Digit Illness Group Insurance

UIN: GODHLGP21488V022021

Inside:

Let's get started!

You're already awesome because you decided to protect your most important asset, your health. Especially with so many new illnesses sprouting every year, one needs to protect oneself against the financial & emotional burden of falling ill.
So, think of Digit as your fitness buddy, keeping pace with you on your way to good health. While you're reading this policy, you get confused or have a query, or you are referring to this policy because you have a claim to make, please call us at 1800-258-4242 or mail us at hello@godigit.com

Based on the declaration provided by You to us, **Go Digit General Insurance Limited** (hereinafter called 'the Company/DIGIT') which forms the basis of this health policy contract, and having received your premium, we take pleasure in issuing this policy to you.

Go Digit General Insurance Limited will cover You under this Policy up to the Sum Insured, during the policy period mentioned in your Policy Schedule / Certificate of Insurance. Of course, like any insurance cover, it is governed by, and subject to certain terms, conditions and exclusions mentioned in this Policy.

Note: This Policy Wording provides detailed terms, conditions and exclusions for all Sections available under this Product. Kindly refer to the Policy Schedule / Certificate of Insurance to know exact details of Sections opted by You. Only Wordings related to Sections mentioned in your Policy Schedule / Certificate of Insurance are applicable.

Disclaimer: The Description mentioned under "Digit Simplification"/ "Examples" throughout the Insurance Policy is only to aid Your understanding of the Coverage / Benefit Offered. In case of dispute, the Terms and Conditions detailed in the Policy Document and Policy Schedule / Certificate of Insurance shall prevail.

DEFINITIONS

Digit Simplification: ***You didn't think you needed to know definitions since your time in school, right? Well, the good news is that you don't need to learn these by heart, as long as you understand them***.
Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them.

1. **Any one illness** means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment was taken.
2. **Cashless facility** means a facility extended by Us to You where the payments, of the costs of treatment undergone by You in accordance with the Policy terms and conditions, are directly made to the Network Provider by Us to the extent Pre-authorization is approved.
3. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
4. **Congenital Anomaly** means a condition which is present since birth, and which is abnormal with reference to form, structure or position.
    a. Internal Congenital Anomaly means a Congenital anomaly which is not in the visible and accessible parts of the body.
    b. External Congenital Anomaly means a Congenital anomaly which is in the visible and accessible parts of the body

5. **Contribution**
   Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any benefit offered on a fixed benefit basis
6. **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. For Section 1, Insured can opt for Co-Payment between 0% to 20%. Co-payment will not be applicable to Section 2 of the Policy.
7. **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.
8. **Disclosure to information norm:** 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.
9. **Emergency / 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.
10. **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-existing diseases. Coverage is not available for the period for which no premium is received.
11. **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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act Or complies with all minimum criteria as under:
    i) has qualified nursing staff under its employment round the clock;
    ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    iii) has qualified medical practitioner(s) in charge round the clock;
    iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
12. **Hospitalization/Hospitalized** 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.
13. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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
14. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.

15. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
16. **Intensive Care Unit (ICU)** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
17. **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 intensivist charges.
18. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
19. **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 doctors in the same locality would have charged for the same medical treatment.
20. **Medical Practitioner/Dentist** 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 its scope and jurisdiction of license.
    The registered practitioner should not be the insured or close member of the family.
21. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i)is required for the medical management of the illness or injury suffered by the insured;
    ii)must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii)must have been prescribed by a medical practitioner;
    iv)must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
22. **Migration** means, the right accorded to 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.
23. **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.
24. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.
25. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
26. **Policy** means the Proposal, the Policy Schedule / Certificate of Insurance (and any endorsement attaching to or forming part thereof) and the Policy Wordings.
27. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule / Certificate of Insurance and includes both the commencement date as well as the expiry date.
28. **Pre-Existing Disease** means any condition, ailment, injury or disease:
    a) 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**
    b) 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 issued by the insurer or its reinstatement.
29. **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.

30. **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.
31. **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.
32. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
33. **Quarantine** means strict detention or isolation of a person suspected of carrying some infectious or contagious disease which is imposed by governmental authority to prevent the spread of disease.
34. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
35. **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.
36. **Room** means a Single Room without wall/permanent partition, dining or waiting room and with or without following amenities: an attendant cot, one television, one sofa, a telephone, refrigerator, wardrobe, computer with internet connection and microwave oven.
37. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
38. **Sum Insured** means the amount as opted by You and stated in the Policy Schedule / Certificate of Insurance against the Section/Cover for each insured person including cumulative bonus (if any) for Individual Sum Insured Policy and aggregately for all insured members for a Floater Policy**.**
39. **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.
40. **Tertiary Care** constitutes of Specialized Advanced Care Unit designed to care to complex medical condition involving super specialist consultant like Neurosurgeon, Neurologist, Spine Surgeons and Reconstructive Surgeons.
41. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
42. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited**.**
43. **You, Your, Yours, Yourself, Policyholder, Insured Person(s) means** the Individual Group Members who will be treated as Insured beneficiary.

DEFINITION, COMPLICATION & DIAGNOSTIC FOR DISEASE/S AND/OR CONDITIONS:

1. Cholera:
    a. **Definition** - Cholera is an acute, diarrheal illness caused by infection of the intestine with the bacterium *Vibrio cholerae* and is spread by ingestion of contaminated food or water.
    b. **Complications**: Persons with severe cholera can develop acute renal failure, severe electrolyte imbalances and coma.
    c. **Diagnostics**: Faecal specimen (hanging drop) and PCR – Positive for **Vibrio cholerae**

2. Amoebiasis
    a. **Definition:** Amoebiasis is an infection caused by Entamoeba Histolytica causing both intestinal and extraintestinal symptoms
    b. **Complication:** Amoebic liver abscess
    c. **Diagnostics:** Presence of amoeba cyst in the stool specimen, Ultrasound confirming liver abscess

3. Typhoid:
   a. **Definition:** Typhoid fever also known as enteric fever caused by Salmonella enterica Typhi leading to Fever, Abdominal pain, weakness and rose-coloured rash
   b. **Complications**: Ileal perforation and / or meningitis, Sepsis
   c. **Diagnostics:** Blood culture, PCR, IgG and IgM studies

4. Viral Hepatitis:
   a. **Definition:** Hepatitis is the infection to the liver due to Viral Infection caused by either Hep A, D or E (water borne). Hepatitis B and C are excluded (as they are chronic and caused from needles and body fluids)
   b. **Complications:** Encephalopathy or liver failure
   c. **Diagnostics:** IgG and IgM studies, Hepatitis A, D and E specific viral markers

5. Tuberculosis:
   a. **Definition:** Tuberculosis is an chronic progressive infection caused by Mycobacterium tuberculosis in lungs, intestine, bones, nervous system and genital organs
   b. **Complications:** Multi drug resistant tuberculosis and /or Tubercular meningitis
   c. **Diagnostics:** Mantoux test, Interferon-gamma release assay, IgG and IgM studies

6. Plague:
   a. **Definition:** Plague is a life-threatening bacterial infection to humans through fleas, contaminated fluid or droplets.
   b. **Complications:** Pneumonia and Septicaemia
   c. **Diagnostics:** Lymph node swelling (BUBO), CSF analysis, Blood and fluid culture tests

7. Diphtheria:
   a. **Definition**: Diphtheria is an upper respiratory tract infection which spreads through touch and droplets starts with thick coating of throat, swelling of glands in neck and fever.
   b. **Complications:** Respiratory failure, paralysis, myocarditis, polyneuropathy and death.
   c. **Diagnostics:** Throat Swab Culture or Sample from a skin lesion (like a sore)

8. Typhus:
   a. **Definition**: Typhus fevers are a group of diseases caused by bacteria that are spread to humans by fleas, lice, and chiggers
   b. **Complications:** Acute respiratory distress, septic shock, myocarditis, meningoencephalitis
   c. **Diagnostics**: Skin biopsy, western blot, immunofluorescence test

9. Leptospirosis:
   a. **Definition**: Leptospirosis is a bacterial infection that affects that spreads from contact of unhealed break or injured skin with contaminated water or soil.
   b. **Complications**: Kidney and Liver failure, Sepsis
   c. **Diagnostics**: Microscopic Agglutination test and IgG/IgM studies

10. Dengue:
   a. **Definition**: Dengue fever is caused by the virus spread through Aedes mosquito bite resulting to fever, severe headache, vomiting, skin rash and life-threatening internal bleeding.

b. **Complications**: Platelets count < 40k, Septic shock and death
c. **Diagnostics**: NS1 test, IgG/IgM studies, CBC with platelet counts

11. Malaria:
    a. **Definition**: Malaria fever is caused by a protozoan – Plasmodium through female anopheles mosquito resulting in fever, weakness, chills, headache, vomiting and Jaundice
    b. **Complications**: kidney failure, Seizures and cerebral malaria, Sepsis
    c. **Diagnostics**: Blood smear, Rapid diagnostic test

12. Filariasis:
    a. **Definition**: Filariasis is caused when the lymphatic system is blocked by microfilaria parasite leading to permanent changes in the limbs.
    b. **Complications**: Permanent disability
    c. **Diagnostics**: Blood smear and Antibodies

13. Kala Azar
    a. **Definition**: A chronic and potentially fatal parasitic disease of the viscera (the internal organs, particularly the liver, spleen, bone marrow and lymph nodes) due to infection by the parasite called Leishmania donovani.
    b. **Complications**: Anaemia, Septicaemia, Hyperpigmentation, Splenic Rupture.
    c. **Diagnostics**: DAT and the rk39 dipstick tests

14. Chikungunya:
    a. **Definition**: Chikungunya is caused by virus through Aedes mosquitoes leading to fever, weakness and severe joint pains
    b. **Complications**: Severe joint pain with disability
    c. **Diagnostics**: IgG and IgM studies

15. Japanese Encephalitis:
    a. **Definition**: Inflammation of brain due to virus leading to disorientation, fever, vomiting, convulsions and death
    b. **Complications**: Encephalopathy and death, Sepsis
    c. **Diagnostics**: CSF and blood culture

16. HIV

    Definition: "HIV Infection" means a positive HIV antibody testing (rapid or laboratory-based enzyme immunoassay). This is usually confirmed by a second HIV antibody test (rapid or laboratory-based enzyme immunoassay) relying on different antigens or of different operating characteristics.

    and /or;

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

17. Zika Virus:
    a. **Definition**: Zika virus is caused by virus through mosquito bite leading to fever, rash, muscle pain and Joint pain. Pregnant women can transfer the virus to the unborn child leading to the microcephaly.
    b. **Complications**: Birth defects in newborn
    c. **Diagnostics**: RT-PCR, Urine analysis, IgG/IgM studies

18.Nipah Virus
   a. **Definition**: Nipah Virus is caused by virus through Bats leading to drowsiness, disorientation and respiratory distress
   b. **Complications**: Inflammation and irreversible damage to brain
   c. **Diagnostics**: RT-PCR, Swab culture, CSF analysis

19.EBOLA
   a. **Definition**: Ebola virus disease is a deadly disease which spreads from few animals like Monkeys, Bats etc., through body fluids and mucus membranes leading to Fever, severe body ache, rashes and Diarrhoea
   b. **Complications**: Septic shock and death
   c. **Diagnostics**: RT – PCR and Ebola Antigen tests

20.Swine Influenza Virus & H1N1 Virus
   a. **Definition**: A rapidly contagious infection transmitted from animals and spread through droplet circulation leading to fever, cough and severe respiratory symptoms.
   b. **Complications**: Pneumonia leading to Respiratory arrest, Lung fibrosis, renal failure, septic shock and death
   c. **Diagnostics**: IgG/IgM studies, Swab cultures (throat), PCR

21.COVID-19, SARS and MERS
   a. **Definition**: A rapidly contagious infection caused by a virus from Coronavirus Family, transmitted from animals and spread through droplet circulation leading to fever, cough, mild to severe respiratory symptoms.
   b. **Complications**: Pneumonia leading to Respiratory arrest, Lung fibrosis, renal failure, septic shock and death
   c. **Diagnostics**: IgG/IgM studies, Swab cultures (throat), PCR

Important Note: In respect of any claim, We will consider the medical practices prevailing at the time of claim for the Disease(s), Condition(s) and/or Virus(es) opted by You and mentioned in Your Policy Schedule.

COVERAGE

SECTION 1. HOSPITALIZATION COVER

***Digit Simplification:* Hospital stays are never fun. And the less said about hospital food, the better! That said, it's good to know that Digit will try and make it easy, should you need to spend some time in a hospital, before you're back on your feet.**

A. Hospitalization Cover

***Digit Simplification:* The day bad luck strikes.**

If You have opted for this cover and if You were Hospitalized due to Illness, as an inpatient, during the Policy Period, solely because You were Infected and Tested Positive due to the below mentioned Disease/s and/or Conditions as opted by You and stated in Your Policy Schedule / Certificate of Insurance, We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You, in respect of an admissible claim.

List of Disease/s and/or Conditions:

1. Cholera
2. Amoebiasis

3. Typhoid
4. Viral Hepatitis
5. Tuberculosis
6. Plague
7. Diphtheria
8. Typhus
9. Leptospirosis
10. Dengue
11. Malaria
12. Filariasis
13. Kala Azar
14. Chikungunya
15. Japanese Encephalitis
16. HIV
17. Zika Virus
18. Nipah Virus
19. EBOLA
20. Swine Influenza Virus
21. H1N1 Virus
22. COVID-19
23. SARS
24. MERS

Important Note: The Disease/s and/or Conditions opted by You are stated in the Your Policy Schedule / Certificate of Insurance and any claim will be paid only in respect of the Disease/s and/or Conditions opted by You and stated in the Your Policy Schedule / Certificate of Insurance subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

The claim can be made under the following benefits and up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room will be subject to a Daily Limit as opted and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover. The Daily Limit options available to Insured are Nil, 1%, 1.5% and 2%. Note: If there is a Limit on "**Accommodation/Room Rent**" and the Room Rent Rate exceeds the limits at the time of Hospitalization then our liability will be restricted to the same proportion as the Admissible Rate Per Day Limit Opted bears to the Actual Rate Per Day of Room Rent Charges except for the cost of medicines and consumables, unless this condition is specifically waived off and mentioned in Your Policy Schedule / Certificate of Insurance. ***Example, if there is a room rent limit of ₹1,500 per day but You go in for a room with a rent of ₹4,500 per day which is three times the allowed limit, when You claim, We will pay one-third of the Total bill amount and deduct the balance i.e. in the same proportion as it increased. This is because the other charges related to Your treatment like Doctor's fees, also increase with the room type. This deduction will not be applicable for the cost of medicines and consumables.***
ICU	Intensive Care Unit

Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables including disposable kits, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

A1. Pre-Hospitalization Expenses

Digit Simplification: Before you get hospitalized, there might be some expenses. This takes care of those!

We will pay for consultations, investigations and the cost of medicines incurred. This will be paid for a period not exceeding 30 or 60 or 90 days as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance, prior to the date of Your admission in a hospital, provided that:

a) Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which Your Subsequent Hospitalization was required.
b) We have accepted a Claim under **Section 1.A. Hospitalization Cover** of this Policy.

A2. Post-Hospitalization Expenses

Digit Simplification: This covers expenses incurred by You after You get discharged!

We will pay for consultations, investigations and the cost of medicines incurred. This will be paid for a period not exceeding 30 or 60 or 90 days as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance, from the date of Your Discharge from the hospital, provided that:

a) The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
b) We have accepted an Inpatient Hospitalization Claim under **Section 1.A. Hospitalization Cover** of this Policy.

A3. Road Ambulance

Digit Simplification: In an emergency, getting to the hospital quickly is paramount!

We will pay for the expenses incurred on Your road transportation by a Healthcare or an Ambulance Service Provider to a Hospital for treatment following an Emergency, provided that:

a) We have accepted a claim under **Section 1. A. Hospitalization Cover.**
b) The maximum liability per Hospitalization is restricted to 1% of Sum Insured up to INR 5,000.
c) The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

A4. Second Medical Opinion

Digit Simplification: Any major illness (like cancer) dictates a second opinion.

If You are required to get hospitalized in a tertiary care facility during the Policy Period, We will arrange and bear the cost for a Second Opinion provided that:

1. We have received Your request to arrange for Second Opinion.
2. We will not provide more than one Opinion for the same Medical Condition within a Policy Period.
3. Medical Practitioner has Certified that You were Infected and Tested Positive due to the Conditions and/ or Disease defined and stated in the Policy Schedule / Certificate of Insurance

SECTION 2. VIRUS DETECTION & QUARANTINE ALLOWANCE

Digit Simplification: ***If even ward boys seem to know You by name, this cover is for You.***

If You have opted for this Section, We will pay you:

a) **Full Fixed Benefit if Result is Positive (bad news i.e.):** 100% of the Sum Insured mentioned in the Policy Schedule / Certificate of Insurance. You can find this mentioned against this Section in respect of the Insured Person(s) whose test result are Positive during the Policy Period for the below mentioned Virus(es) as opted by You and stated in Your Policy Schedule / Certificate of Insurance. Make sure the Insured Person(s) claiming has a Certificate from a Registered Medical Practitioner along with a Positive Virology Report from ICMR - National Institute of Virology Pune, India or Any other Laboratory Authorised by ICMR, confirming the Insured Person(s) has been infected with the Virus(es) as opted and stated in the Policy Schedule / Certificate of Insurance; or

Part Fixed Benefit if result is negative (the relatively better news!): Up to _____%, (Options are 0%, 5%, 10%, 15%, 20%, 25%, 30%,35%, 40%, 45% & 50%) mentioned in the Policy Schedule / Certificate of Insurance, of the Sum Insured will be paid to the Insured Person(s) if the Insured Person(s) is quarantined, during the Policy Period, in dedicated Government Authorized Hospital for a minimum of 7 or 10 or 14 or 21 consecutive (continuous) days, as opted and stated in the Policy Schedule / Certificate of Insurance, for observation and investigation of the below mentioned Virus(es) and the test results are negative (though you must have been troubled, that is a good news, right:). This benefit will be paid only once during Policy Period in respect of the Insured Person(s) against whom claim has been admitted.

Provided always that:

a) We will not pay for any self-Quarantine in any facility other than Government Authorised Hospital.
For example, if You're feeling under the weather and feel You've caught a disease covered in Your Policy and You stay at home for the number of consecutive days mentioned, You will not be covered, as the Quarantine has to be at a Government Authorised Hospital.
Sum insured is always the max You'll get: Regardless of one or more claims during the policy period, the maximum amount payable under the policy for all the benefits under this Section put together shall be restricted to the Sum Insured as mentioned in the Policy Schedule / Certificate of Insurance against this Section in respect of the Insured Person(s). The Benefit under this Section will cease on payment of 100% of the Sum Insured for the respective Insured Person(s) against whom claim has been paid. **Basically, once we've paid you an amount equal to your Sum Insured, no more claims.**

List of Virus(es):

1. Zika Virus
2. Nipah Virus
3. EBOLA
4. Swine Influenza Virus
5. H1N1 Virus
6. COVID-19
7. SARS
8. MERS

Important Note: The Coverage for Virus(es) opted by You are stated in the Your Policy Schedule / Certificate of Insurance and any claim will be paid only in respect of the Virus(es) opted by You and stated in the Your Policy Schedule / Certificate of Insurance subject to Policy Terms & Conditions.

This Cover is subject to terms, conditions, deductible, co-payment, limitations and exclusions mentioned in the Policy.

GENERAL EXCLUSIONS

***Digit Simplification:* We believe in being transparent with you, no hidden terms and conditions. So, here's what you are not covered for:**

Unless specifically mentioned as an inclusion in Your Policy Schedule/ Certificate of Insurance, the below are excluded and any Hospitalization/ Disease/ Condition attributable to the below will not be covered:

Most relevant ones to this cover:

1. **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 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 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by us.

2. **30-day waiting period/Initial 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.

   However, such waiting Period can be reduced Nil, 48 hours, 7 days, 15 days, to as opted by you and mentioned in your policy schedule

   This exclusion is also applicable to any positive diagnostic results or Quarantine which begins or is detected during the Waiting Period opted and mentioned in your policy schedule.

3. **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.

4. 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**

5. **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

6. **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.

7. Geographical Limits

This Policy covers all treatments and quarantine received/done within India and Our liability will be to make Payment Indian Rupees Only.

8. Non-Medical Expenses

Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies including but not limited to charges for admission, discharge, administration, registration, documentation and filing. (Please refer annexure A provided in the policy document or visit our website for complete list of non-medical items)

9. Insufficient Document

We have tried to reduce the number of documents you need to share but we shall not be liable to pay any claim in case all the necessary mandatory documents as mentioned in Our claims process are not submitted to Us.

10. Preventive Treatment

We do not cover inoculations, vaccinations or other treatment, for example drugs or Surgery, which aims to prevent a disease or Illness.

11. Unjustified or Unwarranted Hospitalization

Admission solely for Physiotherapy, evaluation, investigations, diagnosis or observation service unless a claim is accepted under **Section 1 - A. Hospitalization Cover.**

12. Substance abuse and Addictions by the Insured

1. Expenses incurred for the treatment of any Illness caused due to:
   a) Use/misuse/abuse of Alcohol, opioids or nicotine or drugs (whether prescribed or not) by the Insured.
   b) Withdrawal and de-addiction treatment taken by the Insured.
2. Any claim in respect of Cancer of Oral, Oropharynx and respiratory system is specifically excluded in cases where Insured is a tobacco user.

13. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment.

Other Exclusions:

14. Artificial Life Maintenance

Artificial Life Maintenance, including life support machine used, where such treatment is used to maintain the Insured/Patient in a vegetative state. However, expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the Policy.

15. Sexually Transmitted Infections & Disease

Screening, prevention and treatment for sexually transmitted infection or disease including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis is not covered.

16. Sleep Disorders and Sleep Problems

We do not cover treatment directly or indirectly related to sleep disorders and sleep problems, such as snoring, insomnia or sleep apnoea (when breathing stops temporarily during sleep) including but not limited to expense related to purchase of CPAP, BIPAP or similar instruments.

17. Spectacles, Hearing aids & other Expenses

Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, nebulizer and similar products.

18. War and hazardous substances

We do not cover treatment directly arising from or required as a consequence of:
War, invasion, acts of foreign enemy hostilities (whether or not War is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, attempted overthrow of Government or any acts of terrorism.
Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel.

19. Legal Liability

Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

20. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

21. Specific Treatments

We will not pay for expenses related to administration of medications or procedures including but not limited to expense related to Predictive Genome testing.

22. Dental Treatment

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva**.**

23. Organ Donor

The Expenses incurred by You on organ donation.

24. Accidental Injury

The Expenses incurred by You for Treatment of Accidental Injury.

STANDARD GENERAL TERMS AND CONDITIONS

CONDITIONS PRECEDENT TO THE CONTRACT

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.
"Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to tale informed decision in the context of underwriting the risk.

Alterations to the Policy

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or edited by anyone (including an insurance agent or intermediary) except Us (subject to necessary approval from the Insurance Regulatory and Development Authority of India), and any change We make will be through a written endorsement signed and stamped by Us, only on the request from Group Manager/ Insured Member.

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

Non-Disclosure or Misrepresentation:

Digit Simplification: ***In one line, this condition means, make sure all the information you share with us is correct!***

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form either physically or electronically 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 i.e. from the inception date or the renewal date (as the case may be),
b) or the Policy may be modified by Us, at Our sole discretion, upon 30 days' notice by sending an endorsement to Your address shown in the Schedule/Certificate of Insurance;
c) the claim under such Policy if any, shall be rejected/repudiated forthwith.

Insured Person

a. Only those persons named as an Insured Person in the Policy Schedule / Certificate of Insurance shall be covered under this Policy.
b. You can add more persons during the Policy Period but only after payment of an additional premium and subject to acceptance of Proposal by Us (wherever necessary) and after We have issued an endorsement confirming the addition of such person as an Insured Person.

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.

CONDITION APPLICABLE DURING THE CONTRACT

Digit Simplification: ***There are some more conditions you should be aware of during the contract!***

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.

Withdrawal of Product

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

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

Non-Cancellation

This Policy shall be non-cancellable by the Insurers or the Insured except in the event of misrepresentation, fraud, non-disclosure of material facts and non-co-operation by the Insured where the Insurers may cancel the Policy at their discretion.

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;

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

***Digit Simplification:* What You should know when You are about to claim.**

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.

v. The contribution clause shall not be applicable for Section 2.

vi. If You are covered under multiple policies providing Benefit as per Section 2, We shall make the claim payments independent of payments received under other similar polices in respect of the covered event.

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 has made that particular claim, who shall be jointly and severely 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 agents or the hospital/Doctors/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 grounds 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 intension to supress the fact or that such misstatement of or suppression of such material fact are within the knowledge of the Insurer.

Arbitration

If we have any differences with respect to the claim amount to be paid under this policy, it will be referred to arbitration in accordance with the Indian Arbitration and conciliation act 1996, as amended. The making of an award under such arbitration proceedings shall be a condition precedent for the Company to be liable to make any payment under this policy.

Claims Notification and Procedure

In the event of any illness or condition that may result in a claim under this policy, it is a condition precedent to Our liability under the Policy that below procedure should be followed depending on the type of claim:

A. Cashless Claim Process:

Cashless Facility can be availed from our network hospitals only. This is facilitated by our Service Provider / Third Party Administrator (TPA) and we would make a direct payment to the Network Hospital to the extent of Our Liability provided that:

1. We are given a notice at least 72 hours before any planned hospitalization or within 24 Hours of hospitalization in case of an emergency situation.
2. For Cashless Facility You shall follow the below Procedure:
   a. Share the Health Card/Copy of E-Cards along with ID Proof with the Hospital Authority & Obtain the Pre-Authorization Form from the Hospital.
   b. Submit Duly filled & Signed Pre-Authorization Form to the Hospital Counter.
   c. Ensure that the Hospital shares the Duly filled & Signed Pre-Authorization Form to Service Provider / Third Party Administrator (TPA) for further Processing.
   d. Service Provider / Third Party Administrator (TPA) will inform the decision and may issue authorization letter depending on the Policy Terms and Conditions to the Hospital directly.
   e. Once the request for Pre-Authorization has been granted, the treatment must take place within 15 days of the Pre-Authorization Approval Date or the Policy Expiry Date whichever is earlier and shall be valid only if all the details of the Authorised details, Hospital and Location including Dates match with the details of the Actual Treatment Received.
   f. We reserve the right to modify, add or restrict any Network Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of Network Providers.

g. For any queries designated Service Provider / Third Party Administrator (TPA) may be contacted on the contact details mentioned on the Health Card/Copy of E-Cards issued to You.

B. Reimbursement Claim Process:

Reimbursement Facility can be availed from any hospital within India of Your Choice Wherein You will have to make payment directly to the Hospital and submit the documents to Service Provider / Third Party Administrator (TPA) for processing the reimbursement of the claim amount provided that:

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of admission.
2. For Reimbursement Claim You shall follow the below Procedure:
   a. 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.
   b. 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.
   c. 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.
   d. 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.
   "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.
   e. In case of Your Death, We shall reimburse the claim amount to Your Nominee as named in Your Policy Schedule / Certificate of Insurance or Your Legal representative holding a valid succession certificate.

Sr. No	List of Documents / Information	Section 1. Hospitalization Claim	Section 2. Virus Detection And Quarantine Allowance
1	Duly Filled and Signed Claim form	√	√
2	Discharge Summary	√	√
3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)	√	√
4	Original Hospital Main Bill	√	×
5	Original Hospital Bill Break Up	√	×
6	Original Pharmacy Bills	√	×
7	Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital	√	×
8	Consultation Papers	√	√
9	Investigation Reports	√	√

10	Positive Diagnostic Report for the Conditions and/ or Disease defined and stated in the Policy Schedule / Certificate of Insurance	√	√
11	Digital Images/CDs of the Investigation Procedures (if required)	√	×
12	Original Invoice/Sticker (If applicable)	√	×
13	Attending Physician Certificate (If applicable)	√	×
14	Death Certificate (If applicable)	√	×
15	*KYC (Photo ID card) (If applicable)	√	√
16	Bank Details with Cancelled Cheque	√	√

Note: There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions A.1, B.1 and B.2.a may be considered where the reason for delay is proved to our satisfaction.

*KYC documents shall be required at the claim settlement stage where claims pay-out to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per claim.

Complete Discharge

Any payment to the Policyholder, insured person or his/ her nominee or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

CONDITIONS FOR RENEWAL OF THE CONTRACT

Renewal

i. The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
ii. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. 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.
vi. No loading shall apply on renewals based on individual claims experience.

Continuity Benefits

We will grant continuity of benefits which were available to the Insured Members under a health insurance policy which provides similar indemnity benefits in the immediately preceding Cover Year provided that:

i. We shall be liable to provide continuity of only those benefits (for e.g.: Initial waiting period) which are applicable under this Policy;
ii. Any other waiting period that is applicable specific to this policy but was permanently excluded in the previous policy will not be given any credit.

