shall in all cases be a full, valid and an effectual discharge by Us.

4. Electronic Transactions

You agree to adhere to and comply with all such terms and conditions as We may prescribe from time to time, and hereby agree and confirm that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centers, tele-service operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on behalf of Us, for and in respect of this Policy or its terms, or Our other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with Our terms and conditions for such facilities, as may be prescribed from time to time. Sales through such electronic transactions shall ensure that all conditions of Section 41 of the Insurance Act, 1938 prescribed for the proposal form and all necessary disclosures on terms and conditions and exclusions are made known to the Insured. A voice recording in case of tele-sales or other evidence for sales through the World Wide Web shall be maintained and such consent will be subsequently validated/ confirmed by You.

5. **Place/Currency:** No claim shall be payable under this Policy for any treatment or expenses incurred outside India. All claims shall be payable in India and in Indian Rupees only.

6. **Income Tax benefit:** Premium paid under the Policy shall be eligible for benefits under the Income Tax laws prevailing from time to time.

7. **Law Applicable:** Laws of the Republic of India shall govern the validity, construction, interpretation and effect of this Policy or any claim thereunder.

8. If a claim is rejected or partially settled and is not the subject matter of any pending suit or other proceeding or arbitration, as the case may be, within twelve months from the date of such rejection or settlement, the claim shall be deemed to have been abandoned and Our liability

extinguished and shall not be recoverable thereafter.

9. Grace Period

iv. A Grace Period of 30 days is available for Renewal of the Policy. Any Illness, disease or condition contracted during Grace Periodwill not be covered and will be treated as Pre-existing diseases.

v. Policies for which Premium is received after theGrace Period shall be considered as a fresh policy.

vi. For Policies on instalment basis, Grace Period is available as given below.

Installment Premium Option	Grace Period applicable
Yearly	30 days
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

10. Medical Underwriting

Proposers above 55 years of age and those having medical history are subject to Medical Underwriting by the Company. We reserve the right to accept such proposals on standard terms/Decline/Accept with exclusion or Premium loading (up to maximum of 100% on basic Premium).These loadings are applied from Commencement Date of the Policy including subsequent renewal(s) with Us.

11. Endorsements: Following type of endorsement are permissible under the Policy.

1. Non-Financial Endorsements – which do not affect the premium

x. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)

xi. Rectification in gender of the Insured Person (if this does not impact the premium)*

xii. Rectification in relationship of the Insured Person with the Proposer

xiii. Rectification of date of birth of the Insured Person (if this does not impact the premium)*

xiv. Change in the correspondence address of the Proposer (if this does not impact the premium)*

xv. Change in Nominee Details

xvi. Change in Height, weight, marital status (if this does not impact the premium) *

xvii. Change in bank details

xviii. Any other non-financial endorsement

2. Financial Endorsements – which result in alteration in premium

vi. Change in Age/date of birth

vii. Change in Height, weight

viii. Addition of Insured Person (New Born Baby or newly wedded spouse)

ix. Deletion of Insured Person on death or Marital separation

x. Any other financial endorsement

The Policyholder shall apply in a proposal form along with birth Certificate / marriage certificate as the case may be for addition of Insured person.

D. General Conditions Applicable for Section B. 4: my :health hospital Cash Benefit Add on

D.i. Standard Conditions

1. Free Look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The Insured Person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the insured shall be entitled to

i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or

ii. where the risk has already commenced and the option of return of the Policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or

iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

2. Non-Disclosure or Misrepresentation

i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

- cancelled ab initio from the inception date or the Renewal date (as the case may be), or the Policy may be modified by Us, at Our sole discretion, upon 30 day notice by sending an endorsement to Your address shown in the Schedule and
- the claim under such Policy if any, shall be rejected/ repudiated forthwith.

ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;

a) Permanently exclude the disease/condition and continue with the Policy

b) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

c) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

The above options will not prejudice the rights of the Company to invoke cancellation under clause i above.

3. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

4. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

i) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

j) the active concealment of a fact by the Insured Person having knowledge or belief of the fact;

k) any other act fitted to deceive; and

l) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

5. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

6. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

7. Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract

8. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

ii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

iii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

9. Portability

The Insured Person will have the option to port the Policy to other insurers by applying to such Insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to Portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed Insured Person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability, kindly refer the link

https://www.irdai.gov.in/ADMINCMS/cms/frmGuidelines_Layout.aspx?page=PageNo3987

10. Cancellation

i. The Policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

For Policies where instalment option is not availed and no claim has been made under the Policy, We will refund premium in accordance with the table below:

Month	1 Year	2 Year	3 Year
Up to 1 Month	85.0%	92.5%	95.0%
Up to 3 Month	70.0%	85.0%	90.0%
Up to 6 Month	45.0%	70.0%	80.0%
Up to 12 Month	0.0%	45.0%	60.0%
Up to 15 Month	NA	30.0%	50.0%
Up to 18 Month	NA	20.0%	45.0%
Up to 24 Month	NA	0.0%	30.0%

Up to 27 Month	NA	NA	20.0%
Up to 30 Month	NA	NA	12.5%
Up to 36 Month	NA	NA	0.0%

For Policies where Premium is paid by instalment, additional conditions as given below will be applicable.

- When yearly payment option is chosen, cancellation grid as per 1-Year Tenure policies will be applicable
- For all other options, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the policy year. For instalment after 6 months, no refund will be payable.
- In case of admissible claim under the Policy, future instalments for the current policy year will be adjusted in the claim amount and no refund of any premium will be applicable during policy year

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 30 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

11. Premium Payment in Instalments

If the Insured Person has opted for Payment of Premium on an installment basis i.e. Yearly, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

i. Grace Period as mentioned in the table below would be given to pay the installment premium due for the Policy.

Options	Installment Premium Option	Grace Period applicable
Option 1	Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

ii. During such Grace Period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.

iii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

iv. No interest will be charged If the installment premium is not paid on due date.

v. In case of installment premium due not received within the Grace Period, the Policy will get cancelled.

vi. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vii. The Company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Instalment Premium payment through Auto Debit/ECS Facility

a. If Option of Premium payment by Installment is opted through auto Debit/ECS facility, a separate authorization form shall be submitted by Insured Person where Premium to be debited at a chosen frequency will be mentioned upfront

b. Where there is a change either in the terms and conditions of the Coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh

c. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable

d. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode

12. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

13. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

14. Claim Settlement (Provision for Penal Interest)

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which We will send a closure letter or make a part-payment if We have not received the deficiency documents after 45 days from the date of the initial request for such documents

ii. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

iii. All claim payments shall be on reimbursement basis

iv. All claims payment will be made by Us in Indian rupees and into Indian Bank accounts only

v. Upon acceptance of an offer of settlement by the Insured person, the payment of the amount due shall be made within 7 days from the date of acceptance of the offer by the insured. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the

Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the Bank Rate.

vi. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

vii. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the Bank Rate from the date of receipt of last necessary document to the date of payment of claim.

viii. If We, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to You in writing within 30 days of the receipt of documents.

ix. If requested by Us and at Ourcost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

x. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim

15. Nomination

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

D.ii. Specific Terms

1. Geography

This Policy only covers medical treatment taken within India, except under the policies with Global Cover as may be specified in the on the Schedule of Coverage in the policy Schedule.

2. Grace Period

i. A Grace Period of 30 days for Renewals is permissible and the Policy will be considered as continuous for the purpose of all waiting periods. However, we shall not be liable for any treatment availed for an Illness or Accident during the Grace Period

ii. For Renewals received after completion of 30 days Grace Period, the policy would be considered as a fresh policy and all Waiting Periods including those mentioned under Section C will start afresh. All the Renewal benefits earned on the previous Policy will lapse.

iii. All eligible claims reported in the grace period would be payable if otherwise admissible as per terms and conditions of the policy.

iv. For Policies on instalment basis, Grace Period is available as given below.

Installment Premium Option	Grace Period applicable
Yearly	30 days
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

3. Endorsements

The following endorsements are permissible during the Policy Period:

1.1 **Non-Financial Endorsements** – which do not affect the premium

i. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)

ii. Rectification in gender of the Insured Person (if this does not impact the premium)*

iii. Rectification in relationship of the Insured Person with the Proposer

iv. Rectification of date of birth of the Insured Person (if this does not impact the premium)*

v. Change in the correspondence address of the Proposer(if this does not impact the premium)*

vi. Change in Nominee Details

vii. Change in Height, weight, marital status (if this does not impact the premium) *

viii. Change in bank details

ix. Any other non-financial endorsement

1.2 Financial Endorsements – which result in alteration in premium

f. Change in Age/date of birth

g. Change in Height, weight

h. Addition of Insured Person (New Born Baby or newly wedded spouse)

i. Deletion of Insured Person on death or Marital separation

j. Any other financial endorsement

The Policyholder shall apply in a proposal form along with birth Certificate / marriage certificate as the case may be for addition of Insured person.

E. General Conditions Applicable to Section B-5: my:health Koti Suraksha – Personal Accident Cover

E.i. Standard Conditions

1. Free Look period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the Policy.

The Insured Person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the Insured has not made any claim during the Free Look Period, the insured shall be entitled to

vii. a refund of the premium paid less any expenses incurred by the Company on medical examination of the Insured Person and the stamp duty charges or

viii. where the risk has already commenced and the option of return of the Policy is exercised by the Insured Person, a deduction towards the proportionate risk premium for period of cover or

ix. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.

2. Condition Precedent to Admission of Liability

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

3. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

4. Complete Discharge

Any payment to the Policyholder, Insured Person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the Policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5. Moratorium Period

After completion of eight continuous years under the policy, no look back to be applied. This period of eight years is called as Moratorium Period. The moratorium would be applicable for the sums insured of the first policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the policy contract

6. Fraud

If any claim made by the Insured Person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his/her behalf to obtain any benefit under this Policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this Policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who have made that particular claim, who shall be jointly and severally liable for such repayment to the Insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent or the hospital/doctor/any other party acting on behalf of the Insured Person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the Insured Person does not believe to be true;

b) the active concealment of a fact by the Insured Person 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

The Company shall not repudiate the claim and / or forfeit the Policy benefits on the ground of Fraud, if the Insured Person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the Insurer.

