Shri Health Suraksha Insurance Prospectus
UIN: SGLHLIP26035V032627

SHRIRAM
General Insurance
BE INSURED...REST ASSURED
associated with Sanlam group

A. What is Covered?

1. Hospitalization

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for,

i. Room Rent, Boarding, Nursing Expenses all inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.5000/-, per day.
ii. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.10,000/-, per day.
iii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees provided they form part of and included in the Hospital Bill
iv. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Other Expenses

i. Expenses incurred on treatment of cataract subject to the sub limits.
ii. Dental treatment, necessitated due to an injury.
iii. Plastic surgery necessitated due to injury.
iv. All day care treatment
v. Expenses incurred for road ambulance subject to a maximum of 2000/- per hospitalization

Note:

1. Expenses of Hospitalization for a minimum period of 24 consecutive hours only shall be admissible. However, the time limit shall not apply in respect of Day Care Treatment
2. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges.

2. AYUSH Treatment

The Company shall indemnify Medical Expenses incurred for Inpatient Care treatment under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems of medicines during each policy year up to the limit of sum insured as specified in the policy schedule in any AYUSH hospital.

3. Cataract Treatment

The Company shall indemnify Medical Expenses incurred for treatment of Cataract, subject to a limit of 25% of Sum Insured or Rs.40,000/-, whichever is lower, per eye, under one policy year.

4. Pre-Hospitalization

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 30 days prior to the date of admissible Hospitalization covered under the Policy.

5. Post Hospitalization

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days from the date of discharge from the Hospital, towards Consultant fees, Diagnostic charges, Medicines and Drugs wherever required and recommended by the Hospital/ Medical Practitioner, where the treatment was taken, following an admissible Hospitalization covered under the Policy.

6. Following procedure will be covered (wherever medically indicated) either as in patient or as part of the day care treatment in a hospital up to 50% of sum insured, specified the schedule, during the policy period.

a. Uterine Artery Embolization and HIFU (High Intensity Focused Ultrasound)
b. Balloon Sinuplasty
c. Deep Brain Stimulation
d. Oral Chemotherapy
e. Immunotherapy – (Monoclonal Antibody to be given as injection)
f. Intravitreal Injection

g. Robotic Surgeries
h. Stereotactic radio surgeries.
i. Bronchial thermoplasty
j. Vaporization of Prostate (Green laser treatment or holmium laser treatment)
k. IONM- (Intra Operative Neuro Monitoring)
l. Stem Cell Therapy: Hematopoietic stem cell for bone marrow transplant for hematological conditions to covered.

7. Cumulative Bonus (CB)

Cumulative Bonus will be increased by 5% in respect of each claim free policy year (no claims are reported), provided the policy is continuously renewed with the company without a break subject to maximum of 50% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However sum insured will be maintained and will not be reduced in the policy year.

Notes:

i. In case where the policy is on individual basis, the CB shall be added and available individually to the insured person if no claim has been reported CB shall reduce only in case of claim from the same Insured Person.

ii. In case where the policy is on floater basis, the CB shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family. CB shall reduce in case claim from any of the insured Persons.

iii. CB shall be available only if the Policy is renewed/ premium paid within the Grace Period.

iv. If the Insured Persons in the expiring policy are covered on an individual basis as specified in the Policy Schedule and there is an accumulated CB for such Insured Person under the expiring policy, and such expiring policy has been Renewed on a floater policy basis as specified in the Policy Schedule then the CB to be carried forward for credit in such Renewed Policy shall be the one that is to the lowest among all the insured Persons.

v. In case of floater policies where Insured Persons Renew their expiring policy by splitting the Sum Insured in to two or more floater policies/individual policies or in cases where the policy is split due to the child attaining the age of 25 years, the CB of the expiring policy shall be apportioned to such Renewed Policies in the proportion of the Sum Insured of each Renewed policy.

vi. If the Sum Insured has been reduced at the time of Renewal, the applicable CB shall be reduced in the same proportion to the Sum Insured in current Policy.

vii. If the Sum Insured under the Policy has been increased at the time of Renewal the CB shall be calculated on the Sum Insured of the last completed Policy Year.

viii. If claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded CB shall be withdrawn.

ix. If there has been no claim on your expiring policy, you have the option to choose between the Cumulative Bonus or a Renewal Discount at the time of renewal.

The renewal discount in lieu of the cumulative bonus.
The discount in premium is 2% for first 5 claim free renewal and 1% for next 5 claim free renewal.
This discount is offered against a choice of increase in Sum Insured of 5% per annum.
The maximum renewal discount is 15%. In case of a claim, the renewal discount reverts back to the same rate.

B. Eligibility for Policy

Policy can be availed by persons **age of 18 years or above,** as Proposer. Proposer with higher age can obtain policy for family, without covering self.
Policy can be availed for Self and the following family members
a. Legally wedded Spouse
b. Parents and Parents-in-law
c. Dependent children i.e. (natural or legally adopted) between the age of 3 month to 25 years If the child above 18 years is financially independent, he or she shall be ineligible for coverage in the subsequent renewals

C. Sum Insured Available

Sum insured: ₹ 50,000 to 10,00,000 in multiple of 50,000, 15L, 20L, 25L, 50L, 1Cr.

D. Policy Available

Individual as well as Family Floater Basis.

E. Policy Period

1 , 2 and 3 Year

F. What is not Covered?

The Company shall not be liable to make any payment under the policy in connection with or in respect of following expenses till the expiry of waiting period mentioned below:

1. Pre-Existing Diseases (Code- Excl 01)

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 us.
b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent 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 us.