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 → Click Here

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.

For Detailed Guidelines on migration, kindly refer the → Click Here

CUSTOMER GRIEVANCE REDRESSAL POLICY
In case of any grievance the insured person may contact the company through
Website : https://www.godigit.com
Toll Free : 1-800-258- 4242
Email: hello@godigit.com
Senior citizens can contact us on 1-800-258-4242 or write to us at seniors@godigit.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 grievance@godigit.com
For updated details of grievance officer, kindly refer the link: → Click Here

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
Grievance may also be lodged at IRDAI Integrated Grievance Management System- https://igms.irda.gov.in/
The contact details of the Insurance Ombudsman Centres are mentioned below: (Note: Address and contact number of Governing Body of Insurance Council).

Office Location	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	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@ecoi.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@ecoi.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@ecoi.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455, Fax: 0674 - 2596429, Email: bimalokpal.bhubaneswar@ecoi.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@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandīgarh.
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@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532, Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205, Fax: 0361 - 2732937, Email: bimalokpal.guwahati@ecoi.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 - 65504123 / 23312122, Fax: 040 - 23376599, Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363, Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM	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@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA	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@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	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@ecoi.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.: 022 - 26106552 / 26106960, Fax: 022 - 26106052, Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.

NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253, Email: bimalokpal.noida@ecoi.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	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952, Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE	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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Note: GOVERNING BODY OF INSURANCE COUNCIL,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.Tel.: 022 - 26106889 / 671 / 980, Fax: 022 - 26106949, Email: inscoun@ecoi.co.in

Annexure-A

List I – Optional Items

Sl No	Item
1.	BABY FOOD *(Not Payable)*
2.	BABY UTILITIES CHARGES *(Not Payable)*
3.	BEAUTY SERVICES *(Not Payable)*
4.	BELTS/BRACES *(Not Payable)*
5.	BUDS *(Not Payable)*
6.	COLD PACK/HOT PACK *(Not Payable)*
7.	CARRY BAGS *(Not Payable)*
8.	EMAIL/ INTERNET CHARGES *(Not Payable)*
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) *(Not Payable)*
10.	LEGGINGS *(Not Payable)*
11.	LAUNDRY CHARGES *(Not Payable)*
12.	MINERAL WATER *(Not Payable)*
13.	SANITARY PAD *(Not Payable)*
14.	TELEPHONE CHARGES *(Not Payable)*
15.	GUEST SERVICES *(Not Payable)*
16.	CREPE BANDAGE *(Not Payable)*
17.	DIAPER OF ANY TYPE *(Not Payable)*
18.	EYELET COLLAR *(Not Payable)*
19.	SLINGS *(Not Payable)*
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES *(Part Of Cost Of Blood, Not Payable)*
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	Television Charges *(Payable Under Room Charges Not if separately levied)*
23.	SURCHARGES *(Part of Room Charge Not Payable Separately)*
24.	ATTENDANT CHARGES *(Part of Room Charge Not Payable Separately)*
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) *(Patient Diet provided by hospital is Payable)*
26.	BIRTH CERTIFICATE *(Not Payable)*
27.	CERTIFICATE CHARGES *(Not Payable)*
28.	COURIER CHARGES *(Not Payable)*
29.	CONVEYANCE CHARGES *(Not Payable)*
30.	MEDICAL CERTIFICATE *(Not Payable)*
31.	MEDICAL RECORDS *(Not Payable)*
32.	PHOTOCOPIES CHARGES *(Not Payable)*
33.	MORTUARY CHARGES *(Not Payable)*
34.	WALKING AIDS CHARGES *(Not Payable)*
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) *(Not Payable)*
36.	SPACER *(Not Payable)*
37.	SPIROMETRE *(Device Not Payable)*
38.	NEBULIZER KIT *(Not Payable)*
39.	STEAM INHALER *(Not Payable)*
40.	ARMSLING *(Not Payable)*
41.	THERMOMETER *(Not Payable)*
42.	CERVICAL COLLAR *(Not Payable)*
43.	SPLINT *(Not Payable)*
44.	DIABETIC FOOTWEAR *(Not Payable)*
45.	KNEE BRACES (LONG/ SHORT/ HINGED) *(Not Payable)*
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER *(Not Payable)*

47.	LUMBO SACRAL BELT *(Not Payable)*
48.	NIMBUS BED OR WATER OR AIR BED CHARGES *(Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadriplegia for any reason and at reasonable cost of approximately Rs. 200 / day*
49.	AMBULANCE COLLAR *(Not Payable)*
50.	AMBULANCE EQUIPMENT *(Not Payable)*
51.	ABDOMINAL BINDER *(Not Payable)*
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES *(Post hospitalization nursing charges not Payable)*
53.	SUGAR FREE Tablets *(Payable. Sugar free variants of admissible medicines are Not excluded)*
54.	CREAMS POWDERS LOTIONS *(Toiletries are not payable, only prescribed medical pharmaceuticals payable)*
55.	ECG ELECTRODES *(Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be Payable)*
56.	GLOVES *(Sterilized Gloves Payable / Unsterilized Gloves not payable)*
57.	NEBULISATION KIT *(Payable Reasonably only if used during Hospitalization)*
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, etc.]
59.	KIDNEY TRAY *(Not Payable)*
60.	MASK *(Not Payable)*
61.	OUNCE GLASS *(Not Payable)*
62.	OXYGEN MASK *(Not Payable)*
63.	PELVIC TRACTION BELT *(Not Payable)*
64.	PAN CAN *(Not Payable)*
65.	TROLLY COVER *(Not Payable)*
66.	UROMETER, URINE JUG *(Not Payable)*
67.	AMBULANCE *(Payable Reasonably only if used during Hospitalization upto sub-limit mentioned in the policy schedule)*
68.	VASOFIX SAFETY *(Not Payable)*

List II - Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED) *(Not Payable)*
2	HAND WASH *(Not Payable)*
3	SHOE COVER *(Not Payable)*
4	CAPS *(Not Payable)*
5	CRADLE CHARGES *(Not Payable)*
6	COMB *(Not Payable)*
7	EAU-DE-COLOGNE/ ROOM FRESHNERS *(Not Payable)*
8	FOOT COVER *(Not Payable)*
9	GOWN *(Not Payable)*
10	SLIPPERS *(Not Payable)*
11	TISSUE PAPER *(Not Payable)*
12	TOOTHPASTE *(Not Payable)*
13	TOOTHBRUSH *(Not Payable)*
14	BED PAN *(Not Payable)*
15	FACE MASK *(Not Payable)*
16	FLEXI MASK *(Not Payable)*
17	HAND HOLDER *(Not Payable)*
18	SPUTUM CUP *(Payable Under Investigation Charges, Not as Consumable)*
19	DISINFECTANT LOTIONS *(Not Payable-Part of Dressing Charges)*
20	LUXURY TAX *(Only Actual Tax Levied by Government is Payable - Part of Room Charge for Sub Limits)*

21	HVAC *(Part of Room Charge Not Payable Separately)*
22	HOUSE KEEPING CHARGES *(Part of Room Charge Not Payable Separately)*
23	AIR CONDITIONER CHARGES *(Payable Under Room Charges Not if separately levied)*
24	IM IV INJECTION CHARGES *(Part of Nursing Charges, Not Payable)*
25	CLEAN SHEET *(Part of Laundry/housekeeping Not Payable Separately)*
26	BLANKET/WARMER BLANKET *(Not Payable- Part of Room Charges)*
27	ADMISSION KIT *(Not Payable)*
28	DIABETIC CHART CHARGES *(Not Payable)*
29	DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES *(Not Payable)*
30	DISCHARGE PROCEDURE CHARGES *(Not Payable)*
31	DAILY CHART CHARGES *(Not Payable)*
32	ENTRANCE PASS/ VISITORS PASS CHARGES *(Not Payable)*
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE *(To be Claimed by Patient under Post - Hospitalization where admissible)*
34	FILE OPENING CHARGES *(Not Payable)*
35	INCIDENTAL EXPENSES/ MISC. CHARGES (NOT EXPLAINED) *(Not Payable)*
36	PATIENT IDENTIFICATION BAND/ NAME TAG *(Not Payable)*
37	PULSEOXYMETER CHARGES *(Not Payable)*
38	Nursing, DMO/ RMO charges included in room rent under associated medical expenses *(Not Payable)*

List III - Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM *(Not Payable)*
2	DISPOSABLES RAZORS CHARGES (for site preparations) *(Payable for site preparations)*
3	EYE PAD *(Not Payable)*
4	EYE SHIELD *(Not Payable)*
5	CAMERA COVER *(Not Payable)*
6	DVD, CD CHARGES *(Payable only if CD is specifically sought by Insurer/TPA)*
7	GAUSE SOFT *(Not Payable)*
8	GAUZE *(Not Payable)*
9	WARD AND THEATRE BOOKING CHARGE *(Payable Under OT Charges, Not Payable Separately)*
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS *(Rental Charged By The Hospital Payable. Purchase of Instruments Not Payable.)*
11	MICROSCOPE COVER *(Payable Under OT Charges, Not Payable Separately)*
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER *(Payable Under OT Charges, Not Payable Separately)*
13	SURGICAL DRILL *(Payable Under OT Charges, Not Payable Separately)*
14	EYE KIT *(Payable Under OT Charges, Not Payable Separately)*
15	EYE DRAPE *(Payable Under OT Charges, Not Payable Separately)*
16	X-RAY FILM *(Payable Under Radiology Charges, Not as Consumable)*
17	BOYLES APPARATUS CHARGES *(Part Of OT Charges, Not Separately)*
18	COTTON *(Not Payable-Part of Dressing Charges)*
19	COTTON BANDAGE *(Not Payable-Part of Dressing Charges)*
20	SURGICAL TAPE *(Not Payable-payable by the Patient when Prescribed, otherwise included as Dressing Charges)*
21	APRON *(Not Payable -Part of Hospital Services/Disposable Linen to be Part of OT/ICU Charges)*
22	TORNIQUET *Not payable (service is charged by hospital, consumables cannot be separately charged.*
23	ORTHOBUNDLE, GYNAEC BUNDLE (Part of Dressing Charges)

List IV - Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES *(Not Payable)*
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE *Unless A Claim Is Accepted Under Section1 - Hospitalization Cover*
3	URINE CONTAINER *(Not Payable)*
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES *(Not Payable)*
5	BIPAP MACHINE *(Not Payable)*
6	CPAP/ CAPD EQUIPMENTS *(Device Not Payable)*
7	INFUSION PUMP- COST *(Device Not Payable)*
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC (May be Payable when prescribed for patient, not Payable for hospital use in OT or ward or for dressings in hospital)
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES *(Patient diet provided by hospital is payable)*
10	HIV KIT *(Payable Only as Pre-Operative Screening)*
11	ANTISEPTIC MOUTHWASH *(Payable when prescribed)*
12	LOZENGES *(Payable when prescribed)*
13	MOUTH PAINT *(Payable when prescribed)*
14	VACCINATION CHARGES *(Not Payable)*
15	ALCOHOL SWABES *(Not Payable. Part of hospital's own internal cost)*
16	SCRUB SOLUTIONISTERILLIUM *(Not Payable. Part of hospital's own internal cost)*
17	Glucometer& Strips *(Not Payable pre hospitalization or post hospitalization / Reports and Charts required/ Device not payable)*
18	URINE BAG *(Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs)*

List V – Additional Non Payable Items

Sr. No	List of Expenses Generally Excluded ("Non-medical")
1.	BRUSH
2.	COSY TOWEL
3.	MOISTURISER PASTE BRUSH
4.	POWDER
5.	BARBER CHARGES
6.	OIL CHARGES
7.	BED UNDER PAD CHARGES
8.	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS, ETC.,
9.	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
10.	HOME VISIT CHARGES
11.	DONOR SCREENING CHARGES
12.	BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES
13.	BLADE
14.	MAINTENANCE CHARGES
15.	PREPARATION CHARGES
16.	WASHING CHARGES
17.	MEDICINE BOX
18.	COMMODE
19.	DIGESTION GELS
20.	NOVARAPID
21.	VOLINI GEL/ ANALGESIC GEL
22.	ZYTEE GEL
23.	AHD (ANCILLARY AND HOSPITAL DISINFECTION (EG.,BIOMEDICAL WASTE DISPOSAL/MANAGEMENT, SANITATION, SANITIZATION/FUMIGATION CHARGES ETC.)
24.	VISCO BELT CHARGES
25.	EXAMINATION GLOVES

26.	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
27.	PAPER GLOVES
28.	REFERRAL DOCTOR'S FEES
29.	SOFNET
30.	SOFTOVAC
31.	STOCKINGS

Welcome to
Digit Group Total Protect Policy
UIN: GODPAGP21491V022021

Inside:

Let's get started!

You're already awesome because you decided to opt for this Policy which will compensate in case of Your Disability or Death caused by accidents. While you're reading this policy, you get confused or have a query, or you are referring to this policy because you have a claim to make, please call us at 1800-258-5956 or mail us at hello@godigit.com.

Based on the declaration provided by You to us, **Go Digit General Insurance Limited** (hereinafter called 'the Company/DIGIT') which forms the basis of this policy contract, and having received your premium, we take pleasure in issuing this policy to you.

Go Digit General Insurance Limited will cover You under this Policy up to the Sum Insured/Limits mentioned against each Section, during the policy period mentioned in Your Policy Schedule / Certificate of Insurance. Of course, like any insurance cover, it is governed by, and subject to certain terms, conditions and exclusions mentioned in this Policy.

The benefit under each Section will be payable provided that an event or occurrence described under the Sections/Covers occurs during the Policy Period mentioned in Your Policy Schedule/Certificate of Insurance.

Note: This Policy Wording provides detailed terms, conditions and exclusions for all Sections available under this Product. Kindly refer to the Policy Schedule / Certificate of Insurance to know exact details of Sections opted by You. Only Wordings related to Sections mentioned in your Policy Schedule/Certificate of Insurance are applicable.

Disclaimer: The Description mentioned under "Digit Simplification"/ "Examples" throughout the Insurance Policy is only to aid Your understanding of the Coverage / Benefit Offered. In case of dispute, the Terms and Conditions detailed in the Policy Document and Policy Schedule/ Certificate of Insurance shall prevail.

DEFINITIONS

Digit Simplification: ***You didn't think you needed to know definitions since your time in school, right? Well, the good news is that you don't need to learn these by heart, as long as you understand them***.

Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them.

1. **Accident, Accidental** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Activities of daily/independent living** means:
   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
   c) braces, artificial limbs or other surgical appliances;
   d) 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;
   e) Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
   f) Feeding: the ability to feed oneself, food from a plate or bowl to the mouth once food has been prepared and made available.
   g) Mobility: The ability to move indoors from room to room on level surfaces at the normal place of residence
3. **Adventure Sports** means any sport or activity, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. Such sport/activity includes but is not limited to Insured Persons engaging in abseiling, aerial safari, ballooning , black water rafting, bouldering , bushwalking, canoeing , go karting, hiking/trekking, ice skating, jet boating , jet skiing , kayaking , mountain biking (cross country) , mountain biking on tracks and trails , parasailing , parascending (over water only) , rafting , river boarding , rock climbing, rowing / sculling , sea canoeing , sea kayaking, snorkelling , speed boating , surf boat rowing , surfing , tubing, wake skating , wakeboarding , windsurfing yachting, bungee jumping, motor biking , sandboarding , sand skiing , scuba diving, skidoos, skiing / snowboarding , snow mobiling , snow rafting, zip lining , zorbing , triathlon, gliding , hang gliding , parachuting , paragliding , parapenting, skydiving, free solo climbing, base jumping, wing suit flying, big wave surfing, cave diving, white water rafting, highlining, ice climbing, BMX racing, free fall, base jumping, free soloing, motor racing, glacier walking , motor racing including speed and trial runs.
4. **Allopathic treatment or medicine or allopathy** is a pejorative used by proponents of alternative medicine to refer to modern scientific systems of medicine, such as the use of pharmacologically active agents or physical interventions to treat or suppress symptoms or pathophysiologic processes of diseases or conditions.
5. **Alternative/Ayush Treatment** means forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context.
6. **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.
7. **Common Carrier** means any civilian land or water conveyance or Scheduled Airline in each case operated under a valid license for the transportation of passengers for hire.
8. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
9. **Congenital Anomaly:**
   Congenital Anomaly means a condition 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
10. **Contribution**

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any benefit offered on a fixed benefit basis

11. **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. Co-Payment will not be applicable to benefit Sections for example: Accidental Death, Critical Illness and Daily Hospital Cash Cover.
12. **Day Care Centre** means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under
    a) has qualified nursing staff under its employment;
    b) has qualified medical practitioner/s in charge;
    c) has fully equipped operation theatre of its own where surgical procedures are carried out;
    d) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.
13. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
    a) undertaken under General or Local Anaesthesia in a hospital/day care centre in less than 24 hrs because of technological advancement, and
    b) 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.
14. **Dental Treatment** means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery.
15. **Domiciliary Hospitalization:**

    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:
    a) the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
    b) the patient takes treatment at home on account of non-availability of room in a hospital.
16. **Emergency / 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.
17. **Fracture** means a complete or incomplete break in a bone resulting from the application of excessive force.
18. **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-existing diseases. Coverage is not available for the period for which no premium is received.
19. **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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said Act Or complies with all minimum criteria as under:
    a) has qualified nursing staff under its employment round the clock;
    b) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    c) has qualified medical practitioner(s) in charge round the clock;
    d) has a fully equipped operation theatre of its own where surgical procedures are carried out;
    e) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;
20. **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.

21. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function 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
22. **Injury/Bodily Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
23. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
24. **Intensive Care Unit (ICU)** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
25. **ICU 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 intensivist charges.
26. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
27. **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 doctors in the same locality would have charged for the same medical treatment.
28. **Medical Practitioner/Dentist** 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 its scope and jurisdiction of license.
    The registered practitioner should not be the insured or close member of the family.
29. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    a) is required for the medical management of the illness or injury suffered by the insured;
    b) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    c) must have been prescribed by a medical practitioner;
    d) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
30. **Migration** means, the right accorded to 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
31. **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.
32. **Non- Network Provider** means any hospital, day care centre or other provider that is not part of the network.

33. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
34. **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.
35. **Permanent Total Disablement** shall mean either of the following:
    a. Total Paralysis
    b. Total and irrecoverable loss of sight of both eyes, or
    c. Total and irrecoverable physical separation of or the loss of ability to use two Limbs (both hands or both feet or one hand and one foot), or
    d. Total and irrecoverable loss of sight of one eye and physical separation of or the loss of ability to use a limb (either one hand or one foot), or
    e. Total and irrecoverable loss of speech and hearing of both ears

    For the purpose of this definition,
    1. Total Paralysis means complete and irreversible loss of motor function leading to the total loss of function of the entire body from neck down due to an accidental injury to the spinal cord.
    2. Limb means a hand at or above the wrist or foot above the ankle.
    3. Loss of Limb means the physical separation of or the loss of ability to use a limb above the wrist and/or ankle respectively.
36. **Policy** means the Proposal, the Policy Schedule / Certificate of Insurance (and any endorsement attaching to or forming part thereof) and the Policy Wordings.
37. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule /Certificate of Insurance and includes both the commencement date as well as the expiry date.
38. **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
39. **Pre-Existing Disease** means any condition, ailment or injury or related condition(s) for which there were signs or symptoms, and / or were diagnosed, and / or for which medical advice / treatment was received within 48 months prior to the first policy issued by the insurer and renewed continuously thereafter.
40. **Pre-hospitalization Medical Expenses**

    Pre-hospitalization Medical Expenses means medical expenses incurred during pre- defined number of days preceding the hospitalization of the Insured Person, provided that:
    a. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
    b. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
41. **Post-hospitalization Medical Expenses:**

    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:
    a. Such Medical Expenses are for the same condition for which the insured person's hospitalization was required, and
    b. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company.
42. **Professional Sports** means the sports in which the sportsperson or the athlete receives payment for their performance.
43. **Qualified Nurse** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
44. **Reasonable and Customary Charges** means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.
45. **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.

46. **Room** means a Single Room without wall/permanent partition, dining or waiting room and with or without following amenities: an attendant cot, one television, one sofa, a telephone, refrigerator, wardrobe, computer with internet connection and microwave oven.
47. **Room Rent** means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.
48. **Sum Insured** means the amount as opted by You and stated in the Policy Schedule / Certificate of Insurance against the Section/Cover for each insured person including cumulative bonus (if any) for Individual Sum Insured Policy and aggregately for all insured members for a Floater Policy**.**
49. **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.
50. **Terrorism or act of Terrorism** means an act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), or unlawful associations, recognized under Unlawful Activities (Prevention) Amendment Act, 2008 or any other related and applicable national or state legislation formulated to combat unlawful and terrorist activities in the nation for the time being in force, committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public or any section of the public in fear for such purposes.
51. **Tertiary Care** constitutes of Specialized Advanced Care Unit designed to care to complex medical condition involving super specialist consultant like Neuro Surgeon, Neurologist, Spine Surgeons and Reconstructive Surgeons.
52. **Time Excess** means a cost sharing requirement 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.
53. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
54. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited
55. **You, Your, Yours, Yourself, Policyholder, Insured, Insured Member (s) Insured Person(s) means** the Individual Group Members who will be treated as Insured beneficiary both Named and Unnamed as described in the Policy Schedule/Certificate of Insurance.

COVERAGE

SECTION 1. ACCIDENTAL DEATH

Digit Simplification: ***The day bad luck strikes***

If this Cover has been opted and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your Death within twelve (12) months from the date of accident, then We will pay 100% of the Sum Insured, as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

Additional Inbuilt Benefits:

Below are the additional inbuilt benefits under **Section 1. Accidental Death** and We will pay 100% of the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, in the below events:

a. **Disappearance:** We shall be liable to be pay under this benefit, if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months, following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such Insured Member was known to have been travelling as a fare paying passenger or in any event arising as a result of Act of God Perils during the Policy Period, where it is reasonable to believe that such Insured Member has died as a result of an Accidental Injury.

b. **Drowning:** We shall be liable to be pay under this benefit, if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months, on account of Drowning during the Policy Period, where it is reasonable to believe that such Insured Member has died as a result of drowning.

For both (a) and (b) above, We will only pay, when the nominee or the legal heir provides a legally binding indemnity bond or any other document as required by Us which guarantees, that, 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 repaid in full to Us.

Once a claim has been accepted under this Section, this Policy will immediately and automatically cease in respect of that Insured Person. Also, **"Section 5. Children Education Benefit", "Section 6. Marriage Expense for Children", "Section 7. Orphan Benefit for Children", "Section 8. Funeral Expenses", "Section 9. Transportation Expenses", "Section 10. Trauma Counselling"**, **"Section 22. Compassionate Visit"** where ever opted, will cease on payment of entire Sum Insured in respect of the Insured Person against whom a claim has been accepted under this Section.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 2. PERMANENT TOTAL DISABLEMENT

If this Cover has been opted and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your **"Permanent Total Disablement"** within twelve (12) months from the Date of accident, then We will pay 100% of Sum Insured, as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

Specific Conditions:

1. If the Insured Member suffers Accidental Injuries resulting in more than one of the Permanent Total Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned against this Section.
2. Once a claim has been accepted under this Section, this Policy will immediately and automatically cease in respect of that Insured Person. Also, **"Section 5. Children Education Benefit", "Section 6. Marriage Expense for Children", "Section 10. Trauma Counselling", "Section 20. Lifestyle Modification Benefit", "Section 21. Expense for External Aids & Appliances", "Section 22. Compassionate Visit"** where ever opted, will cease on payment of entire Sum Insured in respect of the Insured Person against whom a claim has been accepted under this Section.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 3. PERMANENT PARTIAL DISABLEMENT

If this Cover has been opted and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of Your Permanent Partial Disablement within twelve (12) months from the Date of accident, then We will pay the percentage of Sum Insured, as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, as per the following Scale.

Permanent Partial Disablement –Table of Benefits

Nature of Injury	% of Sum Insured
Loss of each arm at the shoulder joint	70%
Loss of each leg above centre of the femur	70%

Loss of each arm to a point above elbow joint	65%
Loss of each leg up to a point below the femur	65%
Loss of each arm below elbow joint	60%
Loss of each hand at the wrist	55%
Complete and irrecoverable loss of sight of an eye	50%
Loss of each leg to a point below the knee	50%
Loss of each leg up the centre of tibia	45%
Loss of each foot at the ankle	40%
Loss of hearing in each ear	30%
Loss of each thumb	20%
Loss of each index finger	10%
Loss of sense of smell	10%
Loss of each other finger	5%
Loss of each big toe	5%
Loss of sense of taste	5%
Loss of each other toe	2%

For the purpose of this Cover, Loss means:

a. The physical separation of a body part, or
b. The total loss of functional use of body part or organ provided this has continued for at least 12 calendar months from the date of accident, provided that We must be satisfied at the expiry of the 12 calendar months that there is no reasonable medical hope for improvement.

Specific Conditions:

1. If the Insured Member suffers Accidental Injuries resulting in more than one Permanent Partial Disablement, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.
2. If the Insured Member suffers from a Permanent Partial Disablement not listed in the above table then an external medical advisor will determine the disablement percentage.
3. On acceptance of a claim under this Benefit, the Insured Member's Cover under this Benefit and Other Benefit opted under this Policy shall continue, subject to the availability of the Sum Insured, terms, conditions and Exclusion of this Policy.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 4. LOSS OF INCOME BENEFIT

If this Cover has been opted and You sustain an Accidental Bodily Injury during the Policy Period, which is the sole and direct cause of a Temporary Total Disablement and which completely prevents You from performing each and every duty pertaining to Your employment or occupation on a temporary basis, then We will pay a weekly benefit, amount of which is mentioned in Your Policy Schedule/Certificate of Insurance against this Section, provided that:

1. The Temporary Total Disablement is certified by a Medical Practitioner and submission of supporting documents/reports with respect to clinical examination, radiological scanning or imaging and/or neurological fallout testing as submitted to US, failing which We shall not be liable for any claim under this Section.

2. We will stop making payments when We are satisfied that You can engage in Your occupation again or when We have made payments for number of weeks as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance for any one injury calculated from the date of commencement the temporary total disablement as certified by the treating Medical Practitioner, whichever is earlier.
3. We shall not be liable to make any payment under this Benefit in respect of the Insured Person for more than the Total Number of weeks as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance for any and all claims arising within the Policy Period under this Benefit.
4. The benefit shall not be paid for the Time Excess mentioned in Your Policy Schedule/Certificate of Insurance i.e. for the number of days as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance calculated from the date of commencement of Temporary Total Disablement.
5. In case the Temporary Total Disablement is for a period less than a week, the benefit payable shall be calculated on proportionate basis in relation to the weekly benefit.
6. We will not pay any amount in excess of the Insured Person's base weekly income net of tax and other deductions, excluding overtime, bonuses, tips, commissions, or any other special compensation.
7. In case of any dispute with respect to the duration of Temporary Total Disablement, the duration shall be finally determined by a Doctor/Medical Practitioner mutually appointed by the Insured and Insurer, who certifies the final date upon which the Insured recovered and fit to perform each and every duty pertaining to his / her employment or occupation.

This Cover is subject to terms, conditions, time excess, limitations and exclusions mentioned in the Policy.

SECTION 5. CHILDREN EDUCATION BENEFIT

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**" and/or "**Section 2. Permanent Total Disablement**"**,** then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards the cost of education of Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.
2. The dependent child (children) pursuing an education course is a full-time student at an educational institution.
3. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule/Certificate of Insurance.
4. Any Claim under this Section that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal heirs.

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 6. MARRIAGE EXPENSE FOR CHILDREN BENEFIT

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**" and/or "**Section 2. Permanent Total Disablement**"**,** then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards the marriage expenses of Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.
2. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule/Certificate of Insurance.
3. Any Claim under this Section that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal heirs.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 7. ORPHAN BENEFIT FOR CHILDREN

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**" for the Insured Person who is a parent and while as a result of same accident or separate accident occurring during the Policy Period the Insured Person's Spouse (who may or may not be an Insured Person) has also died, then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section to Your dependent child (children) irrespective of whether the child(children) is an Insured Person under the Policy or not and provided that:

1. The dependent child (children) is under the age of 25 years and unmarried as on date of accident.
2. The dependent child (children) does not have any independent source of income.
3. Irrespective of the number of Children, maximum amount is the Sum Insured as mentioned in Your Policy Schedule/Certificate of Insurance.
4. Any Claim under this Section that becomes admissible where the Dependent child (children) is a minor, shall be payable to the legal guardian/heirs.
5. For the purposes of this Section, Child (Children) means those who has/have been born out of a marriage which is legally valid as on the date of the accident and/or those who has/have been adopted in accordance with Indian Law.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 8. FUNERAL EXPENSES

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**", then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards funeral, cremation and/or burial of the body of the deceased Insured Person.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 9. TRANSPORTATION EXPENSES

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**", then We will pay the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards the expenses of transporting the mortal remains of the Insured Person from the place of death to a cremation ground or burial ground or to the residence of the Insured Person.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 10. TRAUMA COUNSELLING

If You have opted for this Cover and We have accepted a claim under "**Section 1. Accidental Death**" and/or **"Section 2. Permanent Total Disablement"** and/or **"Section 3. Permanent Partial Disablement"**, and the treating Medical Practitioner advises Professional Counselling sessions for the psychological upliftment, changes in daily diet or nutrition intake, Psychotherapy or Medications, then We will reimburse up to the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, towards the expenses incurred for the counselling session, provided that, Coverage needs to be availed within Six months from the date of incident covered under this Section and is applicable to:

a. Insured Person's Parents, Spouse and Children – In case of **accidental death** of the Insured Person.
b. Insured Person – In case of **Permanent Total Disablement** and/or **Permanent Partial Disablement** sustained by the Insured during the Policy Period.