7. Cancellation

The Policyholder may cancel this policy by giving 15days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

For Policies where instalment option is not availed and no claim has been made under the Policy, We will refund premium in accordance with the table below:

Month	1 Year	2 Year	3 Year
Up to 1 month	85.0%	92.5%	95.0%
Up to 3 month	70.0%	85.0%	90.0%
Up to 6 month	45.0%	70.0%	80.0%
Up to 12 month	0.0%	45.0%	65.0%
Up to 15 month	Not Applicable	30.0%	55.0%
Up to 18 month	Not Applicable	20.0%	45.0%
Up to 24 month	Not Applicable	0.0%	30.0%
Up to 27 month	Not Applicable	Not Applicable	20.0%
Up to 30 month	Not Applicable	Not Applicable	15%
Up to 36 month	Not Applicable	Not Applicable	0.0%

For Policies where Premium is paid by instalment, additional conditions as given below will be applicable.

- When yearly payment option is chosen, cancellation grid as per 1-Year Tenure policies will be applicable
- For all other options, 50% of current instalment premium will be refunded when the current period is less than 6 months in to the policy year. For instalment after 6 months, no refund will be payable.
- In case of admissible claim under the Policy, future

instalments for the current policy year will be adjusted in the claim amount and no refund of any premium will be applicable during policy year

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the Insured Person under the Policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

8. Premium Payment in Instalments

If the Insured Person has opted for Payment of Premium on an installment basis i.e. Yearly, Half Yearly, Quarterly or Monthly, as mentioned in the Policy Schedule, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy)

xv. Grace Period as mentioned in the table below would be given to pay the installment premium due for the Policy.

Options	Installment Premium Option	Grace Period applicable
Option 1	Yearly	30 days
Option 2	Half Yearly	30 days
Option 3	Quarterly	30 days
Option 4	Monthly	15 days

i. During such Grace Period, coverage will not be available from the due date of installment premium till the date of receipt of premium by Company.

ii. The Insured Person will get the accrued continuity benefit in respect of the "Waiting Periods", "Specific Waiting Periods" in the event of payment of premium within the stipulated Grace Period.

iii. No interest will be charged If the installment premium is not paid on due date.

iv. In case of installment premium due not received within the Grace Period, the Policy will get cancelled.

v. In the event of a claim, all subsequent premium installments shall immediately become due and payable.

vi. The Company has the right to recover and deduct all the pending installments from the claim amount due under the policy.

Instalment Premium payment through Auto Debit/ECS Facility

xiii. If Option of Premium payment by Installment is opted through auto Debit/ECS facility, a separate authorization form shall be submitted by Insured Person where Premium to be debited at a chosen frequency will be mentioned upfront

xiv. Where there is a change either in the terms and conditions of the Coverage or Policy or in the premium rate, the ECS authorization shall be obtained afresh

xv. The Insured Person has the option to withdraw from the ECS mode at least fifteen days prior to the due date of instalment premium payable

xvi. No additional charges will be levied or recovered in any manner from the benefits payable towards cancellation of the ECS mode

11. Possibility of Revision of terms of the Policy including the Premium Rates

The Company, with prior approval of IRDAI, may revise or modify the terms of the Policy including the premium rates. The Insured Person shall be notified three months before the changes are effected.

12. Withdrawal of Policy

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Insured Person about the same 90 days prior to expiry of the policy.

ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as Cumulative Bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

13. Nomination:

The Policyholder is required at the inception of the Policy to make a nomination for the purpose of payment of claims under the Policy in the event of death of the Policyholder. Any change of nomination shall be communicated to the Company in writing and such change shall be effective only when an endorsement on the Policy is made. In the event of death of the Policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate/Endorsement (if any)} and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated as full and final discharge of its liability under the Policy.

9. Non-Disclosure or Misrepresentation

i. If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person, is found to be incorrect, incomplete, suppressed or not disclosed, wilfully or otherwise, the Policy shall be:

a) cancelled ab initio from the inception date or the Renewal date (as the case may be), or the Policy may be modified by Us at Our sole discretion, upon 15-day notice by sending an endorsement to Your address shown in the Schedule and

b) the claim under such Policy if any, shall be prejudiced.

ii. We may also exercise any of the below listed options for the purpose of continuing the health insurance coverage in case of Non-Disclosure/Misrepresentation of Pre-existing diseases subject to your prior consent;

d) Permanently exclude the disease/condition and continue with the Policy

e) Incorporate additional waiting period of not exceeding 4 years for the said undisclosed disease or condition from the date the non-disclosed condition was detected and continue with the Policy.

f) Levy underwriting loading from the first year of issuance of policy or renewal, whichever is later.

The above options will not prejudice the rights of the Company to invoke cancellation under clause i above.

10. Geography

Section B-6 – Personal Accident

This Policy provides coverage Worldwide, except under the covers specifically mentioning as covered in India only under the terms and conditions.

11. Loadings

I. We may apply loading on the premium, based on the declarations made in the proposal form and the health status, habits and lifestyle, past medical records, and the results of the Pre-Policy medical examination of the persons proposed for insurance.

II. The maximum Medical Underwriting loading shall not exceed 100% for each condition and a total of 150% for each Insured Person

III. Loadings will be applied from Commencement date of the Policy including subsequent Renewal(s) with Us or on increased Sum Insured. We will not apply any additional loading on Your policy premium at Renewal based on claim experience in Your Policy. However, increase or decrease of discount in Medical Underwriting loading is subject to terms mentioned under Section B.III. 3 – Health Incentives

IV. We will inform You about the proposed loading with time bound exclusion (if any) through a counter offer letter and will issue the Policy only on Your acceptance within 15 days of the receipt of such counter offer letter. In case, you neither accept the counter offer nor revert to Us within 15 days, We shall cancel Your application and refund the premium paid within next 7 days.

12. Renewal of Policy:

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

xi. The Company shall endeavour to give notice for Renewal. However, the Company is not under obligation to give any notice for Renewal.

xii. Renewal shall not be denied on the ground that the Insured Person had made a claim or claims in the preceding policy years.

xiii. Request for Renewal along with requisite premium shall be received by the Company before the end of the policy period.

xiv. At the end of the policy period, the Policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without Break in Policy. Coverage is not available during the Grace Period.

xv. No loading shall apply on renewals based on individual claims experience.

E.ii. Specific Terms

1. Grace Period

i. A Grace Period of 30 days is available for Renewal of the Policy. Any Illness, disease or condition contracted during Grace Periodwill not be covered and will be treated as Pre-existing diseases.

ii. Policies for which Premium is received after the Grace Period shall be issued as a fresh policy.

iii. For Policies on instalment basis, Grace Period is available as given below.

Installment Premium Option	Grace Period applicable
Yearly	30 days
Half Yearly	30 days
Quarterly	30 days
Monthly	15 days

2. Endorsements

The following endorsements are permissible during the Policy Period:

Non-Financial Endorsements – which do not affect the premium

i. Minor rectification/correction in name of the Proposer / Insured Person (and not the complete name change)

ii. Rectification in gender of the Insured Person

iii. Rectification in relationship of the Insured Person with the Proposer

iv. Rectification of date of birth of the Insured Person (if this does not impact the premium)

v. Change in the correspondence address of the Proposer(if this does not impact the premium)

vi. Change in Nominee Details

vii. Change in Height, weight, marital status (if this does not impact the premium)

viii. Change in bank details

ix. Any other non-financial endorsement

Financial Endorsements – which result in alteration in premium

i. Change in Age/date of birth

ii. Change in Height, weight

iii. Addition of Insured Person (New Born Baby or newly wedded spouse)

iv. Deletion of Insured Person on death or Marital separation

v. Any other financial endorsement

The Policyholder shall apply in a proposal form along with birth Certificate / marriage certificate as the case may be for addition of Insured person.

3. Disclaimer applicable to **HDFC ERGO Mobile App** and associated services

It is agreed and understood that Our my:health mobile app and

Wellness services intention is not to provide specific medical advice but rather to provide users with information to better understand their health and their diagnosed disorders. The information is not a substitute for professional medical care by a qualified doctor or other health care professional.

The information provided is general in nature and is not specific to you. You must never rely on any information obtained using this app for any medical diagnosis or recommendation for medical treatment or as an alternative to medical advice from your physician or other professional healthcare provider. If you think you may be suffering from any medical condition you should seek immediate medical attention.

Reliance on any information on this App is solely at your own risk. **HDFC EGRO General Insurance Company Limited** do not assume any liability towards any loss or damage arising out of or in relation to any opinion, actual or alleged errors, omissions and representations, any decision made or action taken or not taken in reliance upon the information.

Any Benefit/Indemnity payable by the Company, if any, in case of Your loss of life is payable as defined in the Policy Schedule by default to the assignee declared by You; indemnity is payable to Your estate. Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of the payment.

4. Communication & Notice

Policy and any communication related to the Policy shall be sent to through electronic modes or to the address of the Insured as recorded in the Policy.

5. Any Benefit/Indemnity payable by the Company, if any, in case of Your loss of life is payable as defined in the Policy Schedule by default to the assignee declared by You; indemnity is payable to Your estate. Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of the payment.

F. General Conditions Applicable for Section B-6: Travel Insurance

1) This Policy shall be governed by the laws of India and, except as otherwise provided in Section 4(8) of this Policy, the Indian courts alone shall have jurisdiction in any dispute arising hereunder.

2) This Policy shall be voidable in the event of misrepresentation, mis-description or non-disclosure by any or on behalf of the Insured Person of any material particular.

3) **Insured Persons** shall take all reasonable precautions to prevent Accidents and to avoid Sickness and shall comply with all statutory requirements, as a condition precedent to the Company's liability hereunder.

4) Where the Insured Person is required in Terms of this Policy to perform any act or comply with any obligation timely performance or compliance shall be a condition precedent to the Company's liability hereunder.

5) Insurance in respect of an Insured Person will begin under this Policy on the first Day of the Insured Journey (except the Trip Cancellation and Frequent Flyer Cancellation Sections) after the date all of the following are true:

a) this Policy is in force;

b) the Insured Person is eligible to be insured;

c) the required premium has been paid to the Company; and

d) the Company has approved the Insured Person's proposal for this insurance.

6) This Policy may be cancelled at the request of the Policyholder by thirty (30)Days notice given in writing to the Company and the premium paid shall be adjusted on the basis of the Company retaining a minimum of Rs 251(two fifty one only). Refund of premium on cancellation will be made under the Policy subject to no claims being paid or admitted by the Company.