2. First Thirty Days Waiting Period (Code- Excl03)

i. 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.
ii. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
iii. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

3. Specific Waiting Period: (Code- Excl02)

a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24/36 months of continuous coverage after the date of inception of the first policy with the Insurer. 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.

i. 24 Months Waiting Period:

1. Benign ENT disorders
2. Tonsillectomy
3. Adenoidectomy
4. Mastoidectomy
5. Tympanoplasty
6. Hysterectomy

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7. All internal and external benign tumors, cysts, polyps of any kind, including benign breast lumps
8. Benign prostate hypertrophy
9. Cataract and age related eye ailments
10. Gastric/ Duodenal Ulcer
11. Gout and Rheumatism
12. Hernia of all types
13. Hydrocele
14. Non Infective Arthritis
15. Piles, Fissures and Fistula in anus
16. Pilonidal sinus, Sinusitis and related disorders
17. Prolapse inter Vertebral Disc and Spinal Diseases unless arising from accident
18. Calculi in urinary system, Gall Bladder and Bile duct, excluding malignancy.
19. Varicose Veins and Varicose Ulcers
20. Internal Congenital Anomalies
21. Derangement of Knee / Ligament or Tendon, unless due to an accident event within the Policy Period

ii. 36 Months waiting period

1. Treatment for joint replacement unless arising from accident.
2. Age-related Osteoarthritis & Osteoporosis

4. Investigation & Evaluation (Code- Excl04)

a) Expenses related to any admission primarily for diagnostics 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.

5. Rest Cure, rehabilitation and respite care (Code- Excl05)

a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
   i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
   ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

6. Obesity/ Weight Control (Code- Excl06)

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:
1) Surgery to be conducted is upon the advice of the Doctor
2) The surgery/Procedure conducted should be supported by clinical protocols
3) The member has to be 18 years of age or older and
4) Body Mass Index (BMI);
   a) greater than or equal to 40 or
   b) 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:
      i. Obesity-related cardiomyopathy
      ii. Coronary heart disease
      iii. Severe Sleep Apnea
      iv. Uncontrolled Type2 Diabetes

7. 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.

8. 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.

9. **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.

10. **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.

11. **Excluded Providers: (Code-Excl11)**

    Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

12. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code-Excl12)**
13. Treatments received in heath 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)**
14. 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)**
15. **Refractive Error: (Code- Excl15)**

    Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

16. **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.

17. **Birth control, Sterility and Infertility: (Code- Excl17)**
    Expenses related to Birth Control, sterility and infertility. This includes:

    (i) Any type of contraception, sterilization
    (ii) Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
    (iii) Gestational Surrogacy
    (iv) Reversal of sterilization

18. **Maternity Expenses (Code: Excl 18)**
    (i) Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
    (ii) Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

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19. **War** (whether declared or not) and war like occurrence or invasion, acts of forcing enemies hostilities, civil war, rebellion, revolutions, insurrection, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

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

    a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
    b. 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
    c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any illness, incapacitating disablement or death.

21. Any expenses incurred on Domiciliary Hospitalization and Outpatient treatment (OPD treatment)

22. Treatment taken outside the geographical limits of India.

23. In respect of the existing diseases, disclosed by the insured and mentioned in the policy schedule (based on insured's consent). Policy holder is not entitled to get the coverage for specified ICD codes.

24. The expenses that are not covered in the policy are placed under the List -I,II,III and IV of Annexure I.

G. Moratorium Period

After completion of sixty continuous months of coverage (including portability and migration) in health insurance policy, no policy and claim shall be contestable by the company on grounds of non-disclosure, misrepresentation, except on grounds of established fraud. This period of sixty continuous months is called as moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limits.

H. Claim Procedure

1. Procedure for Cashless claims:

i. Treatment may be taken in a network provider and is subject to pre-authorization by the Company or its authorized TPA.
ii. Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization.
iii. The Company TPA upon getting cashless request form and related medical information from the insured person network provider will issue pre-authorization letter to the hospital after verification.
iv. At the time of disclosure, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.
v. The Company TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details.
vi. In case of denial of cashless access the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company/TPA for reimbursement.

2. Procedure for reimbursement of claims

For reimbursement of claims the insured person may submit the necessary documents to TPA applicable)/Company within the prescribed time limit as specified hereunder.

Sl. No.	Type of Claims	Prescribed time Limit

1.	Reimbursement of hospitalization, day care and pre-hospitalization expenses	Within 15 days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within the 15 days from of post hospitalization treatments

I. Notification of Claim

Notice with full particulars shall be sent to the Company /TPA (if applicable) as under

i. Within24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

J. Claim Documents

The claim is to be supported with the following original documents and submitted within the prescribed time limit.

i. Duly completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bill with itemized break up
v. Payment receipt
vi. Discharge summery including complete medical history of the patient along with other details
vii. Investigation/Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases)
ix. Sticker/invoice of the implant, wherever applicable.
x. MLR (Medico Legal Report copy if carried out and FIR (First information report in registered, wherever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address of the prophet, where claim liability above Rs 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate wherever applicable
xiv. Any other relevant document required by PARE

Note:

1. The company shall only accept bills/invoices/medical treatment related documents only in the Insure Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person.

- **Copayment**
  Each and every claim under the Policy shall be subject to a Copayment of 5% applicable to claim amount admissible and payable as per the terms and conditions of the Policy. The amount payable shall be after deduction of the copayment.

- **Claim Settlement (provision for Penal Interest)**

i. The Company shall settle or reject a claim, as may be the case, within 15 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 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 dated 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 Insurer shall be liable to pay interest at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

- **Services Offered by TPA**

Servicing of claims, i.e., claim admissions and assessments, under this Policy by way of pre-authorization of cashless treatment or processing of claims other than cashless claims or both, as per the underlying terms and conditions of the policy.