This Cover is subject to terms, conditions, Co-Payment, limitations and exclusions mentioned in the Policy.

SECTION 11. ACCIDENTAL HOSPITALIZATION COVER

***Digit Simplification:* The day bad luck strikes.**

A. Hospitalization Expenses

If You have opted for this Cover and You suffer an Accidental Injury during the Policy Period that requires Hospitalization as an inpatient, we'll be there for you. We will pay You all Reasonable and Customary Charges that are Medically Necessary and Incurred by You in respect of an admissible claim. The claim can be made under the following benefits and up to the Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room.
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees

B. Day Care Procedures

***Digit Simplification:* Why stay unnecessarily in a hospital when the required procedure requires less than a day!**

If You suffer an Accidental Injury during the Policy Period, due to which You need to undergo medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for a stay less than 24 hour because of technological advancement, We will pay the Medical Expenses Incurred for such Day Care Procedures.

Treatment normally taken on an out-patient basis is not included in the scope of this Cover.

C. Pre-Hospitalization Expenses

***Digit Simplification:* We all know that sometimes you need to shell out money way before you are actually hospitalised; smile, you're covered.**

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover, prior to the date of Your admission in a hospital, provided that:

1. Such Expenses recommended by the Hospital/Medical Practitioner were in fact incurred for the same condition for which Your Subsequent Hospitalization was required.
2. We have accepted an Inpatient Accidental Hospitalization Claim under **Section 11.A. Hospitalization Expenses Cover** of this Policy.

D. Post-Hospitalization Expenses

***Digit Simplification:* This covers for expenses incurred by You after you get discharged!**

We will pay for consultations, investigations and the cost of medicines incurred for a period not exceeding the number of days as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover, from the date of Your Discharge from the hospital, provided that:

1. The expenses are recommended by the Hospital/Medical Practitioner and are for the same condition for which you were hospitalized.
2. We have accepted an Inpatient Accidental Hospitalization Claim under Section **11.A. Hospitalization Expenses Cover** of this Policy.

E. Dental Treatment

***Digit Simplification:* Because you need to open your mouth and your wallet wide, at the dentist's.**

We will pay for the medical expenses incurred by You for any necessary Dental Treatment needed after an accident. A claim here is valid if the accident resulted in an admissible inpatient Hospitalization Claim under **Section 11. A. Hospitalization Expenses Cover.**

F. Road Ambulance

***Digit Simplification:* Emergencies will and shall always be a top priority.**

We will pay for the expenses incurred on Your road transportation by a Healthcare or an Ambulance Service Provider to a Hospital for treatment following an Emergency arising out of an Accident, provided that:

1. We have accepted a claim under **Section 11. A. Hospitalization Expenses Cover.**
2. The maximum liability per Hospitalization is restricted to the amount as mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.
3. The Coverage also Includes Your cost of road Transportation from a Hospital to another nearest Hospital which is prepared to admit You and provide the necessary medical services, if such medical services cannot satisfactorily be provided at a Hospital where You are situated. Such road Transportation has to be prescribed by a Medical Practitioner and/or should be Medically Necessary.

G. Second Medical Opinion

***Digit Simplification:* We want nothing but the best for You. Which is why we encourage you to go in for a second opinion, wherever necessary!**

We shall arrange and bear the cost for Second Opinion from our panel of Medical Practitioners. This is for times when there has been a major accidental injury that requires your hospitalisation in a tertiary care facility during the Policy Period, provided that:

1. We have received Your request to arrange for a Second Opinion.
2. You have the option to choose any One of Our Panel Medical Practitioners.
3. We will not provide more than one Opinion for the same Medical Condition within a Policy Period.

All the above Covers are Subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

H. Transportation of Imported Medicine

We will reimburse the costs incurred by You for freight charges for importing medicines to India, provided that:

1. We have accepted a claim under **Section 11. A. Hospitalization Expenses Cover.**
2. Such medicines, formulations or their alternatives are not available in India.
3. Such medicines are necessary for the medical or surgical treatment of the Insured Person in a Hospital following the Accident.
4. Such medicines shall not include any drugs under clinical trials or medicines, formulations or molecules of unproven efficacy.
5. The Medicines are recommended by the treating Medical Practitioner

Sum Insured Basis

Claim settlement would be done on the basis of Sum Insured Options selected by You and mentioned in Your Policy Schedule/Certificate of Insurance. The two Sum Insured Basis are as mentioned below:

Basis 1: This is the percentage as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section applied on the admissible claim amount of "**Section 1. Accident Death**" and/or **"Section 2. Permanent Total Disablement"** and/or **"Section 3. Permanent Partial Disablement"** and/or **"Section 4. Loss of Income Benefit"** as per the Sections opted by You.

Basis 2: This is the amount opted by You and mentioned Your Policy Schedule/Certificate of Insurance against this Section.

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 12. HOME (DOMICILIARY) HOSPITALIZATION

***Digit Simplification:* Sometimes, admitting the patient in a hospital is not possible!**

If You have opted for this Cover, We will pay the Medical Expenses incurred by You for accidental bodily Injury requiring medical treatment taken at home, which would otherwise have required Hospitalization, up to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section and provided that:

1. The condition of the patient is such that s/he is not in a condition to be moved to a Hospital or
2. The patient takes treatment at home on account of non-availability of room in a Hospital, and
3. The condition for which the medical treatment is required continues for at least 3 days, in which case We will pay the reasonable charge of any necessary medical treatment for the entire period
4. No Payment will be made if the condition for which You require medical treatment is due to any reason other than an accidental bodily injury.

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 13. LONG HOSPITALIZATION CASH BENEFIT

***Digit Simplification:* If even ward boys seem to know You by name, this cover is for You.**

If You have opted for this Cover and You suffer an Accidental Injury during the Policy Period that requires Hospitalization as an inpatient for a minimum number of consecutive days as Opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this Section, We will give you a lump sum amount as mentioned in the Policy Schedule / Certificate of Insurance. Provided that the benefit is payable only once to an Insured Person during the Policy Period.

For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 14. DAILY HOSPITAL CASH COVER

***Digit Simplification:* Staying is Hospital has expenditure beyond Hospital bill!**

If You have opted for this Cover, We agree to pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accidental bodily injury for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay twice the Daily Cash Allowance amount mentioned in the Policy Schedule / Certificate of Insurance against this Section.

Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

This Cover is subject to terms, conditions, time excess, limitations and exclusions mentioned in the Policy.

SECTION 15. OUT-PATIENT (OPD) BENEFIT

***Digit Simplification:* Expenses like doctor's consultation fees, health check-ups, pharmacy bills, dental treatment, diagnostic tests, etc… when You are not hospitalized are covered under this!**

If You have opted for this Cover and You sustain accidental bodily injury, We will pay the Reasonable and Customary Charges for below mentioned expenses incurred by You as an Allopathic Out-patient when OPD treatment is taken from a Medical Practitioner to the extent of the Sum Insured opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

What all is covered under this:

Professional Fees	Fees for Medically Necessary Consultation and Examination by Medical Practitioners to assess Your Health for any injury.
Diagnostic	Medically Necessary Out-patient diagnostic Procedures such as x-rays, pathology, Brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment from a diagnostic centre.
Surgical Treatment	Minor Surgical Procedure such as POP, Suturing, Dressings for Accidents and Animal Bite Related Outpatient Procedures Etc. Carried out by a Medical Practitioner
Medication	Drugs & Medicines prescribed by a Medical Practitioner
Out-Patient Dental Treatment	Any Out-patient dental treatment arising out of an accidental injury.
Rehabilitation	Physiotherapy, Psychiatric Counselling and Therapy

This cover excludes expenses incurred towards Hearing Aids, Spectacles, Implants, Contact Lenses, Vaccinations other than those required for animal bite, Cosmetic Procedures, Ambulatory Devices like Walkers, BP Monitors, Glucometers, Thermometers, Dietician Fees, Vitamins and Supplements.

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 16. EMERGENCY AIR AMBULANCE

***Digit Simplification:* When every minute counts. Sometimes when You meet with an Accident and have an Emergency, time is of a lot of importance.**

If You have opted for this Cover, We will pay You the expenses incurred for Your transportation in an airplane or helicopter for emergency life threatening health conditions which requires immediate and rapid ambulance transportation to the nearest hospital.

This transportation will be from the location where the accident happened the first time and subject to availability of Sum Insured mentioned in Your Policy Schedule / Certificate of Insurance against **Section 11. Accidental Hospitalization Cover** and provided that such Transportation in an airplane or helicopter has been prescribed or certified by a Medical Practitioner and/or is Medically Necessary**.**

Provided that, We have accepted a claim under **Section 11. Accidental Hospitalization Cover.**

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 17. COMA BENEFIT COVER

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Your hospitalization in an Intensive Care Unit of a Hospital in a state of Coma, within 30 days of date of accident, then We will pay You the Sum Insured as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, provided that:

1. The Coma is confirmed by a specialist Medical Practitioner in writing which includes:
   a. no response to external stimuli continuously for at least 96 hours; and
   b. life support systems and measures are necessary to sustain life
2. Permanent neurological deficit must be assessed at least 30 days after the onset of the coma and the reports to be submitted to Us for any benefit to be payable under this Section.

3. Coma resulting directly from alcohol or drug abuse or any other illness other than Accidental Bodily Injury is excluded.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 18. FRACTURE COVER

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Fracture(s) of Bone(s), then We will pay the percentage shown in the below table of benefits applied to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

Fracture Cover - Table of Benefits

Nature of Fracture	% of Sum Insured
Hip or Pelvis (excluding thigh or coccyx)	
Open Fracture of more than one bone with flail pelvis	100%
Open Fracture of more than one bone without flail pelvis	50%
Open Fracture of one bone	50%
Closed Fracture of more than one bone with flail pelvis	50%
Closed Fracture of more than one bone without flail pelvis	25%
Closed Fracture one bone	15%
Thigh	
Open Fracture of neck of Femur	60%
Open Fracture of shaft of femur	45%
Closed Fracture of neck of Femur	25%
Closed Fracture of shaft of femur	25%
Fracture of condyles /patella	15%
Lower Leg	
Open Fracture of more than one bone	60%
Open Fracture of one bone	45%
Closed Fracture of more than one bone	25%
Closed Fracture one bone	15%
Fracture Ribs	
Fracture of Multiple Ribs with Flail Chest	25%
Fracture of Multiple Ribs with without Flail Chest	20%
Fracture of Single rib / Fracture of sternum	10%
Elbows, Arm (including wrist but excluding Colles type fractures)	
Open Fracture of more than one bone	45%
Open Fracture of one bone	35%
Closed Fracture of more than one bone	20%
Closed Fracture one bone	15%
Colles type fracture of the lower arm	
Open Fracture	25%
Closed Fracture	10%
Skull	
Fracture of the skull needing surgical Intervention	60%
Fracture of the skull not needing surgical Intervention	20%
Shoulder Blade, Rib(s), Knee cap, Sternum, Hand (excluding fingers and wrist), Foot (excluding toes or heel)	
Open Fracture	30%
Closed Fracture	15%
Spinal Column (Vertebrae but excluding coccyx)	

Compression fractures of more than one vertebrae	40%
Spinous, transverse process of pedicle fractures of more than one vertebrae	40%
Permanent Spinal Cord damage	40%
Fractures of Single Vertebra	15%
Lower Jaw	
Open Fracture	25%
Closed Fracture	10%
Cheekbone, Clavicle, Coccyx, Upper Jaw, Nose, Toe(s), Finger(s), Ankle, Heel	
Open Fracture of more than one bone	15%
Open Fracture of one bone	12%
Closed Fracture of more than one bone	4%
Closed Fracture one bone	2%
Dislocations requiring surgery under anaesthesia	
Spine	35%
Back (Excluding slipped disc)	35%
Hip	25%
Knee (left or right)	20%
Wrist (left or right)	15%
Elbow (left or right)	15%
Ankle (left or right)	10%
Shoulder Blade (left or right)	10%
Collar bone	10%
Fingers (left or right hand)	5%
Toes (left or right foot)	5%
Jaw	5%
Internal Injuries	
Internal injuries resulting in open abdominal or Thoracic Surgery	25%
Intracranial haemorrhage and/ or physical brain injury	25%

Specific Conditions:

1. If You suffer a Fracture not specified in the below table but the fracture is due to an injury solely and directly due to an accident, then Our Medical Practitioner will decide the amount payable, if any.
2. A fracture which results due to any illness or disease (including malignancy) or due to osteoporosis shall not be payable under this benefit.
3. A fracture where the broken bone penetrates the skin is an Open Fracture and where the broken bone does not penetrate the skin is a Closed Fracture.
4. If the Insured Member suffers Accidental Injuries resulting in more than one fractures, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 19. BURNS COVER

If You have opted for this Cover and You sustain Second Degree Burns or Third Degree Burns solely and directly due to an accident, then We will pay the percentage shown in the below table of benefits applied to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

Burns Cover - Table of Benefits

Nature of Burns	% of Sum Insured

SECOND DEGREE BURNS	
Head	
Second degree burns of 30% or more of the total head surface area	50%
Second degree burns of 20% or more, but less than 30% of the total head surface area	40%
Second degree burns of 10% or more, but less than 20% of the total head surface area	30%
Rest of the Body	
Second degree burns of 20% or more of the total body surface area	50%
Second degree burns of 15% or more, but less than 20% of the total body surface area	40%
Second degree burns of 10% or more, but less than 15% of the total body surface area	30%
Second degree burns of 5% or more, but less than 10% of the total body surface area	10%
THIRD DEGREE BURNS	
Head	
Third degree burns of 30% or more of the total head surface area	100%
Third degree burns of 20% or more, but less than 30% of the total head surface area	80%
Third degree burns of 10% or more, less than 20% of the total head surface area	60%
Rest of the Body	
Third degree burns of 20% or more of the total body surface area	100%
Third degree burns of 15% or more, but less than 20% of the total body surface area	80%
Third degree burns of 10% or more, less than 15% of the total head body area	60%
Third degree burns of 5% or more, less than 10% of the total head body area	20%

For the purpose of this cover,

1. Burns means an injury caused by exposure to heat or flame including chemical and electric burns.
2. **Second Degree Burns** means Burns which involve the epidermis and part of the dermis layer of skin, causing the burn site to appear red, blistered, and may be swollen and painful.
3. **Third Degree Burns** (full thickness burns) means the burns that destroy the outer layer of the skin (epidermis) and the entire layer beneath i.e. the dermis. It also affects deeper tissues resulting in white or blackened, charred skin that may cause numbness, loss of fluid and sometimes shock.

Specific Conditions:

1. The burns that are self-inflicted by You in any way will not be covered under this Benefit;
2. A Medical Practitioner has to confirm the percentage of the surface area of the burn and the diagnosis of the burn to Us in writing.
3. If the Insured Member suffers Accidental Injuries resulting in more than one of the nature of burns mentioned in the above table of benefits, then Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 20. LIFESTYLE MODIFICATION BENEFIT

If You have opted for this Cover and We have accepted a claim under "**Section 2. Permanent Total Disablement**" and/or "**Section 3. Permanent Partial Disablement**", then We will reimburse the Reasonable and Customary Charges/Expenses incurred for improvements to be carried out in the Insured Person's residence and/or vehicle which are certified in writing by a Medical Practitioner to be necessary and following

the accident, up to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section.

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 21. EXPENSE FOR EXTERNAL AIDS & APPLIANCES

If You have opted for this Cover and We have accepted a claim under "**Section 2. Permanent Total Disablement**" and/or "**Section 3. Permanent Partial Disablement**", then We will reimburse the Reasonable and Customary Charges incurred towards purchase of support items such as artificial limbs, crutches, stretcher, tricycle, wheelchairs or any other item which is prescribed by a Medical Practitioner following an injury sustained in the accident, up to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 22. COMPASSIONATE VISIT

If You have opted for this Cover and We have accepted a claim under **"Section 1. Accident Death"** and/or **"Section 2. Permanent Total Disablement"** and/or **"Section 11. Accidental Hospitalization"** due to an accident in a location situated outside the City/Town of Your usual place of residence mentioned in Your Policy Schedule/Certificate of Insurance, then We will reimburse the actual cost incurred for to and fro economy class transportation by the most direct route via a common carrier, up to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, for one of the Insured's "**Immediate Family Member"** to travel to the place of accident or the Hospital in which the Insured Person is hospitalized.

For the purpose of this Section, the term "**Immediate Family Member**" would mean the Insured Person's spouse, siblings, Children above age of 18 years, parents or parents in law.

Specific Conditions:

The benefit is payable under this Section subject to:

1. The Insured Member's treating Medical Practitioner has advised in writing the personal attendance of an Immediate Family Member.
2. The Insured Person is Hospitalized at a distance of at least 100 kilometres from his place of residence.

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 23. MISCARRIAGE DUE TO ACCIDENTAL INJURY

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in **Miscarriage** of a Pregnant Insured Member within 15 days of such accident, then We will pay a lumpsum amount as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance, provided that:

a. The miscarriage shall not be attributed to any natural causes and/or sickness relating to pregnancy or child birth.
b. We shall not be liable for voluntary termination of pregnancy.
c. This benefit is applicable only to the female Insured Member covered under this Policy.

For the purpose of this Cover, **Miscarriage** shall mean the spontaneous or unplanned expulsion of a foetus from the womb within the first 20 weeks of gestation.

This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 24. ADVENTURE SPORTS COVER

If You have opted for this Cover and You sustain accidental bodily injury, whilst engaged in Adventure Sports listed below in a non-professional capacity and under the supervision of a trained professional, which solely and directly results in Your

a. "**Death**" and/or "**Permanent Total Disablement**" within twelve (12) months from the Date of accident; then We will pay 100% of Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section for "**Death**" and/or "**Permanent Total Disablement**";

and/or

b. "**Accidental Hospitalization**", then We will Pay Up to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section for "**Accidental Hospitalization**". We will pay the expenses Incurred in respect of the below items under "**Accidental Hospitalization**":

Accommodation/Room Rent	Hospital accommodation in a ward, shared or private room.
ICU	Intensive Care Unit
Professional Fees	Fees for treatment by specialists, physicians, nurses, surgeons and anaesthetists.
Medication	Drugs, medicines, consumables, prescribed by a specialist or medical practitioner. This also includes Anaesthesia, Blood, Oxygen, Patient's Diet, Surgical appliances & cost of prosthetic and other devices or equipment if implanted during the Surgical Procedure.
Diagnostic	Necessary Procedures such as x-rays, pathology, brain and body scans (MRI, CT scans) Etc. used to make a diagnosis for treatment.
Theatre Fees	Operation Theatre Fees
Day Care Procedures	Medical Expenses incurred for Medical treatment and/or surgical procedure as an inpatient under General or Local Anaesthesia in a hospital/day care centre for a stay less than 24 hour because of technological advancement.

Depending upon the option opted by You and mentioned in Your Policy Schedule/Certificate of Insurance

Option 1: a. "**Death**" and/or "**Permanent Total Disablement**" and b. "**Accidental Hospitalization**"
Option 2: a. "**Death**" and/or "**Permanent Total Disablement**"
Option 3: b. "**Accidental Hospitalization**"

List of Adventure Sports Activities Covered:

If You have opted for this Section, We will cover You against the below listed Adventure Sports only:
"abseiling, aerial safari, ballooning , black water rafting, bouldering , bushwalking up to 3,000 mts, canoeing , go karting, hiking/trekking up to 3,000 mts, ice skating (indoor only) , jet boating , jet skiing , kayaking , mountain biking (cross country) , mountain biking on tracks and trails , parasailing , parascending (over water only) , rafting , river boarding , rock climbing up to 3,000 mts, rowing / sculling , sea canoeing , sea kayaking (coastal waters only) , snorkelling , speed boating , surf boat rowing , surfing , tubing, wake skating , wakeboarding , windsurfing (coastal waters within 3 nautical miles only), yachting (coastal waters only) , bungee jumping, motor biking , sandboarding , sand skiing , skidoos, skiing / snowboarding , snow mobiling , snow rafting, zip lining , zorbing , triathlon, gliding , hang gliding , parachuting , paragliding , parapenting, skydiving with a professional trainer, scuba diving to 50 metres, unless any of the activities are modified/added /deleted and are specifically mentioned in Your Policy Schedule/Certificate of Insurance against this Section."

Specific Conditions:

1. The cover for the Insured Member under this Section shall terminate immediately once a claim is admitted and paid under the Adventure Sports Cover for "**Death**" or "**Permanent Total Disablement**".
2. Our maximum, total and cumulative liability under this Benefit shall be limited to the Sum Insured opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section

3. We will not pay any claim under this Cover, whilst You are Training for or Taking part in sport as a:
   - professional for which You are paid or funded by sponsorship or grant; or
   - as an amateur sportsperson; or
   - You are not performing the activity under the supervision of a trained professional

This Cover is subject to terms, conditions, co-payment, limitations and exclusions mentioned in the Policy.

SECTION 25. CRITICAL ILLNESS

***Digit Simplification:* We are with you for the best of times, and the worst of times.**

If You have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule / Certificate of Insurance against this Section, in case You are diagnosed as suffering from any of the Critical Illnesses or undergoing covered Surgical Procedures as per the Plan Opted by You and mentioned in Your Policy Schedule/Certificate of Insurance as specified below Provided that,

a) This Critical illness or covered surgical procedure has happened to you for the first time in your life.
b) We will not make any payment if You are diagnosed as suffering from Critical Illness within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first "Digit Group Total Protect Policy" with Us covering Critical Illness.
c) You survive for a minimum period of at least 30 days from the date of diagnosis of such Critical Illness, unless this condition is specifically waived by Us.
d) The Critical Illness or the Surgical Procedure Claim is not a consequence of or arising out of any pre-existing condition/disease
e) Once a claim has been Paid under Critical Illness and / or Surgical Procedure, Cover under this Section shall cease and no further payment will be made for any consequent disease or any dependent disease.

Plan wise Covered Critical Illnesses

Sr. No.	Category	Critical Illness	Plan A	Plan B	Plan C
1	**Malignancy**	Cancer of Specified Severity	Covered	Covered	Covered
2	**Cardiovascular system**	Myocardial Infarction	Covered	Covered	Covered
3		Open Heart Replacement or Repair of Heart Valves	Covered	Covered	Covered
4		Surgery to Aorta	Covered	Covered	Covered
5		Primary (Idiopathic) Pulmonary Hypertension	Not Covered	Covered	Covered
6		Aneurysm of Abdominal Aorta	Not Covered	Not Covered	Covered
7		Cardiomyopathy	Not Covered	Not Covered	Covered
8		Pulmonary artery graft surgery	Not Covered	Not Covered	Covered
9		Open Chest CABG	Covered	Covered	Covered
10	**Major Organ Transplant**	End Stage Lung Failure	Covered	Covered	Covered
11		End Stage Liver Failure	Covered	Covered	Covered
12		Kidney Failure Requiring Regular Dialysis	Covered	Covered	Covered
13		Major Organ/ Bone Marrow Transplant	Covered	Covered	Covered
14	**Nervous System**	Apallic Syndrome	Not Covered	Covered	Covered
15		Benign Brain Tumour	Covered	Covered	Covered
16		Coma of Specified Severity	Covered	Covered	Covered

17		Major Head Trauma	Covered	Covered	Covered
18		Permanent Paralysis of Limbs	Covered	Covered	Covered
19		Stroke Resulting in Permanent Symptoms	Not Covered	Covered	Covered
20		Motor Neurone Disease with Permanent Symptoms	Not Covered	Covered	Covered
21		Parkinson's Disease	Not Covered	Not Covered	Covered
22		Muscular Dystrophy	Not Covered	Not Covered	Covered
23		Progressive Supranuclear Palsy	Not Covered	Not Covered	Covered
24		Creutzfeldt-Jakob disease (CJD)	Not Covered	Not Covered	Covered
25		Bacterial Meningitis	Not Covered	Not Covered	Covered
26		Alzheimer's disease	Not Covered	Not Covered	Covered
27		Encephalitis	Not Covered	Not Covered	Covered
28		Multiple Sclerosis with Persisting Symptoms	Covered	Covered	Covered
29	**Others**	Loss of Independent Existence	Not Covered	Covered	Covered
30		Systemic lupus erythematosus	Not Covered	Not Covered	Covered
31		Goodpasture's syndrome	Not Covered	Not Covered	Covered
32		Fulminant Viral Hepatitis	Not Covered	Not Covered	Covered
33		Pneumonectomy	Not Covered	Not Covered	Covered
34		Aplastic Anaemia	Not Covered	Covered	Covered

Critical Illness Definitions Applicable to Benefit Cover 25 Above:

***Digit Simplification:* What all is covered and what is not. Everything in black and white for You!**

1. CANCER OF SPECIFIED SEVERITY

I. 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.

II. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

ix. All tumors in the presence of HIV infection.

2. 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:
   i. A history of typical clinical symptoms consistent with the diagnosis of acute myocardial infarction (For e.g. typical chest pain)
   ii. New characteristic electrocardiogram changes
   iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:
   i. Other acute Coronary Syndromes
   ii. Any type of angina pectoris
   iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

4. SURGERY TO AORTA

I. The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

5. 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.

6. ABDOMINAL AORTA ANEURYSM

An abdominal aortic aneurysm (AAA) is a swelling/dilatation (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body.

a. The diagnosis must be supported by a CT scans or CTA (Angiography) and requiring Endovascular aneurysm repair and the realization of surgery has to be confirmed by a cardiovascular surgeon.
b. Congenital conditions are excluded

7. CARDIOMYOPATHY

A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist).There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least Class 3 of the New York Heart Association classifications of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain) and LVEF of 40% or less.

The following conditions are excluded:

- Cardiomyopathy secondary to alcohol or drug abuse.
- All other forms of heart disease, heart enlargement and myocarditis.

8. PULMONARY ARTERY GRAFT SURGERY:

The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

9. 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:

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

10. END STAGE LUNG FAILURE

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

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

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

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

iv. Dyspnoea at rest.

11. END STAGE LIVER FAILURE

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

i. Permanent jaundice; and

ii. Ascites; and

iii. Hepatic encephalopathy.

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

12. 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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

13. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

vi. 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:**

i. Other stem-cell transplants

ii. Where only Islets of Langerhans are transplanted

14. APALLIC SYNDROME

I. Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

15. 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 relevant medical specialist.

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

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

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.

16. 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:

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.

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

17. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit is 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 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 following are excluded:

i. Spinal cord injury;

18. PERMANENT PARALYSIS OF LIMBS

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

19. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:

iii. Transient ischemic attacks (TIA)

iv. Traumatic injury of the brain

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

20. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. 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.

21. Parkinson's disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to Us.

The diagnosis must be supported by all of the following conditions:

a. the disease cannot be controlled with medication;
b. signs of progressive impairment; and
c. inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months.

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

22. MUSCULAR DYSTROPHY

A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following four conditions:

a. Family history of muscular dystrophy;
b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
c. Characteristic electromyogram; or
d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months.

23. PROGRESSIVE SUPRANUCLEAR PALSY:

A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days.

24. CREUTZFELDT-JAKOB DISEASE (CJD)

A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.

Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.

Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

25. BACTERIAL MENINGITIS

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living.

This diagnosis must be confirmed by:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b. A consultant neurologist certifying the diagnosis of bacterial meningitis.

Bacterial Meningitis in the presence of HIV infection is excluded.

26. ALZHEIMER'S DISEASE

Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our Appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests (e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Independent Living or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

The following conditions are however not covered:

a. non-organic diseases such as neurosis and psychiatric Illnesses;
b. alcohol related brain damage; and
c. any other type of irreversible organic disorder/dementia.

27. ENCEPHALITIS

Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist)

The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.

Exclusions:

• Encephalitis in the presence of HIV infection is excluded.

28. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

29. LOSS OF INDEPENDENT EXISTENCE

I. Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of Activities of Daily Living .

30. SYSTEMIC LUPUS ERYTHEMATOUS

A multi-system, multifactorial, autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. 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 World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specializing in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only hematological and joint involvement are however not covered:

The WHO lupus classification is as follows:

a. Class I: Minimal change – Negative, normal urine.
b. Class II: Mesangial – Moderate proteinuria, active sediment.
c. Class III: Focal Segmental – Proteinuria, active sediment.
d. Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
e. Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

31. GOODPASTURE`S SYNDROME

Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for continuous period of atleast ***30 Days***. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist *or Nephrologist*).