The Company reserves the right to cancel this Policy at any time by sending thirty (30) days notice in writing to the Insured. In the event of such cancellation refund of premium shall be on pro-rata basis.

The Company also reserves the right to cancel this Policy from inception immediately upon becoming aware of any mis-representation, fraud, non-disclosure of material facts or non-cooperation by or on behalf of the Insured. No refund of premium shall be allowed in such cases.

Notice of cancellation will be mailed to the Insured at an address set forth in the Policy Schedule, and will indicate the date of termination. If notice of cancellation is mailed, proof of mailing will be sufficient proof of notice.

7) Insurance in respect of an Insured Person shall immediately terminate on the earliest of the following dates:

a) the date that the Policy is terminated,

b) the date that the Total Sum Insured is paid for covered loss under Section 6 (Accidental Death), Section 7 (Permanent Disablement) of the Policy;

c) in respect of Immediate Family, the date that such person ceases to be the Insured Person's Immediate Family Member; or

d) the date when the actual number of travel days exceeds the Total Number of Travel Days mentioned under Item 6 of the Schedule.

8) The Policyholder and **Insured Person** understand that if a proposal has been completed for this insurance, then all statements and all particulars provided in such proposal, and any attachments thereto, are material to the Company's decision to provide this insurance. The Policyholder and Insured Person further understand that the Company has issued this Policy in reliance upon the truth of such statements and particulars.

Fraud warning:

Any person who, knowingly and with intent to defraud the company or other person, files a proposal for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which will render the policy voidable at the company's sole discretion and result in a denial of insurance benefits.

if a claim is in any respect fraudulent, or if any fraudulent or false plan, specification, estimate, deed, book, account entry, voucher, invoice or other document, proof or explanation is

produced, or if any fraudulent means or devices are used by the insured person, policyholder, beneficiary, claimant or by anyone acting on their behalf to obtain any benefit under this policy, or if any false statutory declaration is made or used in support thereof, or if loss is occasioned by or through the procurement or with the knowledge or connivance of the insured person, policyholder, beneficiary, claimant or other person, then all benefits under this policy are forfeited.

9) The titles of the various paragraphs of this Policy and any endorsements attached to this Policy are inserted solely for convenience of reference and do not limit or affect in any way the provisions to which they relate.

10) The Policyholder shown in Item 1 of the Schedule is responsible for the collection and remittance of all premiums. Premiums are due on or prior to the Policy effective Date shown in Item 2 of the Schedule and, in the case of a multiyear Policy, on or before the annual anniversary of such Policy Effective Date. Timely payment of all premium due in full is a condition precedent to the Company's liability under this Policy.

11) Notices: Notices to the Company under this Policy shall be given in writing to the address shown in the preamble of this Policy. Such notices shall be effective on the date of receipt by the Company at such address.

12) Valuation and Foreign Currency: All premiums, benefit amounts, loss, and other amounts under this Policy are expressed and payable in Indian currency. If judgement is rendered, settlement is denominated or any benefit, Sum Insured or element of loss is stated in a currency other than Indian Rupees, then payment under this Policy shall be made in Indian Rupees at the rate of exchange published by the Reserve Bank of India on the date the final judgement is entered, the amount of settlement is agreed upon or any benefit, Sum Insured or element of loss is due, respectively.

INTERNATIONAL SOS ASSISTANCE COMPANY

International SOS operates a twenty-four (24) hour, seven (7) Days a week, toll-free emergency telephone assistance service. To access the emergency assistance services while travelling, please call one of the following emergency telephone numbers:

Telephone numbers:

Land line: 011-41898872

Fax: 011-41898801

Email: hdfcergo@internationalsos.com

Toll Free No. 1866 202 4700 (For USA Only)

In the event of a travel-related emergency, International SOS will provide the following assistance services:

1) Pre-Departure Services

a) **Banking Facilities:** - information on currencies, banking procedures and bank hours in the country of destination.

b) **Car rental Agency Referral & Limousine Arrangements** - a referral to car rental companies in foreign countries.

c) **Destination Information** - general information on the destination, normally via fax.

d) **Foreign Exchange Information Services** - information concerning exchange rates of major foreign currencies.

e) **Hotel Accommodation Referral** - the names, addresses, contact numbers of hotels in major foreign cities world-wide.

f) **Inoculation Information Services** - information concerning inoculation requirements for foreign countries.

g) **Travel Advisory Services** - information concerning foreign ministry health and security advisories and circulars.

h) **Visa Information Service** - information concerning Visa requirements for foreign countries.

i) **Weather Information Services** - weather forecasts and temperatures of foreign countries.

2) Travel Assistance Services

a) **Arrangement of a Bail Bond** – the arrangement of a bail bond in the event that an Insured Person has been arrested following a car Accident. The Assistance Provider will only arrange the financial guarantee if payment has been secured through an Insured Person's credit card or personal assets.

b) **Arranging an Emergency Cash Advance**: assistance and will handle liaisons with banks to arrange a cash advance (s) to the Insured Person, subject to suitable guarantees.

c) **Arranging for Replacement of Lost Passports** - assistance in contacting with consular authorities in case of the loss or theft of an Insured Person's passport, and arranging its replacement.

d) **Arranging for Replacement of Lost Travel Documents** – assistance in replacing travel documents or tickets in the event of a theft or loss or emergency.

e) **Car Rental** – arrangement of a rented car in the event of an emergency. Payment is for the account of the Insured Person.

f) **Claims Assistance** - details to an Insured Person on how to correctly file a claim to the Company.

g) **Embassy Referral-** the address, contact numbers, and office hours for appropriate embassies and consulates in an emergency.

h) **Emergency Travel Services** – assistance in new travel arrangements and reservations in the event of pre-departure cancellation or interruption, curtailment or delay during the trip, or following a Hospital stay of the Insured Person.

i) **Interpreter Referral** - the name, address, contact numbers and office hours for interpreters world-wide.

j) **Interpreting Assistance** - an interpretation service over the telephone.

k) **Legal Referral** - the name, address, contact numbers, and office hours of lawyers or legal practitioners where and when necessary.

l) **Lost Luggage Assistance** – assistance for an Insured Person who has lost his or her luggage while travelling by contacting the appropriate authorities involved and advising the Insured Person who they should contact to recover their lost luggage.

m) **Lost Travel Documents / Credit Card Assistance** - directions on reporting the loss and requesting replacement in the event an Insured Person loses a travel

document or credit card whilst abroad.

n) **Restaurant Referral** – a referral to restaurants in major foreign cities.

o) **Secretarial Services & Business Centres Referral** - wherever possible, a referral to secretarial services and business centres world-wide.

3) Emergency Medical and Related Services

a) **Medical Advice Over the Phone** - medical advice over the telephone.

b) **Medical Service Provider Referral** - information regarding Physicians, Hospitals, Clinics, Dentists when and where the Insured Person needs treatment.

c) **Arrangement of Doctors Appointments** – assistance in arranging appointments for an Insured Person with medical service providers if necessary.

d) **Replacement of Essential Medicine** - arrangement for the replacement of essential medicines, subject to local regulations.

e) **Arrangement of Hospital Admission** – arrangements for Hospital admission when the medical condition of the Insured Person requires such action.

f) **Guarantee of Medical Expenses Incurred During a Hospital stay** – a guarantee for the medical treatment necessary during an Insured Person's Hospital stay. The guarantees will only be arranged if the Assistance Provider has secured payment through an Insured Person's credit card or through the Insured Person's assets or the insurance Policy.

g) **Monitoring of Medical Condition during a Hospital stay** – Constant monitoring of the Insured Person's medical condition with the attending Physician if an Insured Person is hospitalised.

h) **Emergency Message Transmission** – a messenger service to transmit messages or medical information, upon the Insured Person's request and consent, to the Insured Person's family, friends and / or business associates following a medical emergency.

i) **Arranging Emergency Medical Evacuation** – arrangement of air / surface transportation, medical care during transportation, communications and all usual ancillary services when moving an Insured Person to the nearest Hospital where appropriate treatment can be received.

j) **Arrangement of Medical Repatriation** – arrangement of air / surface transportation, necessary medical care during transportation, communications and all usual ancillary services when moving an Insured Person to his/her country of residence following an emergency medical evacuation for subsequent in-Hospital treatment.

k) **Arrangement of Repatriation of Mortal Remains** - the transportation of the Insured Person's mortal remains from the place of death to his /her home country or arrange for local burial at the place of death.

l) **Arrangement of Compassionate Visit** - the return airfare for an Immediate Family Member of the Insured Person to visit the Insured Person when outside their normal country of residence.

m) **Arrangement of Return of a Dependent Child** - a one-way airfare for the return of a Dependent Child to his or her home country, if such Dependent Child is left unattended due to an Insured Person being hospitalised or expecting to be hospitalised for more than five (5) Days.

n) **Arrangement of Hotel Accommodation** - hotel arrangements for a visiting family member or a Replacement Business Colleague if an Insured Person is hospitalised or is expected to be hospitalised for five (5) or more Days.

Specific Conditions

The decision on the most appropriate means and timing belongs to The Assistance Provider.

G. General Conditions Applicable for Section B-7:**HDFC ERGO Bharat Griha Raksha**

G.i. Standard GENERAL CONDITIONS

1. Renewal of Policy

a. **End of Policy**: This Policy will expire at the end of the Policy Period.

b. **Renewal** is not automatic, We may seek relevant information from You for the purpose of renewal. We can reject Your renewal only on grounds of mis- representation, non-disclosure of material facts, fraud or non-co-operation on Your part.

c. **Application for renewal:** If You wish to renew the Policy, You must apply for renewal before the end of the Policy Period and pay the required premium amount.

(II) Cancellation and Termination of Policy

- **Cancellation by You at any Time**

a. You can cancel this Policy at any time by giving Us notice in writing. The Policy will terminate when We receive Your notice.

b. If You cancel the policy, We will refund premium as follows:

i. If the Policy is cancelled, the premium would be returned to You calculated in accordance with the short period rate table as mentioned below, provided there is no claim under this Policy during the Period of Insurance.