The services offered by a TPA shall not include

i. Claim settlement and claim rejection;

ii. Any services directly to any insured person or to any other person unless such service is in accordance with the terms and conditions of the Agreement entered into with the Company.

- **Payment of Claim**

All claims under the policy shall be payable in Indian currency and through NEFT/ RTGS only.

K. General Terms & Conditions

1. Disclosure of Information

The Policy shall be void and all premium paid thereon shell be forfeited to the company in the event of misrepresentation, mis-description, non-disclosure of material facts.

2. Condition Precedent to Admission of Liability

The due observance and fulfillment of the terms and conditions of the policy, by the insured person, shall be a condition precedent to any liability of the Company to make any payment under the policy.

3. Material Change

The Insured shall notify the Company in writing of any material change in the risk in relation to the declaration made in the proposal form or medical examination report at each Renewal and the Company may, adjust the scope of cover and / or premium, if necessary, accordingly.

4. Records to be Maintained

The Insured Person shall keep an accurate record containing all relevant medical records and shall allow the Company or its representatives to inspect such records. The Policyholder or Insured Person shall furnish such information as the Company may require for settlement of any claim under the Policy, within reasonable time limit and within the time limit specified in the Policy

5. Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Hospital/Nursing Home, as the case may be, for any benefit under the Policy shall in all cases be a full, valid and an effectual discharge towards payment of claims by the Company to the extent of that amount for the particular claim.

6. Notice & Communication

i. Any notice, direction, instruction or any other communication related to the Policy should be made in writing.

ii. Such communication shall be sent to the address of the Company specified in the Policy Schedule.

iii. The Company shall communicate to the Insured at the address mentioned in the schedule.

7. Territorial Limit

All medical treatment for the purpose of this insurance will have to be taken in India only.

8. Multiple Policies

a. In case of multiple policies taken by an insured during a period from the same or one or more insurers to indemnify treatment costs, the policyholder 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 if chosen by the policy holder 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.

b. Policyholder 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(s) shall settle the claim subject to the terms and conditions of this policy.

c. If the amount to be claimed exceeds the sum insured under a single policy after considering the co-pay, the policyholder shall have the right to choose insurers from whom he/she wants to claim the balance amount.

d. Where an insured has policies from more than one insurer to cover the same risk on indemnity basis, the insured shall only be indemnified the hospitalization costs in accordance with the terms and conditions of the chosen policy.

9. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement of 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 shall be forfeited.

Any amount already paid against claims which are found fraudulent later under this policy shall be repaid by all person(s) named in the policy schedule, who shall be jointly and severally liable for such repayment.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the Insured Person or by his agent, with intent to deceive the insurer or to induce the insurer to issue a 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 or 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 policy 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 mis-statement of or suppression of material fact are within the knowledge of the insurer Onus of disproving is upon the policyholder, if alive, or beneficiaries.

10. Cancellation

A. Cancellation by Insured/Policy Holder

The policyholder may cancel his/her policy at any time during the term, by giving 7 days notice in writing. The Company shall

a. refund proportionate premium for unexpired policy period, if the term of policy upto one year and there is no claim (s) made during the policy period
b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced.

B. Cancellation by Insurer

The Company may cancel the policy at any time on the grounds of mis-representation, non-disclosure of material facts, fraud by the insured person, by giving 7 days notice in writing. There would be no refund of premium on cancellation on grounds of mis-representation, non-disclosure of Material facts or fraud

11. Automatic change in Coverage under the policy

The coverage for the Insured Person shall automatically terminate:

1. In the case of his/ her (Insured Person) demise. However, the cover shall continue for the remaining Insured Persons till the end of Policy Period. The other Insured Persons may also apply to renew the Policy. In case, the Insured Person is minor, the Policy shall be renewed only through any one of his/her natural guardian or guardians appointed by Court. All relevant particulars in respect of such person (including his/her relationship with the Insured person) must be submitted to the Company along with the application. Provided no Claim has been made, and termination takes place on account of death of the Insured Person, pro-rata refund of premium of the deceased Insured Person for the balance period of the Policy will be effective.
2. Upon exhaustion of Sum insured and Cumulative Bonus, for the policy year. However, the policy is subject to renewal on the due date as per the applicable terms and conditions.

12. Territorial Jurisdiction

All disputes or differences under or in relation to the interpretation of the terms, conditions, validity, construct, limitations and/or exclusions contained in the Policy shall be determined by the Indian court and according to Indian law.

13. 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 policy at least 30 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.

14. 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 30 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.
- The existing insurer shall provide the information sought by the Acquiring insurer immediately but not more than 72 hours of receipt of request through Insurance Information Bureau of India (IIB) https://iib.gov.in/ portal.
- The Acquiring insurer shall decide and communicate on the proposal immediately but not more than 5 days of receipt of information from Existing insurer.
- The policyholder is entitled to transfer the credits gained to the extent of the Sum Insured, No Claim Bonus, specific waiting periods, waiting period for pre-existing disease, Moratorium period etc from the Existing Insurer to the Acquiring Insurer in the previous policy.
- Portability is not available under the benefit-based health insurance policy.