32. FULMINANT HEPATITIS

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.

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

33. PNEUMONECTOMY

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

The following conditions are excluded:

• Removal of a lobe of the lungs (lobectomy)
• Lung resection or incision

34. APLASTIC ANAEMIA

I. Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

(a) Blood product transfusion;
(b) Marrow stimulating agents;
(c) Immunosuppressive agents; or
(d) Bone marrow transplantation.

The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

Subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 26. HIV COVER

If You have opted for this Cover, We will pay You the Sum Insured as mentioned in Your Policy Schedule / Certificate of Insurance against this Section, in case You are first diagnosed to be suffering from an HIV Infection during the Policy Period and provided that HIV Infection is caused by any of the reasons other than Transmission through unprotected sex (Heterosexual, Homosexual or Bisexual).

For the purpose of this cover,
"HIV Infection" means a positive HIV antibody testing (rapid or laboratory-based enzyme immunoassay). This is usually confirmed by a second HIV antibody test (rapid or laboratory-based enzyme immunoassay) relying on different antigens or of different operating characteristics.
and /or;
a positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virological test obtained from a separate determination.

Special Terms and Conditions Applicable to this Section

a. Coverage under this Section shall terminate in respect of the Insured Member against whom a claim has been accepted. However, the coverage under the Policy for other Sections (if opted) for that Insured Member shall continue under this Policy.
b. Any Claim with respect to an HIV infection detected, diagnosed or which manifested prior to Policy Start Date or during Initial Waiting Period as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance is excluded from the Scope of the Cover provided under this Section.

SECTION 27. EMI PROTECTION COVER

If You have opted for this Cover and You sustain accidental bodily injury which solely and directly results in Your "**Death**" or "**Permanent Total Disablement**" or **"Permanent Partial Disablement"** within twelve (12) months from the Date of accident or suffer from **"Critical Illness"** as per the cover opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section and this completely prevents You from performing each and every duty pertaining to Your employment or occupation mentioned in Your Policy Schedule/Certificate of Insurance for a minimum period of 1 month, We will pay an amount equivalent to Your contribution in EMI of Your Loan from a Financial Institution, up to the Sum Insured and Number of Months opted by You and mentioned in Your Policy Schedule/Certificate of Insurance against this Section, provided that:

a. Satisfactory proof is submitted confirming that "**Permanent Total Disablement**" or **"Permanent Partial Disablement" or "Critical Illness"** has completely prevented You from engaging in Your Employment or Occupation mentioned in Your Policy Schedule/Certificate of Insurance.

b. We will stop making payments when We are satisfied that You can engage in Your Employment or Occupation again or when We have made payments for a maximum period of months, as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance, beginning from the date You met with the Accidental Bodily Injury or were first Diagnosed with Critical Illness or first underwent Surgical Procedures mentioned under Critical Illness, whichever is earlier.
c. The EMI amount would not include any arrears/payment that are overdue and unpaid by the Insured Person prior to the date of accident, due to any reasons whatsoever.

For the Purpose of this Cover;

a. **"Permanent Partial Disablement"** means:
- Loss of arm at the shoulder joint
- Loss of leg above centre of the femur
- Loss of arm to a point above elbow joint
- Loss of leg up to a point below the femur
- Loss of arm below elbow joint
- Loss of hand at the wrist
- Complete and irrecoverable loss of sight of an eye
- Loss of leg to a point below the knee
- Loss of leg up the centre of tibia
- Loss of foot at the ankle

b. **"Critical Illness"** shall mean the below listed illnesses that You are diagnosed as suffering from or Surgical Procedures that You are undergoing, for the first time in your life.

Provided that:

1. We will not make any payment if You are diagnosed as suffering from Critical Illness within the number of days (i.e. Initial Waiting Period) mentioned in Your Policy Schedule/Certificate of Insurance from the date of inception of first "Digit Group Total Protect Policy" with Us covering Critical Illness .
2. You survive for a minimum period of at least 30 days from the date of diagnosis of such Critical Illness, unless this condition is specifically waived by Us.
3. The Critical Illness or the Surgical Procedure Claim is not a consequence of or arising out of any pre-existing condition/disease

Sr. No.	Category	Critical Illness
1	**Malignancy**	Cancer of Specified Severity
2	**Cardiovascular system**	Myocardial Infarction
3		Open Heart Replacement or Repair of Heart Valves
4		Surgery to Aorta
5		Primary (Idiopathic) Pulmonary Hypertension
6		Open Chest CABG
7	**Major Organ Transplant**	End Stage Lung Failure
8		End Stage Liver Failure
9		Kidney Failure Requiring Regular Dialysis
10		Major Organ/ Bone Marrow Transplant
11	**Nervous System**	Apallic Syndrome
12		Benign Brain Tumour
13		Coma of Specified Severity
14		Major Head Trauma
15		Permanent Paralysis of Limbs
16		Stroke Resulting in Permanent Symptoms
17		Motor Neurone Disease with Permanent Symptoms

18		Multiple Sclerosis with Persisting Symptoms
19	**Others**	Loss of Independent Existence
20		Aplastic Anaemia

Note: For Definitions of the above mentioned Critical Illness, please refer **"Section 25. Critical Illness"**

1. CANCER OF SPECIFIED SEVERITY

I. 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.

II. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

ix. All tumors in the presence of HIV infection.

2. 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:

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

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

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

3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

4. SURGERY TO AORTA

I. The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

5. 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.

6. 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:

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

7. END STAGE LUNG FAILURE

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

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

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

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

iv. Dyspnoea at rest.

8. END STAGE LIVER FAILURE

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

iv. Permanent jaundice; and

v. Ascites; and

vi. Hepatic encephalopathy.

IV. Liver failure secondary to drug or alcohol abuse is **excluded.**

9. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

II. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal

transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

10. MAJOR ORGAN /BONE MARROW TRANSPLANT

II. The actual undergoing of a transplant of:

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

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

IV. **The following are excluded:**

i. Other stem-cell transplants

ii. Where only Islets of Langerhans are transplanted

11. APALLIC SYNDROME

II. Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

12. BENIGN BRAIN TUMOR

IV. 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.

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

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

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

VI. 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.

13. 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:

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.

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

14. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit is 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 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 following are excluded:

ii. Spinal cord injury;

15. PERMANENT PARALYSIS OF LIMBS

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

16. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:

iii. Transient ischemic attacks (TIA)

iv. Traumatic injury of the brain

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

17. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. 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.

18. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

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

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

iv. 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. Other causes of neurological damage such as SLE and HIV are excluded.

19. LOSS OF INDEPENDENT EXISTENCE

I. Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of Activities of Daily Living .

20. APLASTIC ANAEMIA

II. Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

(a) Blood product transfusion;
(b) Marrow stimulating agents;
(c) Immunosuppressive agents; or
(d) Bone marrow transplantation.

The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

Subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 28. LOSS OF EMPLOYMENT

If You have opted for this Cover and You are terminated or dismissed or retrenched from Your Employment, by the Employer during the Policy Period as per the Employer's rules/regulations or executed/ implemented by the Employer in compliance of any laws for the time being in force or any directives by any Public Authority, We will pay on any one of the following Basis Opted by You at Policy Inception and mentioned in Your Policy Schedule/Certificate of Insurance:

Basis 1:

a. An amount equal to the EMI payable monthly as mentioned in Your Policy Schedule/Certificate of Insurance. Or
b. 70% of Net Monthly Salary (Take home salary) after deduction of income tax, professional tax, PF Contributions, Bonuses / One-time Variable Pay, Any other deductions, and any reimbursements from the monthly pay slips. For the calculation of Monthly Take home salary, we shall consider the last three months monthly average salary subject to all deductions mentioned above.

The Claim Payable under this Basis shall be restricted to number of months as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance and shall be lower of Point a. and b. above. However, if the number of Outstanding EMI remaining in Your Loan Repayment Schedule, post the commencement of the claim payable under this Section is less than the number months as opted by You, then We shall be restricting our payments to the number of EMI remaining for the related loan.

Basis 2:

a. Fixed Amount Per Month as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance.
b. Or 70% of Net Monthly Salary (Take home salary) after deduction of income tax, professional tax, PF Contributions, Bonuses / One-time Variable Pay, Any other deductions, and any reimbursements from the monthly pay slips. For the calculation of Monthly Take home salary, we shall consider the last three months monthly average salary subject to all deductions mentioned above.

The Claim payable under this Basis shall be restricted to number of months as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance and shall be lower of Point a. and b. above.

Specific Exclusions Applicable to this Section

1. The Company shall not be liable to make any payment under this Section in the event of termination, dismissal, temporary suspension or retrenchment from employment of the Insured being attributed to any dishonesty or fraud or poor performance on the part of the Insured or his wilful violation of any rules of the employer or laws for the time being in force or any disciplinary action against the Insured by the employer.
2. The Company shall not be liable to make any payment under this Policy in connection with or in respect of:
   a. Self-employed persons;
   b. Any claim relating to unemployment from a job which is casual, temporary, seasonal or contractual in nature or any claim relating to an employee not on the direct rolls of the employer;
   c. Any voluntary unemployment;
   d. Unemployment at the time of inception of the Policy Period or arising within first three months of inception of the first policy with Us.

3. Any unemployment from a job under which no salary or any remuneration is provided to the Insured
4. Any suspension from employment on account of any pending enquiry being conducted by the employer/ Public Authority
5. Any unemployment due to resignation, retirement whether voluntary or otherwise
6. Any unemployment due to non-confirmation of employment after or during such period under which the Insured was under probation.
7. If the employment contract and Job Location was outside India.
8. Insured event Arising or resulting from the Insured committing any breach of the law with criminal intent.
9. Insured event Due to, or arising out of, or directly or indirectly connected with or traceable to, war, invasion, act of foreign enemy, hostilities (whether war be declared or not) civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, seizure, capture, arrests, restraints and detainment of all Heads of State and citizens of whatever nation and of all kinds and acts of terrorism.
10. Insured event Directly or indirectly caused by or contributed to by or arising out of usage, consumption or abuse of alcohol and/or drugs.
11. Any consequential or indirect loss or expenses arising out of or related to Insured Event.

Special Terms and Conditions Applicable to this Section

Re Employment

In the event insured gets re-employed but with reduced monthly take home salary. The Company shall pay the 70% of difference between the reduced monthly take home salary and monthly take home salary prior to the insured event, subject to the maximum of the EMI amount and shall be restricted to number of months as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance.

The Claim payable under this policy shall continue to be paid in reduced proportion as per the calculation method above, even if reemployment takes place during the period of severance pay, or during deferred period of 30 days or even after the Claim payable has commenced.

Initial Waiting Period

If the Insured event triggers within 90 days of the issuance of first policy with Us, any claim shall not be Payable under this policy.

Waiting Periods before the Benefit payment starts after an Insured Event

a. If the Employer pays any severance pay Benefit, then the claim payable under this section shall start only after the time period for which severance pay is applicable. For the calculation of "Time Period" for which severance pay shall be applicable, the company shall consider the Severance pay paid by the Employer divided by the monthly take home salary to consider the amount of period for which severance pay shall be applicable.
b. In addition to the point a. above, there will be a further waiting period of one month that shall be applicable before the claim payable under this policy Commences.

In the event, if the Insured has started working again during the waiting periods applicable above, this claim shall only be payable as per the reduced formulae as mentioned in "Re Employment" section above.

SPECIFIC EXCLUSIONS APPLICABLE TO ALL SECTIONS

***Digit Simplification:* We believe in being transparent with you, no hidden terms and conditions. So, here's what you are not covered for:**

We shall not be liable to make any claim payment under this Policy arising out of any of the following unless specifically agreed and mentioned elsewhere in the Policy Schedule/Certificate of Insurance:

STANDARD ONES

1. **30-day waiting period/ Initial 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.

   However, such waiting Period can be amended to the number of days as opted by you and mentioned in your policy schedule.

2. **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

3. **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

except to the extent covered under **Section 12. Home (Domiciliary) Hospitalization** if opted by You.

4. **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.

5. **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.
   However, You would be covered if you participate in a non-professional capacity for any recreational sport which may be under the supervision of a trained professional
   This exclusion will be deleted to the extent of the coverage provided under **"Section 24 – Adventure Sports Cover"**, provided this section is opted by You.

6. **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.

7. **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.

8. Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. Code- **Excl12**

9. 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**

10. 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**

11. **Refractive Error: Code- Excl15**
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

12. **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.

13. **Artificial Life Maintenance**
Artificial Life Maintenance, including life support machine used, where such treatment where such treatment is used to maintain the Insured/Patient in a vegetative state. However, expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the Policy.

14. **Suicide and Self-Injury**
We do not cover treatment directly or indirectly arising from or contributed or aggravated or accelerated by any of the following:
   a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
   b. Intentional self-injury
   c. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

15. **Pre-Existing Disability**
   a. Any Hospitalization for an existing disability from a previous Accident which has occurred prior to the first of this Policy.
   b. Any additional Hospitalization Expenses not resulting from an accidental Injury.

16. **Circumcision**
Circumcision unless necessitated by an Accident;

17. **Defence Operation/Aviation Activities**
We will not pay any claim under this Policy, arising out of Your
   a. whilst engaging in aviation or whilst mounting into, dismounting from or traveling in any aircraft other than as a passenger (fare paying or otherwise) in any duly licensed standard type of aircraft anywhere in the world and except to the extent covered under **"Section 24 – Adventure Sports Cover"**, provided this section is opted by you
   b. whilst the Insured person is operating or learning to operate any aircraft, or performing duties as a member of the crew on any aircraft, or Scheduled Airlines
   c. Involvement in naval, military, air force operation.

18. **Non-Medical Expenses**

Items of personal comfort and convenience including but not limited to television (wherever specifically charged for), charges for access to telephone and telephone calls, internet, foodstuffs (except patient's diet), cosmetics, hygiene articles, body care products and bath additive, barber or beauty service, guest service as well as similar incidental services and supplies including but not limited to charges for admission, discharge, administration, registration, documentation and filing. (Please refer Annexure B provided in the Policy Document or visit our website for complete list of non-medical items)

19. Insufficient Document

Under **"General Condition No. 34 - Claims Notification and Procedure"**, We have provided Section wise list of relevant necessary documents to be submitted at the time of claim. We shall not be liable to pay any claim in case all the relevant necessary documents are not submitted to Us and further We shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last necessary document.

20. Spectacles, Hearing aids & other Expenses

Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, medical supplies including elastic stockings and similar products.

21. Eye Sight & Optical Services

We do not cover treatment for:

a. Correction of refractive errors of the eye including but not limited to short-sight or long-sight, such as glasses, contact lenses or laser eyesight correction Surgery.
b. Intravitreal injection including but not limited to Lucentis, Macugen or any other similar treatment in excess of 5% of Sum Insured opted under **Section 11. Accidental Hospitalization Cover**.

22. Preventive Treatment

We do not cover inoculations, vaccinations of any kind unless forming part of treatment for accidental bodily Injury as prescribed by the Medical Practitioner.

23. Unjustified or Unwarranted Hospitalization

Admission solely for Physiotherapy or observation service**.**

24. Substance abuse and Addictions

a. Any claim resulting from an event where You were under the influence of Alcohol, opioids or nicotine or drugs (whether prescribed or not)
b. Any claim as a result of Withdrawal and de-addiction of Alcohol, opioids or nicotine or drugs (whether prescribed or not)

25. War and hazardous substances

We do not cover treatment directly or indirectly arising from or required as a consequence of:

a. War, invasion, acts of foreign enemy hostilities (whether or not War is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, attempted overthrow of Government; or
b. Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel; or
c. any acts of terrorism, unless specifically agreed by Us and mentioned in Your Policy Schedule/Certificate of Insurance.

26. Legal Liability

Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

27. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

28. Specific Treatments

We will not pay for expenses related to administration of medications or procedures including but not limited to expense related:

a. Hyaluronic acid, Remicade or Botulinum Toxin, Lucentis, Avastin.
b. Intra-articular/intra thecal or cortico-steroid injections.
c. Robotic surgeries however expenses will be covered up-to the conventional procedure cost.
d. Predictive Genome testing

29. Dental Treatment

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva, unless requiring Hospitalisation due to Accident and except to the extent covered under **Section 15. Out-Patient (OPD) Benefit, if opted.**

30. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment.

31. Mental Disorders

Accidental **"Death"** or **"Permanent Total Disablement" or "Permanent Partial Disablement"** due to mental disorders or disturbances of consciousness, strokes, fits or convulsions which affect the entire body and pathological disturbances caused by the mental reaction to the same.

GENERAL CONDITIONS APPLICABLE TO ALL SECTIONS

CONDITIONS PRECEDENT TO THE CONTRACT

***Digit Simplification:** There are some more conditions you should be aware of that we considered before we issued you the policy.*

1. 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.

2. POLICY PERIOD

a. The Policy can be issued for tenure of 1 year, 2 years, 3 years, 4 years and 5 years on Fixed Sum Insured basis and / or Reducing Sum Insured basis. Long Term policies (of more than 1-year tenure) can only be issued in case of loan/ credit linked policies
b. The Policy can also be issued for 1 year on Fixed Sum Insured basis to those who are not loan borrowers of financial institutions

3. CONDITIONS APPLICABLE FOR REDUCING SUM INSURED COVERS (applicable only for Credit Linked Policy)

The Sum Insured under the Policy on the date of occurrence of the Event covered under **"Section 1. Accident Death" and/or "Section 2. Permanent Total Disablement" and/or "Section 3. Permanent Partial Disablement" and/or "Section 25. Critical Illness"** for the purpose of calculation of claim shall be the least of the following:

1. The Principal Outstanding in the books of the Bank/ Financial Institution as on the date of occurrence of the Insured Event; or

2. The Principal Outstanding as per the amortization schedule prepared by Bank/Financial Institution. In the event the Sum Insured as appearing against **"Section 1. Accident Death" and/or "Section 2. Permanent Total Disablement" and/or "Section 3. Permanent Partial Disablement" and/or "Section 25. Critical Illness"** of

the Policy Schedule/ Certificate of Insurance is less than the total of the actual Loan disbursed up to the date of the occurrence of the Insured Event, then the Amortization schedule shall be calculated as if the actual Loan disbursed was equivalent to the Sum Insured.; or

3. The Sum Insured as appearing against **"Section 1. Accident Death" and/or "Section 2. Permanent Total Disablement" and/or "Section 25. Critical Illness"** of the Policy Schedule/ Certificate of Insurance.

Note: We will not consider any of below items while calculating our claim liability

a. Any Top-Ups or Enhancement of Initial Approved Loan amount
b. Any penalty, fee levied by the bank or financial institution
c. Increase in outstanding loan amount due to overdue payment or non-payment of EMI on timely basis

4. OBSERVANCE OF TERMS AND CONDITIONS

The adherence to the terms and conditions of this Policy by You or any Insured Person including the payment of premium by the due dates mentioned in the Policy Schedule / Certificate of Insurance is necessary for us to be liable to pay you the claim money.

5. ASSIGNMENT (IF OPTED) –IT IS HEREBY DECLARED AND AGREED THAT:

a. from the Policy Start Date, the monies payable by the Company to the Insured and all rights, title, benefits and interest of the Insured under this Policy stand assigned in favour of the Bank or Financial Institution as named in the Policy Schedule/ Certificate of Insurance;
b. upon any monies becoming payable under this Policy the same shall be paid by the Company to the Bank or Financial Institution as named in Policy Schedule/ Certificate of Insurance, without any reference/ notice to the Insured, but not exceeding the Principal Outstanding as defined under the Policy. In the event of any monies payable under this Policy exceeding the Principal Outstanding, the Company shall pay such monies as exceeding the Principal Outstanding to the Insured;
c. the receipt of such monies in the manner aforesaid by the Bank or Financial Institution as named in the Policy Schedule/ Certificate of Insurance and the Insured shall completely discharge the Company from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.

6. 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.

7. 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.

"Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to tale informed decision in the context of underwriting the risk.

8. NON-DISCLOSURE OR MISREPRESENTATION

Digit Simplification: ***In one line, this condition means, make sure all the information you share with us is correct!***

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the

proposal form either physically or electronically 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 i.e. from the inception date or the renewal date (as the case may be),
b) or the Policy may be modified by Us, at Our sole discretion, upon 30 days' notice by sending an endorsement to Your address shown in the Policy Schedule/Certificate of Insurance;
c) the claim under such Policy if any, shall be rejected/repudiated forthwith.

9. ELECTRONIC TRANSACTIONS

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

10. SHORT PERIOD COVER

Short Period Policy can be issued for period of less than one year for all Sections**.**

11. ON-DUTY COVER

On-Duty Cover can be provided for a restricted time period of the day i.e. work duty hours only for all Sections, except for "**Section 25. Critical Illness" and "Section 28. Loss of Employment"**

12. GEOGRAPHICAL COVERAGE

Geographical Coverage for each Section is as per the below table and Claims under the Policy will be paid in accordance with the same. All claims will be payable in INR only.

Section with Benefits	Geography Coverage
Section 1. Accidental Death	Worldwide
Section 2. Permanent Total Disablement	Worldwide
Section 3. Permanent Partial Disablement	Worldwide
Section 4. Loss of Income Benefit	Worldwide
Section 5. Children Education Benefit	Worldwide
Section 6. Marriage Expense for Children Benefit	Worldwide
Section 7. Orphan Benefit for Children	Worldwide
Section 8. Funeral Expenses	Worldwide
Section 9. Transportation Expenses	Worldwide
Section 10. Trauma Counselling	Within India
Section 11. Accidental Hospitalization Cover	Within India
Section 12. Home (Domiciliary) Hospitalization	Within India
Section 13. Long Hospitalization Cash Benefit	Within India
Section 14. Daily Hospital Cash Cover	Within India
Section 15. Out-patient Benefit	Within India
Section 16. Emergency Air Ambulance	Within India
Section 17. Coma benefit cover	Worldwide
Section 18. Fracture Cover	Worldwide

Section 19. Burns cover	Worldwide
Section 20. Lifestyle Modification	Worldwide
Section 21. Expense for External Aids and Appliances	Worldwide
Section 22. Compassionate Visit	Worldwide
Section 23. Miscarriage Due to Accidental Injury	Worldwide
Section 24. Adventure Sports Cover	-
A. Death/Permanent Total Disablement	Worldwide
B. Accidental Hospitalization	Within India
Section 25. Critical Illness	Worldwide
Section 26. HIV Cover	Worldwide
Section 27. EMI Protection Cover	Worldwide (Claim Payment Can be done only if loan is availed from Indian Financial Institutions in INR)
Section 28. Loss of Employment	Within India

CONDITION APPLICABLE DURING THE CONTRACT

***Digit Simplification:** There are some more conditions you should be aware of during the contract!*

13.ALTERATIONS TO THE POLICY

This Policy constitutes the complete contract of insurance between the Policyholder and Us. This Policy cannot be changed or edited by anyone (including an insurance agent or intermediary) except Us, (subject to necessary approval from the Insurance Regulatory and Development Authority of India) and any change We make will be through a written endorsement signed and stamped by Us, only on the request from Group Manager/ Insured Member.

14.MATERIAL CHANGE / CHANGE OF OCCUPATION

The Insured/ Insured Member shall immediately notify the Company in writing of any material change in the risk or change in business or occupation during the Policy Period. Insured should also at his own expense take precautions as circumstances may require ensuring safety thereby containing the circumstances that may give rise to a claim. The Company may adjust the scope of the cover and/or the premium, if necessary, accordingly.

The above notification is not mandatory when only the employer changes, but the nature of occupation does not change.

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.WITHDRAWAL OF PRODUCT

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

17.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

18.NO CONSTRUCTIVE NOTICE

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

19.SPECIAL PROVISIONS

Any special provisions subject to which this policy has been entered into and endorsed in the policy or in any separate instrument shall be deemed to be part of this policy and shall have effect accordingly.

20.SPECIAL CONDITIONS RELATING TO GROUP POLICY

All group policies are subject to the following conditions:

a. The insured will maintain sufficient deposit or provide a Bank Guarantee to comply with the requirement of section 64VB.
b. New names can be added to the existing group policies by charging pro-rata premium for the unexpired period of insurance.
c. For deletion of names from Group Policies during the Policy Period, refund of pro- Rata premium can be allowed only if there is no claim in respect of the particular insured Person as on date when request for deletion of name has been received

21.ADDITION /DELETION OF INSURED PERSON(S)

a. No person other than those persons named as the Insured Person(s) or those categories of the Insured specified in the Policy Schedule/ Certificate Of Insurance shall be covered under this Policy unless and until his/her name or the category has been notified in writing to the Company, any additional premium due has been paid and the Company's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person or category of persons as an Insured
b. Cover under this Policy shall be withdrawn from any Insured Person(s) named or any category of persons Insured immediately upon the Policyholder delivering written notice of the same to the Company.

22.ACCUMULATION CLAUSE

The Company's maximum liability in case of losses arising out of one event is limited to accumulation limit Mentioned in Your Policy Schedule/Certificate of Insurance. In the event of claim where the single event loss amount limit exceeds the limit mentioned in Your Policy Schedule /Certificate of Insurance, the benefits payable under this policy to each Insured person will be reduced proportionately in ratio of the overall event limit mentioned in Your Policy Schedule /Certificate of Insurance to the total amount claimed cumulatively by all the affected Insured persons in that event.

23.SPECIAL CONDITIONS APPLICABLE FOR POLICIES ISSUED WITH PREMIUM PAYMENT ON INSTALMENT BASIS

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

1. Grace Period of 15 Days would be given to Pay the instalment premium due for the Policy.
2. During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by Company.
3. 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
4. No interest will be charged If the instalment premium is not paid on due date.

5. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled.
6. In case of any admissible claim in a Policy year:
7. In the event of a claim, all subsequent premium instalments shall immediately become due and payable
8. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy
9. If the claim amount is equivalent or higher than the balance of the instalment premiums payable in that Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person.
10. If the claim amount is lesser than the balance premium payable, then no claim would be payable till the applicable premium is recovered.
11. Where Premium Payment is on Installment Basis, there will be no refund of premium in case of Policy Cancellation requested by You.

24.CANCELLATION

A. Cancellation by You

1. 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
   a. For Non-Credit Linked Policies which are issued for a period of maximum up to one Year, the below scale mentioned under "**Fixed Sum Insured Basis - Cancellation Scale**" shall be applicable.
   b. For Credit linked Policies one of the below mentioned scales will be applicable depending on the Sum Insured Basis Opted by You i.e. Fixed Sum Insured or Reducing Sum Insured.
   c. The refund of premium under the Credit Linked Policies shall be as under:
      i. In the event of full prepayment of the Loan by the Insured, We shall refund a portion of the premium subject to the terms and conditions of the Policy as per the rates mentioned in the below table.
      ii. In event of part prepayment of the Loan, no refunds of premium shall be made under this Policy.
      iii. 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 .

Fixed Sum Insured Basis - Cancellation Scale

Period in Risk	Premium Refund based on Policy Term				
	1 Year	2 Year	3 Year	4 Year	5 Year
Within 3 months	60%	60%	60%	60%	60%
Exceeding 3 months but less than 6 months	40%	50%	55%	55%	55%
Exceeding 6 months but less than 9 months	25%	40%	50%	50%	50%
Exceeding 9 months but less than 12 months	0%	35%	45%	45%	50%
Exceeding 12 months but less than 15 months	NA	25%	40%	40%	45%
Exceeding 15 months but less than 18 months	NA	20%	30%	40%	45%
Exceeding 18 months but less than 21 months	NA	10%	25%	35%	40%
Exceeding 21 months but less than 24 months	NA	0%	20%	30%	35%
Exceeding 24 months but less than 27 months	NA	NA	15%	25%	35%
Exceeding 27 months but less than 30 months	NA	NA	10%	25%	30%
Exceeding 30 months but less than 33 months	NA	NA	5%	20%	25%
Exceeding 33 months but less than 36 months	NA	NA	0%	15%	25%
Exceeding 36 months but less than 39 months	NA	NA	NA	10%	20%

Exceeding 39 months but less than 42 months	NA	NA	NA	5%	20%
Exceeding 42 months but less than 45 months	NA	NA	NA	5%	15%
Exceeding 45 months but less than 48 months	NA	NA	NA	0%	10%
Exceeding 48 months but less than 51 months	NA	NA	NA	NA	10%
Exceeding 51 months but less than 54 months	NA	NA	NA	NA	5%
Exceeding 54 months but less than 57 months	NA	NA	NA	NA	0%
Exceeding 57 months	NA	NA	NA	NA	0%

Reducing Sum Insured Basis – Cancellation Scale

Loan Period	Cancellation Year				
	Year 1	Year 2	Year 3	Year 4	Year 5
1	-	-	-	-	-
2	35%	-	-	-	-
3	42%	19%	-	-	-
4	47%	27%	12%	-	-
5	50%	32%	18%	8%	-
6	52%	36%	22%	12%	-
7	53%	38%	25%	14%	-
8	54%	39%	26%	16%	-
9	54%	40%	28%	17%	-
10	55%	41%	28%	17%	-
11	55%	41%	29%	18%	-
12	55%	42%	30%	19%	-
13	55%	42%	30%	19%	-
14	56%	42%	30%	19%	-
15	56%	43%	31%	19%	-
16	56%	43%	31%	20%	-
17	56%	43%	31%	20%	-
18	56%	43%	31%	20%	-
19	56%	43%	31%	20%	-
20	56%	43%	31%	20%	-
21	56%	44%	32%	20%	-
22	56%	44%	32%	20%	-
23	56%	44%	32%	20%	-
24	56%	44%	32%	21%	-
25	56%	44%	32%	21%	-
26	56%	44%	32%	21%	-

27	56%	44%	32%	21%	-
28	56%	44%	32%	21%	-
29	56%	44%	32%	21%	-
30	56%	44%	32%	21%	-

Note: For Cancellation of Policies opted on Reducing Sum Insured Basis, No Refund will be made during the Last Year of the Policy Term/Period.