For period not exceeding	Rate to be charged
15 days	10% of the Annual rate
1 month	15% of the Annual rate
2 months	30% of the Annual rate
3 months	40% of the Annual rate
4 months	50% of the Annual rate
5 months	60% of the Annual rate
6 months	70% of the Annual rate
7 months	75% of the Annual rate
8 months	80% of the Annual rate
9 months	85% of the Annual rate
> 9 months	The full Annual rate

ii. In case of Policies having tenure more than 1-year, a Short

Period scale for retention of premium as given in above table will be applied to the premium for the current / active Policy Year in which Cancellation is requested. The Premium corresponding to all Future unearned policy years would be refunded in full.

• Cancellation by Us:

a. We will not cancel the Policy during the policy period except on the grounds of mis-representation, non-disclosure of material facts, fraud or non-co- operation on Your part.

b. In case of Total Loss of Your Home Building in a long term policy where You have decided not to reinstate Your Home Building in favour of a cash settlement of Your claim, We will cancel the policy for the remaining duration of the policy period. In such a case We shall refund the proportionate premium for the un-expired policy years after grossing up the premium paid by You towards long term discount, if any.

• Automatic termination of the Policy

This Policy will automatically end in the following cases:

a. Destruction of Your Home Building: This Policy will automatically end 7 (seven) days after Your Home Building collapses or is destroyed by reason other than any Insured Event. If a separable part of Your Home Building or any additional structure falls down or is destroyed by reason other than any Insured Event, the covers will end for such part or additional structure.

You can apply within 7 (seven) days of such fall or destruction for continuing insurance cover. We may agree, but will not be bound, to continue the cover on the same rates, terms and conditions.

b. Exhaustion of Sum Insured: If Your Home Building, or any additional structure, or any item of Home Contents, is lost, destroyed or stolen, or is a Total Loss, and We pay You the full Sum Insured for such item, the insurance cover for that item will automatically end unless the subject matter of insurance is reconstructed and the Sum Insured is reinstated by paying additional premium. If We pay the total Sum Insured for any claim, this Policy will end.

c. Change of use of Your Home Building or Home Contents: The Policy will end

i. if You change the use of Your Home Building from personal residence to any other purpose, or

ii. if You use any item of Home Contents for use that is not personal.

d. Sale of Your Home Building or Home Contents: This Policy will end when You sell, surrender or release Your interest in Your Home Building and/or Home Contents, or Your interest in the Home Building and/or Home Contents comes to an end. The Policy will end to the extent any additional structure of Your Home Building or item of Home Contents if You sell, surrender or release Your interest in such additional structure or item of Home Content, or Your interest in these ends.

e. Effect of death

In the event of the unfortunate death of the Insured during the Policy Period, the Home Building Cover and the Home Contents Cover that You have purchased will continue for the benefit of Your legal representative/s during the Policy Period subject to all the terms and conditions of this Policy.

H. General Conditions applicable for section B-8: E@Secure Insurance

1. Fraud

You must not act in a fraudulent manner. If You, or anyone acting for You:

- Make a claim under the Policy knowing the claim to be false or fraudulently inflated;
- Cause any loss or damage by Your willful act or with Your knowledge;
- Send Us a document to support a claim knowing the document to be forged or false in anyway; or
- Make a statement to support a claim knowing the statement to be false in anyway,

We will not pay the claim and all cover under the Policy will be forfeited and would render the policy void at Our sole discretion and which would result in denial of insurance benefits under this policy. We also reserve the right to recover from You the amount of any claim We have already paid under the Policy.

2. Cancellation

This policy will terminate at the expiration of the period for which premium has been paid or on the expiration date shown in the policy Schedule.

You may cancel this Policy at any time by sending fifteen (15) days notice in writing to Us or by returning the Policy and stating when thereafter cancellation is to take effect. In the event of such cancellation we will retain the premium for the period that this Policy has been in force and calculated in accordance with the short period rate table, provided there is no claim under this Policy during the Period of Insurance.

We reserve the right to cancel this Policy from inception immediately upon becoming aware of any mis-representation, mis-declaration, fraud, non-disclosure of material facts or non-cooperation by You or on Your behalf. No refund of premium shall be allowed in such cases.

Notice of cancellation will be mailed to You at Your address set forth in the Policy Schedule, and will indicate the date on which coverage is terminated. If notice of cancellation is mailed, proof of mailing will be sufficient proof of notice.

In case of any claim under this Policy or any of its individual coverage no refund of premium shall be allowed.

Table of Short Period Scales	
Period of Risk (Not exceeding)	Annual Premium Rate (%)
1 month	15% of the Annual rate
2 months	30% of the Annual rate
3 months	40% of the Annual rate
4 months	50% of the Annual rate
5 months	60% of the Annual rate

6 months	70% of the Annual rate
7 months	75% of the Annual rate
8 months	80% of the Annual rate
9 months	85% of the Annual rate
For a period exceeding 9 months	The full Annual rate.

3. Triggering Multiple Specified Event

Where one loss occurrence triggering multiple Specified Events, in such case Specified Events having highest sub limit will be payable.

4. Changes in Your circumstances

You must notify Us as soon as possible in writing of any change in Your circumstances which may affect this insurance cover. We will advise You if there is any additional premium payable by You.

5. Taking Reasonable Precautions

You must take due care and reasonable precautions to safeguard Your Personal Information, details of Your Bank Accounts and/or Credit/Debit Cards and internet communications. You should also take all practical measures to minimize claims. Such measures include but are not limited to not sharing sensitive account information, regular data backup, logins, PIN/TAN and Personal Information with Third Parties, securing physical access to devices, only installing legal software from trusted sources such as manufacturer app-stores and maintaining an updated and secure state of their software and operating systems as recommended by the manufacturer. You have to keep Yourselfinformed of further recommendations and alerts made from time to time by Us, Your Bank, Social Networks, other service providers or software manufacturers, as well as relevant authorities such as the police, CERT-IN and RBI."

6. Other Insurances

In the event of an incident which results in a claim under this Policy and You have other insurance covering the same loss, We will not pay more than Our share, subject to the maximum Limit of Cover granted under this Policy.

7. Subrogation

We shall at any time be entitled to take proceedings in Your name (at Our expense) to recover, for Our benefit, the amount of any payment made by Us under this Policy and in which case, You must cooperate fully with Us in this respect and must not do anything to prejudice Our rights.

8. Arbitration

Any and all disputes concerning the interpretation or difference of the terms, exclusions or conditions contained herein is understood and agreed to by both the parties are subject to Indian law.

If any difference arises as to the amount to be paid under this Policy (liability being otherwise admitted) or the interpretation of a clause under this Policy (including the Schedule and Endorsements), such difference shall be referred to arbitration, in accordance with the [Indian] Arbitration and Conciliation Act 1996, as amended, and the making of an award shall be a condition precedent to any liability for Us to make any payment under this Policy. Such arbitration panel shall consist of one arbitrator selected by You, one arbitrator selected by Us, and a third independent arbitrator selected by the first two arbitrators in accordance with the provisions of the [Indian] Arbitration and Conciliation Act, 1996 (as amended). The arbitration shall be governed by Indian Law and the venue of arbitration shall be within India.

(i) All proceedings in any arbitration shall be conducted in English and a daily transcript in English of such proceedings shall be prepared.

(ii) The cost of arbitration undertaken in accordance with this section shall be borne by the parties associated with the arbitration and shall share equally in the costs of the arbitration proceedings and presiding arbitrator.

(iii) It is clearly agreed and understood that no reference to arbitration can be made if We have either not admitted or have disputed liability in respect of any claim under or in respect of this Policy.

(iv) In the event that these arbitration provisions shall be held to be invalid then all such disputes or differences shall be referred to the exclusive jurisdiction of the Indian Courts.

It is further expressly agreed and declared that if We shall disclaim liability in respect of any claim and is not within 12 calendar months from the date of such disclaimer be made the subject matter of a suit or proceeding before a Court of law or any other forum, it shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

9. Indian Contract Act 1872

A person or any entity who is not a party to this Policy shall have no rights under the Contracts (Rights of Third Parties) Act 2001 or any similar act, common law or any provision of law in any other jurisdiction to enforce any of its terms.

10. Premium Payment

It is hereby agreed that, as a condition precedent to any liability under this Policy, any premium due must be paid and actually realised by Us in full. In the event of non-realisation of the premium, the Policy shall be treated as void-ab-initio

11. Clerical Error

A clerical error by Us shall not invalidate the insurance cover otherwise validly in force, nor continue the insurance cover otherwise not validly in force.

12. Governing Law

This Policy shall be governed by the laws of India.

13. Assignment

No assignment of interest under this Policy shall be binding upon Us. Wedo not assume any responsibility for the validity of an assignment.

14. Sanctions/Embargoes

We shall not be deemed to provide cover and provide any benefit hereunder to the extent that the provision of such cover, payment of such loss or claim or provision of such benefit would expose Us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions,

law or regulations of the European Union, United States of America and/or any other applicable national economic or trade sanction law or regulations.

15. Territorial scope

Where legally permissible by the law of this policy and the jurisdiction in which the payment is to be made and subject to all terms and conditions of this policy, this policy shall apply to any Loss incurred or claims made in India, unless otherwise stated in the schedule.

16. Jurisdiction

Subject to the provisions of Clause 9, this policy is subject to the exclusive jurisdiction of the Courts of India.

17. The Proposal Form

In issuing this policy, We have relied on the statements and particulars in the proposal form which shall form the basis of this policy and are considered as being incorporated therein. You shall not conceal or misrepresent or wrongfully declare any material fact or circumstance when making any representation.

18. No Third party Rights

Notwithstanding what is stated in any Law, this policy is not intended to confer any rights or benefits on and or enforceable by any Third Party other than You and accordingly no Third Party shall acquire any rights in relation to or under this policy nor can enforce any benefits or claim under term of this contract against You.

19. Policy Renewal

We shall be under no obligation to renew the policy on expiry of the period for which premium has been paid. We reserves the right to offer revised rates, terms and conditions at renewal based on claim experience and a fresh assessment of the risk. This policy may be renewed only by mutual consent and subject to payment in advance of the total premium at the rate in force at the time of renewal. We, however, shall not be bound to give notice that the policy is due for renewal or to accept any renewal premium. Unless renewed as herein provided, this policy shall automatically terminate at the expiry of the Period of Insurance.