15. Renewal of Policy

i. The health insurance policy shall be renewable except on grounds of established fraud, or non-disclosure misrepresentation by the insured, provided the policy is not withdrawn and also subject to Moratorium clause.
ii. A Company shall not deny the renewal of a health insurance policy on the ground that the insured had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates following payment of the benefit covered under the policy like critical illness policy
iii. The Company shall condone a delay in renewal up to the grace period from the due date of renewal without considering such condonation as a break in policy
iv. For individual products, the loadings on renewal premium shall be at portfolio and not based upon any individual policy claim experience. However, discount in premium may be provided by Company to individual policyholders for good claims experience
v. Company shall not resort to fresh underwriting by calling for medical examination, fresh proposal form etc. at renewal stage where there is no change in sum insured offered. Provided that where there is an improvement in the risk profile, the company may endeavour to recognize that for removal of loadings at the point of renewal.
vi. The Company shall endeavor 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 15/30 days as per the due date of premium payment to maintain continuity of benefits without break in policy also.
x. If the premium is paid in instalments during the policy period, policy coverage will be available for the grace period
xi. No loading shall apply on renewals based on individual claims experience

16. Premium Payment in Installments

If the insured person has opted for Payment of Premium on an instalments basis i.e. Half Yearly, Quarterly or Monthly, as mentioned in Your Policy Schedule/Certificate of Insurance, the following Conditions shall apply (notwithstanding any terms contrary elsewhere in the Policy

a. Instalments shall be payable on or before the due date for continuity of coverage under the Policy.
b. You will have Grace Period of 15 days from the due date for payment of instalment for monthly mode and for other modes it is 30 days.
c. We will not charge interest on the instalment premium paid during the Grace Period
d. If the policy is renewed during grace period, all the credits (sum insured, No Claim Bonus, Specific Waiting periods, waiting periods for pre-existing diseases, Moratorium period etc.) accrued under the policy shall be protected.
e. In case We do not receive the premium within the Grace Period, the Policy will be terminated
f. In the event of a claim during the Grace Period, all the subsequent premium instalments shall immediately become due and payable.
g. We shall have the right to recover and deduct any or all the pending instalments from the claim amount due under the Policy.

If You are opting for Electronic Clearing Service for Instalment premium payment, then kindly ensure that:

a. Electronic Clearing Service (ECS) Mandate form is completely filled & signed by You.
b. The Premium amount which would be auto debited & frequency of instalment is duly filled in the ECS Mandate form.
c. New ECS Mandate Form is required to be filled in case of any change in the Premium due to change of Sum Insured / age / plan /coverages/revision in premium.
d. You need to inform us at least 15 days prior to the due date of instalment premium if You wish to discontinue with the ECS facility.

Non-payment of premium on due date as opted by You in the mandate form subject to an additional 15 days of Relaxation Period will lead to termination of the policy.

17. Possibility of Revision of Terms of the Policy Including the Premium Rates

The Company, with prior approval of competent authority, 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.

18. Free look period

At the time of inception of the policy, the Insured will be allowed a period of 30 days from the date of receipt of the policy to review the terms and conditions of the policy and to return the policy if not acceptable. In such a case, the premium refund shall be as follows:

If the Insured has not made any claim during the free look period, the Insured shall be entitled to –

a. A refund of the premium paid less any expenses incurred by the Insurer on medical examination of the insured persons and the stamp duty charges and any policy administrative charges or
b. Where the risk has already commenced and the option of return of the policy is exercised by the policy holder, a deduction towards the proportionate risk premium for period on cover or
c. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period.
d. Free look period shall not be applicable at the time of renewal.
e. This option is available if policy period is one year or more
f. Refund of free look cancellation will be provided within 7 days

19. Endorsement (Change in Policy)

This Policy constitutes the complete contract of insurance. This Policy cannot be modified by anyone (including an insurance agent or broker) except the company. Any change made by the company shall

i. be evidenced by a written endorsement signed and stamped.
ii. The policyholder may be changed only at the time of renewal. The new policyholder must be the legal heir immediate family member Such change would be subject to acceptance by the company and payment of premium (if any). The renewed Policy shall be treated as having been renewed without break. The policyholder may be changed during the Policy Period only in case of his/her demise him/her moving out of India.

20. Change of Sum Insured

Sum insured can be changed (increased/ decreased) only at the time of renewal, subject to underwriting by the Company. For any increase in SI, the waiting period shall start afresh for the incremental portion of the sum insured.

21. Terms and condition of the Policy

The terms and conditions contained herein and, in the Policy, Schedule shall be deemed to form part of the Policy and shall be read together as one document.

22. 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 For Claim settlement under reimbursement, the Company will pay the policyholder, In the event of death of the policyholder, the Company will pay the nominee (as named in the Policy Schedule/Policy Certificate/Endorsement of any) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the Policyholder whose discharge shall be treated full and final as of discharge its liability under Policy.

Nomination can be changed any time during the term of the policy.

OPTIONAL COVERS – VALUE PACK ADD-ON

The Covers listed below shall be available to the Insured Person only if the additional premium has been received by Us. The optional cover is applicable to an Insured Person only if it is specified in the Policy.

Covers under this Section are subject to the terms, conditions, waiting periods and exclusions of this Policy.

1. Pre and Post Hospitalization Medical Expenses.

Pre-Hospitalization

The Company shall indemnify Pre-Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 60 days prior to the date of admissible Hospitalization covered under the Policy.

Post Hospitalization

The Company shall indemnify Post Hospitalization Medical Expenses incurred, related to an admissible Hospitalization requiring Inpatient Care, for a fixed period of 90 days from the date of discharge from the Hospital, towards consultant fees, Diagnostic charges, Medicines and Drugs wherever required and recommended by the Hospital/ Medical Practitioner, where the treatment was taken, following an admissible Hospitalization covered under the Policy.

In case the insured or proposer has taken these coverages then the terms and conditions stated above shall be read as revised with respect to scope of cover/terms and conditions contains in part 4.4 and 4.5 respectively of the policy coverages and shall deem to be modified accordingly or superseded.