B. CANCELLATION BY US

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.

Note :Please note KYC documents (Photo ID card) shall be required if the premium refund to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per premium refund.

25. LAW AND JURISDICTION

It is hereby declared and agreed that this contract of insurance and all claims thereunder shall be governed by Indian Law and any legal proceeding in respect thereof shall be raised a competent court of India. All claims shall be paid in Indian Rupees only.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

Digit Simplification: What You should know when You are about to claim.

26.MULTIPLE POLICIES (Applicable to Indemnity Sections under this Policy)

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.

v. The contribution clause shall not be applicable where the cover/ benefit offered:
   - is fixed in nature (For Example: Accidental Death, Permanent Total Disablement, Permanent Partial Disablement, Critical Illness, Daily Hospital Cash Cover)
   - does not have any relation to the treatment costs;

27.PHYSICAL EXAMINATION

Any medical official or other agent of the company shall be allowed to examine the Insured Person(s) in case of alleged injury or disablement when and as often as may be reasonably be required on behalf of the Company.

28. 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 has made that particular claim, who shall be jointly and severely 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 agents or the hospital/Doctors/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 grounds 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 intension to supress the fact or that such misstatement of or suppression of such material fact are within the knowledge of the Insurer.

29.ARBITRATION

If we have any differences with respect to the claim amount to be paid under this policy, it will be referred to arbitration in accordance with the Indian Arbitration and conciliation act 1996, as amended. The making of an award under such arbitration proceedings shall be a condition precedent for the Company to be liable to make any payment under this policy.

30.COMPLETE DISCHARGE

Any payment to the Policyholder, insured person or his/ her nominee or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

31.RECORDS TO BE MAINTAINED

You shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

32.POLICY DISPUTE

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

33.AUTOMATIC TERMINATION OF COVER FOR INSURED PERSON

The cover for the Insured Member shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under "Death" or "Permanent Total Disablement".

34.CLAIMS NOTIFICATION AND PROCEDURE

If the Insured Person meets any accidental injury or suffers from Critical illness or any specific condition covered under the Policy that may result in a claim under this policy, it is a condition precedent to Our liability under the Policy that below procedure should be followed depending on the type of claim:

1. **Cashless Claim Process (Applicable Only for "Section 11. Accidental Hospitalization Cover":**

Cashless Facility can be availed from our network hospitals only. This is facilitated by our Service Provider / Third Party Administrator (TPA) and we would make a direct payment to the Network Hospital to the extent of Our Liability provided that:

1. We are given a notice within 24 Hours of hospitalization in case of an emergency situation
2. For Cashless Facility You shall follow the below Procedure:
   a. Share the Health Card/Copy of E-Cards along with ID Proof with the Hospital Authority & Obtain the Pre-Authorization Form from the Hospital.
   b. Submit Duly filled & Signed Pre-Authorization Form to the Hospital Counter.
   c. Ensure that the Hospital shares the Duly filled & Signed Pre-Authorization Form to Service Provider / Third Party Administrator (TPA) for further Processing.
   d. Service Provider / Third Party Administrator (TPA) will inform the decision and may issue authorization letter depending on the Policy Terms and Conditions to the Hospital directly.
   e. Once the request for Pre-Authorization has been granted, the treatment must take place within 15 days of the Pre-Authorization Approval Date or the Policy Expiry Date whichever is earlier and shall be valid only if all the details of the Authorised details, Hospital and Location including Dates match with the details of the Actual Treatment Received.
   f. We reserve the right to modify, add or restrict any Network Provider for Cashless Facility in Our sole discretion. Before availing Cashless Facility, please check the applicable updated list of Network Providers.
   g. For any queries designated Service Provider / Third Party Administrator (TPA) may be contacted on the contact details mentioned on the Health Card/Copy of E-Cards issued to You.

2. Reimbursement Claim Process

A. For all Section with Accidental Hospitalization Cover

Reimbursement Facility can be availed from any hospital within India of Your Choice Wherein You will have to make payment directly to the Hospital and submit the documents to Service Provider / Third Party Administrator (TPA) for processing the reimbursement of the claim amount provided that:

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated 48 hours of date of admission.
2. For Reimbursement Claim You shall follow the below Procedure:
   a. 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.
   b. 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.
   c. 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.
   d. 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.
   "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due.
   e. In case of Your Death, We shall reimburse the claim amount to Your Nominee as named in Your Policy Schedule/Certificate of Insurance or Your Legal representative holding a valid succession certificate.

Note: There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions A.1 and A.2.a above may be considered where the reason for delay is proved to our satisfaction.

B. For All Other Covers without Accidental Hospitalization Cover

Upon the occurrence of any event that may result in a Claim under this Policy, then as a condition precedent to our liability:

a. Policyholder or the Insured Person or someone claiming on his/her behalf must inform Us in writing immediately and in any event within 30 days from the date of occurrence any accident/incident that may result in a claim and submit all documents to us within 30 days from the date of intimation.
b. Insured Person must immediately consult a Doctor and follow the advice and treatment that he recommends, where ever required.
c. Insured Person must take reasonable steps to lessen the consequence of Bodily injury.
d. Insured Person should allow examination by our medical advisors if we ask for this.
e. Policyholder or Insured Person or someone claiming on his/her behalf must promptly give us documentation and other information we ask for to investigate the claim or our obligation to make payment for it.
f. In case of the Insured Person's death, someone claiming on his/her behalf must inform us in writing immediately and send us a copy of the post mortem report (if conducted) within 30 days.
g. All Claims shall be settled/repudiated within 30 days from the date of receipt of the last necessary claim document subject to the Policy Terms and Conditions. In case of any delay in payment for all approved claims beyond 30 days from the receipt of the last necessary claim document, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by You.

Note: There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions a and f above may be considered where the reason for delay is proved to our satisfaction.

List of Claim Documents:

In addition to the Duly Completed Claim Form signed by the Insured/Insured's Nominee/Legal Heir & NEFT Details or Cancelled Cheque of the Insured/Insured's Nominee/Legal Heir, ID proof (KYC document) of insured and Nominee, address proof wherever applicable, We need to have the below documents, wherever applicable:

Section	Documents
Section 1. Accidental Death **Section 24. Adventure Sports Cover** **Section 7. Orphan Benefit For Children**	• Copy of Address Proof (Ration Card or Electricity Bill Copy). • Attested Copy of Death Certificate. • Death Summary/Certificate from the hospital authority (wherever applicable) • Burial Certificate (wherever applicable). • Attested Copy of Statement of Witness, if any lodged with police authorities. (wherever applicable). • Attested Copy of FIR / Panchanama / Inquest Panchanama. (wherever applicable). • Attested Copy of Post Mortem Report (Only if conducted). • Attested Copy of Viscera report if any (Only if Post Mortem is conducted). • For Adventure Sports Cover, please submit Certificate of Participation from Sports Event organizer/service provider / Pre-participation fitness certificate (wherever applicable).

	• Attested Copy of Passport or any other valid document which will suffice as a proof of relationship between the insured, insured's spouse and orphan child. (Applicable only for Orphan Benefit)
Section 2. Permanent Total Disablement **Section 3. Permanent Partial Disablement** **Section 24. Adventure Sports Cover**	• Attested Copy of disability certificate from relevant government Medical authority. • Attested copy of FIR. (If required) • All Investigation reports confirming the disability. • Complete Treatment record with follow-up documentation. • For Adventure Sports Cover, please submit Certificate of Participation from Sports Event organizer/service provider / Pre-participation fitness certificate (wherever applicable). • Disability assessment report from Digit empanelled medical specialist (if required)
Section 4. Loss of Income Benefit	• Attested copy of FIR. (If required) • All Investigation reports confirming the disability • For Employed persons: Certificate from HR with details of medical leave availed during the period of Injury • Certificate from the treating doctor mentioning the extent of Injury along with the period of disability • Certificate from Treating doctor with date of full recovery & resuming of duties
Section 5. Children Education Benefit	• Bonafide Certificate from School / College or Certificate from the Educational Institution
Section 6. Marriage Expense for Children Benefit	• Proof of Relationship with the Insured Person • Photo Identity Proof of Child • Age Proof of the Dependent Child
Section 8. Funeral Expenses	• Original Invoice of Expenses Incurred during Funeral.
Section 9. Transportation Expenses	• Original Invoices of expenses incurred for Carriage of Dead Body/repatriation of mortal remains.
Section 10. Trauma Counselling	• Documents as mentioned under Section 1. Accidental Death and/or Section 2. Permanent Total Disablement and/or Section 3. Permanent Partial Disablement • Original Invoice of Expenses Incurred for Counselling. • Medical Practitioner's letter advising Counselling. • Treatment plan for Counselling from Specialist.
Section 11. Accidental Hospitalization Cover **Section 13. Long Hospitalization Cash Benefit** **Section 14. Daily Hospital Cash Cover**	• Discharge Summary • Original Hospital Main Bill • Original Hospital Bill Break Up of Various Expenses • Original Pharmacy Bills • Prescriptions for the Medicines purchased (except hospital supply) and investigations done outside the Hospital • Consultation Papers

	• Investigation Reports • Digital Images/CDs of the Investigation Procedures (if required) • MLC/FIR Report (If applicable) • Original Invoice/Sticker (If applicable) • Post Mortem Report (If applicable) • Attending Physician Certificate (If applicable) • Death Certificate (If applicable)
Section 12. Home (Domiciliary) Hospitalization	• Attending Physician Certificate mentioning the need for Home (Domiciliary Hospitalization) • Original Pharmacy Bills • Consultation Papers • Original Investigation bills and Reports • Original Invoices in respect of payment made to the treating Medical Practitioner.
Section 15. Out-patient Benefit	• Consultation Papers • Original Investigation bills and Reports • Digital Images/CDs of the Investigation Procedures (if required) • Original Pharmacy Bills
Section 16. Emergency Air Ambulance	• Original bills and receipts paid for the transportation from Registered Ambulance Service Provider • Letter from Medical Practitioner indicating emergency need for such transportation and fitness for transportation.
Section 17. Coma Benefit Cover	• Certificate from the Treating Medical Practitioner certifying the cause and severity of Coma. • All relevant medical summary leading to Coma.
Section 18. Fracture Cover	• X Ray Confirming the Fracture & site of Fracture • Pre and post-operative radiological imaging reports with films confirming the extent of the fracture • Certificate from Treating Medical Practitioner with extent of Injury, Cause of injury, Site of Injury & Date of Injury. • Treatment Details • Discharge Summary (if Hospitalized)
Section 19. Burns cover	• Certificate from Treating Medical Practitioner with extent of Burns Injury/Cause of Burns. • Treatment Details • Medico Legal Certificate copy / First Information Report Copy (If applicable) • Discharge Summary (if Hospitalized)
Section 20. Lifestyle Modification	• Certification from Medical Practitioner necessitating the Modification.

	• Original Invoices of actual expenses incurred for the Modifications.
Section 21. Expense for External Aids and Appliances	• Prescription of treating Medical Practitioner for use of External Aids and Appliance. • Original Invoices of actual expenses incurred for the purchase of External Aids and Appliance
Section 22. Compassionate Visit	• Letter from Medical Practitioner advising presence of Immediate Family Member. • Original travel tickets / bills and receipts mentioning the actual expenses of the travel with the date of booking & date of travel • Age Proof of the Person who has visited the Insured
Section 23. Miscarriage Due to Accidental Injury	• Treating Medical Practitioners Certificate mentioning reason for Miscarriage and date of accidental injury. • Medical Reports & Investigations Done • Discharge Summary (if applicable)
Section 25. Critical Illness **Section 26. HIV Cover**	• Medical Reports/ Records • Investigation Tests Report • Copy of Hospital Summary/Discharge Card • Medical Practitioner's Certificate confirming the Illness /Treatment advise / Medical Reference.

Section 27. EMI Protection cover	• Current Outstanding Loan Certificate from Financer.
	• Loan Disbursement Letter along with the payment record till the date of Accident or first diagnosis of Critical Illness or first underwent surgical procedure.
	• Certificate from HR with details of medical leave availed during the period of Injury.
	• Copy of Address Proof (Ration Card or Electricity Bill Copy).
	• In Case of Death
	  ○ Attested Copy of Death Certificate.
	  ○ Death Summary/Certificate from the hospital authority (wherever applicable)
	  ○ Burial Certificate (wherever applicable).
	  ○ Attested Copy of Statement of Witness, if any lodged with police authorities. (wherever applicable).
	  ○ Attested Copy of FIR / Panchanama / Inquest Panchanama. (wherever applicable).
	  ○ Attested Copy of Post Mortem Report (Only if conducted).
	  ○ Attested Copy of Viscera report if any (Only if Post Mortem is conducted).
	• In case of Permanent Total Disablement, Permanent Partial Disablement
	  ○ Attested Copy of disability certificate from relevant government Medical authority.

	○ Attested copy of FIR. (If required) ○ All Investigation reports confirming the disability. ○ Complete Treatment record with follow-up documentation. ○ Disability assessment report from Digit empanelled medical specialist (if required)
Section 28. Loss of Employment	• Certificate from the Employer confirming the termination, dismissal, temporary suspension or retrenchment from employment of the Insured furnishing the date of termination, dismissal, temporary suspension or retrenchment from employment of the Insured with the reasons for the same. In case of temporary suspension, the period of suspension should also be mentioned in such certificate. • Appointment Letter • Latest Copy of Salary Revision, if any. • Last 3 Months Salary Slip • Form 16 • Loan Account Statements duly signed by the Financial Institution. • Contact details of Employer-Phone No. Mobile No., E-mail ID, Contact person in HR/Admin/Personnel dept. • Appointment Letter Employer if Re employed • Age proof of Insured: Aadhar Card, Election ID Card / PAN Card/ School Leaving • Form 26AS which shows tax deducted at source • Income tax return for relevant financial year • Self-declaration • Any other document as required by the Company /TPA to investigate the Claim or Our obligation to make payment for it, including documents related to proof that the insured has not found any job or has not started working again in family business or started his / her own venture.

For the purpose of Claims clarification, we may require additional documents in case of any insured event arising leading to claim.

*KYC documents shall be required at the claim settlement stage where claims pay-out to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per claim

CONDITIONS FOR RENEWAL OF THE CONTRACT

35.RENEWAL OF POLICY

i. The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.
ii. The Company shall endeavour to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
iii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iv. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
v. 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.
vi. No loading shall apply on renewals based on individual claims experience.
vii. We shall not deny the renewal of Your policy on the ground that You had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates after the payment of Sum Insured (For Example: Accidental Death, Permanent Total Disablement, Permanent Partial Disablement, Critical Illness, Daily Hospital Cash Cover)

36.CONTINUITY BENEFITS

We will grant continuity of benefits which were available to the Insured Members under a health insurance policy which provides similar benefits in the immediately preceding Cover Year provided that:

i. We shall be liable to provide continuity of only those benefits (for e.g.: Initial wait period etc) which are applicable under this Policy;
ii. The Insured Members to whom continuity benefits will be provided should be covered under the Group Insurance Policy.
iii. Any other wait period that is applicable specific to this policy but was permanently excluded in the previous policy will not be given any credit.

37.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 → Click Here

38.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.

For Detailed Guidelines on migration, kindly refer the → Click Here

CUSTOMER GRIEVANCE REDRESSAL POLICY

In case of any grievance the insured person may contact the company through
Website : https://www.godigit.com
Toll Free : 1-800-258- 4242
Email: hello@godigit.com
Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.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 grievance@godigit.com
For updated details of grievance officer, kindly refer the link: → Click Here

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
Grievance may also be lodged at IRDAI Integrated Grievance Management System- https://igms.irda.gov.in/

The contact details of the Insurance Ombudsman Centres are mentioned below: (Note: Address and contact number of Governing Body of Insurance Council).

Office Location	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	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@ecoi.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@ecoi.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@ecoi.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455, Fax: 0674 - 2596429, Email: bimalokpal.bhubaneswar@ecoi.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@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandīgarh.
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@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481 / 23213504, Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205, Fax: 0361 - 2732937, Email: bimalokpal.guwahati@ecoi.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 - 65504123 / 23312122, Fax: 040 - 23376599, Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363, Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM	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@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA	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@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	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@ecoi.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.: 022 - 26106552 / 26106960, Fax: 022 - 26106052, Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253, Email: bimalokpal.noida@ecoi.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	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952, Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE	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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Note: GOVERNING BODY OF INSURANCE COUNCIL,3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.Tel.: 022 - 26106889 / 671 / 980, Fax: 022 - 26106949, Email: inscoun@ecoi.co.in

ANNEXURE - A
LIST OF DAY CARE PROCEDURES

Sr. No	Day Care Procedures for Accidental Injuries
1	Surgery for ligament tear
2	Surgery for meniscus tear
3	Surgery for Hemarthrosis/Pyoarthrosis
4	Removal of fracture pins/ nails
5	Removal of metal wire
6	Foreign body removal from nose
7	Suturing - CLW -under LA or GA
8	Surgical debridement of wound
9	Closed reduction on fracture, luxation
10	Reduction of dislocation under GA
11	Tennis elbow release
12	Arthroscopic knee aspiration
13	Aspiration of Hematoma
14	Incision and Drainage
15	Foreign body removal from cornea
16	Foreign body removal from posterior chamber of eye

17	Foreign body removal from lens of the eye
18	Foreign body removal from orbit and eye ball
19	Reduction of nasal fracture
20	Foreign body removal from conjunctiva

Annexure-B
List I – Optional Items

Sl No	Item
1.	BABY FOOD *(Not Payable)*
2.	BABY UTILITIES CHARGES *(Not Payable)*
3.	BEAUTY SERVICES *(Not Payable)*
4.	BELTS/BRACES *(Not Payable)*
5.	BUDS *(Not Payable)*
6.	COLD PACK/HOT PACK *(Not Payable)*
7.	CARRY BAGS *(Not Payable)*
8.	EMAIL/ INTERNET CHARGES *(Not Payable)*
9.	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL) *(Not Payable)*
10.	LEGGINGS *(Not Payable)*
11.	LAUNDRY CHARGES *(Not Payable)*
12.	MINERAL WATER *(Not Payable)*
13.	SANITARY PAD *(Not Payable)*
14.	TELEPHONE CHARGES *(Not Payable)*
15.	GUEST SERVICES *(Not Payable)*
16.	CREPE BANDAGE *(Not Payable)*
17.	DIAPER OF ANY TYPE *(Not Payable)*
18.	EYELET COLLAR *(Not Payable)*
19.	SLINGS *(Not Payable)*
20.	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES *(Part Of Cost Of Blood, Not Payable)*
21.	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22.	Television Charges *(Payable Under Room Charges Not if separately levied)*
23.	SURCHARGES *(Part of Room Charge Not Payable Separately)*
24.	ATTENDANT CHARGES *(Part of Room Charge Not Payable Separately)*
25.	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE) *(Patient Diet provided by hospital is Payable)*
26.	BIRTH CERTIFICATE *(Not Payable)*
27.	CERTIFICATE CHARGES *(Not Payable)*
28.	COURIER CHARGES *(Not Payable)*
29.	CONVEYANCE CHARGES *(Not Payable)*
30.	MEDICAL CERTIFICATE *(Not Payable)*
31.	MEDICAL RECORDS *(Not Payable)*
32.	PHOTOCOPIES CHARGES *(Not Payable)*
33.	MORTUARY CHARGES *(Not Payable)*
34.	WALKING AIDS CHARGES *(Not Payable)*
35.	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL) *(Not Payable)*
36.	SPACER *(Not Payable)*
37.	SPIROMETRE *(Device Not Payable)*

38.	NEBULIZER KIT *(Not Payable)*
39.	STEAM INHALER *(Not Payable)*
40.	ARMSLING *(Not Payable)*
41.	THERMOMETER *(Not Payable)*
42.	CERVICAL COLLAR *(Not Payable)*
43.	SPLINT *(Not Payable)*
44.	DIABETIC FOOTWEAR *(Not Payable)*
45.	KNEE BRACES (LONG/ SHORT/ HINGED) *(Not Payable)*
46.	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER *(Not Payable)*
47.	LUMBO SACRAL BELT *(Not Payable)*
48.	NIMBUS BED OR WATER OR AIR BED CHARGES *(Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia / quadriplegia for any reason and at reasonable cost of approximately Rs. 200 / day*
49.	AMBULANCE COLLAR *(Not Payable)*
50.	AMBULANCE EQUIPMENT *(Not Payable)*
51.	ABDOMINAL BINDER *(Not Payable)*
52.	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES *(Post hospitalization nursing charges not Payable)*
53.	SUGAR FREE Tablets *(Payable. Sugar free variants of admissible medicines are Not excluded)*
54.	CREAMS POWDERS LOTIONS *(Toiletries are not payable, only prescribed medical pharmaceuticals payable)*
55.	ECG ELECTRODES *(Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be Payable)*
56.	GLOVES *(Sterilized Gloves Payable / Unsterilized Gloves not payable)*
57.	NEBULISATION KIT *(Payable Reasonably only if used during Hospitalization)*
58.	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, etc.]
59.	KIDNEY TRAY *(Not Payable)*
60.	MASK *(Not Payable)*
61.	OUNCE GLASS *(Not Payable)*
62.	OXYGEN MASK *(Not Payable)*
63.	PELVIC TRACTION BELT *(Not Payable)*
64.	PAN CAN *(Not Payable)*
65.	TROLLY COVER *(Not Payable)*
66.	UROMETER, URINE JUG *(Not Payable)*
67.	AMBULANCE *(Payable Reasonably only if used during Hospitalization upto sub-limit mentioned in the policy schedule)*
68.	VASOFIX SAFETY *(Not Payable)*

List II - Items that are to be subsumed into Room Charges

Sl No	Item
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED) *(Not Payable)*
2	HAND WASH *(Not Payable)*
3	SHOE COVER *(Not Payable)*
4	CAPS *(Not Payable)*
5	CRADLE CHARGES *(Not Payable)*
6	COMB *(Not Payable)*
7	EAU-DE-COLOGNE/ ROOM FRESHNERS *(Not Payable)*
8	FOOT COVER *(Not Payable)*
9	GOWN *(Not Payable)*
10	SLIPPERS *(Not Payable)*
11	TISSUE PAPER *(Not Payable)*
12	TOOTHPASTE *(Not Payable)*

13	TOOTHBRUSH *(Not Payable)*
14	BED PAN *(Not Payable)*
15	FACE MASK *(Not Payable)*
16	FLEXI MASK *(Not Payable)*
17	HAND HOLDER *(Not Payable)*
18	SPUTUM CUP *(Payable Under Investigation Charges, Not as Consumable)*
19	DISINFECTANT LOTIONS *(Not Payable-Part of Dressing Charges)*
20	LUXURY TAX *(Only Actual Tax Levied by Government is Payable - Part of Room Charge for Sub Limits)*
21	HVAC *(Part of Room Charge Not Payable Separately)*
22	HOUSE KEEPING CHARGES *(Part of Room Charge Not Payable Separately)*
23	AIR CONDITIONER CHARGES *(Payable Under Room Charges Not if separately levied)*
24	IM IV INJECTION CHARGES *(Part of Nursing Charges, Not Payable)*
25	CLEAN SHEET *(Part of Laundry/housekeeping Not Payable Separately)*
26	BLANKET/WARMER BLANKET *(Not Payable- Part of Room Charges)*
27	ADMISSION KIT *(Not Payable)*
28	DIABETIC CHART CHARGES *(Not Payable)*
29	DOCUMENTATION CHARGES/ ADMINISTRATIVE EXPENSES *(Not Payable)*
30	DISCHARGE PROCEDURE CHARGES *(Not Payable)*
31	DAILY CHART CHARGES *(Not Payable)*
32	ENTRANCE PASS/ VISITORS PASS CHARGES *(Not Payable)*
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE *(To be Claimed by Patient under Post -Hospitalization where admissible)*
34	FILE OPENING CHARGES *(Not Payable)*
35	INCIDENTAL EXPENSES/ MISC. CHARGES (NOT EXPLAINED) *(Not Payable)*
36	PATIENT IDENTIFICATION BAND/ NAME TAG *(Not Payable)*
37	PULSEOXYMETER CHARGES *(Not Payable)*
38	Nursing, DMO/ RMO charges included in room rent under associated medical expenses *(Not Payable)*

List III - Items that are to be subsumed into Procedure Charges

Sl No.	Item
1	HAIR REMOVAL CREAM *(Not Payable)*
2	DISPOSABLES RAZORS CHARGES (for site preparations) *(Payable for site preparations)*
3	EYE PAD *(Not Payable)*
4	EYE SHIELD *(Not Payable)*
5	CAMERA COVER *(Not Payable)*
6	DVD, CD CHARGES *(Payable only if CD is specifically sought by Insurer/TPA)*
7	GAUSE SOFT *(Not Payable)*
8	GAUZE *(Not Payable)*
9	WARD AND THEATRE BOOKING CHARGE *(Payable Under OT Charges, Not Payable Separately)*
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS *(Rental Charged By The Hospital Payable. Purchase of Instruments Not Payable.)*
11	MICROSCOPE COVER *(Payable Under OT Charges, Not Payable Separately)*
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER *(Payable Under OT Charges, Not Payable Separately)*
13	SURGICAL DRILL *(Payable Under OT Charges, Not Payable Separately)*
14	EYE KIT *(Payable Under OT Charges, Not Payable Separately)*
15	EYE DRAPE *(Payable Under OT Charges, Not Payable Separately)*
16	X-RAY FILM *(Payable Under Radiology Charges, Not as Consumable)*
17	BOYLES APPARATUS CHARGES *(Part Of OT Charges, Not Separately)*

18	COTTON *(Not Payable-Part of Dressing Charges)*
19	COTTON BANDAGE *(Not Payable-Part of Dressing Charges)*
20	SURGICAL TAPE *(Not Payable-payable by the Patient when Prescribed, otherwise included as Dressing Charges)*
21	APRON *(Not Payable -Part of Hospital Services/Disposable Linen to be Part of OT/ICU Charges)*
22	TORNIQUET *Not payable (service is charged by hospital, consumables cannot be separately charged.*
23	ORTHOBUNDLE, GYNAEC BUNDLE (Part of Dressing Charges)

List IV - Items that are to be subsumed into costs of treatment

Sl No.	Item
1	ADMISSION/REGISTRATION CHARGES *(Not Payable)*
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE *Unless A Claim Is Accepted Under Section1 - Hospitalization Cover*
3	URINE CONTAINER *(Not Payable)*
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES *(Not Payable)*
5	BIPAP MACHINE *(Not Payable)*
6	CPAP/ CAPD EQUIPMENTS *(Device Not Payable)*
7	INFUSION PUMP- COST *(Device Not Payable)*
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC (May be Payable when prescribed for patient, not Payable for hospital use in OT or ward or for dressings in hospital)
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES *(Patient diet provided by hospital is payable)*
10	HIV KIT *(Payable Only as Pre-Operative Screening)*
11	ANTISEPTIC MOUTHWASH *(Payable when prescribed)*
12	LOZENGES *(Payable when prescribed)*
13	MOUTH PAINT *(Payable when prescribed)*
14	VACCINATION CHARGES *(Not Payable)*
15	ALCOHOL SWABES *(Not Payable. Part of hospital's own internal cost)*
16	SCRUB SOLUTIONISTERILLIUM *(Not Payable. Part of hospital's own internal cost)*
17	Glucometer& Strips *(Not Payable pre hospitalization or post hospitalization / Reports and Charts required/ Device not payable)*
18	URINE BAG *(Payable where medically necessary till a reasonable cost - maximum 1 per 24 hrs)*

List V – Additional Non Payable Items

Sr. No	List of Expenses Generally Excluded ("Non-medical")
1.	BRUSH
2.	COSY TOWEL
3.	MOISTURISER PASTE BRUSH
4.	POWDER
5.	BARBER CHARGES
6.	OIL CHARGES
7.	BED UNDER PAD CHARGES
8.	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS, ETC.,
9.	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION
10.	HOME VISIT CHARGES
11.	DONOR SCREENING CHARGES
12.	BAND AIDS, BANDAGES, STERILE INJECTIONS, NEEDLES, SYRINGES
13.	BLADE
14.	MAINTENANCE CHARGES
15.	PREPARATION CHARGES

16.	WASHING CHARGES
17.	MEDICINE BOX
18.	COMMODE
19.	DIGESTION GELS
20.	NOVARAPID
21.	VOLINI GEL/ ANALGESIC GEL
22.	ZYTEE GEL
23.	AHD (ANCILLARY AND HOSPITAL DISINFECTION (EG.,BIOMEDICAL WASTE DISPOSAL/MANAGEMENT, SANITATION, SANITIZATION/FUMIGATION CHARGES ETC.)
24.	VISCO BELT CHARGES
25.	EXAMINATION GLOVES
26.	OUTSTATION CONSULTANT'S/ SURGEON'S FEES
27.	PAPER GLOVES
28.	REFERRAL DOCTOR'S FEES
29.	SOFNET
30.	SOFTOVAC
31.	STOCKINGS

Digit Group Hospital Cash Policy

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Inside:

Let's get started!