Section E. Claims Procedure

Applicable for Section B-1: my: Health Suraksha

Procedure	Cashless Hospitalization		Cashless claims for Hospitalizations outside India	Reimbursement Claims	Home Healthcare Claims
	Emergencies	Planned			
Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website				
Claim Intimation Timelines	Within 24 hours of the Emergency Hospitalization	At least 72 hours prior to the planned Hospitalization	Within 24 hours of the Emergency Hospitalization At least 72 hours prior to the planned Hospitalization	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier	Immediately on diagnosis of Illness
Particulars to be provided to Us for Claim notification	i. The health card issued by Us ii. KYC documents iii. The Policy Number iv. Name of the Policyholder v. Name and address of Insured Person in respect of whom the request is being made vi. Nature of the Illness/Injury and the treatment/Surgery required vii. Name and address of the attending Medical Practitioner viii. Hospital where treatment/Surgery is proposed to be taken or /Hospital where the Insured person is admitted ix. Proposed /Actual Date of admission				Following particulars in addition to those listed under Hospitalization Claim: i.Treatment details ii.Preferred date and time for initial assessment
Particulars to be provided for pre-authorization	i. Policy Number ii. Name of the Insured person(s) named in the Policy schedule availing treatment iii. Nature of disease/Illness/Injury iv. Name and address of the attending Medical Practitioner/Hospital v. Date of admission & probable date of discharge vi. Approximate Claim Expenses vii. Any other relevant information as required			Not Applicable	Following particulars in addition to those listed under Hospitalization Claim: Probable date of start of treatment

Process for obtaining Pre-Authorization	i. If the particulars are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation ii. On receipt of duly filled pre authorization form from the Network Provider along with other sufficient details to assess the request, We may; • Issue the authorization letter specifying the sanctioned amount any specific limitation on the claim and non-payable items, if applicable or • Reject the request for pre-authorization specifying reasons for the rejection.	i. We shall send Release of Information form to the Insured Person for signature and consent. ii. After receiving the signed Release Of Information form, We will retrieve hospitalization documents along with invoices iii. If these details are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation iv. On receipt of the complete documents We may • issue the guarantee of payment specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable or or • reject the request for pre-authorization specifying reasons for the rejection		On receipt of duly filled pre authorization form with other sufficient details to assess the request, We will inform our Home Healthcare service provider who will follow the following process: i. Meet the treating medical practitioner and verify the requirement along with the prescription/ discharge summary (if applicable) and the condition of the patient ii. Verify the past medical history of the patient iii. Complete physical examination of the patient iv. Check if the patient requires any equipment, devices etc v. Share the care plan and treatment cost estimation with Us. i. On receipt of the complete documents We may; • issue the authorization letter specifying the sanctioned amount, any specific limitation on the claim and non-payable items, if applicable or • reject the request for pre-authorization under Home Healthcare specifying reasons for the rejection. On rejection of Pre-Authorization under Home Healthcare, Claim procedure under Cashless treatment or Reimbursement may be followed.
List of Claim documents	Not Applicable		As enlisted below	Not Applicable

List of Documents for Reimbursement Claims:

i. Duly signed, stamped and completed Claim Form

ii. Photo ID & Age Proof

iii. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents

iv. Copy of the Network Provider's Registration Certificate / Hospital registration no in case of Hospitalization

v. Original Discharge Card / Day Care Summary / Transfer Summary

vi. Original final Hospital Bill with all original deposit and final payment receipt

vii. Original invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.

viii. All previous consultation papers indicating history and treatment details for current Illness

ix. All original diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre

x. All original medicine / pharmacy bills along with prescription by Medical Practitioner

xi. MLC / FIR Copy – in Accidental cases only

xii. Copy of Death Summary and copy of Death Certificate (in death claims only)

xiii. Pre and Post-Operative Imaging reports

xiv. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress

xv. Original invoice for Vaccination and payment receipt

xvi. KYC documents

Conditions for obtaining Cashless facility:

i. Cashless facility can be availed only at Our **Network Provider**. The complete list of **Network Providers** and empanelled Service Providers is available on Our website and can be obtained by contacting Us.

ii. We reserve the right to modify, add or restrict any **Network Provider** for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check the updated list of **Network Providers** before applying for Cashless Claim.

iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital and locations match with the details as per Cashless authorized.

iv. We will make payment for the Cashless authorized amount directly to the **Network Provider**.

v. If the claim is not notified to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

Applicable for Section B-2 my: health Critical Suraksha Plus

On the occurrence of any Critical Illness or undergoing Surgical Procedure that may give rise to a Claim under this Policy, the Procedure set out below shall be followed.

Procedure	Cashless Hospitalization
Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website
Claim Intimation Timelines	Within 14 days of the diagnosis of Critical Illness or undergoing Surgical Procedure
Particulars to be provided to Us for Claim notification	• Policy Number, • Name of the Insured Person(s) named in the Policy Schedule availing treatment, • Nature of disease/illness/injury, • Name and address of the attending Medical Practitioner/Hospital • Date of admission & probable date of discharge • Date and time of event if applicable • Date of admission if applicable
Claims documents for Critical Illnesses Cover and Multipay Critical Illness Cover	• Claim Form duly signed • Copy of Discharge Summary / Discharge Certificate; • First consultation letter from treating Medical Practitioner • Medical certificate confirming diagnosis, and the treatment from Medical Practitioner • certificate from treating Medical Practitioner, specifying the duration and etiology • OT Notes in case of Surgery • Medical certificate from treating Medical Practitioner specifying the diagnosis and need for the surgery • MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable • All pathological/Histopathological and radiological Investigation Reports • NEFT details & cancelled cheque Provide KYC (Know your customer) form along with photocopy of any one of following KYC documents for all claims amounting to Rs 1 lakh and above (Aadhaar Card, Passport, Driving Licence Voter ID, etc) We may require the Insured Person to undergo medical examination by Medical Practitioner authorized by Us to obtain an independent medical opinion for the processing of the claim. Any cost towards such medical examination will be borne by Us.

Claims documents and process for Second Expert medical Opinion	• Duly filled claim form along with the copy of all medical reports including investigation reports and discharge summary (if any)Consultation fees payment Receipt / invoice • For availing Second Expert medical Opinion from Network Service Provider • Select Our network Medical Practitioner from whom you would prefer to take the second opinion. (Please refer our Website or call at 24X 7 toll free line to obtain the list of Our panel doctors). • On receipt of the complete set of documents, We will forward the same to the concerned doctor. • The Second Opinion shall be forwarded to the member within 15 working days of receipt of the complete set of documents.
Claims documents for loss of Job	• Duly Completed Claim Form signed by Insured Person; • Form 16A • Termination letter/Resignation Letter/ Resignation Acceptance letter • NEFT details & cancelled cheque
Condonation of delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

Applicable for Section B-3 my:health Medisure Super Top Up Insurance

It is a condition precedent to Our liability that upon the discovery or happening of any illness/injury that may give rise to a claim under this Policy, You shall:-

Claim Notification

Give immediate notice to the Company/TPA named in this Policy/Health Card, by calling the Help Line number as specified in the Policy/Health Card, or in writing to the address shown in the Schedule with particulars as below:

- Policy Number,
- Name of the person(s) named in the Schedule to this Policy availing treatment,
- Nature of disease/illness/injury,
- Name and address of the attending Medical Practitioner/ Hospital
- Date of admission & probable date of discharge
- Approximate Claim Expenses
- Any other relevant information

Intimation of claim must be done at least 72 hours prior to Hospitalization in case of planned Hospitalization and within 24 hours of Hospitalization in case of an emergency Hospitalization.

In case where initial covered Medical expenses were not expected to exceed the deductible but subsequently found to be exceeding the opted deductible, notification must be done immediately along with the copy of intimation made to other Insurer.

2. Cashless Facility for Hospitalization

i) We may provide Cashless facility for Hospitalization expenses either directly or through the Third Party Administrator (TPA) if treatment is undergone at a Network Hospital by issue of pre-authorization by Us or the TPA.

ii) For the purpose of considering pre-authorization and Cashless facility, You shall submit to the TPA complete information of the illness or injury requiring treatment along with necessary certification from the Medical Practitioner and/or Hospital.

iii) If claim for treatment appears admissible, We or TPA shall issue pre-authorization to the Hospital concerned for Cashless facility whereby Hospitalization expenses shall be paid directly by Us directly or through the TPA as confirmed in the pre-authorization.

iv) Cashless facility for Hospitalization will not be available for treatment in Non-Network Hospital and may be declined even for treatment at Network Hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such a case, You shall bear the expenses and claim reimbursement, immediately after discharge from Hospital/ Nursing Home in accordance with the stipulations herein.

v) Cashless facility for Hospitalization benefit shall be limited exclusively to Hospitalization Expenses incurred for treatment at a Network Hospital for illness or injury which are covered under the Policy and shall be extended only for Coverage mentioned under Scope of cover(A)"Inpatient Hospitalization expenses" and Scope of cover (B) "Day care Procedures"

3. Claims Processing for Reimbursement

i) After intimation as aforesaid, further submit following documents to the TPA at Your own expense within 30 days of discharge from the Hospital, the following:-

- Claim Form Duly filled with requisite information and signed by Insured & Hospital
- Copy of the claim intimation
- Original Hospital Main Bill
- Original Hospital Bill break up (Where issued by the Hospital)
- Original Hospital Bill Payment Receipt
- Hospital Discharge Card/Summary
- Original Pharmacy Bill with supporting prescriptions
- Medical Investigation report: ECG/X-Ray/USG/CT/MRI/ Histopathology/pathological and all other medical investigation report in support of diagnosis as advised by the treating doctor.
- All Doctor's consultation note: confirming provisional & final diagnosis/advise for admission/medical complication/ proposed line of treatment/past medical history
- Original bills and receipts for claiming Ambulance charges(if any)

- By signing the claim form you are authorizing us to collect the following documents from the Hospital. If you have obtained these documents, then please submit the same
- Operation Theatre Notes in surgical cases
- Bar code sticker & Invoice for implants and prosthesis (if used)
- In case of Accidental Injuries, Medico Legal Certificate and/ or First information Report, where applicable and self statement giving description of the incident
- Indoor case papers

Pre and Post hospitalization Claims documents

- Duly filled claim form(s)(If claimed Separately)
- Pharmacy Bills with supporting prescriptions
- Medical investigation test reports and payment receipts with doctor's advice note for such investigations.
- All Doctor's consultation note with original bills and receipts for claiming Doctors fees,

ii) Documents pertaining to the Post-Hospitalization claim shall be submitted to the TPA within 15 days from the date of expiry of Post-Hospitalisation coverage period.

iii) At any time You may be required to authorize and permit the TPA and/or Us or anyone deputed by Us or TPA to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim.

iv) You should under go medical examination by Medical Practitioner designated by Us or the TPA and the cost of such medical examination will be borne by Us.