2. Room Capping

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for,

i. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home up to 2% of the sum insured subject to maximum of Rs.10000/-, per day.
ii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees provided they form part of and included in the Hospital Bill
iii. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Note –

- In case the insured or proposer has taken these coverages then the terms and conditions stated above shall be read as revised with respect to scope of cover/terms and conditions contains in part 4.1 of the policy coverages and shall deem to be modified accordingly or superseded.
- This cover is applicable above 2.5 lakhs of sum insured.

3. ICU Capping

The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for,

i. Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to 5% of the sum insured subject to maximum of Rs.20,000/-, per day.
ii. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees provided they form part of and included in the Hospital Bill
iii. Anesthesia, blood, oxygen, operation theatre charges, surgical appliances, medicines and drugs, costs towards diagnostics, diagnostic imaging modalities and such similar other expenses.

Note –

- In case the insured or proposer has taken these coverages then the terms and conditions stated above shall be read as revised with respect to scope of cover/terms and conditions contains in part 4.1 of the policy coverages and shall deem to be modified accordingly or superseded.
- This cover is applicable above 2.5 lakhs of sum insured.

4. Co-Pay Waiver

If this Add on is opted, then mandatory Copayment section 9.5 shall not be applicable on admissible claim under the base Policy other terms and conditions of the Add on are to be read in conjunction with the terms and conditions of the base Policy.

5. Single AC Room

If insured opt this cover, Section 4.1 (i) of policy wording "Hospitalization" shall be modified as below.
The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for

i. Room Rent, Boarding, Nursing Expenses all-inclusive as provided by the Hospital / Nursing Home up to Single AC Room available in hospital.

D.1 Definitions - Single AC room means an air-conditioned room in a Hospital where a single patient along with the attendant is accommodated and which has an attached toilet (lavatory & bath). Such room type shall be the most basic and the most economical of all accommodations available as a single room in that Hospital.
Note - You can opt either coverage 2 or 5

6. ICU No Limit

If insured opt this cover, Section 4.1 (ii) of policy wording "Hospitalization shall be modified as below.
The Company shall indemnify Medical Expense incurred for Hospitalization of the Insured Person during the Policy year, up to the Sum Insured and Cumulative Bonus specified in the Policy Schedule, for Intensive Care Unit (ICU) charges/ Intensive Cardiac Care Unit (ICCU) charges all-inclusive as provided by the Hospital / Nursing Home up to actual expenses subject to maximum of policy sum insured.
Note - You can opt either coverage 3 or 6

7. Restoration Benefit

In consideration of the payment of additional premium, the policy is extended to cover Restoration Benefit add-on.
Restoration benefit is an Add-on which can be endorsed along with the Base Plan only and cannot be bought in isolation or as a separate product. The Add-on shall be available only if it is specifically mentioned in Your Base Plan's policy schedule.

1. **What is cover**

Upon complete exhaustion of the Sum Insured and Cumulative Bonus during the Policy Year, The Company will restore Sum Insured unlimited times subject to maximum 100% of Sum Insured each time.

1.1. **Conditions**

i. Restoration Benefit is available immediately upon exhaustion of the Sum Insured and Cumulative Bonus, during the policy period.

ii. The Restoration Benefit is applicable for hospitalization due to illness or accident for Inpatient Treatment or Day Care procedure including AYUSH Hospitalization.

iii. The Restoration Benefit can be utilized for subsequent Hospitalization only for an illness or disease unrelated to the illness / disease for which claim/s was /were not made.

iv. If policy is on individual basis than it will be available for individual whereas in family floater it will be available for all covered members on floater basis.

v. Any unutilized Restoration Benefit will not be carried forward to any subsequent Policy Years.

1.2. **Illustration for Restoration Benefit**

The order of utilization of Sum Insured will as follow

- Base policy Sum Insured
- Cumulative Bonus (CB)
- Restoration Sum Insured

Particulars	New Policy	Renewal Policy With CB
Base Sum insured (₹)	10 lakhs	10 lakhs
Cumulative Bonus (CB) (₹)	0 lakhs	2.5 lakhs
Total Sum insured (SI) available (₹)	10 lakhs	12.5 lakhs
Claim 1st		
Medical/ Hospitalization Expenses (₹)	5 lakhs	10 lakhs
Claim Paid (₹)	5 lakhs (5 lakh from SI)	10 lakhs (10 lakh from SI)
Sum Insured Restoration	No	No
SI available (₹) for next claim	5 lakhs (Available SI amount :5 lakhs)	2.5 lakhs (Available CB amount :2.5 lakhs)
Claim 2nd for different disease		
Medical/ Hospitalization Expenses (₹)	10 lakhs	5 lakhs
Claim Paid (₹)	5 lakhs (5 lakhs from SI)	2.5 lakhs (2.5 lakh from CB)
Sum Insured Restoration	10 lakhs	10 lakhs
SI available (₹) for next claim	10 lakhs	10 lakhs
Claim 3rd for same disease		
Medical/ Hospitalization Expenses (₹)	12 lakhs	15 lakhs
Claim Paid (₹)	No claim as same disease	No claim as same disease
Claim 4th for different disease		
Medical/ Hospitalization Expenses (₹)	10 lakhs	10 lakhs
Claim Paid (₹)	10 lakhs (10 lakhs from restored SI)	10 lakhs (10 lakhs from restored SI)
Sum Insured Restoration	10 lakhs	10 lakhs

8. Bonus Boost (BB)

In consideration of the payment of additional premium, the policy is extended to cover Bonus Boost (BB) Benefit add-on. Inbuilt Cumulative Bonus will replace with below wording

Bonus Boost will be increased sum insured by 25% in respect of each claim free policy year (when no claims are reported), provided the policy is continuously renewed with the company without a break subject to maximum of 250% of the sum insured under the current policy year. If a claim is made in any particular year, the cumulative bonus accrued shall be reduced at the same rate at which it has accrued. However, sum insured will be maintained and will not be reduced in the policy year.