You're already awesome because you decided to protect your most important asset, your health. Especially with so many new illnesses sprouting every year, one needs to protect oneself against the financial & emotional burden of falling ill.
So, think of Digit as your fitness buddy, keeping pace with you on your way to good health. While you're reading this policy, you get confused or have a query, or you are referring to this policy because you have a claim to make, please call us at 1800-258-4242 or mail us at hello@godigit.com

Based on the declaration provided by You to us, **Go Digit General Insurance Limited** (hereinafter called 'the Company/DIGIT') which forms the basis of this health policy contract, and having received your premium, we take pleasure in issuing this policy to you.

Go Digit General Insurance Limited will cover You under this Policy up to the Sum Insured, during the policy period mentioned in your Policy Schedule / Certificate of Insurance. Of course, like any insurance cover, it is governed by, and subject to certain terms, conditions and exclusions mentioned in this Policy.

Note: This Policy Wording provides detailed terms, conditions and exclusions for all Sections available under this Product. Kindly refer to the Policy Schedule / Certificate of Insurance to know exact details of Sections opted by You. Only Wordings related to Sections mentioned in your Policy Schedule / Certificate of Insurance are applicable.

Disclaimer: The Description mentioned under "Digit Simplification"/ "Examples" throughout the Insurance Policy is only to aid Your understanding of the Coverage / Benefit Offered. In case of dispute, the Terms and Conditions detailed in the Policy Document and Policy Schedule / Certificate of Insurance shall prevail.

DEFINITIONS

Digit Simplification: ***You didn't think you needed to know definitions since your time in school, right? Well, the good news is that you don't need to learn these by heart, as long as you understand them***.
Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them.

1. **Accident** means sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Any one illness** means continuous period of illness and it includes relapse within forty-five days from the date of last consultation with the hospital where treatment has been taken.
3. **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
4. **Condition Precedent** means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
5. **Congenital Anomaly** refers to 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.
6. **Contribution**

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion of Sum Insured. This clause shall not apply to any benefit offered on a fixed benefit basis.

7. **Credit Linked Policy** means a policy in which the policy period can be extended upto the underlying credit period not exceeding five years
8. **Day Care Centre means** any institution established for day care treatment of disease/ injuries or a medical setup within 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 criteria as under:
   i. has qualified nursing staff under its employment;
   ii. has qualified medical practitioner (s) in charge;
   iii. has a fully equipped operation theatre of its own where surgical procedures are carried out
   iv. maintains daily records of patients and shall make these accessible to the Company's authorized personnel.
9. **Day Care Treatment** means medical treatment, and/or surgical procedure which is:
   i. Undertaken under general or local anaesthesia in a hospital/day care centre in less than twenty-four hours because of technological advancement, and
   ii. which would have otherwise required a hospitalisation of more than twenty-four hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition.
10. **Dental Treatment** means a treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery.
11. **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.
12. **Disclosure to information norm:** 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.
13. **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-existing diseases. Coverage is not available for the period for which no premium is received.
14. **Hazardous Activities** means any sport or activity, which is potentially dangerous to the Insured Person whether he/she is trained or not in such sport or activity. Such sport/activity includes but not limited to Insured Persons whilst engaging in speed racing of any kind (other than on foot), professional or competitive sport, bungee jumping, parasailing, ballooning, parachuting, base jumping, skydiving, paragliding, mountain or rock climbing necessitating the use of guides or ropes, potholing, abseiling, deep sea diving, biathlon, big game hunting, black water rafting, bmx stunt/ obstacle riding, bobsleighing/ using skeletons, bouldering, boxing, canyoning, caving/spelunking/pot holing, cave tubing, climbing/ trekking/ walking over 4,000 meters, cycle racing, cyclo-cross, drag racing, endurance testing, hang gliding, harness racing, hell skiing, high diving (above 5 meters), hunting, ice hockey, ice speedway, jousting, judo, karate, kendo, luging, marathon running, martial arts, micro - lighting, modern pentathlon, motor cycle racing, motor rallying, parapenting, piloting aircraft, polo, powerlifting, power boat racing, quad biking, river- boarding, river bugging, river bugging, rodeo, roller hockey, rugby, ski acrobatics, ski doo ski jumping, ski racing, sky diving, small bore target shooting, speed trials/ time trials, triathlon, water ski jumping, weight lifting, wrestling snow and ice sports or involving a naval military or air force operation. Insured Person whilst flying or taking part in aerial activities except as a fare-paying passenger in a regular schedule airline or air charter company.
15. **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 Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) and the said Act Or complies with all minimum criteria as under:
    i) has qualified nursing staff under its employment round the clock;
    ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
    iii) has qualified medical practitioner(s) in charge round the clock;

iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel;

16. **Hospitalization/Hospitalized** 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.
17. **Illness** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the policy period and requires medical treatment.
    i. **Acute Condition** means a disease, illness or injury that is likely to response 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.
    ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics
    a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/ or tests
    b. it needs ongoing or long-term control or relief of symptoms
    c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it
    d. it continues indefinitely
    e. it recurs or is likely to recur
18. **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
19. **Inpatient Care** means treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.
20. **Intensive Care Unit (ICU)** means an identified section, ward or wing of a hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
21. **Maternity expenses** means;
    a) medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization);
    b) expenses towards lawful medical termination of pregnancy during the policy period.
22. **Medical Advice** means any consultation or advice from a Medical Practitioner including the issuance of any prescription or follow-up prescription.
23. **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 doctors in the same locality would have charged for the same medical treatment.
24. **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 the licence.
    The registered practitioner should not be the insured or close member of the family.
25. **Medically Necessary Treatment** means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which:
    i)is required for the medical management of the illness or injury suffered by the insured;
    ii)must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
    iii)must have been prescribed by a medical practitioner;
    iv)must conform to the professional standards widely accepted in international medical practice or by the medical community in India.
26. **Migration** means, the right accorded to 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.
27. **Newborn Baby m**eans baby born during the Policy Period and is aged upto 90 days.

28. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
29. **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.
30. **Policy** means these Policy wordings, the Policy Schedule/Certificate of Insurance and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to the Insured person.
31. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule / Certificate of Insurance and includes both the commencement date as well as the expiry date.
32. **Policy year**
    a. **For Annual Policy –** Policy year means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such policy period, as mentioned in the Policy Schedule / Certificate of Insurance.
    b. **For Long Term Policy-** Policy year means each period in multiples of twelve (12) months beginning from the date of commencement of the policy period and any subsequent additional months, not constituting a period of twelve months, will be considered as a complete policy year. Such policy will end on last day of the policy period, as mentioned in the Policy Schedule/Certificate of Insurance.
    Digit Explanation of Long-Term Policy*: *Say you bought a Group Hospital Cash policy with us for a period of 32 months with Policy Inception Date as 1st January 2020. This means that you are covered for three policy years:
    - ***1st January 2020 to 31st December 2020 (counted as one policy year)***
    - ***1st January 2021 to 31st December 2021 (counted as your second policy year).***
    - ***1st January 2022 to 31st August 2022 (counted as your third policy year)***

    You can exhaust your sum insured in each of these policy years
33. **Pre-Existing Disease** Pre-existing disease means any condition, ailment, injury or disease
    a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or
    b) 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.
34. **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.
35. **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.
36. **Sum Insured** means the amount as opted by You and stated in the Policy Schedule / Certificate of Insurance against the Section/Cover for each insured person including cumulative bonus (if any) for Individual Sum Insured Policy and aggregately for all insured members for a Floater Policy**.**
37. **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.
38. **Unproven/Experimental treatment** means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
39. **Waiting Period** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.
40. **We, Us, Our, Ours, Digit, Company, Insurer** means Go Digit General Insurance Limited**.**
41. **You, Your, Yours, Yourself, Policyholder, Insured Person(s) means** the Individual Group Members who will be treated as Insured beneficiary.

COVERAGE

***Digit Simplification:* Staying is Hospital has expenditure beyond Hospital bill! This helps you cover that.**

All the Benefits available under this Policy are described below. The Benefits opted by You are specifically mentioned in the Policy Schedule/Certificate of Insurance.

SECTION 1. ACCIDENTAL HOSPITALIZATION CASH ALLOWANCE COVER

This Cover protects You in case of Your Hospitalization as an inpatient due to an Accidental Injury during the Policy Period, We will pay You as per the Sum Insured Basis Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

Sum Insured Basis Option:
You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

1. **Basis 1 - Per Day Benefit**
   If You have opted for this Basis We will pay You a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accidental bodily injury for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

   If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay an amount equivalent to the percentage of the Daily Cash Allowance as opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this Basis.

2. **Basis 2 – Fixed Lump Sum Benefit**
   If You have opted for this Basis We will pay You a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Hospitalisation arising out of accidental bodily injury for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

   Conditions Applicable to both Basis 1 & 2:
   - In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year on Floater Sum Insured basis.
   - For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
   - Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
   - This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 2. ACCIDENTAL & ILLNESS HOSPITALIZATION CASH ALLOWANCE COVER

This Cover protects You in case of Your Hospitalization as an inpatient due to an Accidental bodily Injury or Illness during the Policy Period. We will pay You as per the Sum Insured Basis Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

Sum Insured Basis Option:
You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

1. **Basis 1 - Per Day Benefit**
   If You have opted for this Basis We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

   If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay an amount equivalent to the percentage of the Daily Cash Allowance as opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this Basis.

2. **Basis 2 – Fixed Lump Sum Benefit**
   If You have opted for this Basis We agree to pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Conditions Applicable to both Basis 1 & 2:

- In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year on Floater Sum Insured basis.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 3. CRITICAL ILLNESS HOSPITALIZATION CASH ALLOWANCE COVER

This cover protects You in case of Your Hospitalization as an inpatient due to a Critical Illnesses or undergoing related Surgical Procedures during the Policy Period, as per the **Plan Opted by You** and mentioned in Your Policy Schedule/Certificate of Insurance. We will pay You as per the **Sum Insured Basis Opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The above is provided that,

a) This Critical illness or Covered Surgical Procedure has happened to You for the first time in Your life.
b) The diagnosis of the Critical Illness or Covered Surgical Procedure and hospitalization should have happed after the **Critical Illness Initial Waiting Period mentioned in Your Policy Schedule/Certificate of Insurance against this section**.
c) No Claim under this option shall be admissible if the Critical Illness or the Surgical Procedure is a result of any pre-existing condition/disease.

Sum Insured Basis Option:

You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

1. **Basis 1 - Per Day Benefit**
   If You have opted for this Basis, We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Hospitalisation arising out of the Critical Illnesses or Surgical Procedures mentioned in Your Plan, for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

If You are hospitalised in the **Intensive Care Unit (ICU)** of a Hospital for each continuous and completed period of 24 hours, We will pay an amount equivalent to the percentage of the Daily Cash Allowance as opted by You and mentioned in the Policy Schedule / Certificate of Insurance against this Basis.

2. Basis 2 – Fixed Lump Sum Benefit

If You have opted for this Basis, We will pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Hospitalisation arising out arising out of the Critical Illnesses or Surgical Procedures mentioned in Your Plan, for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Conditions Applicable to both Basis 1 & 2:

- In case of **Individual Sum Insured basis**, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year on **Floater Sum Insured basis**.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the time excess as opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

Plan wise Covered Critical Illnesses

Sr. No.	Category	Critical Illness	Plan A	Plan B	Plan C
1	**Malignancy**	Cancer of Specified Severity	Covered	Covered	Covered
2	**Cardiovascular system**	Myocardial Infarction	Covered	Covered	Covered
3		Open Heart Replacement or Repair of Heart Valves	Covered	Covered	Covered
4		Surgery to Aorta	Covered	Covered	Covered
5		Primary (Idiopathic) Pulmonary Hypertension	Not Covered	Covered	Covered
6		Aneurysm of Abdominal Aorta	Not Covered	Not Covered	Covered
7		Cardiomyopathy	Not Covered	Not Covered	Covered
8		Pulmonary artery graft surgery	Not Covered	Not Covered	Covered
9		Open Chest CABG	Covered	Covered	Covered
10	**Major Organ Damage/Transplant**	End Stage Lung Failure	Covered	Covered	Covered
11		End Stage Liver Failure	Covered	Covered	Covered
12		Kidney Failure Requiring Regular Dialysis	Covered	Covered	Covered
13		Major Organ Damage or Transplant / Bone Marrow Transplant	Covered	Covered	Covered
14	**Nervous System**	Apallic Syndrome	Not Covered	Covered	Covered
15		Benign Brain Tumour	Covered	Covered	Covered
16		Coma of Specified Severity	Covered	Covered	Covered
17		Major Head Trauma	Covered	Covered	Covered
18		Permanent Paralysis of Limbs	Covered	Covered	Covered
19		Stroke Resulting in Permanent Symptoms	Not Covered	Covered	Covered
20		Motor Neurone Disease with Permanent Symptoms	Not Covered	Covered	Covered
21		Parkinson's Disease	Not Covered	Not Covered	Covered
22		Muscular Dystrophy	Not Covered	Not Covered	Covered
23		Progressive Supranuclear Palsy	Not Covered	Not Covered	Covered

24		Creutzfeldt-Jakob disease (CJD)	Not Covered	Not Covered	Covered
25		Bacterial Meningitis	Not Covered	Not Covered	Covered
26		Alzheimer's disease	Not Covered	Not Covered	Covered
27		Encephalitis	Not Covered	Not Covered	Covered
28		Multiple Sclerosis with Persisting Symptoms	Covered	Covered	Covered
29	**Others**	Loss of Independent Existence	Not Covered	Covered	Covered
30		Systemic lupus erythematosus	Not Covered	Not Covered	Covered
31		Goodpasture's syndrome	Not Covered	Not Covered	Covered
32		Fulminant Viral Hepatitis	Not Covered	Not Covered	Covered
33		Pneumonectomy	Not Covered	Not Covered	Covered
34		Aplastic Anaemia	Not Covered	Covered	Covered

Critical Illness Definitions:

Digit Simplification: What all is covered and what is not. Everything in black and white for You!

1. CANCER OF SPECIFIED SEVERITY

I. 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.

II. The following are excluded –

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

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

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

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

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

vi. Chronic lymphocytic leukaemia less than RAI stage 3

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

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

ix. All tumors in the presence of HIV infection.

2. 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:

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

ii. New characteristic electrocardiogram changes

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

II. The following are excluded:

i. Other acute Coronary Syndromes

ii. Any type of angina pectoris

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

3. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

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

4. SURGERY TO AORTA

I. The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

5. 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.

6. ABDOMINAL AORTA ANEURYSM

An abdominal aortic aneurysm (AAA) is a swelling/dilatation (aneurysm) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body.

a. The diagnosis must be supported by a CT scans or CTA (Angiography) and requiring Endovascular aneurysm repair and the realization of surgery has to be confirmed by a cardiovascular surgeon.

b. Congenital conditions are excluded

7. CARDIOMYOPATHY

A diagnosis of cardiomyopathy by a Specialist Medical Practitioner (Cardiologist).There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities for a minimum period of 30 days to at least Class 3 of the New York Heart Association classifications of functional capacity (heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain) and LVEF of 40% or less.

The following conditions are excluded:

- Cardiomyopathy secondary to alcohol or drug abuse.
- All other forms of heart disease, heart enlargement and myocarditis.

8. PULMONARY ARTERY GRAFT SURGERY:

The undergoing of surgery requiring median sternotomy on the advice of a Cardiologist for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

9. 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:

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

10. END STAGE LUNG FAILURE

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

i. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
ii. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
iii. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
iv. Dyspnoea at rest.

11. END STAGE LIVER FAILURE

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

i. Permanent jaundice; and
ii. Ascites; and
iii. Hepatic encephalopathy.

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

12. 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 (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

13. MAJOR ORGAN DAMAGE or TRANSPLANT / BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

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

i. Other stem-cell transplants
ii. Where only Islets of Langerhans are transplanted

14. APALLIC SYNDROME

I. Universal necrosis of the brain cortex, with the brain stem intact. Diagnosis must be definitely confirmed by a Registered Medical practitioner who is also a neurologist holding such an appointment at an approved hospital. This condition must be documented for at least one (1) month.

15. 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 relevant medical specialist.

i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

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.

16. 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:
   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.

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

17. MAJOR HEAD TRAUMA

I. Accidental head injury resulting in permanent Neurological deficit is 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 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 following are excluded:
   i. Spinal cord injury;

18. PERMANENT PARALYSIS OF LIMBS

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

19. STROKE RESULTING IN PERMANENT SYMPTOMS

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

II. The following are excluded:
   iii. Transient ischemic attacks (TIA)
   iv. Traumatic injury of the brain
   v. Vascular disease affecting only the eye or optic nerve or vestibular functions.

20. MOTOR NEURON DISEASE WITH PERMANENT SYMPTOMS

I. 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.

21. Parkinson's disease

The unequivocal diagnosis of progressive, degenerative idiopathic Parkinson's disease by a Neurologist acceptable to Us.

The diagnosis must be supported by all of the following conditions:

a. the disease cannot be controlled with medication;
b. signs of progressive impairment; and
c. inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months.

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

22. MUSCULAR DYSTROPHY

A group of hereditary degenerative diseases of muscle characterised by progressive and permanent weakness and atrophy of certain muscle groups. The diagnosis of muscular dystrophy must be unequivocal and made by a Neurologist acceptable to Us, with confirmation of at least 3 of the following four conditions:

a. Family history of muscular dystrophy;
b. Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
c. Characteristic electromyogram; or
d. Clinical suspicion confirmed by muscle biopsy.

The condition must result in the inability of the Insured Person to perform at least 3 of the 6 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 a continuous period of at least 6 months.

23. PROGRESSIVE SUPRANUCLEAR PALSY:

A diagnosis of progressive supranuclear palsy by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical impairment of eye movements and motor function for a minimum period of 30 days.

24. CREUTZFELDT-JAKOB DISEASE (CJD)

A Diagnosis of Creutzfeldt-Jakob disease must be made by a Specialist Medical Practitioner (Neurologist). There must be permanent clinical loss of the ability in mental and social functioning for a minimum period of 30 days to the extent that permanent supervision or assistance by a third party is required.
Social functioning is defined as the ability of the individual to interact in the normal or usual way in society.
Mental functioning would mean functions /processes such as perception, introspection, belief, imagination reasoning which we can do with our minds.

25. BACTERIAL MENINGITIS

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal chord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks resulting in permanent inability to perform three or more Activities for Loss of Independent Living.

This diagnosis must be confirmed by:

a. The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
b. A consultant neurologist certifying the diagnosis of bacterial meningitis.

Bacterial Meningitis in the presence of HIV infection is excluded.

26. ALZHEIMER'S DISEASE

Alzheimer's disease is a progressive degenerative Illness of the brain, characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathological changes. It affects the brain, causing symptoms like memory loss, confusion, communication problems, and general impairment of mental function, which gradually worsens leading to changes in personality.

Deterioration or loss of intellectual capacity, as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease, resulting in progressive significant reduction in mental and social functioning, requiring the continuous supervision of the Insured Person. The diagnosis must be supported by the clinical confirmation of a specialist Medical Practitioner (Neurologist) and supported by Our Appointed Medical Practitioner, evidenced by findings in cognitive and neuro radiological tests

(e.g. CT scan, MRI, PET scan of the Brain). The disease must result in a permanent inability to perform three or more Activities with Loss of Independent Living or must require the need of supervision and permanent presence of care staff due to the disease. This must be medically documented for a period of at least 90 days

The following conditions are however not covered:

a. non-organic diseases such as neurosis and psychiatric Illnesses;
b. alcohol related brain damage; and
c. any other type of irreversible organic disorder/dementia.

27. ENCEPHALITIS

Severe inflammation of the brain tissue due to infectious agents like viruses or bacteria which results in significant and permanent neurological deficits for a minimum period of 30 days, certified by a specialist Medical Practitioner (Neurologist)

The permanent deficit should result in permanent inability to perform three or more Activities for Loss of Independent Living.

Exclusions:

• Encephalitis in the presence of HIV infection is excluded.

28. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The unequivocal diagnosis of Definite Multiple Sclerosis confirmed and evidenced by all of the following:
   i. investigations including typical MRI findings which unequivocally confirm the diagnosis to be multiple sclerosis and
   ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months.

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

29. LOSS OF INDEPENDENT EXISTENCE

I. Confirmation by a Consultant Physician of the loss of independent existence due to illness or trauma, lasting for a minimum period of 6 months and resulting in a permanent inability to perform at least three (3) of Activities of Daily Living .

30. SYSTEMIC LUPUS ERYTHEMATOUS

A multi-system, multifactorial, autoimmune disorder characterized by the development of autoantibodies directed against various self-antigens. 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 World Health Organization (WHO) classification). The final diagnosis must be confirmed by a registered Medical Practitioner specializing in Rheumatology and Immunology acceptable to Us, Other forms, discoid lupus, and those forms with only hematological and joint involvement are however not covered:

The WHO lupus classification is as follows:

a. Class I: Minimal change – Negative, normal urine.
b. Class II: Mesangial – Moderate proteinuria, active sediment.
c. Class III: Focal Segmental – Proteinuria, active sediment.
d. Class IV: Diffuse – Acute nephritis with active sediment and/or nephritic syndrome.
e. Class V: Membranous – Nephrotic Syndrome or severe proteinuria.

31. GOODPASTURE`S SYNDROME

Goodpasture's syndrome is an autoimmune disease in which antibodies attack the lungs and kidneys, leading to permanent lung and kidney damage. The permanent damage should be for continuous period of atleast ***30 Days***. The Diagnosis must be proven by Kidney biopsy and confirmed by a Specialist Medical Practitioner (Rheumatologist *or Nephrologist*).

32. FULMINANT HEPATITIS

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.

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

33. PNEUMONECTOMY

The undergoing of surgery on the advice of an appropriate Medical Specialist to remove an entire lung for disease or traumatic injury suffered by the life assured.

The following conditions are excluded:

• Removal of a lobe of the lungs (lobectomy)
• Lung resection or incision

34. APLASTIC ANAEMIA

I. Irreversible persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two (2) of the following:

(a) Blood product transfusion;
(b) Marrow stimulating agents;
(c) Immunosuppressive agents; or
(d) Bone marrow transplantation.

The Diagnosis of aplastic anaemia must be confirmed by a bone marrow biopsy. Two out of the following three values should be present:

- Absolute Neutrophil count of 500 per cubic millimetre or less;
- Absolute Reticulocyte count of 20,000 per cubic millimetre or less; and
- Platelet count of 20,000 per cubic millimetre or less.

Subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 4. COMPANION BENEFIT COVER

We will pay towards the expenses incurred on one of Your attendants, accompanying You at the Hospital/Nursing Home, in case of Your Hospitalization as an inpatient due to an Accidental bodily Injury and/or Illness during the Policy Period. We will pay You as per the **Sum Insured Basis Opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The above is provided that:

1. Claim for Hospitalisation in respect of the Insured Person has been admitted;
2. Insured Person's attendant should be his/her spouse, siblings, Children above age of 18 years, parents or parents in law.

Sum Insured Basis Option:

You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

1. Basis 1 - Per Day Benefit

If You have opted for this Basis, We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Insured Person's Hospitalisation arising out of accidental bodily injury and/or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

2. Basis 2 – Fixed Lump Sum Benefit

If You have opted for this Basis, We will pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Insured Person's Hospitalisation arising out of accidental bodily injury and/or

illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Conditions Applicable to both Basis 1 & 2:

- In case of **Individual Sum Insured basis**, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year Per Family on **Floater Sum Insured basis**.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the **time excess as opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 5. PARENT ACCOMODATION

We will pay towards expenses incurred on accommodation of parents at the Hospital/Nursing Home, in case of Your Hospitalization as an inpatient due to an Accidental bodily Injury and/or Illness during the Policy Period. We will pay You as per the Sum Insured Basis Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The above is provided that:

1. Claim for Hospitalisation in respect of the Insured Person has been admitted;
2. The Insured Person hospitalized is a Child aged 16 Years or below, unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance.

Sum Insured Basis Option:

You would have chosen one among the following **two 'Basis' of payment**. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

1. **Basis 1 - Per Day Benefit**

   If You have opted for this Basis, We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Insured Person's Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

2. **Basis 2 – Fixed Lump Sum Benefit**

   If You have opted for this Basis, We will pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Insured Person's Hospitalisation arising out of accidental bodily injury or illness for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Conditions Applicable to both Basis 1 & 2:

- In case of Individual Sum Insured basis, maximum number of days will be Per Policy Year Per Insured Person and in case of Floater Policy the maximum number of days will be Per Policy Year Per Family on Floater Sum Insured basis.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- Payment of claim under this benefit is subject to the **time excess as opted by You** and mentioned in Your Policy Schedule / Certificate of Insurance against this Section.
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

SECTION 6. DAY CARE PROCEDURE BENEFIT

We will pay the Sum Insured Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Section, in case You require to undergo a Day Care Procedure as an inpatient for less than 24 hours in a Hospital

or Day Care Centre during the Policy Period as a result of Accidental bodily Injury and/or Illness during the Policy Period.

Conditions Applicable

- We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year, unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance.
- This benefit is applicable on an Individual Sum Insured basis irrespective of type of Policy (Individual/Floater).
- This Cover is subject to terms, conditions, limitations and exclusions mentioned in the Policy.

SECTION 7. MATERNITY BENEFIT

This Cover protects You in case of Your Hospitalization as an inpatient under the Maternity Benefit, for the delivery of the Insured Person's child (including caesarean section) or for the Medically necessary and lawful termination of pregnancy during this Policy Period. We will pay You as per the Sum Insured Basis Opted by You and mentioned in Your Policy Schedule / Certificate of Insurance against this Cover.

The above is provided that:

a. The treatment is taken as an In-patient in a Hospital
b. "Maternity Benefit Waiting Period" as mentioned in the Policy Schedule/Certificate of Insurance against this Section is applicable

Sum Insured Basis Option:

You would have chosen one among the following two 'Basis' of payment. Please check your Policy Schedule/ Certificate of Insurance for the chosen 'Basis':

1. **Basis 1 - Per Day Benefit**
   If You have opted for this Basis, We will pay a Daily Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of 24 hours of Insured Person's Hospitalisation under the Maternity Benefit, for the delivery of the Insured Person's child (including caesarean section) or for the Medically necessary and lawful termination of pregnancy for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

2. **Basis 2 – Fixed Lump Sum Benefit**
   If You have opted for this Basis, We will pay a Fixed Cash Allowance, amount for this is mentioned in Your Policy Schedule / Certificate of Insurance against this Section. This will be paid for each continuous and completed period of the number of days of Insured Person's Hospitalisation under the Maternity Benefit, for the delivery of the Insured Person's child (including caesarean section) or for the Medically necessary and lawful termination of pregnancy for a maximum number of days as mentioned in Your Policy Schedule / Certificate of Insurance against this Section.

Conditions Applicable to both Basis 1 & 2:

- Permanent "**Exclusion No. 11 Reproductive Medicine & Other Maternity Expenses**" of the Policy Wordings stands partially deleted to the extent of the Coverage provided under this Section.
- For this cover, completion of every 24 Hours of In-patient Hospitalization from the time of Admission is considered to be a day.
- We shall be liable to make payment under this cover in respect of an Insured Person only once during the Policy Year, unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance.
- This benefit is applicable on an Individual Sum Insured basis irrespective of type of Policy (Individual/Floater).
- This Cover is subject to terms, conditions, limitations, deductible and exclusions mentioned in the Policy.

WAITING PERIODS - EXCLUSION

Digit Simplification: Some covers have a defined period in which you cannot make claims. This makes sure that someone who just got detected with the disease doesn't buy the policy to cover the charges 😉 Read on:

We are not liable to pay for any claims arising out of any Hospitalization which begins during waiting periods except if Your Hospitalization is as a result of accidental bodily injury.