We may carry out verification/investigation on a case to case basis to ascertain the facts/collect additional information/ documents of the case to determine the assessment of loss. Verification carried out, if any, will be done by individuals or entities authorized by Us to carry out such verification/ investigation(s) and the costs for such verification/investigation shall be borne by Us.

For determining the amount of admissible claim, applicable taxes prevailing at the time of the claim will be considered as part of claim amount and Our aggregate liability, including any payment towards such Taxes shall in no case exceed the Sum Insured.

4.TPA to Pay or Reject

The TPA where appointed, shall process and communicate rejection, if a claim is found to be not admissible under this Policy as authorized by Us. However all decisions shall be Our responsibility.

5.Representation against Rejection

Where rejection is communicated, You, may if so desired, represent to Us within 15 days for reconsideration of the decision.

6.Condition Precedent

The terms and conditions of the Policy must be fulfilled by the Insured Person for the Company to make any payment for claim(s) arising under the Policy.

7. Claims Service Assurance

1) If You notify a cashless facility request by sending the pre-authorization form duly filled in and signed through email, fax to Us or Our representative, then within 6 hours of the actual receipt of such a request, We will respond with:

a) Approval, or

b) Rejection.

If such request has been notified during office hours (9am to 9 pm) on Monday to Saturday and We fail to either approve or reject or seek further information after the expiry of 6 hours from the actual receipt of the request then, We shall be liable to pay You for the delay in the following manner:

i) For delay beyond 6 hours: Rs.1,000/-

ii) The maximum amount that We shall be liable to pay to You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

If such request has been notified after office hours on a working day or at any time during a holiday and We fail to either approve or reject after the expiry of 8 hours from the actual receipt of the request, then We shall be liable to pay You for the delay in the following manner:

iii) For delay beyond 8 hours: Rs.1,000/-

iv) The maximum amount that We shall be liable to pay You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

2) In case of reimbursement claims, We shall communicate our decision on payment within 6 working days after You submit the complete details, information and document requirements in respect of the claim. If You have provided such information and documents as required by Us and We fail to communicate our decision, then We shall pay You Rs. 1,000/- for a delay beyond 6 days. The maximum amount that We shall be liable to pay You for any delay, in respect of a single Hospitalization, shall at no time exceed Rs.1,000/-.

3) We will not be liable to make any payments under Clauses 1 and 2 above in case of any natural event or manmade disturbance which impedes Our ability to make a decision or to communicate such decision to You.

4) Any amounts paid under this Clause will not affect the Sum Insured as specified in the Schedule. Our liability to make payments under this Clause shall at all times be restricted to the amounts specified in Clause 1 and 2 above including the maximum amount specified therein and You shall not be entitled to any sum whatsoever, in excess of those amounts. Any payment made under this Clause by Us will not amount to any admission of liability for a claim notified by You. Service Assurance is applicable only to the first response on a single claim and to no subsequent correspondence.

The above compensation shall be paid to You notwithstanding Our obligation to pay interestat a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by the Company in cases of delay in settlement of claims, as per Reg. 9(6) of IRDA (Protection of PolicyHolder's Interests) Regulations 2002

8. Claim Settlement (Provision for Penal Interest)

xi. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which We will send a closure letter or make a part-payment if We have not received the deficiency documents after 45 days from the date of the initial request for such documents

xii. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

xiii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the Policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the Bank Rate.

xiv. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

xv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the Policyholder at a rate 2% above the Bank Rate from the date of receipt of last necessary document to the date of payment of claim.

xvi. If We, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to You in writing within 30 days of the receipt of documents.

xvii. If requested by Us and at Ourcost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

xviii. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim

Applicable for Section B-4. my:health Hospital Cash Benefit Add on

On the occurrence of any Injury, Illness or that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed.

Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website
Claim Intimation Timelines	Within 24 hours of the Emergency Hospitalization At least 72 hours prior to the planned Hospitalization
Particulars to be provided to Us for Claim notification	a. Policy Number, b. Name of the Insured person(s) named in the Policy schedule availing treatment, c. Nature of disease/illness/injury, d. Name and address of the attending Medical Practitioner/Hospital e. Date of admission & probable date of discharge
Claims documents	a. Claim Form duly signed by the insured; b. Copy of Discharge Summary / Discharge Certificate; c. First consultation letter from treating Medical Practitioner d. certificate from treating Medical Practitioner's specifying the diagnosis, duration and aetiology e. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable f. NEFT details & cancelled cheque
Condonation of delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

Applicable for Section B-5. my:health Koti Suraksha

Section B – Personal Accident

1. Notification of a Claim

Procedure	Cashless Hospitalization	Cashless claims for Hospitalizations outside India	Reimbursement Claims
Claim Intimation	You shall intimate the Claims to us through any available mode of communication as specified in the Policy, Health Card or our Website		
Claim Intimation Timelines	Within 24 hours of the Hospitalization.	Within 24 hours of the Emergency Hospitalization.	Within 48 hours of admission or before discharge from the Hospital, whichever is earlier.
Particulars to be provided to us for claim notification	1. Duly completed and signed claim form 2. Policy/Certificate Copy 3. First Information Report and Final Police report, wherever is necessary 4. Any other supporting documents as may be required by the Company 5. Insured Person's own Indian bank cancelled cheque copy and bank details in attached format.		

Accidental Death	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Death certificate 4. Post mortem if conducted/FSL (Forensic science laboratory)report – To check for drug abuse/intoxication
Permanent Disablement	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury; 4. Disability certificate from a government certified Medical Practitioner or government Hospital confirming the extent and nature of disability; 5. Original Discharge summary from the Hospital Medical reports, case histories, investigation reports,treatmentpapers as applicable. 6. Letter from treating Medical Practitioner mentioning the reason and date for disablement and confirming the disablement.
Temporary Total Disablement	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury; 4. Original Discharge summary from the Hospital 5. Medical reports, case histories, investigation reports, treatment papers as applicable. 6. Letter from treating Medical Practitioner mentioning the reason and date for disablement and confirming the disablement. And advised days of rest. 7. Leave certificate from the employer (If Employed) 8. Fitness certificate from Medical practitioner 9. Insured's own Indian bank cancelled cheque copy and bank details in attached format
Hospital Cash- Accident Only	1. Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for Hospital cash benefit 2. First consultation letter from treating Medical Practitioner 3. Certificate from treating Medical Practitioner, specifying the duration and etiology 4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable 5. NEFT details & cancelled cheque of Claimant or Nominee (in case claimant expired), Provide legal heir certificate in case nominee is minor.
Broken Bones	1. Medical Practitioner's Report 2. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury; 3. Disability certificate from a government certified Medical Practitioner or government hospital confirming the extent and nature of disability; 4. Original Discharge summary from the hospital 5. Medical reports, case histories, investigation reports, treatment papers as applicable. 6. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable 7. Relevant treatment papers clearly mentioning the areas of fracture with their severity.
Burns	1. Attested copy of certificate from treating Medical Practitioner specifying type of burns with percentage of burns 2. Attested copy of FIR. (If any) 3. All X-Ray / Investigation reports and films supporting to disability.
Medical Evacuation	1. Consultation note or Emergency Room's Medical Practitioner medical report 2. Copy of the passport showing the date of entry and exit related to journey (to & fro) from India. 3. All relevant Original Invoices for the expenses incurred towards ambulance facility. 4. A covering letter from claimant mentioning the details of loss.
Emergency Medical Expenses	1. Consultation note or Emergency Room's Medical Practitioner medical report. 2. Relevant treatment papers or Discharge Summary. 3. Copy of the passport showing the date of entry and exit related to journey (to & fro) from India. 4. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable 5. All relevant Original Invoices for the expenses incurred.
Dependent Child Education Benefit	1. Consultation Note OR Emergency Room's Medical Practitioner medical report OR 2. Relevant Treatment Papers OR Discharge Summary. . 3. Letter from treating Medical Practitioner, mentioning the cause of death if death occurred after a long period from the date of incident. 4. Disability certificate from a government certified Medical Practitioner or government hospital confirming the extent and nature of disability; 5. Death certificate 6. Final police investigation report 7. Post-mortem Report or Coroner's Report 8. MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable.

Chauffeur Benefit	1. Medical Practitioner's Report 2. Medico Legal Certificate 3. Investigation Reports like Laboratory test, X-rays and reports essential of confirmation of the Injury; 4. Original Discharge summary from the Hospital 5. Medical reports, case histories, investigation reports, treatment papers as applicable. 6. Letter from treating Medical Practitioner mentioning the reason and date for disablement and confirming the disablement. 7. Original invocies of transport
Particulars to be provided for pre-authorization	1. Policy Number 2. Name of the Insured person(s) named in the Policy schedule availing treatment 3. Nature of disease/Illness/Injury 4. Name and address of the attending Medical Practitioner/Hospital 5. Date of admission & probable date of discharge 6. Approximate Claim Expenses
	Any other relevant information as required
Process for obtaining Pre-Authorization	i. If the particulars are not provided in full or are insufficient for Us to consider the request, We will request additional information or documentation ii. On receipt of duly filled pre authorization form from the Network Provider along with other sufficient details to assess the request, We may; Issue the authorization letter specifying the sanctioned amount any specific limitation on the claim and non-payable items, if applicable or Reject the request for pre-authorization specifying reasons for the rejection.
Condonation of Delay	If the claim is not notified/ or submitted to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

2. List of documents for Reimbursement Claims

i. Completely filled claim form, duly signed (by claimant/ proposer) and stamped (by hospital).

ii. Photo ID & Age Proof

iii. Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents

iv. Copy of the Hospital's Registration Certificate/Hospital Registration number in case of hospitalization in any non-network hospital of **HDFC ERGO GIC** or certificate from hospital authorities providing facilities available including number of beds.

v. Original Discharge Card / Day Care Summary / Transfer Summary

vi. Original final hospital bill with all original deposit and final payment receipt and refund receipt(s), if advance amount refunded

vii. Original invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.

viii. All previous consultation papers indicating history and treatment details for current Illness and advice for current hospitalization.

ix. All original diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre

x. All original medicine / pharmacy bills along with prescription by Medical Practitioner

xi. MLC / FIR Copy – in Accidental cases only

xii. History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases.

xiii. Copy of Death Summary and copy of Death Certificate (in death claims only)

xiv. Pre and Post-Operative Imaging reports

xv. Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer).

xvi. Original invoice for Vaccination and payment receipt

xvii. KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Proposer carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Proposer.

xviii. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)

xix. Settlement letter(s), copy(-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer.