1. **Conditions**

i. In case where the policy is on individual basis, the Bonus Boost benefit shall be added and available individually to the insured person if no claim has been reported. Bonus Boost benefit shall reduce only in case of claim from the same Insured Person.

ii. In case where the policy is on floater basis, the Bonus Boost benefit shall be added and available to the family on floater basis, provided no claim has been reported from any member of the family.

iii. Bonus Boost benefit shall be available only if the Policy is renewed/ premium paid within the Grace Period.

iv. If the Sum Insured has been reduced at the time of Renewal, the applicable Bonus Boost benefit shall be reduced in the same proportion to the Sum Insured in current Policy.

v. If the Sum Insured under the Policy has been increased at the time of Renewal the Bonus Boost benefit shall be calculated on the Sum Insured of the last completed Policy Year.

vi. If claim is made in the expiring Policy Year, and is notified to Us after the acceptance of Renewal premium any awarded Bonus Boost benefit shall be withdrawn.

vii. The entire Bonus Boost benefit will be forfeited if the Policy is not continued / renewed on or before Policy Period end date or the expiry of the grace period.

viii. The Bonus Boost benefit will be calculated on the expiring Sum Insured.

ix. In a floater Policy, the Bonus Boost so accrued in the previous Policy Year(s), will only be available to those Insured Person(s) who were Insured in the previous Policy Year(s) and continue to be Insured with the Company in the subsequent Policy Year(s).

x. In case Sum Insured under the Policy is reduced at the time of renewal, the applicable Bonus Boost benefit shall be reduced in proportion to the Sum Insured.

Illustration

Annual SI	BB after 1 year	SI reduced by	Revised annual SI	Revised BB
10 lakhs	2.5 lakhs	5 lakhs	5 lakhs	1.25 lakhs

xi. In case Sum Insured under the Policy is increased at the time of renewal, the Bonus Boost benefit shall be calculated on the Sum Insured applicable on the last completed Policy Year.

xii. **Individual to Floater Policy Split**

If the Insured Persons in the expiring Policy are covered on an individual basis and there is an accumulated Bonus Boost benefit for each Insured Person under the expiring Policy, and such expiring Policy has been renewed with the Company on a floater basis then the Bonus Boost benefit to be carried forward for credit in such renewed Policy shall be the lowest among all the Insured Persons

Insured	Annual SI	BB after 1 year	New Sum insured	BB in New policy
1	10 lakhs	2.5 lakhs	10 lakhs	1.25 lakhs
2	5 lakhs	1.25 lakhs		

xiii. **Floater to Individual Policy Split**

If the Insured Persons in the expiring policy are covered on a Floater basis and such Insured Persons renew their expiring Policy with us by splitting the Floater Sum Insured in to 2 (two) or more Individual/ Floater covers, then the Bonus Boost benefit of the expiring Policy shall be apportioned to such renewed Policy in the proportion of the Sum Insured of each of the renewed Policy.

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Insured	Annual SI	BB after 1 year	New Sum insured	BB in each policy
1	10 lakhs	2.5 lakhs	7.5 lakhs	1.5 lakhs
2			5 lakhs	1 lakh

9. **Consumables Waiver**

In consideration of the payment of additional premium, it is hereby agreed and declared that, notwithstanding anything to the contrary in this policy or in any of its conditions, the policy extends to indemnify for expenses incurred for consumables as specified in 'Annexure I – List I' which are consumed during the period of hospitalization directly related to the insured's medical or surgical treatment of illness/disease/injury. Details of Annexure I-List I,is available in Policy Wordings and our Website.

For this claim to be paid, the main claim must be admissible Under "In-patient Hospitalization" or "Daycare Treatment".
However, the following items shall be excluded from scope of this coverage:

a. Items of personal comfort, toiletries, cosmetics and convenience shall be excluded from scope of this coverage.
b. External durable devices like Bilevel Positive Airway Pressure (BIPAP) machine, Continuous Positive Airway Pressure (CPAP) machine, Peritoneal Dialysis (PD) equipment and supplies, Nimbus/water/air bed, dialyzer and other medical equipment.
c. Any item which is neither medical consumable nor medically necessary nor prescribed by Doctor.
d. Pre and post hospitalization expenses will be excluded from this cover.

10. Ambulance Plus

In consideration of the payment of additional premium, it is hereby agreed and declared that, notwithstanding anything to the contrary in this policy or in any of its conditions, the policy extends to indemnify for expenses incurred for Road or Air Ambulance subject to if we will pay claim under section 4 – Coverage.

A. Road Ambulance

Expenses incurred on Road Ambulance services which are offered by a healthcare or an ambulance service provider (including inter-hospital transfer, diagnostic transfers, or return to the hospital) shall be indemnified for actuals up to Sum Insured, upon recommendation of the treating Medical Practitioner in case of life-threatening emergency.