A. Initial Waiting Period

a. Expenses related to the treatment of any illness within number of days as mentioned in Your Policy Schedule / Certificate of Insurance 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.

B. Pre-existing Disease Waiting Period

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of number of months continuous coverage after the date of inception of the first policy with insurer. These number of months as opted by You are mentioned in Your Policy Schedule/Certificate of Insurance.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
Example, if you have increased the Sum Insured by INR 3000 while renewing Your Policy, fresh waiting period for Pre-existing Disease, will be applied to this increased part of Sum Insured.
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.
Example, if a disease has a waiting period of 2 years and one year is already completed according to Your last policy, then when You renew with us as per the Portability Guidelines, the Waiting Period will not be 2 years, it will only be 1 Year.
d. Coverage under the policy after the expiry of number of months, as opted by You are mentioned in Your Policy Schedule/Certificate of Insurance, for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

C. Maternity Benefit Waiting Period

Maternity Benefit in this Policy shall not be covered until the number of months of continuous coverage as opted by You and mentioned in Your Policy Schedule/Certificate of Insurance, have elapsed since inception of the first Policy with Us.

However:

a. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then Maternity Benefit Waiting Period would be reduced by the number of Your continuous preceding years of coverage under the previous health insurance Policy.
Example, if a Maternity Benefit has a waiting period of 2 years and one year is already completed according to Your last policy, then when You renew with us as per the Portability Guidelines, the Waiting Period will not be 2 years, it will only be 1 Year.
b. In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
Example, if you have increased the Sum Insured by INR 3000 while renewing Your Policy, fresh waiting period for Maternity Benefit, will be applied to this increased part of Sum Insured.

D. Specific Illness Waiting Periods

a. Expenses related to the treatment of the listed Conditions; surgeries/treatments shall be excluded until the expiry of number of months of continuous coverage after the date of inception of the first policy with us. These number of months as opted by You are mentioned in Your Policy Schedule/Certificate of Insurance. 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.

Example, if you have increased the Sum Insured by INR 3000 while renewing Your Policy, fresh waiting period for Pre-existing Disease, will be applied to this increased part of Sum Insured.

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.
f. List of specific diseases/procedures:
   a. Non-infective arthritis, Osteoarthritis and Osteoporosis (if age related), Systemic Connective Tissue disorders, Dorsopathies, Spondylopathies, Inflammatory Polyarthropathies, Arthrosis and Intervertebral disorders (unless due to accident)
   b. Pancreatitis, calculus disease of gall bladder/biliary tract and urogenital system, Gastric & Duodenal erosions/ulcers, Varices of GI tract, Cirrhosis of Liver, Rectal prolapse.
   c. Cataract, Glaucoma and Disorder of retina
   d. Hyperplasia of Prostate, Urethral strictures, Hydrocele/Varicocele and spermatocele
   e. All Abnormal Utero-vaginal bleeding, female genital Prolapse, Endometriosis/Adenomyosis, Fibroids, Ovarian Cyst, Pelvic Inflammatory disease
   f. Haemorrhoids, Fissure, Fistula and pilonidal sinus/cyst and fistula.
   g. Hernia of all sites,
   h. Varicose veins of lower extremities,
   i. Disease of middle ear and mastoid including otitis Media, Cholesteatoma, Perforation of Tympanic Membrane, Sinusitis, Tonsillitis, Adenoid hypertrophy, Nasal septum deviation, Turbinate hypertrophy, Nasal polyp, Mastoiditis, Nasal concha bullosa,
   j. All internal and external benign or In Situ Neoplasms/Tumours, Cyst, Sinus, Polyp, Nodules, Swelling, Mass or Lump including breast lumps (each of any kind unless malignant),
   k. Internal Congenital Anomaly,
   l. Psychiatric illness and Disorders listed below:

ICD Code	Psychiatric Illness & Disorders
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood [affective] disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F99-F99	Unspecified mental disorder

   m. Neurodegenerative disorders including but not limited to Alzheimer's disease and Parkinson's disease.
   n. Joint replacement unless due to Accident.

GENERAL EXCLUSIONS

Digit Simplification: We believe in being transparent with you, no hidden terms and conditions. So, here's what you are not covered for:

We shall not be liable to make any claim payment under this Policy caused by, based on, arising out of or howsoever attributable to any of the following unless specifically agreed and mentioned elsewhere in the Policy Schedule/Certificate of Insurance:

STANDARD ONES

1. **Artificial Life Maintenance**
   Artificial Life Maintenance, including life support machine used, where such treatment is used to maintain the Insured/Patient in a vegetative state.

2. **Breach of Law with Criminal Intent, Suicide and Self-Injury**
   Any claim as a result of the following:
   a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
   b. Intentional self-injury

c. Participation in any illegal or unlawful or criminal act
d. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

3. Cosmetic, Aesthetic and Re-Shaping Treatment & Surgeries

a. Plastic Surgery or Cosmetic Surgery or Treatments to change Your appearance (***Example a tummy tuck, facelift, tattoo, ear piercing***), unless necessary as a part of medically necessary treatment certified by the attending Medical Practitioner for reconstruction following an Accident, Cancer or burns.
b. Treatment for alopecia, baldness, wigs, or toupees and all treatment related to the same.
c. Circumcision unless necessary for the treatment of a disease or necessitated by an Accident;
d. Aesthetic or change-of-life- treatments of any description such as sex transformation operations.

4. External Congenital Anomaly

Screening, Counselling or treatment related to external Congenital Anomaly.

5. Geographical Limits

Claims related to Hospital Cash under this Policy, will be paid only if the Hospitalization is done within India, unless specifically agreed other wise and mentioned in Your Policy Schedule/Certificate of Insurance.
Our liability will be to make any Payment under this Policy will be in Indian Rupees Only.

6. Hazardous Activities / Defence Operation

We will not pay any claim under this Policy, whilst You are:
a. Involved in any **Hazardous Activity**.
b. Involved in naval, military, air force operation

7. Professional Sports

We will not pay any claim under this Policy, whilst You are under training or taking part in sport as a professional for which You are paid or funded by sponsorship or grant.
However, You would be covered if you participate in a non-professional capacity for any recreational sport which is **NOT** a **Hazardous Activity** and You are under the supervision of a trained professional.

8. Home Care Nursing

Any claim in respect of Convalescence/ recovery, cure, rest cure, sanatorium treatment, rehabilitation measures, private duty nursing, respite care, long-term nursing care or custodial care.

9. Insufficient Document

We have tried to reduce the number of documents you need to share but we shall not be liable to pay any claim in case all the necessary mandatory documents as mentioned in Our claims process are not submitted to Us.

10. Preventive Treatment

We do not cover inoculations, vaccinations or other treatment, for example drugs or Surgery, which aims to prevent a disease or Illness except it is post dog or animal bite and treated as an in-patient.

11. Reproductive Medicine & Other Maternity Expenses

Any assessment or treatment method for:
a. Birth Control
   Any type of contraception, sterilization, abortions, voluntary termination of pregnancy (except under **SECTION 7. MATERNITY BENEFIT** for Medical Termination of Pregnancy (MTP) as governed by MTP Act 1971) or family planning.
b. Infertility
   We shall not be liable to make any payment in respect of expenses incurred towards Infertility/Subfertility including but not limited to IVF, IUI, ZIFT, ICSI Procedures and similar methods of assisted conception.
c. Sexual disorder and Erectile Dysfunction

Treatment of any sexual disorder including impotence (irrespective of the cause) and sex changes or gender reassignments or erectile dysfunction.

d. Any claim related to pregnancy, complications arising from pregnancy or medical termination of pregnancy unless You have specifically opted for **SECTION 7. MATERNITY BENEFIT.**

12. Sexually Transmitted Infections & Disease

Screening, prevention and treatment for sexually transmitted infection or disease including but not limited to Genital Warts, Syphilis, Gonorrhoea, Genital Herpes, Chlamydia, Pubic Lice and Trichomoniasis is not covered.

13. Sleep Disorders and Sleep Problems

We do not cover treatment related to sleep disorders and sleep problems, such as snoring, insomnia or sleep apnoea (when breathing stops temporarily during sleep) including but not limited to expense related to purchase of CPAP, BIPAP or similar instruments.

14. Spectacles, Hearing aids & other Expenses

Provision or fitting of hearing aids, spectacles or contact lenses including optometric therapy, any treatment and associated expenses for alopecia, baldness, wigs, or toupees, medical supplies including elastic stockings, diabetic test strips, and similar products.

15. Unproven or Experimental treatment

We do not cover any kind of Unproven or Experimental Treatment:

a. Services including device, treatment, procedure or pharmacological regimens which are considered as experimental, investigational or unproven.
b. Stem Cell Transplant: Any stem cell transplant other than for Bone Marrow Transplant.

16. Unjustified or Unwarranted Hospitalization

Admission solely at Hospital primarily for evaluative or diagnostic or observation purposes for which no active treatment is given, X-Ray or laboratory examinations or other diagnostic studies, not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any Illness or Injury, whether or not requiring Hospitalization

17. Vitamins/ Nutritional Supplements

Vitamins, tonics, nutritional supplements unless they form part of the treatment for Injury or disease as certified by the attending Medical Practitioner, are not covered.

18. War and hazardous substances

We do not cover treatment arising from or required as a consequence of:

a. War, invasion, acts of foreign enemy hostilities (whether or not War is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, attempted overthrow of Government.
b. Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel.
c. Any acts of terrorism unless specifically agreed otherwise and mentioned in Your Policy Schedule / Certificate of Insurance

19. Legal Liability

Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

20. Substance abuse and Addictions by the Insured

1. Expenses incurred for the treatment of any Illness or accidental Injury caused due to:

a) Use/misuse/abuse of Alcohol, opioids or nicotine or drugs (whether prescribed or not) by the Insured unless associated with Psychiatric Illness.
b) Withdrawal and de-addiction treatment taken by the Insured.

2. Any claim in respect of Cancer of Oral, Oropharynx and respiratory system is specifically excluded in cases where Insured is a tobacco user.

21. Dental Treatment

Treatment, procedures and preventive, diagnostic, restorative, cosmetic services related to disease, disorder and conditions related to natural teeth and Gingiva, unless requiring Hospitalisation due to Accident.

22. Non-Allopathic Treatment

We shall not pay for any non-allopathic treatment.

23. Organ Donor

The Expenses incurred by You on organ donation.

24. Weight loss Surgery

We do not cover any claims related to:

i. Weight management services and treatment, vitamins and tonics related to weight reduction programs including treatment of obesity (including morbid obesity), any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition or rest cures;

ii. Bariatric Surgery (weight loss Surgery), such as gastric banding or a gastric bypass, or the removal of surplus or fat tissue**.**

25. Out-Patient (OPD) Treatment

Any claim in respect of Out-Patient (OPD) Treatment will be not be covered.

SPECIFIC ONES (CAN'T BE WAIVED)

26. Behavioural and Neurodevelopment Disorders

Medical Expenses related to Behavioural and Neurodevelopment delays and disorders such as:

a. Disorders of adult personality including gender related problems, gender change
b. Learning disability including but not limited to speech and language including stammering, dyslexia, Attention Deficit Hyperactive Disorder;
c. Neurodevelopmental disorders including but not limited to cerebral palsy, autism spectrum disorder.

27. Ear, Eyesight & Optical Services

We do not cover any claims in respect of treatment for Correction of refractive errors of the eye including but not limited to short-sight or long-sight, such as glasses, contact lenses or laser eyesight correction Surgery.

28. Prosthetics and other devices

Prosthetics and other devices NOT implanted internally by surgery.

29. Specific Treatments

i. Admission primarily for administration of monoclonal antibodies or Intra-articular or intra-lesional injections or Intravenous immunoglobulin infusion or supplementary medications like Zolendronic Acid.

ii. Treatment for Age Related Macular Degeneration (ARMD), Treatment such as External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy will not be covered unless it forms a part of in-patient treatment in case of hospitalisation.

GENERAL CONDITIONS

CONDITIONS PRECEDENT TO THE CONTRACT

Policy Period

The Policy can be issued for tenure of 1 year, 2 years, 3 years, 4 years and 5 years on Per Day Benefit or Fixed Lumpsum Benefit Sum Insured basis. Long Term policies (of more than 1-year tenure) can only be issued in case of loan/ credit linked policies, subject to maximum of loan period.

Condition Precedent to admission of Liability

The due observance and fulfilment 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 for claim(s) arising under the policy.

Disclosure of Information

Digit Simplification: ***In one line, this condition means, make sure all the information you share with us is correct!***

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.

Insured Person

a. Only those persons named as an Insured Person in the Policy Schedule / Certificate of Insurance shall be covered under this Policy.
b. You can add more persons during the Policy Period but only after payment of an additional premium and subject to acceptance of Proposal by Us (wherever necessary) and after We have issued an endorsement confirming the addition of such person as an Insured Person.

Role of Group Administrator/ Policyholder

i. The Policy holder should provide the complete list of members to Us at the time of policy issuance and renewal. Further intimation should be provided to Us on the entry and exit of the members at periodic intervals. Insurance will cease once the member leaves the group except when it is agreed in advance to continue the benefit even if the member leaves the group.
ii. In case of employer-employee policies, the employer may issue confirmation of insurance protection to the individual employees with clear reference to the Group Insurance policy and the benefits secured thereby.
iii. In case of such policies, claims of the individual employees may be processed through the employer.
iv. In case of non-employer-employee policies, We shall generally issue the Certificate of Insurance. However, We may provide the facility to the Group Administrator to issue the Certificate of Insurance to the members.
v. In case of such policies, the Group Administrator may facilitate the claims process for the members.

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 (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.

Assignment (If Opted) – It Is Hereby Declared and Agreed That:

a. from the Policy Start Date, the claim amount payable by Us to the Insured and all rights, title, benefits and interest of the Insured under this Policy stand assigned in favour of a person or an Institution or a company as named in the Policy Schedule/ Certificate of Insurance;
b. upon any claim amount becoming payable under this Policy the same shall be paid by Us to assignee as named in Policy Schedule/ Certificate of Insurance, without any reference/ notice to the Insured;
c. the receipt of such claim amount by the assignee as named in the Policy Schedule/ Certificate of Insurance and the Insured shall completely discharge Us from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.

Electronic Transactions

The Insured agrees to adhere to and comply with all such terms and conditions as the Company may prescribe from time to time, and hereby agrees and confirms that all transactions effected by or through facilities for conducting remote transactions including the Internet, World Wide Web, electronic data interchange, call centres, teleservice operations (whether voice, video, data or combination thereof) or by means of electronic, computer, automated machines network or through other means of telecommunication, established by or on

behalf of the Company, for and in respect of the policy or its terms, or the Company's other products and services, shall constitute legally binding and valid transactions when done in adherence to and in compliance with the Company's terms and conditions for such facilities, as may be prescribed from time to time.

No Constructive Notice

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

CONDITION APPLICABLE DURING THE CONTRACT

***Digit Simplification:* There are some more conditions you should be aware of during the contract!**

Free look period

The Free Look Period shall be applicable at the inception of the Policy and not on renewals or at the time of porting the policy.

The insured shall be allowed a period of fifteen days from date of receipt of the Policy 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, 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;

Alterations to the Policy

This Policy constitutes the complete contract of insurance. This Policy cannot be changed or edited by anyone (including an insurance agent or intermediary) except Us (subject to necessary approval from the Insurance Regulatory and Development Authority of India), and any change We make will be through a written endorsement signed and stamped by Us, only on the request from Group Manager/ Insured Member.

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 affected.

Withdrawal of Product

i. In the likelihood of this product being withdrawn in future, the Company will intimate the Group Manager/ Insured Person about the same 90 days prior to expiry of the policy.
ii. Group Manager / 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 waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

Migration:

The Group Manager / 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.

For Detailed Guidelines on migration, kindly refer the link .....@godigit.com.

Special Conditions Relating To Group Policy

All group policies are subject to the following conditions:

a. The insured will maintain sufficient deposit or provide a Bank Guarantee to comply with the requirement of section 64VB.
b. New names can be added to the existing group policies by charging premium as agreed between Group Manager and Us.
c. For deletion of names from Group Policies during the Policy Period, refund of premium can be allowed only if there is no claim in respect of the particular insured Person as on date when request for deletion of name has been received

Special Conditions Applicable For Policies Issued With Premium Payment On Instalment Basis

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

1. Grace Period of 15 Days would be given to Pay the instalment premium due for the Policy.
2. During such Grace Period, Coverage will not be available from the instalment premium payment due date till the date of receipt of premium by US.
3. The Benefit of "Waiting Periods" shall continue in the event of default payment being received within the Grace Period.
4. No interest will be charged If the instalment premium is not paid on due date.
5. In case of instalment premium due not received within the Grace Period the Policy will get Cancelled and a fresh policy would be issued with fresh waiting periods.
6. In case of any admissible claim in a Policy year:
   a. If the claim amount is equivalent or higher than the balance of the instalment premiums payable in that Policy Year, would be recoverable from the admissible claim amount payable in respect of the Insured Person.
   b. If the claim amount is lesser than the balance premium payable, then no claim would be payable till the applicable premium is recovered.
7. Where Premium Payment is on Installment Basis, there will be no refund of premium in case of Policy Cancellation requested by You.

Important Note (ECS Or NACH Mode):

1. Installment can also be paid through ECS or NACH mode. In cases where monthly installment is allowed by NACH or ECS mandate, three (3) installments need to be paid at the inception of the Policy, unless this condition is specifically amended by Us.
2. We shall inform You in case of any change either in the terms and conditions of the Policy Contract or in the Premium Rate and afresh ECS authorization needs to be submitted by You.
3. You can withdraw from the ECS mode of payment at least fifteen days prior to the due date of instalment premium payable as per the ECS/NACH mandate form submitted by You, by submitting written communication to Us as well as Your Bank.

Cancellation

A. Cancellation by You

1. You can choose to cancel the policy, giving us a 15 days' notice period by recorded delivery.
2. Below Cancellation Scales will be applicable depending on the Policy Tenure & Period On Risk.
3. The refund of premium under the Credit Linked Policies shall be as under:
   a. In the event of full prepayment of the Loan by the Insured, We shall refund a portion of the premium subject to the terms and conditions of the Policy as per the rates mentioned in the below table.
   b. In event of part prepayment of the Loan, no refunds of premium shall be made under this Policy.
4. No refunds of premium shall be made where any claim has been admitted by the Company or has been lodged with the Company.

Cancellation Scale

Period in Risk	Premium Refund based on Policy Term				
	Less than 18 months	More than 18 months but less than 30 months	More than 30 months but less than 42 months	More than 42 months but less than 54 months	More than 54 months but less than equal to 60 months
Within 3 months	60.0%	60%	60%	60%	60%
Exceeding 3 months but less than 6 months	50.0%	55%	55%	55%	55%
Exceeding 6 months but less than 9 months	40.0%	45%	50%	50%	50%
Exceeding 9 months but less than 12 months	25.0%	40%	45%	50%	50%
Exceeding 12 months but less than 15 months	15.0%	35%	40%	45%	45%
Exceeding 15 months but less than 18 months	5.0%	25%	35%	40%	45%
Exceeding 18 months but less than 21 months	NA	20%	30%	35%	40%
Exceeding 21 months but less than 24 months	NA	15%	25%	35%	35%
Exceeding 24 months but less than 27 months	NA	5%	20%	30%	35%
Exceeding 27 months but less than 30 months	NA	0%	20%	25%	30%
Exceeding 30 months but less than 33 months	NA	NA	15%	25%	25%
Exceeding 33 months but less than 36 months	NA	NA	10%	20%	25%
Exceeding 36 months but less than 39 months	NA	NA	5%	15%	20%
Exceeding 39 months but less than 42 months	NA	NA	0%	15%	20%
Exceeding 42 months but less than 45 months	NA	NA	NA	10%	15%
Exceeding 45 months but less than 48 months	NA	NA	NA	5%	10%
Exceeding 48 months but less than 51 months	NA	NA	NA	5%	10%
Exceeding 51 months but less than 54 months	NA	NA	NA	0%	5%
Exceeding 54 months but less than 57 months	NA	NA	NA	NA	0%
Exceeding 57 months	NA	NA	NA	NA	0%

B. CANCELLATION BY US

Policy may be cancelled by Us on the grounds of misrepresentation, fraud or non-disclosure of material facts by sending to You fifteen days' notice by recorded delivery at last known address/e-mail ID without refund of premium.

Note: Please note KYC documents (Photo ID card) shall be required if the premium refund to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per premium refund.

Complete Discharge

Any payment to the Insured Person or his/ her nominees or his/ her legal representative or to the Assignee, 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 claim by the Company to the extent of that amount for the particular claim

Notice & Communication

Any notice, direction, instruction or any other communication related to the Policy should be made in writing. Such communication shall be sent to the address of the Company or through any other electronic modes specified in the Policy Schedule/Certificate of Insurance.

The Company shall communicate to the Insured at the address or through any other electronic mode mentioned in the Policy Schedule/Certificate of Insurance.

Law And Jurisdiction

It is hereby declared and agreed that this contract of insurance and all claims thereunder shall be governed by Indian Law and any legal proceeding in respect thereof shall be raised a competent court of India. All claims shall be paid in Indian Rupees only.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

***Digit Simplification:* What You should know when You are about to claim.**

Multiple Policies

If two or more policies are taken by You during the period for which You are covered under this Policy from one or more insurers, the contribution clause shall not be applicable and We will make the claim payments independent of payments received under other similar polices in respect of the covered event.

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 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/Certificate of Insurance, 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 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 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.

Arbitration

(i) If any dispute or difference shall arise as to the quantum to be paid by the Policy, (liability being otherwise admitted) such difference shall independently of all other questions, be referred to the decision of a sole arbitrator to be appointed in writing by the parties here to or if they cannot agree upon a single arbitrator within thirty days of any party invoking arbitration, the same shall be referred to a panel of three

arbitrators, comprising two arbitrators, one to be appointed by each of the parties to the dispute/difference and the third arbitrator to be appointed by such two arbitrators and arbitration shall be conducted under and in accordance with the provisions of the Arbitration and Conciliation Act 1996, as amended by Arbitration and Conciliation (Amendment) Act, 2015 (No. 3 of 2016).

(ii) It is clearly agreed and understood that no difference or dispute shall be preferable to arbitration as herein before provided, if the Company has disputed or not accepted liability under or in respect of the policy.

(iii) It is hereby expressly stipulated and declared that it shall be a condition precedent to any right of action or suit upon the policy that award by such arbitrator/arbitrators of the amount of expenses shall be first obtained.

Claims Notification and Procedure

In the event of any illness or condition that may result in a claim under this policy, it is a condition precedent to Our liability under the Policy that below procedure should be followed depending on the type of claim:

Reimbursement Claim Process:

1. We or Our Service Provider / Third Party Administrator (TPA) should be intimated within 48 hours of date of admission.
2. For Reimbursement Claim You shall follow the below Procedure:
    a. Within 30 Days from the date of discharge, You should submit all original documents pertaining to the hospitalization as mentioned is the List of Claim Documents.
    b. On receipt of intimation from You regarding a claim under the Policy, We are entitled to investigate and obtain information on the alleged injury or illness requiring hospitalization, if required,
    c. All Claims shall be settled/repudiated within 30 days from the date of receipt of the last necessary claim document subject to the Policy Terms and Conditions. In case of any delay in payment for all approved claims beyond 30 day from the receipt of the last necessary claim document, We shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by You.
    d. In case of Your Death, We shall reimburse the claim amount to Your Assignee / Nominee as named in Your Policy Schedule / Certificate of Insurance or Your Legal representative holding a valid succession certificate.

Sr. No	List of Documents / Information
1	Duly Filled and Signed Claim form
2	Discharge Summary
3	Medical Records (Optional Documents may be asked on need basis: Indoor case papers, OT notes, PAC notes etc.)
4	Copy of Hospital Main Bill
8	Investigation Reports & Consultation Papers
9	Positive Diagnostic Report for the Critical Illness and/or Surgical procedures as per the plan opted and stated in the Policy Schedule / Certificate of Insurance
10	Attending Physician Certificate (If applicable)
11	Document to Confirm Relationship with the Patient for Companion Benefit / Parent Benefit
14	Death Certificate (If applicable)
15	*KYC (Photo ID card) (If applicable)
16	Bank Details with Cancelled Cheque

Note: There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions 1 and 2.a may be considered where the reason for delay is proved to our satisfaction.

*KYC documents shall be required at the claim settlement stage where claims pay-out to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per claim.

CONDITIONS FOR RENEWAL OF THE CONTRACT

Renewal

The policy shall ordinarily be renewable except on grounds of fraud, moral hazard, misrepresentation by the insured person. The Company is not bound to give notice that it is due for renewal.

i. Renewal shall not be denied on the ground that the insured had made a claim or claims in the preceding policy years
ii. Request for renewal along with requisite premium shall be received by the Company before the end of the Policy Period.
iii. At the end of the Policy Period, the policy shall terminate and can be renewed within the Grace Period to maintain continuity of benefits without Break in Policy. Coverage is not available during the grace period.
iv. If not renewed within Grace Period after due renewal date, the Policy shall terminate.

Portability

The Insured Person will have the option to port the Policy to other insurers as per extant Guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance plan with an Indian General/Health insurer as per Guidelines on portability, the proposed Insured Person will get all the accrued continuity benefits in waiting periods as under:

i. The waiting periods specified in Your Policy Schedule/Certificate of Insurance shall be reduced by the number of continuous preceding years of coverage of the Insured Person under the previous health insurance Pol icy.
ii. Portability benefit will be offered to the extent of sum of previous sum insured and accrued bonus (as part of the base sum insured), portability benefit shall not apply to any other additional increased Sum Insured.

For Detailed Guidelines on Portability, kindly refer the link www…….@godigit.com

Moratorium Period

After completion of eight continuous years under this policy no look back would 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 eight continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no claim under this policy 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 as per the policy.

CUSTOMER GRIEVANCE REDRESSAL POLICY

In case of any grievance the insured person may contact the company through
Website: www.godigit.com
Toll free: 1800 258 4242
E-mail: hello@godigit.com
Courier: Go Digit Health Claims Team, Corporate office: Atlantis, 95, 4th B Cross Road, Koramangala Industrial Layout, 5th Block, Bengaluru, Karnataka 560095
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 Mr. Praveen Bhat (Grievance Redressal Officer) at grievance@godigit.com
For updated details of grievance officer, kindly refer the link www…….@godigit.com.

Grievance may also be lodged at IRDAI Integrated Grievance Management System - https://igms.irda.gov.in/
Insurance Ombudsman - 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. The contact details of the Insurance Ombudsman offices have been provided below:

contact details of the Insurance Ombudsman offices are as below:

Office Location	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	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@ecoi.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@ecoi.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@ecoi.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455, Fax: 0674 - 2596429, Email: bimalokpal.bhubaneswar@ecoi.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@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandīgarh.
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@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504, Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM).	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.

	Tel.: 0361 - 2132204 / 2132205, Fax: 0361 - 2732937, Email: bimalokpal.guwahati@ecoi.co.in	
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 - 65504123 / 23312122, Fax: 040 - 23376599, Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363, Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM	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@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
KOLKATA	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@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	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@ecoi.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.: 022 - 26106552 / 26106960, Fax: 022 - 26106052, Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253, Email: bimalokpal.noida@ecoi.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	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952, Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE	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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Note: EXECUTIVE COUNCIL OF INSURERS, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.Tel.: 022 - 26106889 / 671 / 980, Fax: 022 - 26106949, Email: inscoun@ecoi.co.in

Digit Group Hospital Cash Benefit Policy

Various Options under each Section

Section Description	No of Days Option based on Sum Insured Basis		Daily Cash Allowance / Fixed Cash Allowance (INR) Options	Time Excess Options	Other Options
	No of Days Options available for Per Day Benefit	No of Days Options available for Fixed Lump Sum Benefit			
Section 1. Accidental Hospitalization Cash Allowance Cover	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	**ICU Benefit Options under Basis 1 – Per Day Benefit: 100% / 150% / 200% / 300% of Daily Cash Allowance**

Section 2. Accidental & Illness Hospitalization Cash Allowance Cover	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	**ICU Benefit Options under Basis 1 – Per Day Benefit: 100% / 150% / 200% / 300% of Daily Cash Allowance**
Section 3. Critical Illness Hospitalization Cash Allowance Cover	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation*	**Plan Options: Plan A / Plan B / Plan C** **ICU Benefit Options under Basis 1 – Per Day Benefit: 100% / 150% / 200% / 300% of Daily Cash Allowance**
Section 4. Companion Benefit Cover	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	-

Section 5. Parent Accommodation	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	-
Section 6. Day Care Procedure Benefit	Not Applicable	Not Applicable	INR 50 to INR 50,000	Not Applicable	-
Section 7. Maternity Benefit	Maximum No Of Days Options: 3 to 120 Days	a. Continuous & Completed Days Options: 2 to 15 Days b. Maximum No of Days will be in 1 to 12 multiples of Continuous & Completed Days opted.	INR 50 to INR 50,000	a. For Basis 1 – Per Day Benefit: 0 to 10 Days b. For Basis 2 – Fixed Lump Sum Benefit: Time Excess will be in Intervals of 0 to 3. ***Example 1:*** *An Insured has opted for Continuous & Completed 3 Days cover for maximum of 21 Days (i.e. 3 Days * Multiple of 7) and the time excess of 2 intervals. Then no claim will be paid for first 6 Days, (i.e. 3 Days * 2 Interval of time excess) of hospitalisation.* ***Example 2:*** *An Insured has opted for Continuous & Completed 5 Days cover for maximum of 30 Days (i.e. 5 Days * Multiple of 6) and the time excess of 1 interval. Then no claim will be paid for first 5 Days (i.e. 5 Days * 1 Interval of time excess) of hospitalisation.*	-

Waiting Period Options

Sr. No	Particulars	Applicable To Sections	Number of Days/Months/Years Options
1.	**Initial Waiting Period**	Section 2, 4, 5, and 6	0 Day / 7 Days / 15 Days / 30 Days
2.	**Critical Illness Initial Waiting Period**	Section 3	0 Day / 30 Days / 60 Days / 90 Days
3.	**Pre-existing Disease Waiting Period**	Section 2, 4, 5, 6 and 7	0 Year / 1 Year / 2 Years / 3 Years / 4 Years
4.	**Specific Illness Waiting Period**	Section 2, 4, 5, and 6	0 Year / 1 Year / 2 Years
5.	**Maternity Benefit Waiting Period**	Section 7	0 Month / 9 Months / 1 Year / 2 Years

Digit Group Janata Personal Accident Policy

Policy Wordings

UIN: GODPAGP21540V012021

PREAMBLE

Whereas the Insured named in the Policy Schedule/ Certificate of Insurance (hereinafter called the "Insured") has made to Go Digit General Insurance Limited (hereinafter called the "Company"), a proposal which is hereby agreed to be the basis of this Policy and has paid the premium specified in the Policy Schedule/ Certificate of Insurance, now the Company agrees, subject always to the following terms, conditions, exclusions, and limitations, to indemnify the Insured and subject always to the Sum Insured against such loss as is herein provided.