*** In case of death of proposer, the same document reuqirement would be for nominee/legal heir of proposer(NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remanining legal heir(s).

3. Conditions for obtaining Cashless facility

i. Cashless facility can be availed only at Our Network Provider. The complete list of Network Providers and empanelled Service Providers is available on Our website and can be obtained by contacting Us.

ii. We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities at Our sole discretion. The same shall be duly updated on Our website. You shall check

the updated list of Network Providers before applying for Cashless Claim.

iii. Pre-authorization is valid for 15 days from date of issuance and if all the details of the Hospitalization/treatment, including dates, Hospital and locations match with the details as per Cashless authorized.

iv. We will make payment for the Cashless authorized amount directly to the Network Provider.

v. If the claim is not notified to Us within the specified time limits, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control

4. Payment of a Claim

i. If there are any deficiencies in the necessary claim documents which are not met or are partially met, We will send a maximum of 3 (three) reminders following which We will send a closure letter or make a part-payment if We have not received the deficiency documents after 45 days from the date of the initial request for such documents

ii. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per policy terms and conditions, We shall offer within a period of 30 days a settlement of the claim to the insured.

iii. However, where the circumstances of a claim warrant an investigation, We will initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, We will settle the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay in payment of Claim beyond stipulated period, the Company will be liable to pay interest at a rate which is 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

v. If We, for any reason decide to reject the claim the reasons regarding the rejection shall be communicated to You in writing within 30 days of the receipt of documents.

vi. If requested by Us, at Our cost, the Insured Person must submit to medical examination by Our Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the medical and Hospitalization records pertaining to the Insured Person's treatment and to investigate the circumstances pertaining to the claim.

vii. We and Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of the claim.

Claims Procedure Applicable for Section B-6: Travel Insurance

1) Written notice of any occurrence which may give rise to a claim under this Policy must be given to the Company as soon as practicable and in any case within thirty (30) Days after such occurrence. Written Notice of Claim must be given to the Company immediately in the case of death, or within thirty (30) Days after the Date of Loss in all other cases.

2) All certificates, information and evidence required by the Company shall be furnished at no expense to the Company and shall be in such form and of such nature as the Company may prescribe. When required by the Company, at its own expense, the Insured Person shall submit to medical examination in respect of any alleged claim that may give rise to a benefit being paid.

3) Complete, written proof of loss must be given to the Company within sixty (60) Days after the Date of Loss, or as soon as reasonably possible. Such proof of loss must contain:

I. the Policy Number, and

II. the preliminary medical report describing the nature and extent of all injuries or Sicknesses, and providing a precise diagnosis, and

III. all invoices, bills, prescriptions, Hospital certificates which will permit the Company to accurately determine the total amount of Medical Expenses (if applicable) incurred by the Insured Person, and

IV. in the case where another party was involved (e.g. a car collision), the names, contact details and if possible insurance details of the other party, and

V. in the case of death, an official death certificate, succession certificate pursuant to the Indian Succession Act 1925, as amended, and any other legal documents establishing the identity of any and all beneficiaries, and

VI. proof of age, where applicable, and

VII. such other information as the Company may require to handle the claim.

a) If an Accident:

I. detailed circumstances of the Accident and the names of any witnesses, and

II. any police reports concerning the Accident, and

III. the date a Physician was seen due to the Bodily Injury, and

IV. the Physician's contact details, or

b) If a Sickness:

I. the date symptoms of the Sickness began, and

II. the date a Physician was seen due to the Sickness, and

III. the Physician's contact details.

The Company shall base its assessment of the claim on the complete, written proof of loss.

4) The Company at its own expense shall have the right and opportunity to examine the Insured Person whose Bodily Injury or Sickness is the basis of a claim and as often as it may be reasonably required during the pendancy of the claim and to make an autopsy in case of death, where it is not forbidden by law.

5) In respect of any disablement claim, no benefit shall be payable before any disablement is recognised as definitive and permanent by a Physician appointed by the Company.

6) Medical advice of a Physician shall be sought and followed promptly on the occurrence of any Bodily Injury or Sickness and the Company shall not be liable for any part of any claim which in the opinion of a Physician appointed by the Company arises from the unreasonable or willful neglect or failure of an Insured Person to seek and remain under

the care of a Physician.

7) No claim may be brought under this Policy, nor may any legal action be brought against the Company to recover under such claim:

a) in cases of Accidental death, more than three (3) years after the date of death or the date the claim is denied in whole or in part, whichever is later; or

b) in all other cases, more than three (3) years after the Date of Loss or date the claim is denied in whole or in part, whichever is later.

No such legal action may be brought against the Company unless there has been full compliance with all the terms and conditions of this Policy. In the event of any failure to timely submit any claim or commence legal action with respect to any claim, all benefits under this Policy in respect of such claim shall be forfeited.

8) If any difference shall arise as to the amount to be paid under this Policy (liability being otherwise admitted) such difference shall be referred to arbitration in accordance with the Indian Arbitration and Conciliation Act 1996, as amended, and the making of an award shall be a condition precedent to any liability for the Company to make any payment under this Policy.

9) The Company will effect payment of covered claims subject to: i) the Company having received complete, written proof of loss and such other information as the Company may require to handle the claim; and ii) the premium for the Policy having been paid. In such cases, the Company shall effect payment within 7days.

10) No benefit shall be payable in respect of an Insured Person under more than one of the following insurances: Accidental death or Accidental disablement.

11) No sum payable under this Policy shall carry interest.

12) Where amounts recoverable from the Company are delayed pending finalisation of any claim, payments on account may be made to the Insured Person at the Company's discretion, on receipt by the Company of certification by a Physician appointed by the Company.

13) An Insured Person has the right to designate a beneficiary. All beneficiary designations shall be in writing, filed with the Policyholder, and provided to the Company at the time of claim and such other time as the Company may require.

The Insured Person, and no one else, unless there is an irrevocable assignment, has the right to change the beneficiary. The Insured Person does not need the consent of anyone to do so. Changes must be in writing, filed with the Policyholder and provided to the Company at the time of claim and such other time as the Company may require. The Company does not assume any responsibility for the validity of these changes.

The Insured Person's rights under this Policy may be assigned by giving the Company prior written notice. The assignment may be made irrevocable. However, the Company will only recognize an assignment if the Insured Person has given the Company prior written notice and has the Company's written acknowledgement of the assignment. The Company does not assume any responsibility for the validity of an assignment.

Benefit shall be payable only to the Insured Person, his or her Beneficiary, or the Insured Person's legal personal representatives or assignee if applicable, whose receipt shall effectively discharge the Company.

14) In the event of a claim under this Policy, the Policyholder, the Insured Person and the Beneficiary, if applicable, must fully cooperate with the Company in its handling of the claim including, but not limited to, the timely submission of all medical and other reports, and full Cupertino with all physical examinations and autopsies that the Company may require.

15) The Company shall not be bound or be affected by any notice of any trust, charge, lien, or other dealing with or in relation to this Policy.

Claims Procedure Applicable for Section B-7: HDFC ERGO Bharat Griha Raksha

a. If You suffer a loss because of an Insured Event, You must make a claim for Your financial loss at Your cost. The procedure for making a claim is given below. These include things that You must do, and that You must not do. It is important to comply with these to ensure that it does not prejudice Your claim in any manner.

1. Immediate notice to Us

a. As soon as any physical loss or damage occurs to Your Home Building or Home Contents due to an Insured Event, You must immediately give notice to Us of the loss or damage. This is necessary for Us to survey/ investigate the loss or damage, as may be required.

b. You can give notice to any of Our offices or call-centres.

c. You must state in this notice

i. the Policy Number,

ii. Your name,

iii. details of report to the police that You made,

iv. details of report to any Authority that You made,

v. details of the Insured Event,

vi. a brief statement of the loss,

vii. particulars of any other insurance of Your Home Building or any of Your Home Contents,

viii. details of loss or damage under any Optional Cover or Add-ons,

ix. submit photographs of loss or physical damage, wherever possible.

2. Steps to prevent loss and damage

a. You must take all reasonable steps to prevent further loss or damage to Your Home Building and Home Contents.

b. Until We have inspected Your Home Building and Home Contents, and have given Our consent,

i. You must not sell, give away or dispose of any damaged items of any property for which You are making a claim;

ii. You must not wash or clean, or remove any damaged item or debris, except for any urgent necessity;

iii. You must not carry out repairs, unless such repairs are urgent and You cannot contact Us.

3. Immediate notice to Authorities

a. As soon as any loss or damage occurs to the Insured Property, You must give immediate report to appropriate legal authorities. For example, You must report to the fire brigade of the local authority and the police if there is damage by fire/ explosion / implosion or lightning. In case of subsidence /landslide/rockslide, You must inform the District Administration. In the event of impact damage of any kind or Riot Strikes, Malicious damages and acts of terrorism, You must inform the police. If there is a theft within 7 (seven) days following an Insured Event You must inform the police.

b. We may, but not necessarily, waive this condition if We are satisfied that by reason of extreme hardship it was not possible for You or any other person on Your behalf to give such report.

4. Submit Claim

a. Claim form:

i. You must submit Your claim in Our claim form at the earliest opportunity, but within 30 days from the date You first notice the loss or damage. The claim form is available in any of Our branches, and on Our web-site.

ii. You must state in Your claim the details of any other insurance policy that covers the damage or loss for which You have filed Your claim, whether You have purchased such other insurance, or someone else has purchased it for You.

b. We shall not be liable for any loss or damage after the expiry of 12 months from the happening of the loss or damage unless the claim is the subject of pending action or arbitration. If We disclaim liability for a claim You have made and if the claim is not made a subject matter of a suit in a court of law within a period of 12 months from the date of disclaimer, the claim shall not be recoverable hereunder.