We will not cover:

a. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital.
b. Any transportation or Road ambulance expenses incurred outside the geographical scope of India

B. Air Ambulance

We will cover the expenses on air ambulance services in respect of an Insured Person which are offered by a healthcare or an air ambulance service provider and which have been used during the Policy Period to transfer the Insured Person to the nearest Hospital with adequate emergency facilities for the provision of Emergency Care, provided that:

i. Our maximum liability under this Benefit for any and all claims arising during the Policy Year will be restricted to the policy Sum insured.
ii. It is for a life-threatening emergency health condition/s of the Insured Person which requires immediate and rapid ambulance transportation from the place where the Insured Person is situated at the time of requiring Emergency Care to a hospital provided that the transportation is for Medically Necessary Treatment, is certified in writing by a Medical Practitioner, and road ambulance services cannot be provided.
iii. Such air ambulance providing the services, should be duly licensed to operate as such by a competent government Authority.
iv. This cover is limited to transportation from the area of emergency to the nearest Hospital only;

v. We will not cover:
   a. Any transportation from one Hospital to another;
   b. Any transportation of the Insured Person from Hospital to the Insured Person's residence after he/she has been discharged from the Hospital
   c. Any transportation or air ambulance expenses incurred outside the geographical scope of India.

vi. We have accepted a claim under Section 41. Hospitalization in respect of the Insured Person for the same Accident/Illness for which air ambulance services were availed.

vii. We shall not be liable if Medically Necessary Treatment can be provided at the Hospital where the Insured Person is situated at the time of requiring Emergency Care.

11. Zone Based Discount

For the purpose of premium computation, the country has been divided into 3 zones.

Zone	Cities
Zone 1	Delhi, Gurugram, Karnal, Sonipat, Rohtak, Bhiwani, Chakri Dadri, Mahendragarh, Faridabad, Jind, Panipat, Nuh, Jhajjar Rewari, Palwal, Bagpath, Bulandashahr, Noida, Ghaziabad, Hapur, Meerut, Muzaffarnagar, Shamali, Hisar, Bhiwadi, Ahmedabad, Vadodara, Surat, Mumbai (including Thane district, Navi Mumbai), Chennai, Kolkata.
Zone 2	Telangana (incl. Hyderabad), Pune, Bangalore, Andhra Pradesh, Uttarakhand, Bhopal, Indore, Lucknow, Patna, Gujrat (excluding Ahmedabad, Vadodara and Surat)
Zone 3	Rest of India excluding Zone 1&2

- The premium will depend on the city of residence and pin code of the insured person. Please inform Us immediately in case of any change in the address otherwise it may impact your claim admissibility or amount. The premium will be charged on prorate basis in case of midterm address change involving migration from Lower Zone to Higher Zone (means zone 3 ⟶ zone 1)

12. Pre-Existing Disease Waiting Period Reduction

In consideration of the payment of additional premium, it is hereby agreed and declared that, notwithstanding anything to the contrary in this policy or in any of its conditions by choosing this add-on cover, the applicable Pre-existing waiting period 36 month for claim related to pre-existing disease shall be reduced to 24 months, this benefit is applicable only if you are suffering with any pre-existing disease/ conditions.

Section 41 of Insurance Act 1938

PROHIBITIONOF REBATES –

1. No person shall allow or offer to allow, either directly or indirectly as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectuses or tables of the Insurer.
2. Any person making default in complying with the provision of this Section shall be punishable with fine, which may extend to ten lakh rupees.

Premium Table excluding Tax

Age (Years)	0.5 Lacs	1 Lacs	1.5 Lacs	2 Lacs	2.5 Lacs	3 Lacs	3.5 Lacs	4 Lacs	4.5 Lacs	5 Lacs
0-18	3,022	3,372	3,665	3,924	4,180	4,394	4,594	4,783	4,964	5,161
19-25	3,239	3,639	3,957	4,259	4,520	4,744	4,970	5,190	5,394	5,616
26-30	3,292	3,731	4,081	4,393	4,657	4,880	5,122	5,350	5,580	5,825
31-35	3,316	3,792	4,147	4,457	4,752	4,976	5,218	5,449	5,678	5,920
36-40	4,026	4,563	4,972	5,321	5,663	5,930	6,209	6,468	6,728	7,013
41-45	4,073	4,680	5,134	5,522	5,896	6,240	6,547	6,837	7,125	7,422
46-50	5,684	6,495	7,207	7,768	8,275	8,757	9,186	9,594	10,053	10,524
51-55	7,586	8,662	9,603	10,364	11,096	11,698	12,270	12,826	13,390	13,994
56-60	9,688	11,090	12,264	13,280	14,227	15,023	15,808	16,573	17,337	18,116
61-65	12,708	14,568	16,066	17,390	18,621	19,703	20,850	22,011	23,088	24,197
66-70	16,278	18,653	20,561	22,356	24,031	25,341	26,726	28,261	29,600	31,004
71-75	20,568	23,601	25,915	28,236	30,263	31,781	33,514	35,518	37,204	38,964
76-80	24,914	28,460	31,221	33,852	36,308	38,222	40,472	42,734	44,768	46,927
Above 80	29,882	33,285	36,327	39,185	41,804	44,027	46,633	49,244	51,579	54,024
Age (Years)	5.5 Lacs	6 Lacs	6.5 Lacs	7 Lacs	7.5 Lacs	8 Lacs	8.5 Lacs	9 Lacs	9.5 Lacs	10 Lacs
0-18	5,457	5,657	5,832	6,008	6,172	6,330	6,475	6,617	6,746	6,874
19-25	5,900	6,105	6,301	6,488	6,666	6,833	6,988	7,139	7,276	7,415
26-30	6,063	6,276	6,478	6,672	6,855	7,028	7,188	7,345	7,487	7,632
31-35	6,157	6,379	6,580	6,773	6,965	7,136	7,305	7,468	7,610	7,760
36-40	7,310	7,567	7,815	8,042	8,271	8,485	8,682	8,874	9,047	9,224
41-45	7,670	7,941	8,200	8,440	8,677	8,898	9,107	9,306	9,489	9,676
46-50	10,868	11,260	11,624	11,970	12,308	12,620	12,919	13,201	13,462	13,723
51-55	14,543	15,071	15,559	16,016	16,475	16,885	17,297	17,685	18,028	18,382
56-60	18,837	19,518	20,158	20,749	21,355	21,909	22,427	22,923	23,380	23,833
61-65	25,018	25,931	26,779	27,566	28,368	29,108	29,794	30,460	31,068	31,674
66-70	31,846	33,017	34,100	35,118	36,138	37,048	37,969	38,838	39,606	40,393

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71-75	39,970	41,440	42,801	44,082	45,362	46,507	47,662	48,809	49,720	50,691
76-80	48,120	49,847	51,529	53,093	54,624	56,019	57,392	58,705	59,861	61,029
Above 80	56,082	58,104	60,076	61,917	63,718	65,359	66,970	68,507	69,858	71,222

Age (Years)	15 Lakhs	20 Lakhs	25 Lakhs	50 Lakhs	1Cr
0-18	7,484	8,001	8,517	10,065	11,356
19-25	8,142	8,703	9,265	10,949	12,353
26-30	8,446	9,029	9,611	11,359	12,815
31-35	8,584	9,176	9,768	11,544	13,024
36-40	10,169	10,871	11,572	13,676	15,429
41-45	10,761	11,504	12,246	14,472	16,328
46-50	15,259	16,311	17,364	20,521	23,151
51-55	20,290	21,690	23,089	27,287	30,785
56-60	26,269	28,081	29,893	35,328	39,857
61-65	35,085	37,505	39,925	47,184	53,233
66-70	44,957	48,058	51,158	60,460	68,211
71-75	56,497	60,393	64,290	75,979	85,719
76-80	68,044	72,736	77,429	91,507	1,03,239
Above 80	78,336	83,739	89,141	1,05,349	1,18,855

A. Floater Calculation

	Rate Applicable
Floater Premium	100% premium for highest age
	45% of individual premium for all other members

B. Discount /Loading

Discount	Percentage (%)	Remarks
1. Direct Discount	20%	If policy bought by direct channel
2. Family Discount	10%	If 2 and more family member are covered under Individual Policy Not applicable on floater
3. Online Discount	5%	If policy purchased online
4. Shriram Group Employee Discount	5%	Discount will be offered to Employees of SGIC and Shriram Group companies.
5. Non TPA Discount	3%	If an insured opt out of TPA services.

6. Claims Free-Renewal Discount	• 2% for first 5 claim free year • 1% for next 5 claim free year	This discount is offered against a choice of increase in Sum Insured of 5% per annum. The maximum renewal discount is 15%. In case of a claim, the renewal discount reverts back to 0%.

C. Instalment Loading

Instalment Frequency	Loading
Annual	0%
Half yearly	2%
Quarterly	3%
Monthly	4%

D. OPTIONAL COVERS – VALUE PACK ADD-ONS

Add-ons Coverages	Revised Limits	Loading/Discount
1. Pre /Post Hospitalization	60/90 Days	2%
2. Room Capping	Up to 2% of the sum insured subject to maximum of Rs.10000/-, per day	5%
3. ICU Capping	Up to 5% of the sum insured subject to maximum of Rs.20,000/- per day	3%
4. Co-Pay Waiver	5% co-payment not applicable on Claim	5%
5. Single AC Room	Up to the Policy Sum Insured	5%
6. ICU – No Limit	Up to the Policy Sum Insured	4%
7. Restoration Benefit	Upon complete exhaustion of the Sum Insured and Cumulative Bonus Sum Insured will restore unlimited times subject to maximum 100% of Sum Insured each time for unrelated disease	5%
8. Bonus Boost	Inbuilt cumulative bonus will be replaced with Bonus Boost benefit where Sum insured will increase by 25% of SI in respect of each claim free year of insurance maximum up to 250% of SI. In the event of claims the Bonus Boost shall be reduced at same rate.	7%
9. Consumables Waiver	Pay for expenses incurred on consumables as specified in List -1 of Annexure – I Policy wording	5%
10. Ambulance Plus	Up to the Policy Sum Insured	1%
11. Zone Based Discount	You are eligible for discount as per the Your Zone.	Zone – 1: 0% Zone – 2: 25% Zone – 3: 30 %
12. Long Term Discount	a. 2 Year b. 3 Year	a. 5% for 2 years b. 10% for 3 years
13. Pre-existing disease waiting period reduction	On payment of additional premium, PED waiting period will reduce from 36 month to 24 month it is applicable if You are suffering with any pre-existing disease / conditions	Loading as per the table A

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Benefit Illustration in respect of policies offered on individual and family floater basis

Annexure-A

Age of the members insured	Coverage opted on individual basis covering each member of the family separately (at a single point in time)		Coverage opted on individual basis covering multiple members of the family under a single policy (Sum insured is available for each member of the family)				Coverage opted on family floater basis with overall Sum insured (Only one sum insured is available for the entire family)			
	Premium (Rs.)	Sum Insured (Rs.)	Premium (Rs.)	Discount, if any	Premium after discount (Rs.)	Sum Insured (Rs.)	Premium or consolidated premium for all members of family (Rs.)	Floater discount, if any	Premium after discount (Rs.)	Sum insured (Rs.)
31-35	7760	10,00,000	7760	776	6984	10,00,000	16984	4268	12,716	10,00,000
36-40	9224	10,00,000	9224	922	8302	10,00,000				
Total Premium for all members of the family is Rs. 16,984, when each member is covered separately. Sum insured available for each individual is Rs. 10,00,000.			Total Premium for all members of the family is Rs. 15,286 when each member is covered separately. Sum insured available for each individual is Rs. 10,00,000.				Total Premium for all members of the family is Rs. 12,716, when each member is covered separately. Sum insured available for each individual is Rs. 10,00,000.			

Note: Premium rates specified in the above illustration shall be standard premium rates without considering any loading. Also, the premium rates shall be exclusive of taxes applicable.