A. DEFINITIONS

***Digit Simplification:* You didn't think you needed to know definitions since your time in school, right? Well, the good news is that you don't need to learn these by heart, as long as you understand them**.

Certain words and phrases used throughout the Policy have specific meanings, and this section helps to understand them.

1. **Accident or Accidental** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.
2. **Hazardous or Adventure sports** shall mean any sport or activity, which is dangerous to the Insured Person whether he/she is trained, or not. These activities shall be considered to be hazardous irrespective of the safety precautions taken while undergoing these activities/sports. Such sport/Activity includes, but is not limited to, Abseiling, Adventure racing, Animal Conservation/ Game Reserve, Archery, Base jumping, Bicycle touring, Big game hunting, Black water rafting, Biathlon, BMX Stunt/ Obstacle riding, Bobsleighing/ using Skeletons, Bouldering, Boxing, Bull-fighting, Canyoning, Bungee jumping, Cave tubing/ Cave Diving, Caving/ Pot holing, Clay Pigeon Shooting, Climbing/ Trekking/Walking over 2,000 meters altitudes, Cross Channel, Swimming, Cycle Racing, Cyclo cross, Drag racing, Dry/Desert/Dune Skiing/Bashing, Endurance testing, Fencing, Field hockey, Flying as a pilot, Free Diving/ No Limits Driving, Gaelic Football, Gliding, Gymnastics, Hang gliding, Heptathlon, Harness racing, Heli Skiing/ Boarding, High diving (above 5 meters), Horse racing, Horse riding and Jumping, Hot air ballooning, Hunting on Horseback, Hunting/Shooting, Hurling, Ice and Street Hockey, Ice climbing, Ice skating, Ice speedway, Jet boating, Jet Skiing, Jousting, Judo, Karate, Kayaking, Kendo, Kite Skiing, Kite Surfing/Land boarding/buggying, Lacrosse Luge/ Tobogganing, Luging, Manual Labour, Marathon running, Martial Arts, Micro – lighting, Modern pentathlon, Motor cycle racing (All types), Motor rallying, Mountain biking, Mountain Boarding, Mountain Running, Mountaineering/ Rock climbing, Orienteering (Involving climbing), Parachuting, Paragliding/ Parapenting, Parasailing, Parascending (Over land and water), Parkour/Parcours/Free Running, Piloting aircraft or learning to pilot an aircraft, Point to Point, Polo, Power boat racing, Powerlifting, Professional sports of any kind, Quad biking/all terrain vehicles, Rifle range shooting, River boarding, River boardings, River bugging, Rock scrambling, Rodeo, Roller hockey, Rugby, Running of the bulls, Safari tours, Sail boarding (racing/high speed/extreme), Sailing, Sand boarding, Scuba Diving, Shark feeding/cage diving, Skate boarding, Ski acrobatics, Ski doo Ski jumping, Ski racing, Sky diving, Small bore target shooting, Snorkelling, Snow mobiling, Snow Skiing, Snowboarding, Speed trials/ Time trials, Steeple Chasing, Surfing, Team Sports played in competitive contest, Tomb stoning/cliff diving/quarry diving, Trial bike riding, Triathlon, Tubing on snow, Tubing, Wakeboarding, War games(non-armed forces), Water skiing or Water Ski jumping, Weight Lifting, Wrestling, White or black water rafting, White water kayaking, Wind surfing, Yachting, Zip Line, Zorbing and Hydro-zorbing and activities of similar nature.
3. **Bodily Injury** / **Injury** means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
4. **Condition Precedent** shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
5. **Disclosure to information norm**: 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.
6. **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-existing diseases. Coverage is not available for the period for which no premium is received.
7. **Insured Person** means the person named in the Policy Schedule/ Certificate of Insurance

8. **Medical Practitioner/ Physician/Doctor** 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.
9. **Migration** means, the right accorded to 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
10. **Nominee** means a person selected by the policyholder to receive the benefit in case of death of the insured thus giving a valid discharge to the insurer on settlement of claim under an insurance policy.
11. **Notification of Claim** means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication.
12. **Permanent Total Disability** shall mean either of the following:
    a. Total Paralysis
    b. Total and irrecoverable loss of sight of both eyes, or
    c. Actual Loss by physical separation of two Limbs (both hands or both feet or one hand and one foot), or
    d. Total and irrecoverable loss of use of two Limbs (both hands or both feet or one hand and one foot),
    e. Total and irrecoverable loss of sight of one eye and physical separation of or Total and irrecoverable loss of use a limb (either one hand or one foot), or
    f. Total and irrecoverable loss of speech and hearing of both ears

    For the purpose of this benefit,
    a. Total Paralysis means complete and irreversible loss of motor function leading to the total loss of function of the entire body from neck down due to an accidental injury to the spinal cord.
    b. Limb means a hand at or above the wrist or foot above the ankle.
    c. Physical separation means separation of limb(s) from the body above the wrist and/or ankle.
    d. Total & irrecoverable loss of Use of limb(s) means complete and irreversible loss of functional, normal or characteristic use of the hand or foot provided loss of use continues for a period of 180 days from the onset of loss of use and at the expiry of 180 days there is no reasonable medical hope of improvement.
13. **Permanent Partial Disability** - Medical practitioner certified total and irrecoverable loss of sight of one eye, or total and irrecoverable loss of use of a hand or a foot.
14. **Policy** means the proposal, the Policy Schedule/ Certificate of Insurance, the Policy documents and any endorsements attaching to or forming part thereof either on the effective date or during the Policy Period.
15. **Policy Period** means the period between the commencement date and the expiry date specified in the Policy Schedule /Certificate of Insurance and includes both the commencement date as well as the expiry date
16. **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
17. **Renewal** defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time bound exclusions and for all waiting periods.
18. **Schedule** means the Schedule attached to and forming part of this Policy.
19. **Sum Insured** means the amount as opted by You and as stated in the Policy schedule/ Certificate of Insurance as the total sum insured or limited to the specific insurance details in any section of this policy. The Sum Insured shall be subject at all times to the terms and conditions of the Policy, including but not limited to the exclusions and any additional limitations noted in the wording of each section.
20. **Terrorism or act of Terrorism** means an act or series of acts, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), or unlawful associations, recognized under Unlawful Activities (Prevention) Amendment Act, 2008 or any other related and applicable national or state legislation formulated to combat unlawful and terrorist activities in the nation for the time being in force, committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public or any section of the public in fear for such purposes.

21. **We, Our, Ours, Us** means the Go Digit General Insurance Limited.
22. **You, Your, Yourself, Policyholder, Insured, Insured member(s), Insured Person(s)** means the Individual Group Members who will be treated as Insured beneficiary both Named and Unnamed as described in the Policy Schedule/Certificate of Insurance.

B. COVERAGE

If the Insured person shall sustain any Bodily Injury resulting solely and directly from Accident, then We shall pay to the Insured / nominee / assignee (as applicable) the sum hereinafter set forth:

a. **Death**: We will pay 100% of the Sum Insured as stated in the Policy schedule/ Certificate of Insurance in the event of Accidental Bodily Injury causing the Insured's death within 12 months of the Accidental Bodily Injury being sustained.

Additional Benefit under Death Cover

Disappearance: We shall be liable to be pay under this benefit, if the Insured Member's full body cannot be located within a period of consecutive twelve (12) months, following a forced landing, stranding, sinking, or wrecking of a Common Carrier in which such Insured Member was known to have been travelling as a fare paying passenger or in any event arising as a result of Act of God Perils during the Policy Period, where it is reasonable to believe that such Insured Member has died as a result of an Accidental Injury.

b. **Permanent Total Disability**: In the event of Accidental Bodily Injury causing the Insured's Permanent Total Disability within 12 months of the Accidental Bodily Injury being sustained, We will pay 100% of the Sum Insured as stated in the Policy schedule/Certificate of Insurance

c. **Permanent Partial Disability**: In the event of Accidental Bodily Injury causing the total and irrecoverable loss of sight of one eye, or total and irrecoverable loss of use of a hand or a foot, We will pay 50% of the Sum Insured stated in the Policy Schedule/ Certificate of Insurance.

It is also hereby further expressly agreed and declared that upon payment of claim under the benefit, the Total Sum Insured shall stand reduced by the amount paid under the said claim.

C. EXCLUSIONS

Digit Simplification: We believe in being transparent with you, no hidden terms and conditions. So, here's what you are not covered for:

No payment will be made by Us for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following:

1. **Breach of Law with Criminal Intent, Suicide and Self-Injury**

   We do not cover any accidental bodily injury arising from or contributed or aggravated or accelerated by any of the following:

   a. Suicide or attempted suicide, while sane or insane, or due to use, misuse or abuse of narcotic or intoxicating drugs or alcohol or solvent
   b. Intentional self-injury
   c. Use or consumption of narcotic or intoxicating drugs or alcohol or solvent, or taking of drugs (except under the direction of a Medical Practitioner)

2. **Pre-Existing Condition-** Any accidental bodily injury or disablement arising out of or contributed by or traceable to any disability existing on the date of issue of this Policy.

3. **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. Please refer definition of Hazardous or Adventure Sports as provided in the policy document.

However, You would be covered if you participate in a non-professional capacity for any recreational sport which may be under the supervision of a trained professional.

4. **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.

5. **War and hazardous substances**
   We do not cover treatment directly or indirectly arising from or required as a consequence of:
   a. War, invasion, acts of foreign enemy hostilities (whether or not War is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, attempted overthrow of Government; or
   b. Chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel; or
   c. any acts of terrorism.

6. **Legal Liability**
   Any Legal Liability due to any errors or omission or representation or consequences of any action taken on the part of any Hospital or Medical Practitioner.

7. **Insufficient Document**
   Under **"General Condition No. 28 - Claims Notification and Procedure"**, We have provided list of relevant necessary documents to be submitted at the time of claim. We shall not be liable to pay any claim in case all the relevant necessary documents are not submitted to Us and further We shall settle or reject a claim, as may be the case, within thirty days of the receipt of the last necessary document.

8. **Defence Operation**
   We will not pay any claim under this Policy, whilst You are involved in naval, military, air force operation.

D. CONDITIONS

CONDITIONS PRECEDENT TO THE CONTRACT

***Digit Simplification:* There are some more conditions you should be aware of that we considered before we issued you the policy.**

1. **POLICY PERIOD**
   The Policy can be issued for tenure of 1 year. However, in case of Credit Linked Policy, policy tenure can be extended up to 5 years subject to maximum of Loan Period. Short term policy (ie. Less than 1 year) can also be issued for specific events.

2. **DISCLOSURE OF INFORMATION**
   a. 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.
   b. "Material facts" for the purpose of this policy shall mean all relevant information sought by the Company in the proposal form and other connected documents to enable it to tale informed decision in the context of underwriting the risk.

3. **ALTERATIONS TO THE POLICY**
   This Policy constitutes the complete contract of insurance. This Policy cannot be changed or edited by anyone (including an insurance agent or intermediary) except Us (subject to necessary approval from the Insurance

Regulatory and Development Authority of India), and any change We make will be through a written endorsement signed and stamped by Us, only on the request from Group Manager/ Insured Member.

4. 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.

5. NON-DISCLOSURE OR MISREPRESENTATION

Digit Simplification: ***In one line, this condition means, make sure all the information you share with us is correct!***

If at the time of issuance of Policy or during continuation of the Policy, the information provided to Us in the proposal form either physically or electronically 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 i.e. from the inception date or the renewal date (as the case may be),
b. or the Policy may be modified by Us, at Our sole discretion, upon 30 days' notice by sending an endorsement to Your address shown in the Policy Schedule;
c. the claim under such Policy if any, shall be rejected/repudiated forthwith.

6. INSURED PERSON

a. Only those persons named as an Insured Person in the Policy Schedule / Certificate of Insurance shall be covered under this Policy.
b. You can add more persons during the Policy Period but only after payment of an additional premium and subject to acceptance of Proposal by Us (wherever necessary) and after We have issued an endorsement confirming the addition of such person as an Insured Person.

7. ASSIGNMENT (IF OPTED) –IT IS HEREBY DECLARED AND AGREED THAT:

a. From the Policy Start Date, the monies payable by the Company to the Insured and all rights, title, benefits and interest of the Insured under this Policy stand assigned in favour of the Bank or Financial Institution as named in the Policy Schedule;
b. upon any monies becoming payable under this Policy the same shall be paid by the Company to the Bank or Financial Institution as named in Policy Schedule, without any reference/ notice to the Insured, but not exceeding any outstanding liability of the Insured towards the assignee. In the event of any monies payable under this Policy exceeding the outstanding liability of the Insured towards the assignee, the Company shall pay such monies as exceeding the outstanding liability to the Insured and/or nominee;
c. the receipt of such monies in the manner aforesaid by the Bank or Financial Institution as named in the Policy Schedule and the Insured shall completely discharge the Company from all liability under the Policy and shall be binding on the Insured and the heirs, executors, administrators, successors or legal representatives of the Insured, as the case may be.

8. 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. ELECTRONIC TRANSACTIONS

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

CONDITION APPLICABLE DURING THE CONTRACT

***Digit Simplification:* There are some more conditions you should be aware of during the contract!**

10. SPECIAL CONDITIONS APPLICABLE FOR POLICIES ISSUED WITH PREMIUM PAYMENT ON INSTALMENT BASIS

If the insured person has opted for Payment of Premium on an instalment 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. Grace Period of 15 days would be given to pay the instalment premium due for the Policy.
b. During such grace period, Coverage will not be available from the due date of instalment premium till the date of receipt of premium by Company.
c. 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.
d. No interest will be charged If the instalment premium is not paid on due date.
e. In case of instalment premium due not received within the grace Period, the Policy will get cancelled.
f. In the event of a claim, all subsequent premium instalments shall immediately become due and payable.
g. The company has the right to recover and deduct all the pending instalments from the claim amount due under the policy.

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 affected.

12. WITHDRAWAL OF PRODUCT

a. 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.
b. 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. 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. MATERIAL CHANGE / CHANGE OF OCCUPATION

The Insured/ Insured Member shall immediately notify the Company in writing of any material change in the risk or change in business or occupation during the Policy Period. Insured should also at his own expense take

precautions as circumstances may require ensuring safety thereby containing the circumstances that may give rise to a claim. The Company may adjust the scope of the cover and/or the premium, if necessary, accordingly. The above notification is not mandatory when only the employer changes, but the nature of occupation does not change.

15.NO CONSTRUCTIVE NOTICE

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

16.SPECIAL PROVISIONS

Any special provisions subject to which this policy has been entered into and endorsed in the policy or in any separate instrument shall be deemed to be part of this policy and shall have effect accordingly.

17.SPECIAL CONDITIONS RELATING TO GROUP POLICY

All group policies are subject to the following conditions:

a. The insured will maintain sufficient deposit or provide a Bank Guarantee to comply with the requirement of section 64VB.
b. New names can be added to the existing group policies by charging premium for the unexpired period of insurance as mutually agreed between Group Manager and Us.
c. For deletion of names from Group Policies during the Policy Period, refund of premium as mutually agreed between Group Manager and Us can be allowed only if there is no claim in respect of the particular insured Person as on date when request for deletion of name has been received

18.ADDITION /DELETION OF INSURED PERSON(S)

a. No person other than those persons named as the Insured Person(s) or those categories of the Insured specified in the Policy Schedule/ Certificate Of Insurance shall be covered under this Policy unless and until his/her name or the category has been notified in writing to the Company, any additional premium due has been paid and the Company's agreement to extend cover has been indicated by it issuing an endorsement confirming the addition of such person or category of persons as an Insured
b. Cover under this Policy shall be withdrawn from any Insured Person(s) named or any category of persons Insured immediately upon the Policyholder delivering written notice of the same to the Company.

19.CANCELLATION

i. Cancellation by You

a. 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

Cancellation Scale

Period in Risk	Premium Refund based on Policy Term				
	More than or equal to 12 months but Less than 18 months	More than or equal to 18 months but less than 30 months	More than or equal to 30 months but less than 42 months	More than or equal to 42 months but less than 54 months	More than or equal to 54 months but less than equal to 60 months
Within 3 months	60.0%	60%	60%	60%	60%
Exceeding 3 months but less than 6 months	50.0%	55%	55%	55%	55%
Exceeding 6 months but less than 9 months	40.0%	45%	50%	50%	50%

Exceeding 9 months but less than 12 months	25.0%	40%	45%	50%	50%
Exceeding 12 months but less than 15 months	15.0%	35%	40%	45%	45%
Exceeding 15 months but less than 18 months	5.0%	25%	35%	40%	45%
Exceeding 18 months but less than 21 months	NA	20%	30%	35%	40%
Exceeding 21 months but less than 24 months	NA	15%	25%	35%	35%
Exceeding 24 months but less than 27 months	NA	5%	20%	30%	35%
Exceeding 27 months but less than 30 months	NA	0%	20%	25%	30%
Exceeding 30 months but less than 33 months	NA	NA	15%	25%	25%
Exceeding 33 months but less than 36 months	NA	NA	10%	20%	25%
Exceeding 36 months but less than 39 months	NA	NA	5%	15%	20%
Exceeding 39 months but less than 42 months	NA	NA	0%	15%	20%
Exceeding 42 months but less than 45 months	NA	NA	NA	10%	15%
Exceeding 45 months but less than 48 months	NA	NA	NA	5%	10%
Exceeding 48 months but less than 51 months	NA	NA	NA	5%	10%
Exceeding 51 months but less than 54 months	NA	NA	NA	0%	5%
Exceeding 54 months but less than 57 months	NA	NA	NA	NA	0%
Exceeding 57 months	NA	NA	NA	NA	0%

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. CANCELLATION BY US

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.

Note: Please note KYC documents (Photo ID card) shall be required if the premium refund to the Insured Member exceeds a threshold limit of Rs. 1 Lakhs per premium refund.

20. LAW AND JURISDICTION

It is hereby declared and agreed that this contract of insurance and all claims thereunder shall be governed by Indian Law and any legal proceeding in respect thereof shall be raised a competent court of India. All claims shall be paid in Indian Rupees only.

CONDITIONS APPLICABLE WHEN A CLAIM ARISES

***Digit Simplification:* What You should know when You are about to claim**

21. PHYSICAL EXAMINATION

Any medical official or other agent of the company shall be allowed to examine the Insured Person(s) in case of alleged injury or disablement when and as often as may be reasonably be required on behalf of the Company.

22. 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 has made that particular claim, who shall be jointly and severely 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 agents or the hospital/Doctors/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 grounds 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 intension to supress the fact or that such misstatement of or suppression of such material fact are within the knowledge of the Insurer.

23. ARBITRATION

If we have any differences with respect to the claim amount to be paid under this policy, it will be referred to arbitration in accordance with the Indian Arbitration and conciliation act 1996, as amended. The making of an award under such arbitration proceedings shall be a condition precedent for the Company to be liable to make any payment under this policy.

24.COMPLETE DISCHARGE

We will 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. The payment made by Us to the Insured Person or to the Nominee/legal representative or to the Hospital, as the case may be, of any Medical Expenses or compensation or benefit under the Policy shall in all cases be complete, valid and construe as an effectual discharge in favour of Us.

25.RECORDS TO BE MAINTAINED

You shall keep an accurate record containing all relevant medical records and shall allow Us or our representative(s) to inspect such records. You or the Insured Person as the case may be, shall furnish such information as may be required by Us under this Policy at any time during the Policy Period and up to three years after the Policy expiration, or until final adjustment (if any) and resolution of all claims under this Policy.

26.POLICY DISPUTE

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein shall be governed by Indian law and shall be subject to the jurisdiction of the Indian Courts.

27.AUTOMATIC TERMINATION OF COVER FOR INSURED PERSON

The cover for the Insured Member shall terminate immediately in the event of admissible claim and settlement of 100% Sum Insured under "Death" or "Permanent Total Disablement".

28.CLAIMS NOTIFICATION AND PROCEDURE

If the Insured Person meets any accidental injury that may result in a claim under this policy, it is a condition precedent to Our liability under the Policy that below procedure should be followed:

a. Policyholder or the Insured Person or someone claiming on his/her behalf must inform Us in writing immediately and in any event within 30 days from the date of occurrence any accident/incident that may result in a claim and submit all documents to us within 30 days from the date of intimation.
b. Insured Person must immediately consult a Doctor and follow the advice and treatment that he recommends, wherever required.
c. Insured Person must take reasonable steps to lessen the consequence of Bodily injury.

d. Insured Person should allow examination by our medical advisors if we ask for this.
e. Policyholder or Insured Person or someone claiming on his/her behalf must promptly give us documentation and other information we ask for to investigate the claim or our obligation to make payment for it.
f. In case of the Insured Person's death, someone claiming on his/her behalf must inform us in writing immediately and send us a copy of the postmortem report (if conducted) within 30 days.

*__Note:__ There are times when You or any other person who could claim on Your behalf, may be in such a state of hardship, that You or Such other person is unable to give us a notice or file a claim within the prescribed time limit. In such cases, condonation of delay can be done by waiver of conditions (a) and (f) above may be considered where the reason for delay is proved to our satisfaction.

LIST OF CLAIM DOCUMENTS:

In addition to the Duly Completed Claim Form signed by the Insured/Insured's Nominee/Legal Heir & NEFT Details or Cancelled Cheque of the Insured/Insured's Nominee/Legal Heir, ID proof (KYC document) of insured and Nominee, address proof wherever applicable, We need to have the below documents, wherever applicable:

Accidental Death	• Copy of Address Proof (Ration Card or Electricity Bill Copy). • Attested Copy of Death Certificate. • Death Summary/Certificate from the hospital authority (wherever applicable) • Burial Certificate (wherever applicable). • Attested Copy of Statement of Witness, if any lodged with police authorities. (wherever applicable). • Attested Copy of FIR / Panchanama / Inquest Panchanama. (wherever applicable). • Attested Copy of Post Mortem Report (Only if conducted). • Attested Copy of Viscera report if any (Only if Post Mortem is conducted). • Copy of FIR and the missing report filed with Policy (In case of Disappearance) • Attested copy confirming disappearance from appropriate authority following a forced landing, stranding, sinking or wrecking of Common Carrier (in case of Disappearance)
Permanent Total Disablement **Permanent Partial Disablement**	• Attested Copy of disability certificate from relevant government Medical authority. • Attested copy of FIR. (If required) • All Investigation reports confirming the disability. • Complete Treatment record with follow-up documentation. • Disability assessment report from Digit empanelled medical specialist (if required)

PAYING A CLAIM

a. Insured agree that the Company need only make payment when Insured or someone claiming on Insured's behalf has provided the Company with necessary documentation and information.
b. The Company will make payment to Insured or Insured's Nominee. If there is no Nominee and Insured is incapacitated or deceased, The Company will pay Insured's heir, executor or validly appointed legal representative and any payment The Company makes in this way will be a complete and final discharge of The Company's liability to make payment.
c. On receipt of all the documents and on being satisfied with regard to the admissibility of the claim as per policy terms and conditions, The Company shall offer within a period of 30 days a settlement of the claim to the Insured. Upon acceptance of an offer of settlement by the Insured, 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 cases of delay in

the payment, The Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

d. If the Company for any reasons decides to reject the claim under the policy the reasons regarding the rejection shall be communicated to Insured in writing within 30 days of the receipt of documents. Insured may take recourse to the Grievance Redressal procedure stated in the document.

CONDITIONS FOR RENEWAL OF THE CONTRACT

29. RENEWAL

a. Your policy shall ordinarily be renewable for lifetime except on grounds of fraud, moral hazard or misrepresentation or non- cooperation by You, provided the policy is not withdrawn.

b. We shall not deny the renewal of Your policy on the ground that You had made a claim or claims in the preceding policy years, except for benefit based policies where the policy terminates after the payment of Sum Insured (For Example: Accidental Death, Permanent Total Disablement, Permanent Partial Disablement, Critical Illness, Daily Hospital Cash Cover)

c. If you get delayed in renewing your policy, you can renew it within 30 days from the due date of renewal. Just that the coverage will not be available for such break in period.

d. If the Policy is not renewed within the above Grace Period of 30 days from the due date of renewal, You can still renew the policy with Us. But it will then be issued as a fresh policy, subject to Our Underwriting criteria and no continuing benefits (if any) shall be available from the expired Policy.

30. 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 → Click Here

31. 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.

For Detailed Guidelines on migration, kindly refer the → Click Here

CUSTOMER GRIEVANCE REDRESSAL POLICY

In case of any grievance the insured person may contact the company through
Website : https://www.godigit.com
Toll Free : 1-800-258- 4242
Email: hello@godigit.com
Senior citizens can now contact us on 1-800-258-4242 or write to us at seniors@godigit.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 grievance@godigit.com
For updated details of grievance officer, kindly refer the link: → Click Here

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
Grievance may also be lodged at IRDAI Integrated Grievance Management System- https://igms.irda.gov.in/

The contact details of the Insurance Ombudsman Centers are mentioned below: (Note: Address and contact number of Governing Body of Insurance Council).

Office Location	Contact Details	Jurisdiction of Office (Union Territory, District)
AHMEDABAD	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@ecoi.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@ecoi.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@ecoi.co.in	Madhya Pradesh, Chhattisgarh.
BHUBANESHWAR	Office of the Insurance Ombudsman, 62, Forest park, Bhubaneshwar – 751 009. Tel.: 0674 - 2596461 /2596455, Fax: 0674 - 2596429, Email: bimalokpal.bhubaneswar@ecoi.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@ecoi.co.in	Punjab, Haryana, Himachal Pradesh, Jammu & Kashmir, Chandīgarh.
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@ecoi.co.in	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
DELHI	Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23232481/23213504, Fax: 011 - 23230858 Email: bimalokpal.delhi@ecoi.co.in	Delhi.
GUWAHATI	Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001(ASSAM). Tel.: 0361 - 2132204 / 2132205, Fax: 0361 - 2732937, Email: bimalokpal.guwahati@ecoi.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 - 65504123 / 23312122, Fax: 040 - 23376599, Email: bimalokpal.hyderabad@ecoi.co.in	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
JAIPUR	Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363, Email: Bimalokpal.jaipur@ecoi.co.in	Rajasthan.
ERNAKULAM	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@ecoi.co.in	Kerala, Lakshadweep, Mahe-a part of Pondicherry.

KOLKATA	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@ecoi.co.in	West Bengal, Sikkim, Andaman & Nicobar Islands.
LUCKNOW	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@ecoi.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.: 022 - 26106552 / 26106960, Fax: 022 - 26106052, Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane.
NOIDA	Office of the Insurance Ombudsman, Bhagwan Sahai Palace 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253, Email: bimalokpal.noida@ecoi.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	Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952, Email: bimalokpal.patna@ecoi.co.in	Bihar, Jharkhand.
PUNE	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@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

Note: EXECUTIVE COUNCIL OF INSURERS, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054.Tel.: 022 - 26106889/671/980, Fax: 022 - 26106949, Email: inscoun@ecoi.co.in