5. Establish loss

a. You must prove that the Insured Event has occurred, and the extent of physical loss or damage You have suffered with full details.

b. When We request,

i. You must support Your claim for Home Building and/ or Home Contents with plans, specification books, vouchers, invoices pertaining to costs incurred by You for reconstruction/replacement/repairs.

ii. You must allow Us, Our officers, surveyors or representatives to inspect the loss or damage to Your Home Building and/ or Home Contents and to take measurements, samples, damaged items or parts, and photographs that are relevant.

iii. You must give Us authority to see the relevant records and get information about the Event and Your loss from the police or any other authority.

c. For Optional Cover of Personal Accident, Death Certificate and Post Mortem report (wherever necessary) shall be submitted.

6. Fraudulent claim

If You, or anyone on Your behalf, make a false or fraudulent claim, or support a claim with any false or fraudulent statement or documents:

i. We will not pay,

ii. We can cancel the Policy: in such a case, You will lose all benefits under this Policy and premium that You have paid, and

iii. We can also inform the police, and start legal proceedings against You.

7. Other insurance

a. If You have any other policy with Us or any other Insurance Company (taken by You or by anyone else for You) covering in whole or in part any claim that You have made under this Policy, You have a right to ask for settlement of Your claim under any of these policies.

b. If You choose to claim under this Policy from Us, We will settle Your claim within the limits and the terms and conditions of this Policy.

c. After We pay the amount under Your claim, We have the right to ask for contribution from the Insurers that have given You the other policies.

d. We will ensure that Our actions do not impose any liability on You.

8. Recovery action by Us

a. When We accept and pay Your claim under the Policy, We can start legal proceedings to recover the amount or property from the third party who has caused the loss or damage to Your Home Building or Home Contents. You must give authority to Us to take such action and exercise this right effectively, when We request You, whether before or after making payment of Your claim. You must give all information, cooperation, assistance and help for this purpose. You must not do anything which will prejudice Our right. We can do this

i. without seeking Your consent,

ii. in Your name, and

iii. whether or not Your loss has been fully compensated.

b. Any amount We recover from such person will be applied first to the costs of the legal proceedings and recovery, then to the claim amount We have paid or must pay to You. We will pay You any balance.

c. You can start legal proceedings against any person who has caused the loss or damage only with Our prior consent, and on conditions that We will impose. You must not compromise or settle any claim against such person without Our consent. If You recover any amount from such person, You must return to Us the amount We have paid for Your claim. We can take over the conduct of legal proceedings that You have started and continue the proceedings in Your name.

Claims Procedure applicable for Section B-8: E@Secure Insurance

I. In the event of a claim, and to report a claim upon discovery of an occurrence of a Specified Event, You must give written notice to Us along with duly filled claim form at the address mentioned in the Policy Schedule with full details thereof, within 7days after such claim is first made. Such notice shall be effective on the date of receipt by Us at such address.

a. It is the duty of the Insured to defend Claims and arrange for legal representation , hearing , investigation and experts. We shall have the right to effectively associate with You in respect of conduct and management of the Claim to which Policy may apply, and may, at Our option, elect to assume conduct of Your defense and /or investigation of any such claim.

b. The payment of claims is dependent on You providing all necessary information. Upon learning of any circumstances likely to give rise to a claim, You must provide all relevant documents including receipts, bills and other records in support of Your claim.

c. You must make no admission or settlement and must not enter into any correspondence or exchange of communications about the claim without Our prior written authorization.

d. All claims are paid in Indian Rupee. If You suffer a loss which is in a foreign currency, the amount will be converted into Indian Rupee at cash rate of exchange published in the currency conversion website, of Reserve Bank of India or, if it has ceased to be current, a currency conversion website selected by Us, on the date of the loss.

II. On receipt of all required information/documents that can be considered relevant and necessary for the claim, We shall, with in a period of 30 days offer a settlement of the claim to You. If, for any reasons to be recorded in writing and communicated to You, We decide to reject a claim under the policy, it shall be within a period of 30 days from the receipt of all required information/documents that are relevant and necessary for the claim.

III. In the event the claim is not settled within 30 days as stipulated above, We shall be liable to pay interest at a rate, which is 2% above the Bank Rate from the date of receipt of last relevant and necessary document from You by Us till the date of actual payment.

All benefits are only payable when approved by Us.

* Note – We may condone delay in claim intimation/ document submission on merit, where it is proved that delay in reporting of claim or submission of claim documents, is due to reasons beyond the control of the Insured.

Notwithstanding the above, delay in claim intimation or submission of claim documents due to reasons beyond the control of the Insured shall not be condoned where such claims would have otherwise been rejected even if reported in time.

In the event of a claim, and to report a claim upon discovery of an occurrence of a Specified Event, You must give Us such information and co-operation as it may reasonably require including but not limited to:

(a) Submission of fully completed and signed claim form

(b) Copy of FIR lodged with Police Authorities / Cyber cell

(c) Copies of legal notice received from any affected person/ entity

(d) Copies of summon received from any court in respect of a suit filed by an affected party/entity

(e) Copies of invoices for expenses You incurred for the services of IT specialist

(f) Copies of invoices for expenses You incurred in amending / rectifying Your Personal Information

(g) Evidence of Your consultation with Psychologist / Psychiatrist

(h) Evidence of unpaid wages

(i) Copy of Your last drawn monthly salary.

(j) Evidence of expenses incurred by You in rectifying records regarding your identity

(k) Copies of correspondence with bank evidencing that bank is not reimbursing You

Contact Us

	within India	**Outside India**
Contacts us at	Customer Service No : 022-62346234 / 0120-62346234 Phone (UAN) :1860 2000 700 (Local charges applicable) Fax (UAN) : 1860 2000 600 (Local charges applicable) Email:healthclaims@hdfcergo.com	Toll Free No: 800 08250825 Global Toll Free No : +800 08250825 (accessible from locations outside India only) Landline no (Chargeable) : 0120-4507250 Email: travelclaims@hdfcergo.com
Claim document submission at address	HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower-1 5th Floor, C - 25, Sector 62 Noida – 0120 398 8360	

Grievance Redressal Procedure

In case of any grievance the insured person may contact the company through:

- Website: www.hdfcergo.com
- Toll free: 022 6234 6234 / 0120 6234 6234
- Contact Details for Senior Citizen: 022 6234 6234 / 0120 6234 6234

- E-mail: care@hdfcergo.com

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, Insured Person may contact the grievance officer at cgo@hdfcergo.com

For updated details of grievance officer, kindly refer the link:

https://www.hdfcergo.com/customer-voice/grievances

Contact Points	First Contact Point	Escalation level 1	Escalation level 2
Contacts us at	https://www.hdfcergo.com/customer-care/grievances Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 1 Call - : 022 6234 6234 / 0120 6234 6234	https://www.hdfcergo.com/customer-care/grievances/escalation level 2 Call - : 022 6234 6234 / 0120 6234 6234
Contact Point for Senior Citizen	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com	https://www.hdfcergo.com/customer-care/grievances Call - : 022 – 6242 – 6226 Email - seniorcitizen@hdfcergo.com
Write to us at	care@hdfcergo.com	grievance@hdfcergo.com	cgo@hdfcergo.com
	Grievance cell of any of our Branch office	The Grievance Cell, HDFC ERGO General Insurance Company Ltd 6ht Floor, Leela Business Park, AndheriKurla Road, Andheri , Mumbai – 400059	The Compliance Officer, Registered & Corporate Office: HDFC House, 1st Floor, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400020

i. If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

ii. Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/

List of Ombudsman

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory, District**
AHMEDABAD - Shri Kuldip Singh Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor, Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06 Email: bimalokpal.ahmedabad@cioins.co.in	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
BENGALURU Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N-19, Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in	Karnataka.
BHOPAL Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462 003. Tel.: 0755 - 2769201 / 2769202 | Fax: 0755 - 2769203 Email: bimalokpal.bhopal@cioins.co.in	Madhya Pradesh Chattisgarh

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory, District**
BHUBANESHWAR - Shri Suresh Chandra Panda Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009. Tel.: 0674 - 2596461 /2596455 Fax: 0674 - 2596429 Email: bimalokpal.bhubaneswar@cioins.co.in	Orissa.
CHANDIGARH Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468 Fax: 0172 - 2708274 Email: bimalokpal.chandigarh@cioins.co.in	States of Punjab, Haryana (excluding 4 districts viz Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir, Ladakh and Chandigarh.
CHENNAI Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453, Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284 Fax: 044 - 24333664 Email: bimalokpal.chennai@cioins.co.in	Tamil Nadu, Puducherry Town and Karaikal (which are part of Puducherry).
DELHI - Shri Sudhir Krishna Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504 Email: bimalokpal.delhi@cioins.co.in	Delhi, 4 Districts of Haryana viz. Gurugram, Faridabad, Sonepat and Bahudurgarh
GUWAHATI Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2632204 / 2602205 Email: bimalokpal.guwahati@cioins.co.in	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
HYDERABAD Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 23312122 Fax: 040 - 23376599 Email: bimalokpal.hyderabad@cioins.co.in	State of Andhra Pradesh, Telangana and Yanam - a part of Union Territory of Puducherry.
JAIPUR Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in	Rajasthan.
ERNAKULAM - Ms. Poonam Bodra Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road, Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in	Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry

NAMES OF OMBUDSMAN AND ADDRESSES OF OMBUDSMAN CENTRES	
Office Details	**Jurisdiction of Office Union Territory, District**
KOLKATA - Shri P. K. Rath Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in	States of West Bengal, Sikkim and Union Territories of Andaman & Nicobar Islands.
LUCKNOW -Shri Justice Anil Kumar Srivastava Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 Email: bimalokpal.lucknow@cioins.co.in	Districts of Uttar Pradesh : Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
MUMBAI Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 69038821/23/24/25/26/27/28/28/29/30/31 Fax: 022 - 26106052 Email: bimalokpal.mumbai@cioins.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA - Shri Chandra Shekhar Prasad Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120 - 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
PATNA - Shri N. K. Singh Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952 Email: bimalokpal.patna@cioins.co.in	Bihar, Jharkhand.
PUNE - Shri Vinay Sah Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune – 411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

IRDA REGULATION NO 12: This Policy is subject to regulation 12 of IRDA (Protection of Policyholder's Interests) Regulation 2017.

Annexure I - List of Non-Medical Expenses

S. No.	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT'S DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES

S. No.	Item
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (TOILETRIES ARE NOT PAYABLE, ONLY PRESCRIBED MEDICAL PHARMACEUTICALS PAYABLE)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY